This Instruction implements Air Force Policy Directive (AFPD) 41-1, Health Care Programs and Resources and DoD Instruction (DoDI) 1322.24, Medical Readiness Training. It sets procedures for medical readiness planning, training, exercising and reporting in support of the full spectrum of medical operations, including expeditionary, humanitarian assistance, all-hazard response, global health engagement and stability operations. This Instruction applies to Active Component (AC) and air reserve component (ARC) units and may be supplemented at any level, but all direct Supplements must be routed to the Office of Primary Responsibility (OPR) for this publication for coordination prior to certification and approval. Note: The term MAJCOM, when used in this publication, refers to all Major Commands (MAJCOM), Field Operating Agencies (FOA), Direct Reporting Units (DRU), Air National Guard (ANG), unless otherwise indicated. The term “medical unit commander” for AC medical units refers to the MTF Commander. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. In addition, copies of all submitted waiver documents for this Instruction will be provided to the parent MAJCOM/SGX, regardless of Tier waiver approval authority. This publication may be supplemented at any level, but all Supplements must be routed to the OPR of this publication for coordination prior to certification and approval. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). This
Instruction describes processes, which direct the creation of various records using a prescribed form, report, document, or system. This Instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. System of Records notice F036 AF PC C, Military Personnel Records System, applies. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, Recommendation for Change of Publication; route AF Forms 847 from the field through the appropriate functional chain of command.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Significant changes include: reinsertion of the requirement to maintain a medical readiness training and exercises schedule (MRTES); streamlining of roles and responsibilities; reinsertion of Medical Readiness Committee (MRC) frequency and membership requirements; addition of new Comprehensive Medical Readiness guidance; revision of the Medical Contingency Response Plan (MCRP); removal of Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive Emergency Preparedness and Response Course (CBRNE EPRC) language pending publication of DOD guidance.

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Chapter 1

AIR FORCE MEDICAL SERVICE READINESS PROGRAM

1.1. Mission Overview.

1.1.1. The Air Force Medical Service (AFMS) provides seamless health service support to AF and Combatant Commanders (CCDR) and assists in sustaining the performance, health and fitness of every Airman in-garrison and while deployed within the Continental United States (CONUS) or overseas (OCONUS) in support of global operations. This capability is summarized by the phrase “global medical readiness” which includes the full spectrum of medical operations (expeditionary deployment operations, humanitarian assistance, all-hazards response, and global health engagement to support building partnerships and stability operations). It also includes the necessary planning, training, and readiness support functions, such as readiness reporting, associated with these operations. Components of this global system are fully integrated, with forward-deployed health services, and en-route care to facilities providing comprehensive, definitive medical specialty care.

1.1.2. The foundational emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapidly responding modular medical capability, which can be tailored to meet specific requirements. If more definitive care is required, the AF supports an effective “evacuate and replace” policy through aeromedical evacuation (AE) of joint and combined forces. With this focus on preventive medicine, superior health care, and aeromedical evacuation, the AFMS promotes and advocates the optimization of human performance sustainment and enhancement, including the optimal integration of human capabilities with operational systems. To achieve the mission, the AFMS developed processes to support operational strategies, emergency management, medical readiness training, manpower and equipment force packaging, medical readiness resourcing, aeromedical evacuation and global medical operations plans and reporting. The following sections will introduce these areas:

1.2. Operational Strategies.

1.2.1. The AFMS employs multiple planning strategies to ensure capabilities are organized, trained, equipped, and available to meet contingency requirements.

1.2.1.1. Modular Capabilities. The AFMS provides a light, lean, modularized medical capability that can be deployed rapidly to support operations overseas and at home.

1.2.1.2. Most initial medical support begins with either the Global Reach Laydown (GRL) team or the Squadron Medical Element (SME). The GRL unit type code (UTC) FFGRL consists of four personnel and is assigned to the Contingency Response Group (CRG) to provide medical support during rapid opening of contingency airfields. The purpose of the CRG is to bring significant order, foresight, speed, and safety during the critical opening days of a contingency. The SME is a small team embedded within a Line of the AF (LAF) aviation unit, designed to provide aerospace medicine support to an AF flying squadron. This team deploys with the squadron and provides care and initial preventive medicine surveillance. As support to the expeditionary squadron grows, the SME can be augmented with additional capabilities, such as independent duty medical
technicians (IDMTs) and preventive aerospace medicine (PAM) teams. The PAM team provides aerospace medicine support during the opening of a contingency airbase, including performing the GRL role described in this Instruction if that UTC is not tasked. If the bed down site becomes a more permanent operating site or the population at risk (PAR) increases, the AFMS can deploy the Expeditionary Medical Support (EMEDS) system. The scalable nature of EMEDS allows the AF to deploy capabilities from small teams that can provide highly skilled medical care for a limited number of casualties, to a medical system as large as an Air Force Theater Hospital (AFTH) that can provide specialized medical care to a PAR of several thousand.

1.2.1.3. For casualties requiring more definitive care than that provided by the EMEDS, the Global Patient Movement System can provide rapid movement of patients to the appropriate level of care. As a component of the USAF Mobility Air Forces (MAF) system, AE crews provide en-route medical care to stabilized patients during transport on MAF aircraft. Critical Care Air Transport Teams (CCATTs) provide advanced specialty medical capability to evacuate critically ill, injured, or burned patients requiring continuous stabilization and advanced care during transport.

1.2.1.4. These modular capabilities are organized by force modules to complement increases in combat capability. As a bed down grows, predetermined support assets, including medical assets, are deployed to that location. These predetermined modules provide an organized expansion capability, offer predictability to the supporting units, and simplify the planning process.

1.2.1.5. In addition to missions associated with aircraft bed down locations, AFMS forces may deploy in support of stability operations to build partner nation governance and security capacity as well as provide humanitarian aid and disaster relief.

1.2.2. Capabilities-based Planning. The AF has shifted from a programs/platforms mentality to capabilities-based planning. Commanders and their planners identify requirements for specific capabilities not for units, and those capabilities are then associated with trained and available unit type codes (UTCs). In order to quantify capabilities, the Office of the Secretary of Defense (OSD) has directed that all Services observe, assess, and report their units’ ability to perform through mission essential tasks (METs) measured against a specific standard.

1.2.3. AFMS Force Presentation. AFMS personnel assigned to warfighting organizations are placed in either a standard deployable UTC or an associate UTC and given an AEF assignment in accordance with the Medical Resource Letter (MRL) and Medical Readiness Decision Support System (MRDSS). Personnel assigned to institutional force (IF) units (e.g. HAF, MAJCOM, training units) will have an AEF Indicator (AEFI) of X.

1.2.3.1. UTC assigned medical forces are presented as Health Service Support (HSS) Demand Force Teams (DFTs) to meet CCDR requirements and/or AF missions. AC capabilities are managed at a minimum 1:2 deploy-to-dwell ratio and ARC capabilities are managed at a 1:5 mobilization-to-dwell ratio. Medical DFTs are presented in five categories, as described below, to provide the full range of HSS to deployed and in-place warfighters and enable global patient movement with CCATTs and patient staging capabilities.
1.2.3.1.1. Home Station Health Service Support Teams provide and enhance a healthy and fit force including maintaining health/fitness of deployed in-place forces and restoring the physical and mental health of redeployed service members.

1.2.3.1.2. Expeditionary Medical Support Teams provide rapidly deployable medical capability for forward operating locations of varying sizes in support of an Air Expeditionary Task Force or other contingency operations.

1.2.3.1.3. Expeditionary En-route Care Teams provide patient movement capabilities and equipment in support of the global patient movement mission.

1.2.3.1.4. Special Operations Medical Support Teams provide small, highly skilled, tactically trained medical teams that utilize lean and tailored equipment packages in support of US Special Operations Command (USSOCOM) missions.

1.2.3.1.5. The National Guard Homeland Response Force/CBRNE Enhanced Response Force Package (NG HRF/CERFP) provide unique military and civilian life saving capabilities and expertise to assist the Governors in responding to a CBRNE or other mass casualty incident, which may include large numbers of fatalities. These NG HRFs/CERFPs can be available 24 hours a day, 7 days a week for regional or national deployment for response operations. Guidance for the HRF/CERFP mission can be found in NGR 500-4/ANGI 10-2504, National Guard CBRNE Enhanced Response Force Package Management, and NGB HRF/CERFP Yearly Guidance. These documents prescribe policies, procedures, training, and responsibilities governing the deployment and employment of HRF/CERFP in support of the National Guard Homeland Security mission.

1.2.3.2. All UTC assigned personnel will be aligned to a specified HSS DFT and postured in AEF vulnerability periods in accordance with the approved AFMS Prioritization and Sequencing Guidance and the AFMS Medical Resource Letter (MRL).

1.2.4. Constant Deployer Model (CDM). The AFMS supports the Air and Space Expeditionary Force (AEF) strategy and ensures personnel are postured evenly across the AEF. These deployable forces are mainly assigned to large medical treatment facilities using a CDM. The model maximizes laydown of key teams at facilities most able to provide the complex clinical caseload required for clinical currency while simultaneously providing sufficient copies of a UTC to support each AEF vulnerability period. By concentrating deployment capability at large facilities, individuals and teams are able to leverage their home-station responsibilities to maintain readiness currency in individual tasks, and to a large degree, team METs. Additional guidance and information may be found in AFI 10-401, Air Force Operations Planning and Execution, AEF On-line page, and the AFMS Posturing and Sequencing Guide.

1.2.5. Consultant Balanced Deployments (CBD). The CBD concept ensures AEF deployment requirements are met using the most qualified individuals available at any one time from across the AFMS by balancing deployments for their specialty, primarily those considered critical operational readiness Air Force Specialty Codes (AFSC). Additionally, this concept limits interruptions to home station health care and maximizes individual career development and growth. Refer to the AFMS Posturing and Sequencing (P&S) Guidance for additional information.
1.2.6. Stability Operations. The term “stability operations” refers to various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, and provide essential government services, emergency infrastructure reconstruction, and humanitarian relief. The Air Force must be prepared to work with other Services to conduct stability operations throughout all phases of conflict in both combat and non-combat environments. Stability operations may be small or large scale, lasting for the short or long-term.

1.2.6.1. Integrated military and civilian operations are essential to successful stability operations; consequently, the Air Force will collaborate with other Services and US governmental agencies, foreign governments, international government and nongovernmental organizations, and private sector firms as directed to plan, prepare for and conduct stability operations. The AFMS has a critical role in supporting stability operations by providing essential medical services and providing humanitarian assistance.

1.2.6.2. AF medical personnel and capabilities must be prepared to meet military and civilian health requirements in medical stability operations. To meet this requirement, training will be provided to prepare personnel for stability operations in accordance with DoDI 3000.05, Stability Operations, and DoDI 6000.16, Military Health Support for Stability Operations.

1.2.7. Joint Interoperability. The AF fights jointly. In recent years, OSD has reinforced commitment to joint interoperability and joint training in most strategic planning and training documents. This commitment is seen in using METs for training and expanding training opportunities through the use of joint field exercises as training venues for AFMS teams, when appropriate. Teams that are likely to deploy with medical teams from a different Service, or in direct support of a joint operation such as casualty staging and CCATTs, are prime candidates for a joint exercise operation.

1.3. Installation Medical Response.

1.3.1. AF fixed medical facilities worldwide plan for conducting their home station and expeditionary missions simultaneously. Home station missions include protecting the airbase population, reducing harmful effects, assisting in the sustainment of critical missions, facility expansion, which can increase the bed capacity of some MTFs to receive and care for large numbers of casualties; medical surveillance; Chemical, Biological, Radiological, Nuclear (CBRN) detection and analysis; patient decontamination; and medical response/support to contingencies confined to the installation or involving Federal, State, Local, or Tribal agencies, or Host Nation governments, including CBRN incidents.

1.3.2. The AFMS participates in the National Disaster Medical System (NDMS) through Air Force Federal Coordinating Centers (FCCs). AF FCCs are designated MTFs that are responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). PRAs are designated airfields that provide adequate patient staging facilities, local patient transport assets, and patient reception and transport to local voluntary, pre-identified, non-federal, acute care medical facilities capable of providing definitive care for domestic disaster victims. FCCs also serve as Primary Receiving Centers and Secondary Centers capable of receiving, treating, holding, and disbursing military patients resulting from a military or homeland contingency. In
addition, the AFMS provides patient staging to include critical care staging (through a composite capability with Department of Health and Human Services) to prospective evacuees in support of NDMS. It is equipped and staffed with patient care and support personnel for a throughput-planning factor of 140 patients in a 24-hour period per supported Aerial Port of Embarkation (APOE); a total of four (4) APOEs may be established for patient movement operations. Additional information on NDMS can be found on the AF Medical Readiness SharePoint Site.

1.3.3. Air National Guard medical personnel may be tasked to serve at the Joint Force Headquarters (JFHQ) Joint Operations Center as planners and liaison officers to provide state level Defense Support to Civil Authorities (DSCA). To maintain a capability to respond to all contingencies, the ANG relies on highly trained medical warriors and state-of-the-art, light, ruggedized medical equipment. Comprehensive planning and realistic exercises ensure personnel are prepared to support globally integrated operations (GIO).

1.3.4. Overarching guidance for the AF emergency response program and the AF Incident Management System (AFIMS) is contained in AFI 10-2501, *Air Force Emergency Management Program*. Specific details on the AFMS emergency management mission are provided throughout this Instruction and in AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*.

1.4. Comprehensive Medical Readiness Program.

1.4.1. Expeditionary medics must be “Readiness Current” to provide the best care to our patients. The “Readiness Currency Continuum” is built on three interlinking processes: Clinical Currency for Readiness (Category I), Readiness Skills Training (Category II), and Unit Type Code (UTC) Readiness Training (Category III). Each builds upon the other and assumes a capability of experience with which to proceed to the next level.

1.4.2. Readiness currency starts with Clinical Currency, the ability of our medics to provide quality healthcare in support of the readiness mission. Medics build on their clinical currency by adding individual readiness skills that will enable them to perform the functions of their AFSC in a deployed setting. Next is UTC readiness training, which enables medics to execute AFMS expeditionary missions.

1.5. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRA).

1.5.1. To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MEFPAK responsibilities to specific MAJCOM/SGs. Air Combat Command is the MRA for medical ground-based unit type codes (UTCs) and the lead MAJCOM for the Medical Counter-CBRN program. Air Mobility Command is the MRA for en-route care, the Patient Movement Items (PMI) program, and En-route Care Safe-to-Fly program. Air Force Special Operations Command is the MRA for special operations medical UTCs.

1.5.2. Additional MAJCOMs with mission or theater-unique capabilities or requirements may also serve as a MRA with AF/SG3/5X approval. Pilot units work closely with the MRAs to construct UTCs, associated mission capability statements (MISCAPs), and manpower details.
1.6. Medical Readiness Resourcing.

1.6.1. To maintain a robust medical readiness capability, the AFMS manages the funding for training, exercises, personnel and equipment through an internal planning, programming, and budgeting system.

1.6.1.1. Readiness Requirements Planning and Resourcing (RRPR). The goal of the RRPR is to program for and execute Line of the Air Force Working Capital Fund Medical Dental Division, Line of the Air Force O&M, and Defense Health Program (DHP) Medical Resources. The primary objectives of the RRPR process is to: (1) create a knowledgeable, cross-functional decision process that enables and tracks the execution of AFMS readiness programs; (2) capture the AFMS specific capability requirements needed by CCDRs to support joint war fighting medical support, (3) focus resource needs for organize, train and equip functions; (4) provide a validation mechanism to review requirements and apply resources; (5) communicate AF/SG intent regarding application of resources; and (6) provide best possible recommendations to the AF/SG regarding readiness programs.

1.6.1.1.1. Medical Readiness Panel (MRP). The MRP is the AFMS center of expertise for all readiness-specific organize, train, equip and plan functions and serves as the first level of corporate review. The panel is the initial point of entry for issues from PEMs and MRAs that require corporate review. The panel reviews and develops options for presentation to the corporate board. Throughout the year, the MRP focuses upon information collection and meets as required. The MRP is chaired by AF/SG3/5X.

1.6.1.1.2. The MRP ensures resources are provided across the AFMS to create and maintain global response initiatives. Medical readiness resources are provided by Defense Health Programs (DHP) funding for operations and maintenance (O&M) and PMI, and LAF funding for War Reserve Materiel (WRM) and HSMR assets.

1.6.1.2. Business Planning. Medical treatment facility commanders execute a business plan that maximizes the use of assigned personnel and available resources. This strategy allows a commander to plan and execute effective training at a predictable cost in terms of both resources and medical treatment facility production in three ways: readiness case analysis, currency case analysis, and business case analysis. Readiness is a critical element of business planning and should include training requirements, exercise opportunities, and deployment and contingency response obligations.

1.6.1.3. MC-CBRN Resources. The AFMS plans for contingencies that exceed the normal operating capacity of field units. The AFMS utilizes LAF MC-CBRN funds to provide additional materiel needed to execute the mission during these situations. These HSMR assets are presented as 886 allowance standards (AS) for AC and reserve units, and 976 AS for ANG (Attachment 3) to enable standardized logistics and maintenance support. This materiel will continue to be modernized and funded within the DoD Chemical Biological Defense Program (CBDP) and AF Operations & Maintenance (O&M) program element (PE) 28036F (Medical Counter-CBRN) (AC and non-collocated AFRC units) and ANG O&M PE 58036F (MC-CBRN), but will be fielded as all-hazards installation medical response resources in support of the Medical Contingency Response Plan (MCRP), Installation Emergency Management Plan (IEMP) 10-2 or sister
service emergency management (EM) plans, DSCA or local support agreements. LAF funding may only be used to replenish items for shelf life management and to replenish those consumed during contingencies, exercises, and training involving CBRN hazards. Replenishment of AS materiel consumed during contingencies, exercises, and training not involving CBRN hazards will be replenished using appropriate exercise funding or DHP if an MTF Health Services related mission requirement. Note: The term MC-CBRN refers to the funding and resourcing associated with all-hazard home station medical response (HSMR) capabilities/functions.

1.6.1.3.1. For full-time non-collocated AFRC bases, HSMR assets are maintained by the Bioenvironmental Engineering/Public Health Office. For ANG Medical Units, this capability will be assigned under the 976 MC-CBRN program to the full-time medical staff.

1.6.1.3.2. MC-CBRN resources are programmed at the AF/SG and NGB/SG levels by consolidating input from MAJCOMs and DRUs, and advocating for MC-CBRN requirements through the AF Installation and Mission Support Center (AFIMSC) Agile Combat Support Panel and ANG Installation Support Panels.

1.6.2. Unit Medical Operations Resourcing. The unit Medical Readiness Committee (MRC), or Executive Management Committee (EMC) for ARC units, identifies unit readiness training and resource requirements and provides a consolidated document to their respective MAJCOM. For a full discussion of medical resource processes and procedures, see AFMAN 41-120, Medical Resource Management Operations

1.7. Aeromedical Evacuation (AE).

1.7.1. The AFMS partners with the Operations (A3) community to provide global patient movement capability. AMC/A3 provides comprehensive operational AE readiness guidance in AFI 10-2912, Aeromedical Evacuation Readiness Programs, while the SG is responsible for clinical guidance for AE crews and medical/training guidance for SG managed en-route care UTCs. AMC/SG manages WRM medical equipment allowance standards associated with en-route care.

1.7.2. Training, plans, and reporting requirements listed in this instruction for medical units do not apply to AE units.

1.8. Special Command Considerations.

1.8.1. Policy guidance for commanders of Limited Readiness Capability (LRC) units differs from other MTFs in this Instruction. LRC units are medical functional flights and small medical squadrons that do not provide the full scope of readiness capabilities or resources found in a typical Medical Group. Major Command Surgeons identify and designate appropriate units within their MAJCOM as LRC units in Medical Readiness Decision Support System (MRDSS).

1.8.1.1. LRC units are often assigned to non-medical squadrons or to groups (e.g. Air Base Squadrons, Mission Support Groups or Air Base Groups). In some cases, the LRC units may report directly to the wing.
1.8.1.2. Tenant units on bases where at least two Services share resources are considered LRC units. Joint Base MTFs, in which AF is the host unit, are not considered LRC MTFs.

1.8.2. ARC medical units are considered LRC units. This does not include Aeromedical Evacuation (AE) units.
Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Purpose.

2.1.1. This chapter describes roles and responsibilities for Air Force Medical Readiness (MR) programs, including those at the Air Force, MAJCOM, installation and unit levels. It also describes responsibilities of supported and supporting organizations such as the Air Force Inspection Agency, Air Force Expeditionary Medical Skills Institute, and others.

2.2. Air Force Surgeon General (AF/SG). This individual will:

2.2.1. Develop medical policy for SECAF approval and issue guidance and procedures to implement the policy.

2.2.2. Advocate for, obtain, and allocate resources for medical activities.

2.2.3. Continually evaluate AFMS ability to support AF and DoD missions.

2.2.4. Integrate AFMS capabilities with other Air Force and Joint capabilities at the development and execution stages.

2.2.5. Establish and disseminate training and assessment guidance.

2.2.6. Establish the MR Panel by charter to plan, program, and budget for readiness resources.

2.3. Director, Manpower, Personnel and Resources (AF/SG1/8). This individual will:

2.3.1. Establish medical force development guidance.

2.3.2. Provide policy and guidance related to training, recruitment and retention of AFMS personnel.

2.3.3. Establish threshold manning levels required to support contingency requirements using planning tools including the Critical Operational Readiness Requirement (CORR).

2.3.4. Program sufficient forces to meet evolving operational requirements.

2.3.5. Serve as consultant/advisor to the AFMS on the development of training affiliation agreements (TAA) and memoranda of understandings (MOU) for standardized training opportunities in accordance with AFI 41-108, Training Affiliation Agreement Program.

2.4. Director, Medical Operations and Research (AF/SG3/5). This individual will:

2.4.1. Develop medical readiness doctrine, guidance, and policy. Publish and maintain associated directives.

2.4.2. Recommend medical readiness strategies to the AF/SG.

2.4.3. Ensure Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA) is maintained and funded, and continues to be enhanced as AFMS mission requirements evolve.

2.4.4. Formulate the AFMS AEF strategy and provide policy and guidance related to UTC posturing, and medical force presentation.
2.4.5. Publish the Medical Resource Letter (MRL), identifying AFMS UTC and HSMR assemblage apportionment.

2.4.6. Designate the Chief, Expeditionary Medical Policy and Operations (AF/SG3/5X) to:

2.4.6.1. Maintain the MRL, ensuring expeditionary medical capabilities are balanced across the entire AEF.

2.4.6.2. Coordinate with MAJCOM medical functional area managers (FAMs) to ensure maximum support of the AFMS UTC posturing strategy.

2.4.6.3. Provide functional oversight and guidance to MAJCOM/SGXs on all aspects of medical readiness, to include policies, procedures, and publications; deployment and operational information and taskings; training development and opportunities; installation medical response guidance; and resource allocation.

2.4.6.4. Provide MAJCOM/SGXs with two-year notional deployment tasking visibility, as generated in the Agile Combat Support-Consolidating Processing System.

2.4.6.5. Provide functional guidance and oversight of the Consultant Balanced Deployment (CBD) program.


2.4.6.6.1. Collect, track and evaluate change requests and publish changes to this Instruction as mission dictates.

2.4.6.6.2. Update, coordinate and maintain the Medical Readiness Self-Assessment Communicator (SAC).

2.4.6.7. Through the respective MAJCOMs, identify specific MTFs to operate as Laboratory Response Network (LRN) laboratories.

2.4.6.8. Chair the Medical Readiness Panel (MRP). Provide oversight of the RRPR Process including: (1) Management of the program objective memorandum (POM) requirements change process; (2) Managing POM requirements in the POM Grid application across the Fiscal Years to reflect approved changes; and (3) Reconciliation of POM requirements to the MRL and identification of disconnects to the MRAs for correction of the MRL.

2.4.6.9. Establish the Medical Readiness Decision Support System (MRDSS) Configuration Control Board (CCB) by charter. The MRDSS CCB validates and prioritizes proposed baseline software changes.

2.4.6.10. Establish the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements. The Exercise Oversight Working Group (EOWG) will, as an RTOC sub-working group, plan, coordinate and oversee the AFMS exercise program. The RTOC and EOWG charter can be found on the AF Medical Readiness SharePoint site. Units with unique or extensive
exercise requirements beyond the scope of unit funding may submit their proposals through their MAJCOM/SGXs to the RTOC for consideration.

2.4.6.11. Appoint a member of the AF/SG3/5X staff as the Medical Readiness (MR) Panel Program Element Manager (PEM) for Defense Health Program (DHP). The MR Panel PEM is the primary advocate for medical readiness funding and supports the PMI program, RTOC, MRDSS CCB, and the International Health Specialist (IHS) program. The MR Panel PEM will:

2.4.6.11.1. Coordinate on all Medical Readiness programs, using all aspects of the AF Planning, Programming, Budgeting, and Execution System (PPBES) process, for both manpower and financial requirements.

2.4.6.11.2. Provide all MR Programs’ requirements to the MR Panel for approval and submit the Panel’s recommendations to the AFMS Group and, when applicable, on through the AFMS Corporate process.

2.4.6.11.3. Provide annual FINPLANs for all budget activity numbers to the MR Panel Chair to include analyses and recommendations for the coming fiscal year.

2.4.6.12. Appoint a PEM for LAF Program Element (PE) 28036f, on behalf of the AFMS, for MC-CBRN program funding throughout all aspects of the AF Planning, Programming, Budgeting, and Execution System (PPBES) process. The MC-CBRN PEM will:

2.4.6.12.1. Provide MC-CBRN programming requirements to the Medical Readiness Panel for approval, per recommendation by HQ ACC/SGXH, as lead MAJCOM, with oversight by AFMSA/SG3XC.

2.4.6.12.2. Advocate for sustainment requirements through AF/A4 and the AFIMSC for garrisoned airbases.

2.4.6.12.3. Upon initial distribution, facilitate flow of MC-CBRN funds programmed for sustainment of MTF assemblages and training to MAJCOM comptrollers for further distribution to ABW comptrollers. The PEM will forward funding to program execution offices to process funding documents for central bills such as maintenance contracts and central procurement items according to ACC/SGX execution year priorities, as approved by AFMSA/SG3XC.

2.4.6.13. Appoint a PEM for AFMS War Reserve Materiel (WRM) that provides Air Force Working Capital Funds (Fund Code 4930) for UTC materiel requirements and LAF Operating and Maintenance funding (Fund Code 30) for maintenance and sustainment support services. The PEM will:

2.4.6.13.1. Serve as the primary advocate addressing issues and coordinating functional concerns across various staffs.

2.4.6.13.2. Facilitate an annual portfolio management workgroup meeting each December to produce the AFMS WRM Prioritized POM Position (PPP) with the outcome documented in the AF Medical Logistics Web enabled Spend/Production Plan database application.

2.4.6.14. As the Associate Corps Chief for Readiness:
2.4.6.14.1. Work with AF/A3OD to establish and periodically review criteria for award of the “R” AFSC prefix for medical personnel, for inclusion in the AF Officer Classification Directory (AFOCD) and AF Enlisted Classification Directory (AFECD).

2.4.6.14.2. Develop a process to identify MAJCOM, Component Numbered Air Force (C-NAF), Joint, Air Staff, and other staff positions eligible for the “R” AFSC prefix.

2.4.6.14.3. Establish a process to periodically review both R-coded positions and R-coded personnel. Revocation of a person’s R prefixed AFSC will be coordinated with the member’s commander and local Military Personnel Section.

2.4.6.15. Advocate for, obtain, and allocate resources for medical readiness activities, including training.

2.4.6.16. Provide functional guidance and assistance to MAJCOM/SGXs on all aspects of medical readiness, to include decisions, procedures, and publications; deployment and operational information and taskings; training development and opportunities; Defense Critical Infrastructure Program (DCIP); installation medical response guidance; HSMR oversight; Emergency Management guidance, Defense Support of Civil Authorities (DSCA) guidance, NDMS to include FCCs and resource allocation, to include equipment funding.

2.4.6.17. Provide recommendations to AFMOA/SGAL on procuring, storing, sustaining, reporting, and updating Medical Readiness program equipment and supplies.

2.4.6.18. Provide policy guidance for the Comprehensive Medical Readiness Program (CMRP).

2.4.6.19. Collaborate with HAF, joint, and ASD (HA) offices to analyze strategic guidance in support of concepts and strategies to counter CBRN threats.

2.4.6.20. Advise AF/SG on international health strategy, current operations, and other pertinent international health issues to support the Air Force medical service force development process, and represent AF/SG in matters related to international health, as requested. Organize, train and equip AF medical service members assigned to full-time international health specialist positions assigned to the MAJCOM, NAF and GCC regions.

2.4.6.21. Advise AF/SG on doctrine, lessons learned, and futures analysis issues to support Air Force Medical Service programs. Supports medical TTP/doctrine development, collects and disseminates medical lessons learned, and synthesizes national strategic guidance into AFMS concepts.

2.4.6.22. Conduct an AFMS post-deployment questionnaire to obtain feedback from recently deployed personnel concerning their deployment training and preparation. Provide feedback from post-deployment questionnaires to appropriate POCs for resolution and track open items to resolution.

2.4.6.23. Provide a forum for MAJCOMs to present lessons learned and assist in vetting lessons learned to the appropriate working group, organization, or governing body to manage resolution.
2.5. Air Force Personnel Center Medical Directorate (HQ AFPC).

2.5.1. The Directorate of Personnel Operations (DP2) will:

2.5.1.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and other continuing education credit for medical readiness training courses.

2.5.1.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

2.5.2. The Directorate of AEF Operations (DPW) Functional Area Scheduler will:

2.5.2.1. Identify/recommend any changes to the UTC alignment.

2.5.2.2. Source UTCs using available tools, including MRDSS ULTRA, following applicable sourcing rule sets to meet all CCDR crises, rotational, and individual augmentation requirements as stated in time-phased force deployment data (TPFDD).

2.5.2.3. After consulting with the AFMS Functional Area Manager (FAM) use the MAJCOM coordinated and AF/SG approved battle rhythm to source CCDR crisis response requirements, and/or AF/SG3/5X approved rotational taskings.

2.5.2.4. Track residual capability and notify HQ ACC/SGX, AFMS FAM, AF/SG3/5XO (Medical Operations Center), and MAJCOM FAMs when surge operations are required.

2.6. Component Numbered Air Force (C-NAF) Surgeons. These individuals will:

2.6.1. Determine operational and rotational UTC deployment requirements and enter them into the TPFDD.

2.6.2. Coordinate changes in operational requirements with AF/SG3/5X to facilitate sourcing.

2.6.3. Periodically review and validate plan requirements as part of the RRPR process.

2.6.4. Execute medical readiness missions in support of C-NAF and Combatant Command theater plans.

2.6.4.1. Comply with Joint and Air Force deployment guidance and deconflict operational guidance as needed.

2.6.4.2. Coordinate International Health Services (IHS) capability (AD or ARC) in support of theater health engagement activities in accordance with AFI 44-162, International Health Specialist (IHS) Program.

2.6.5. Assess the effectiveness of deployed medical operations.

2.6.5.1. Conduct periodic assessments of Deployed MTFs in enduring operations for more than two years with permanent (365 days), and other facilities as deemed appropriate by the C-NAF/SG. Scheduling is subject to CCDR approval and Area of Responsibility (AOR) activity.

2.6.5.2. Conduct the assessments using the Deployed MTF Functional Verification and Hand-off Tool. Utilize subject matter expertise from outside agencies, including AFIA, AFMOA, HAF, MAJCOM, and/or MRA, as required, to fill specifically identified functional knowledge gaps.
2.6.6. Evaluate Building Partnerships, Building Partnership Capacity, and Stability Operations against developed measures of effectiveness. Measures of effectiveness must be linked to a specified end state objective and be specific, measurable, attainable, realistic, and timely.

2.6.7. Ensure lessons learned are identified via Joint Lessons Learned Information System (JLLIS) to inform higher headquarters of capability gaps and deficiencies that may require changes to existing organize, train, and equip policies and functions.

2.6.8. Provide guidance for reporting unit operational status, availability, and patient care capabilities during contingency operations.

2.7. Air Force Medical Operations Agency (AFMOA). This organization will:

2.7.1. Provide oversight to AFMS consultant and career field manager (CFM) functions.

2.7.2. Support Comprehensive Medical Readiness Program (CMRP) by forming and chairing the AFMOA CMRP Committee to review Category I and II criteria and approve or disapprove CMRP checklist changes. Maintain the CMRP flowchart (Criteria for Creating/Reviewing CMRP Items) on the AF Medical Readiness SharePoint Site. The AFMOA CMRP Committee will be chartered by the AFMOA/CC.

2.7.3. Support Consultant Balanced Deployment (CBD) functions.

2.7.4. Provide funding, management direction and oversight in support of WRM Consolidated Storage and Deployment Center (CSDC) operations in accordance with established memorandum of understanding (MOU).

2.7.5. Provide medical logistics policy, procedures, management, and execution for medical contingency materiel programs in accordance with AFI 41-209, Medical Logistics Support, and AFI 41-201, Managing Clinical Engineering Programs.

2.7.6. Provide policy, guidance and requirements management for the AFMS WRM Force Health Protection Program, which includes the Biological and Chemical Warfare countermeasures and Anti-Malaria programs.

2.7.7. Manage and execute the AFMS WRM FY Spend Plan Production Plan.

2.8. Consultants, Corps Directors and Air Force Career Field Managers (CFM). These individuals will:

2.8.1. Provide functional support for the Comprehensive Medical Readiness Program (CMRP). (T-1) They will develop Category I and Category II training criteria. The CMRP checklists are divided into two categories, Category I, Clinical Currency for Readiness, and Category II, Readiness Skills Training.

2.8.1.1. Determine critical knowledge and performance skills required for deploying personnel. Determine CMRP task training frequency requirements considering the AEF deployment cycle, training platform constraints, the perishability of required skills, duration of associated certifications, and lessons learned.

2.8.1.2. Determine which CMRP checklist tasks require Sustained Medical and Readiness Training (SMART) Regional Currency Site (RCS) or Centers for Sustainment of Trauma and Readiness Skills (C-STARS) attendance and, in coordination with
USAFSAM and develop RCS and C-STARS curricula. CMRP checklists for clinical specialties will describe how and where Category I clinical currency training requirements will be met.

2.8.1.3. Develop, maintain, refine and validate CMRP checklists and training sources utilizing the CMRP flowchart provided on the AF Medical Readiness SharePoint Site. Submit updated CMRP checklists to the AFMOA CMRP Committee for vetting prior to publication.

2.8.1.4. Notify the Air Force Expeditionary Medical Skills Institute (AFEMSI) when CMRP checklists have been updated and approved by the AFMOA CMRP Committee. Provide implementation guidance in memo form, for dissemination to the field. The implementation memo should include, at a minimum: suggested methods for accomplishing new tasks that may exceed capabilities at some MTFs; alternate sources of training credit; and an implementation timeline. Personnel are normally given six months to complete training on new tasks unless the new tasks address a critical training or capability shortfall, in which case specific guidance must be provided.

2.8.1.5. Review CMRP checklists annually for currency and provide changes or status update to AFEMSI on the anniversary date of the existing checklist.

2.8.1.6. Review the global/consultant CMRP training gap analysis report in MRDSS ULTRA quarterly to monitor gap analyses inputted by unit AFSC functional training managers. Maintain a list of current training sources, which may include venues such as C-STARS platforms or SMART RCS, and facilitate completion of CMRP training gaps.

2.8.1.7. Review post-deployment questionnaires containing CMRP training feedback. Identify potential training deficiencies and identify corrective actions, such as changes to existing CMRP checklists and implement required corrective actions or changes.

2.8.1.8. Manage requests for CMRP training exemptions on a case-by-case basis and update approved exemptions in MRDSS ULTRA

2.8.2. Reference Chapter 5 of this Instruction for additional CMRP guidance.

2.9. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRA). These agencies will:


2.9.2. Develop and maintain UTCs to meet operational requirements. Appoint pilot units for each UTC. Pilot units may be medical organizations outside the MRA with coordination of the gaining MAJCOM/SG. Develop UTC METs based on force module packaging or for stand-alone UTCs, and will incorporate them into the appropriate MRA Playbook. MRAs and Pilot Units will select DoD standardized supply and equipment items to satisfy the clinical and operational needs of assigned UTCs in accordance with AFI 41-209 and DoDI 6430.02, Defense Medical Materiel Program.

2.9.3. Prepare a playbook for each UTC, consolidating incremental UTCs into a single playbook for each medical force package, as appropriate. The playbook will serve as a consolidated resource for all information regarding the UTC, to include: personnel and equipment detail; mission capability; concept of operations (CONOPS); tactics, techniques,
and procedures (TTP); individual UTC weapons and arming requirements; mission essential
task lists (METL).

2.9.4. Manage WRM UTC requirements; provide operational oversight and direction of
WRM stored at AFMS Consolidated Storage and Deployment Centers (CSDC); verification
of CCDR deployment taskings; recommendations and input to Readiness Requirements
Planning and Resourcing Process. Participate and support WRM CSDC operations in
accordance with established MOUs.

2.9.4.1. Verify CCDR requirements and task assets for deployment as necessary in
coordination with the CSDC WRM managers and associated wing installation
deployment officers.

2.9.4.2. Coordinate requests to store and manage additional UTCs at CSDC and MTF
locations with the MAJCOM/SGX, AFMOA/SGALX and the MTF/CC.

2.9.4.3. Maintain control, oversight, configuration management, and tasking authority
for WRM managed and maintained at the CSDCs.

2.9.4.4. Coordinate with AFMSA/SG3X and AFMOA/SGALX all requests to deploy a
WRM UTC for training or exercises.

2.9.4.5. Provide recommendations and input to the WRM spend plan process to ensure
appropriate funding to support sustainment, reconstitution, modernization and production
requirements of UTCs.

2.9.5. Develop Category III training requirements for each UTC or platform.

2.9.5.1. Identify funding requirements for training and exercises to the RTOC, EOWG
and AFMSA/SG3X as appropriate.

2.9.5.2. Designate an MRA level training scheduler for the Formal Training
Management Scheduler (FTMS) within MRDSS ULTRA.

2.9.6. Coordinate with appropriate joint training agencies, Air Force agencies, and
MAJCOM/SG to ensure the AFMS participates in major exercises, including Joint Chiefs of
Staff (JCS) exercises, in accordance with AFMS guidance.

2.9.7. Plan and coordinate field development evaluations as necessary for the possible
fielding of UTC, platforms, or installation response equipment with the pilot unit, other
MAJCOM/SGXs, AFMSA/SG3X or operational test agencies, as appropriate.

2.9.8. Identify procurement and sustainment lifecycle costs in coordination with
AF/SG3/5X, AFMSA/SG3X and AFMOA/SGALX.

2.9.9. Coordinate timelines and provide oversight and guidance on UTC development and
modernization to designated pilot units.

2.9.9.1. Identify pilot unit responsibilities in writing, outlining processes associated with
program modernization or enhancements.

2.9.9.2. Ensure pilot units review UTC weapons requirements biennially. Update the
Weapons and Munitions Forecasting Table for AFMS UTCs on the AF Medical
Readiness SharePoint Site as necessary.
2.9.10. Ensure medical readiness requirements are represented in Combat Air Forces/Mobility Air Forces/Special Operations Forces (CAF/MAF/SOF) and AFMS strategic planning; AFMS sponsored medical modernization Research and Development efforts; AFMS and Line Program Objective Memorandum development/deliberations; integrated product teams and High Performance Teams capability gaps and requirement identification.

2.9.11. Annually, meet with each component to collect the required information necessary to establish their Total Demand List (TDL). The TDL will include ALL requirements cited in all CCDR plans. At least once every two years MRAs will conduct a face-to-face meeting with each component and conduct a detailed assessment of CCDR plans to ensure all requirements are accurately described and accounted for on the TDL. Any theater operational requirement not currently a part of the AFMS deployable capability should be included as well.

2.9.12. Apply AF/SG strategic planning guidance, derived from Joint Strategic Capabilities Plan (JSCP), War and Mobilization Plan (WMP), and Defense Planning guidance (DPG), to the TDL to arrive at the Readiness Requirements List (RRL). Present recommended RRLs annually to the MRP. The RRL will be vetted and approved by the MRP and coordinated through the AFMS corporate process. The final RRL will be presented to the AF/SG for approval and will become the presentation of forces/capability for the CCDRs and guide resource programming.

2.9.13. Once approved, and prior to the annual WRM portfolio management workgroup meeting, ensure the AF Medical Logistics Web enabled Spend/Production database POM Grid application accurately reflects the most current RRL. Upon approval of the annual WRM portfolio, update the MRL to reflect changes to listed equipment UTCs.

2.9.14. As the lead MAJCOM for HSMR capabilities, ACC/SG will:

2.9.14.1. Develop spend plan for PE 28036F development as well as central maintenance/procurement contract requirements. Maintain HSMR allowance standards, AFTTP, mission essential tasks and operational standards, training requirements and quota management. Oversee PE 28036F spend plan development as well as central maintenance/procurement contract requirements.

2.9.14.2. Provide consultative support to MAJCOMs, including site support visits upon request.

2.9.14.3. Oversee the Response Training and Assessment Program (RTAP). Lead efforts in the development and maintenance of RTAP tools (e.g. Tactical Drill (TD) development and maintenance), RTAP AFMS Knowledge Exchange (Kx) site, and RTAP implementation and training.

2.9.15. As the MAJCOM for PMI and the PMI Program Management Office, AMC/SG will provide funding for centralized procurement/life cycle management, program management direction and oversight in support of PMI Centers, PMI operational support, and training platforms. AMC is also responsible for development and maintenance of the PMI CONOPS and management of the PMI Asset Tracking System.
2.9.15.1. Provide funding for centralized procurement/life cycle management, program management direction and oversight in support of PMI Centers, PMI operational support, and training platforms.

2.9.15.2. Develop and maintain the PMI CONOPS for use in a multi-modal environment and multi-domain and responsible for the management of the PMI Asset Tracking System.

2.10. Major Command Surgeons (MAJCOM/SG) and National Guard Surgeon (NGB/SG). These individuals will:

2.10.1. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their expeditionary and home station missions in accordance with AF War and Mobilization Plan, Vol. 1 (AF WMP 1) guidance, Operation Plan (OPLAN) requirements and other applicable directives. For ARC units, this is a gaining MAJCOM responsibility in accordance with AFI 10-301, Responsibilities of Air Reserve Component (ARC) Forces.

2.10.2. Assist with the implementation of AF guidance on contingency operations, training, and assessment.

2.10.3. In concert with AFMOA, ensure subordinate medical unit manning documents (UMD) are postured to balance readiness, business case, and clinical currency requirements.

2.10.4. Provide oversight to the MAJCOM/SGX office (or standing force headquarters equivalent). The MAJCOM/SGX will:

2.10.4.1. Assist medical readiness officers (MROs), medical readiness NCOs (MRNCOs), and civilian medical readiness managers (MRMs) in resolving issues with their units’ readiness programs.

2.10.4.2. Review unit Medical Contingency Response Plans (MCRPs), or equivalent plans/annexes/checklists for LRC units, prior to publication to validate medical response capabilities and verify compliance with AF directives. Ensure each team checklist includes specific instructions to support each MCRP annex. Reviews must be completed within 60 days of submission by the unit or concurrence is implied.

2.10.4.3. Collect and evaluate readiness guidance change requests from units and other subordinate organizations. Submit consolidated requests to AFMSA/SG3X.

2.10.4.4. Coordinate with MRAs as necessary regarding input to UTC manning, equipment, and training requirements.

2.10.4.5. Monitor MRDSS ULTRA data to identify personnel, training, and equipment/supply trends, shortfalls and compliance.

2.10.4.6. Identify MAJCOM MR program resource requirements for inclusion in the MAJCOM/SG POM and Execution Year budget submission. Additionally, notify the AF/SG MR Panel of resource requirements.

2.10.4.6.1. Coordinate with ACC/SGXH to advocate to AF/SG3/5X and the MAJCOM FM for resources associated with LAF funded MR programs.

2.10.4.6.2. Coordinate with other functional experts on MR resource requirements, as necessary.
2.10.4.6.3. Designate a MAJCOM resource advisor (RA) for LAF PE 28036F (PE 58036F for ANG), MC-CBRN Program, as applicable. Provide program oversight for MC-CBRN at the MAJCOM level to include distribution of MC-CBRN funding and other resources to help installation close capability gaps.

2.10.4.6.4. Coordinate with ACC/SGX for MC-CBRN sustainment funding priorities, training quotas and consultative support. Manage all-hazards response processes that require integration or coordination with the MAJCOM A-staff.

2.10.4.7. Coordinate and submit consolidated exercise requirements to the EOWG. Designate MAJCOM representatives to the RTOC and EOWG to provide input to training and exercise priorities and schedules.

2.10.4.8. Maintain situational awareness of FCC capabilities by reviewing annual self-assessment checklists and FCC exercise AAR.

2.10.4.9. Designate a MAJCOM/SGX representative to provide support to MRDSS ULTRA Unit System Administrators. The MAJCOM MRDSS ULTRA representative will create, review, and delete MRDSS ULTRA Unit System Administrator user accounts, as appropriate, and ensure accuracy and positive control of sensitive information contained within MRDSS ULTRA. This individual will provide assistance and guidance to Unit System Administrators with data entry and contact the MRDSS Help Desk if technical assistance is required.

2.10.4.10. Designate a MAJCOM level training scheduler for the FTMS within MRDSS ULTRA.

2.10.4.11. Appoint a MAJCOM Functional Area Manager. In addition to roles and responsibilities in AFI 10-401, 10-403, 10-201, and 10-244, this individual or office will:

2.10.4.11.1. Consistently ensure the accuracy of the MRL within MRDSS data, the UTC Availability (UTA) database, as well as UTC, resource and capability readiness reports.

2.10.4.11.2. Submit MRL change requests using the MRL admin function of MRDSS and ensure changes have been accepted prior to updating the UTA database.

2.10.4.11.3. Assist subordinate units in determining the appropriate level of home station services to provide during AEF deployments.

2.10.4.12. Upon coordination, provide to subordinate unit readiness offices a 2-year deployment outlook for consideration in business plan development.

2.10.4.13. Review after action reports (AARs) to identify items requiring resolution or risk acceptance, and submit these items to the appropriate level for resolution, tracking, and decision making (e.g. MTF, C-NAF/MAJCOM, HAF). Provide MRAs and consultants with a copy of any validated AARs containing information relevant to their specialties.

2.10.5. Air Education and Training Command (AETC), Medical Modernization Division (AETC/SGR). This organization will:

2.10.5.1. Serve as a consultant/advisor to the AFMS on use of patient simulators and distance learning for development and sustainment of expeditionary clinical skills.
2.10.5.2. Coordinate to obtain on-site simulators and qualified simulator staff to execute trauma skills sustainment training in support of capabilities-based training MET objectives.

2.10.5.3. Provide oversight of contracted simulation personnel at trauma skills sustainment training sites.

2.10.5.4. Support E&T personnel on opportunities to integrate blended learning approaches to enhance cognitive, psychomotor and affective based training at the individual, team and unit level to meet capability-based training MET objectives.

2.10.5.5. Develop standardized simulation scenarios to enhance delivery and assessment of effect of training to meet capability-based training MET objectives.

2.10.6. AF Materiel Command (AFMC), AF Research Lab (AFRL), 711th Human Performance Wing, AF Research Laboratory, AF Research Laboratory Center, United States Air Force School of Aerospace Medicine (USAFSAM). This organization will:

2.10.6.1. Administer the SMART RCS and C-STARS operating locations to maximize efficiency and effectiveness. (T-1)

2.10.6.1.1. Collaborate with similar Joint sustainment programs for benchmarking purposes. (T-2)

2.10.6.1.2. Oversee standardized program curricula for all SMART RCS and C-STARS locations. Monitor these programs for quality and effectiveness, and work with the AF/SG Consultants and CFMs to update the curricula as needed. Collect student progress data every six months, at a minimum. (T-1)

2.10.6.1.3. Brief the RTOC annually on SMART RCS and C-STARS utilization, issues, and trends. (T-3)

2.10.6.2. Provide consultative and staff assistance services to all clinical sustainment training sites. (T-1)

2.10.6.2.1. Collaborate with the Air Education and Training Command Surgeon (AETC/SG) to assist MTFs in establishing clinical sustainment training programs and support associated POM submissions as necessary. (T-2)

2.10.6.2.2. Monitor MTF execution of clinical sustainment training programs and establish associated inspection criteria. Compile and report data on all trauma skills sustainment training sites to AF/SG3/5X and MAJCOM/SGXs via the RTOC. Compile an annual training summary for AETC/SG. (T-2)

2.10.6.3. Develop and conduct advanced training for critical care UTCs at advanced trauma facilities, as directed. (T-2)

2.10.6.4. Administer the CMRP by: (T-2)

2.10.6.4.1. Complete the required CMRP Course Resource Estimates (CRE) and submit them to the Force Development Panel for approval. Once the Force Development panel approves the CRE, submit the appropriate POM requests for funding and/or manpower, if necessary.
2.10.6.4.2. Work with SG consultants, corps directors and CFMs to ensure CMRP checklists are reviewed annually and updated as necessary.

2.10.6.4.3. Notify personnel 30 days in advance of CMRP checklist updates, using an MRDSS ULTRA system message and the messaging functions provided by the MRDSS Kx and AF Medical Readiness SharePoint sites to maximize distribution.

2.10.6.4.4. Post CMRP checklist updates in MRDSS ULTRA and checklist updates on the AFMS Kx site only after approval by the AFMOA CMRP Committee.

2.10.6.5. Review and evaluate new advanced clinical skills sustainment programs. (T-3)

2.10.6.6. Promote medical research, particularly with expeditionary impact, across the military/civilian spectrum. (T-3)

2.10.6.7. Provide technical expertise and consultative reach back support for occupational and environmental health, public health, epidemiology, clinical and environmental laboratory sciences, nuclear/radiological response, and occupational health physics. (T-2)

2.10.6.8. Manage the Individual Proficiency Analytical Testing (I-PAT) program, validating Bioenvironmental Engineering (BE) operator proficiency in accordance with respective 4B0X/43EX Career Field Education and Training Plan's (CFETPs), to ensure operational and analytical competencies are maintained in the performance of the BE mission. (T-1)

2.11. Medical Unit Commander. The commander will:

2.11.1. Be knowledgeable of all assigned unit readiness missions. (T-2)

2.11.1.1. Annually, or as changes occur, review and validate assigned UTCs on the MRL. (T-2)

2.11.1.2. Annually, or as changes occur, review the unit’s Designed Operational Capability (DOC) statement. Document this review in the MRC minutes. (T-2)

2.11.2. Accurately report the unit’s readiness, in accordance with AFI 10-201, *Force Readiness Reporting*. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CICSM 3150.01, CJCSI 3401.01)

2.11.3. Include input from the MR Office in the development of the business plan. (T-2)

For ARC units, this involves input into the annual training plan.

2.11.4. Approve the MCRP, or equivalent plans/annexes/checklists for LRC units, for publication after full coordination, establishing and maintaining the capability to provide and/or arrange for all-hazard response, treatment, staging, and transport of casualties. (T-1)

2.11.5. Approve installation medical response Memoranda of Understanding/Memoranda of Agreement/Mutual Aid Agreement (MOU/MOA/MAA) with military and civilian agencies, after full coordination. (T-1)

2.11.6. Establish and maintain response capabilities and support public health emergency requirements in accordance with AFPD 10-25, *Emergency Management*; AFTTP 3-42.32, *Home Station Medical Response To Chemical, Biological, Radiological, And Nuclear (CBRN) Incidents*; DoDI 6200.03, *Public Health Emergency Management within the
Department of Defense; AFI 10-2519, Public Health Emergencies and Incidents of Public Concern; AFI 10-2501, Air Force Emergency Management Program, AFMAN 10-2608, Disease Containment; and this Instruction, organically within the medical organization; through written MOU/MOA/MAA with other organizations in the local area; or through a combination of these methods. (T-0: DoDI 6200.03) For units without the 886I AS, or with less than three assigned laboratory personnel, maintain the laboratory biological detection capability through MOU/MOA/MAA with a state or local lab. (T-0: DoDI 6440.03)

2.11.7. Establish an effective medical readiness training program.

2.11.7.1. Ensure assigned personnel meet training requirements in accordance with applicable reporting instructions, AFI 10-401, Air Force Operations Planning And Execution, AFI 10-403, Deployment Planning And Execution, AFI 36-2201, Air Force Training Program, and this Instruction. (T-1)

2.11.7.2. Ensure through UTC course attendance, exercises, deployments, or through equivalency credit, as approved by the MAJCOM or MRA, that training requirements for all assigned missions are met. (T-1)

2.11.7.3. Oversee the Comprehensive Medical Readiness Program (CMRP). (T-1)

2.11.7.3.1. Designate an AFSC Functional Training Manager for each assigned specialty. Reference paragraph 2.20. of this Instruction for AFSC Functional Training Manager responsibilities.

2.11.7.3.2. Review gap analysis reports for each assigned AFSC in MRC meetings. Ensure AFSC functional training managers develop plans for mitigating CMRP training gaps (Category I-Clinical Currency, Category II-Readiness Skills Training, Category III-UTC).

2.11.7.3.3. Grant credit for specific CMRP tasks that are accomplished as part of participation in a deployment or exercise. For ARC units, medical unit commanders may grant CMRP credit for tasks accomplished as part of assigned duties at the member’s civilian place of employment. Documentation must be provided as evidence for each task credited in this manner.

2.11.7.3.4. Grant waivers for CMRP training for individuals who will be non-deployable for the duration of their deployment vulnerability period (DVP), when appropriate. Waived individuals must complete CMRP training once they are returned to deployable status.

2.11.7.4. Certify in MRDSS ULTRA that individuals who are tasked to deploy are fully trained, prior to each deployment. (T-1)

2.11.7.5. Direct the MR Office to prepare and maintain the Annual Medical Readiness Training and Exercise Schedule (MRTES) and submit it to the Medical Readiness Committee (MRC) for review and approval. The MRTES should be aligned with the wing’s exercise calendar. (T-2) A sample template is provided on the AF Medical Readiness SharePoint Site.

2.11.7.6. Support the SMART and C-STARS programs. (T-1) Training platform and frequency requirements are provided on the CMRP checklists for affected specialties. Ensure assigned personnel capitalize on local clinical currency opportunities and taking
an active role in developing and maintaining TAAs/MOUs with local medical facilities.
In consultation with the unit’s three letter functionals (e.g. SGA, SGN, SGH, SGB),
prioritize personnel for SMART RCS attendance.
2.11.8. Form and chair the MRC. (T-2) LRC units may incorporate the MRC into the EMC,
as appropriate. MRC requirements are not applicable to Deployed MTFs. For the purposes
of this Instruction, MRC will refer to any committee charged with this function, unless
specifically noted.
2.11.8.1. MRC meetings will be held quarterly, at a minimum, and the duration must be
sufficient to address all required agenda items, as listed in Table 3.1.
2.11.8.2. MRC membership will consist of the executive management team, including
functional advisors (SGA, SGD, SGN, SGP, etc.), squadron commanders, and unit
superintendents, medical readiness staff members (MRO, MRNCO, MRM, as
applicable), MTF Emergency Manager (MEM), Unit Deployment Manager (UDM), Unit
Training Manager (UTM), Wing Inspection Team (WIT) Medical Team Chief,
Bioenvironmental Engineer (BEE), Public Health Emergency Officer (PHEO)/ANG
PHEO Liaison, Public Health Officer (PHO) (or Senior 4B/4E if no officers assigned),
Medical Logistics Flight Commander, Education and Training Officer (or representative),
Reserve Affairs Liaison, at a minimum, and: (T-2)
2.11.8.2.1. Functional training managers, when providing CMRP updates.
2.11.8.2.2. MCRP team chiefs, when providing team updates.
2.11.8.2.3. NDMS FCC Coordinator, when providing updates.
2.11.9. Fund participation in CCDR-directed operations with appropriations specifically
provided to the CCDR for such purposes. (T-1) Medical units may not use Defense Health
Program (DHP) appropriations for CCDR-directed operations.
2.11.10. If the MTF maintains WRM assemblages for other units (e.g. RED HORSE, SME,
or AE), provide opportunities for those units to train and exercise with the equipment. (T-3)
However, the medical unit is not responsible for ensuring that training and exercising are
accomplished. These events should be discussed in the MRC/EMC to support project
oversight.
2.11.11. For units with collocated personnel and WRM UTCs, at the discretion of the unit
commander, use WRM for a planned exercise. Follow procedures prescribed in AFI 41-209,
*Medical Logistics Support*, to release the WRM UTCs for the exercise. (T-3)
2.11.12. When the base is host to ARC or other units with similar personnel UTCs, ensure
they are given the opportunity to train with the host unit’s UTCs; ARC Medical units will
coordinate training schedules with their AD host MTF. (T-3) Refer questions to the
appropriate MEFPACK responsible agency (MRA) through the parent MAJCOM.
2.11.13. Appoint a primary and alternate for each position listed below using MRDSS
ULTRA and track associated training requirements. (T-2) Additional written appointment
letters are not required unless mandated by other directives or instructions.
2.11.13.1. MRO, MRNCO, or MRM, as appropriate.
2.11.13.2. Medical Readiness Training Manager. Formal Training Management Scheduler (FTMS) users for MRDSS ULTRA must be appointed in writing and appointment letters will be forwarded to the parent MAJCOM/SGX FTMS scheduler.

2.11.13.3. AFSC Functional Training Manager for each assigned AFSC.

2.11.13.4. MCRP Team Chiefs (or equivalent for LRC units).

2.11.13.5. Unit Plans Officer or NCO.

2.11.13.6. MRDSS ULTRA Unit System Administrator.

2.11.13.7. UTC Team Chiefs or UTC Family Group Team Chiefs. Appoint team chiefs and alternates for each assigned UTC or a UTC family group leader and alternate for each group of UTCs. The decision as to whether to appoint team chiefs for individual UTCs or UTC family groups is at the discretion of the unit commander. UTC family groups may be comprised of multiple copies of the same UTC, as might be the case at a CDM site, or complimentary UTCs (e.g., FFPM1, FFPM2, FFPM3, etc.) based on unit necessity. **Note:** The Patient Decontamination Team, UTC FFGLB, requires the appointment of a UTC team chief and NCOIC. Additionally, Pilot Units are required to appoint team chiefs and alternates for their pilot UTCs.

2.11.13.8. Reserve Affairs Liaison. Each Active Component (AC) unit will appoint a Reserve Affairs Liaison and alternate to manage reserve training at the unit for reservists seeking to do Annual Tour (AT) days with the AC unit.

2.11.13.9. For ARC units, an AT Monitor and alternate, one of which must be a full-time medical staff member.

2.11.13.10. For NDMS-FCC facilities, an FCC Director and FCC Coordinator (Not applicable to ARC units).

2.12. Medical Unit MRO, MRNCO, and MRM.

2.12.1. These individuals are referred to collectively as the MR Office within this Instruction, unless a paragraph addresses one individual specifically. MR Office roles and responsibilities are addressed in Chapter 3 of this Instruction.

2.13. Public Health Officer (PHO) (43HX) or Public Health NCOIC (PHNCO) (4E071/4E091). These individuals will: (T-0: DoDI 6490.03, DoDI 6490.07, DoDI 6420.01).

2.13.1. Perform medical intelligence functions. In support of wing deployment operations, work with LAF intelligence personnel, National Center for Medical Intelligence (NCMI), and parent MAJCOM Public Health personnel to obtain a medical intelligence assessment to include health threats from infectious disease, poisonous/venomous flora and fauna, disease risks, environmental health hazards, industrial hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, and host nation CBRN warfare medical defense capabilities. Use available medical intelligence sources to prepare the medical threat assessments for deployment locations and to compile medical intelligence/force health protection briefings for all wing deploying forces during base deployment processing.
2.13.2. Attend the Joint Medical Operations Course to gain perspectives on joint planning and use of medical threat assessments. Priority for attendance should be officers filling positions that directly impact planning, e.g. COCOM, International Health Specialist, or NCMI billets. For stand-alone AFRC installations, Bioenvironmental Engineering/Public Health Office Director or his/her designee will attend the course.

2.13.3. Attend Contingency Preventive Medicine (CPM) Course, #B3OZY4XXX 0B1C. The Public Health Apprentice, Officer, or NCMI course may be attended in lieu of the CPM Course for ARC personnel performing medical intelligence functions (Note: not applicable to BE/PH office at stand-alone AFRC installations).

2.13.4. Serve as a functional advisor to the MR Office for planning, training, and execution of the unit installation medical response program.

2.13.5. Perform food vulnerability assessments to support planning and recommended corrective actions in anticipation of, and in response to, an incident, in accordance with AFMAN 10-246, Food & Water Protection Program. Collect samples and coordinate initial testing of foods suspected of deliberate bacterial contamination with Office of Special Investigation (OSI), Security Forces Squadron (SFS), Laboratory Biological Detection Team (LBDT), and PHEO to determine an appropriate course of action.

2.13.6. Conduct medical surveillance and epidemiological investigations of the installation population and beneficiaries for sentinel events, diseases, and adverse health effects due to All-Hazard events. Ensure medical surveillance, conducted in accordance with AFI 48-105, Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance and AFI 10-2519, Public Health Emergencies and Incidents of Public Health Concern, includes baseline health surveillance to assist in detecting an All-Hazard incident (not applicable to ARC medical units).

2.13.7. Conduct All-Hazard risk communication to provide All-Hazard incident health risk information to wing personnel and their families.


2.13.9. For AFRC units, the full-time Bioenvironmental Engineering (BE)/Public Health office is responsible for providing full-time public health support to accomplish PHO/PHNCO requirements. For AFRC units tasked with the Aerospace Medicine Function (FFDAF, FFDAG, FFDCC, FFDCD, FFPMR, and FFABC UTCs) will be responsible for this duty in conjunction with their AD Public Health host. Individuals performing this duty may be assigned to another collocated reserve unit.

2.13.10. Units without a PHO/PHNCO should contact the parent MAJCOM PHO for guidance.

2.14. Bioenvironmental Engineer (BEE) (043E3) or BE Technician (4B071/4B091). The BEE will: (T-0: DoDI 3020.52, DoDI 6055.17, and DoDI 6490.03)

2.14.1. Serve as a functional advisor to the MR Office for planning, training, and execution of the unit’s contingency response program.

2.14.3. At AFRC installations, the BEE functions are performed by the full-time BE/Public Health personnel, who are aligned under the Mission Support Group or Wing at AFRC host locations.

2.15. NDMS FCC Director. This individual will: (T-0: DoDD 6010.22)

2.15.1. Be the MDG/CC or senior designee (not delegable below SQ/CC).

2.15.2. Be responsible for the management and execution of the FCC mission and associated NDMS Patient Reception Areas (PRAs) in accordance with DoDD 6010.22, National Disaster Medical System.

2.16. NDMS FCC Coordinator. This individual will:

2.16.1. Be responsible for the management of the day-to-day operations and the alert and activation of the FCC and associated NDMS PRAs.

2.16.2. Publish a PRA plan in accordance with Air Force and DoD Directives. Additional information on developing PRA Plans can be found on the AF Medical Readiness SharePoint Site. Submit the PRA plan to the parent MAJCOM/SGX for review prior to publication. (T-1)

2.16.3. Complete and submit an annual FCC PRA Self-Assessment Checklist to the parent MAJCOM/SGX and AFMSA/SG3X. FCC PRA Self-Assessment Checklists can be found in Annex Q of the NDMS FCC Guide or on the AF Medical Readiness SharePoint Site. (T-1)

2.16.4. Provide annual orientation to the PRA plan for NDMS partner medical facilities, Patient Reception Teams as well as representatives of local emergency management agencies, EMS, public safety, police, and fire services. (T-1)

2.16.5. Conduct a FCC patient reception exercise annually with a full-scale exercise once every three years (T-0: DoDD 6010.22).

2.16.6. Participate in NDMS bed reporting exercises. (T-0: DoDD 6010.22).

2.16.7. Submit AARs for NDMS exercises to the parent MAJCOM/SGX and AFMSA/SG3X within 30 days of the incident or exercise. (T-2)

2.17. Reserve Affairs Liaison. This individual will: (T-2)

2.17.1. Serve as the single point of contact for supported Reserve Medical Units (RMU) Annual Tour Monitor(s) and HQ AFRC/SGN staff for any questions and/or issues regarding Annual Training at their facility. Upon request, provide to HQ AFRC/SGN a list of unit training activities and AFSCs that can be supported by the unit.

2.17.2. Evaluate Training Plans received and approve or disapprove Annual Tours based on, but not limited to, the feasibility of requested training, availability of trainers, MTF capabilities, etc. Plan and coordinate access to medical readiness training for RMU personnel based on training requirements outlined in the Training Plan.

2.17.3. Attend the MRC and brief as necessary.
2.17.4. Provide detailed reporting instructions to supported RMUs and assist with MTF in-processing.

2.17.5. Review After Action Reports and provide recommendations for improvement to the RMU Annual Tour Monitor, as necessary.

2.17.6. Reference the Reserve Affairs Liaison Guide provided on the AF Medical Readiness SharePoint site for additional duties and requirements.

2.18. **MCRP Team Chiefs.** These individuals will:

2.18.1. Prepare and maintain the team’s response checklists. Plan for all installation medical response scenarios, including incidents with CBRN aspects. (T-3) **Note:** this applies to all MCRP teams.

2.18.2. Maintain and inventory team equipment and supplies in accordance with AFI 41-209, *Medical Logistics Support*. (T-2)

2.18.3. Conduct team training and/or assign trainers, as necessary, to ensure all team members receive training. (T-2) MCRP team training requirements are listed on the MCRP Team Training Matrix, provided on the AF Medical Readiness SharePoint. Additional team-specific training requirements are listed in Chapter 5 of this Instruction.

    2.18.3.1. Ensure make-up training is conducted for individuals who miss training events, within 60 days of return from leave, deployment, etc. (T-2)

    2.18.3.2. Incorporate team-related RTAP Tactical Drills (TDs) in the development of training lesson plans and medical/non-wing level training events, as applicable. (T-2)

2.18.4. Ensure personnel assigned to response teams designated to use 886 assets are trained based on command guidance and execution of AFTTP 3-42.32 for the respective AS. (T-0: DoDI 3020.52) Reference AFTTP 3-42.32 for specific requirements and training resources.

2.18.5. Maintain an active MRDSS ULTRA account and document team training for assigned personnel in MRDSS ULTRA or designate a team member to accomplish this task. (T-2)

2.18.6. Attend the MRC and brief the status of team capabilities to the MRC. (T-3) Included in this update should be the status of team manning, training, and an overall assessment of the team’s capabilities. Also, brief the status of assigned equipment and supplies, inventory results and get well plans.

2.18.7. For team chiefs identified in Table 4.4 or 4.5, be responsible for maintaining assigned HSMR assemblages. These team chiefs will: (T-1)

    2.18.7.1. Designate a team representative to work with the Medical Logistics Flight to manage the team’s assemblage. Although medical logistics is responsible for maintaining AS data in Defense Medical Logistics Standards Support (DMLSS), team chiefs are ultimately responsible for ensuring the readiness status of their assemblages. (T-3)

    2.18.7.2. Conduct an inventory of team equipment and supplies once annually and after use for exercises or real world events, in accordance with AFI 41-209. Medical logistics and/or a contracted logistics inventory team and the team chief and team members will
collaboratively perform the inventory functions. AS training for team members and operational testing of equipment will be conducted once annually, in conjunction with an exercise or an inventory. The annual inventory requirement may also be met with a post-exercise inventory as long as all required inventory actions are accomplished. (T-3)

2.18.7.3. Review AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, and Nuclear (CBRN) Incidents* annually. (T-3)

2.18.8. For LRC unit installation medical response teams identified to support the IEMP 10-2 or equivalent installation emergency management plan, prepare and maintain unit response procedures and supporting checklists, based on unit capabilities. Individuals or teams designated to provide medical response support will complete all associated training. (T-1)

2.19. UTC Team Chiefs or UTC Family Group Leaders. These individuals will: (T-3)

2.19.1. Review the Functional Verification and Hand-off Tool maintained on the AF Medical Readiness SharePoint Site prior to each applicable DVP.

2.19.2. Ensure UTC members review the UTC Tactics, Techniques and Procedures (TTP), Mission Capability Statements (MISCAPS), Mission Essential Task Lists (METLs), training requirements and allowance standards (AS) prior to each applicable DVP and document the review in MRDSS ULTRA.

2.20. Unit AFSC Functional Training Managers.

2.20.1. AFSC functional training managers at the unit level include enlisted functional managers and the senior officer from each corps. For clinical Biomedical Sciences Corps (BSCs), CMRP oversight is provided by the SGH (or equivalent), or the SGP at ARC units. These individuals will:

2.20.1.1. Review assigned CMRP checklists to identify training tasks. Conduct or oversee CMRP training, as designated on the CMRP Matrix, provided on the AF Medical Readiness SharePoint site, and document it in MRDSS ULTRA. (T-1)

2.20.1.2. Perform a CMRP training gap analysis annually and anytime CMRP training requirements or MTF capabilities change, and document the gaps in MRDSS ULTRA. Brief the MRC on the gap analysis data annually and anytime there is a change. (T-1)

2.20.1.2.1. CMRP Gap analyses will identify those training needs which cannot be met in the local unit or geographic area (TAA, MOU or special training event) and require TDY travel/funding. These gaps will be identified as NON LOCAL in MRDSS. Identifying items as gaps does not relieve members of the training requirements, but may require assistance from the education and training office or the specialty consultant/CFM.

2.20.1.2.2. Develop a plan to complete all CMRP training requirements, including gaps. (T-2)

2.20.1.3. When assigned CMRP checklists are changed, follow implementation guidance provided by the consultant, corps director or CFM. (T-2) If no implementation guidance is provided, training for new tasks must be completed within six months of publication of the new CMRP checklist.
2.20.1.4. Verify clinical currency for newly assigned personnel and on a recurring basis, prior to each AEF deployment vulnerability period. The purpose of the clinical currency verification is to validate individual clinical currency status regardless of the number of CMRP checklist tasks that have been completed at a given point in time. An individual may be considered clinically current for readiness if their skills meet or exceed CMRP checklist requirements even if the number or acuity of cases has not been achieved. Conversely, an individual may have completed all task requirements but lack adequate skills to be considered clinically current for readiness. Document the clinical currency verification on the readiness page in MRDSS ULTRA. (T-1) The functional training manager is accountable for clinical currency verification of assigned unit personnel. Specialty consultants will accomplish clinical currency verification for unit functional training managers. (T-1)

2.20.1.5. Attend the MRC/EMC and brief the status of assigned CMRP training to the quarterly, on a rotational basis, as determined by the commander. Brief the results of the gap analysis when there has been a change to the CMRP checklist. (T-3) CMRP checklists can be accessed within MRDSS ULTRA or through the AFMS Knowledge Exchange (Kx) Site.

2.20.2. Reference Chapter 5 of this Instruction for additional CMRP guidance.
Chapter 3
MEDICAL READINESS PROGRAM MANAGEMENT

3.1. The Medical Readiness Office.

3.1.1. The MR Office is the hub of readiness activities at the unit level. Personnel assigned to this office manage programs spanning the full range of global medical operations activities. To meet program requirements, there must be a minimum of two full-time personnel assigned to the MR Office. (T-2) For ARC, “full-time” refers to traditional reservists/guardsmen filling the MRO or MRNCO roles. Waivers for this requirement must be coordinated with the parent MAJCOM/SGX and Associate Corps Chief for Readiness prior to submission in accordance with AFI 33-360. Two primary positions in the MR Office are the Medical Readiness Officer (MRO) and the Medical Readiness NCO (MRNCO). Depending on the size of the facility and the medical readiness program, the MRO may be appointed on a part-time basis. In this instance, a second enlisted member must be assigned to meet the two-person minimum staffing requirement. Whether full or part-time, the MRO must have sufficient time and resources to perform required MRO functions. A DoD civilian Medical Readiness Manager (MRM) may fill either the MRO or MRNCO position in a full-time capacity.

3.1.2. Tenure. The MRO, MRNCO and MRM will serve in their positions for a minimum of 24 months, unless reassigned due to a permanent change in station (PCS). (T-2)

3.1.3. Core Competency. Medical readiness is a core competency for the 041AX officers and the 4A0X1 enlisted personnel. Therefore, 041AX medical service corps officers and 4A0X1 healthcare managers should be the primary AFSCs assigned to the Medical Readiness Office. Individuals with other specialties may be added to the medical readiness staff as appropriate. For AFRC units only, when 041AX and/or 4A0X1 personnel are not assigned, personnel with any medical AFSC may serve as the MRO or MRNCO. Unit level medical readiness positions are not authorized the “R” AFSC prefix. However, unit level MR enlisted personnel may be awarded the 325 special experience identifier (SEI) upon successful completion of the Medical Readiness Management Course (MRMC) and a year of serving in the MR Office. Member should submit AF Form 2096 to base Education & Training to update records with 325 SEI.

3.1.4. Training. All personnel assigned to the MR Office (military and civilians) must successfully complete the Medical Readiness Management Course (MRMC). The MRO, MRM and all enlisted personnel assigned to 325 SEI coded positions will complete the course within six months of assignment. (T-2) The remaining MR Office personnel will attend within 12 months of assignment. (T-3) ARC MR Office personnel will attend within 12 months of assignment. (T-3)

3.1.4.1. Prerequisites for attending the MRMC include completing position-specific and UDM MRDSS ULTRA training.

3.1.4.2. MRMC attendance is scheduled using the MRDSS ULTRA Formal Training Management Scheduler (FTMS). Reference the ROE for MRMC Scheduling on the AF Medical Readiness SharePoint Site.
3.1.4.3. For individuals who do not successfully complete the MRMC, the MRMC staff will identify failed areas/topics to the individuals' home unit for additional training and supervision until competency is achieved.

3.2. Unit Plans Officer/NCO. This individual will: (T-2)

3.2.1. Coordinate and publish the MCRP, medical input to the IEMP 10-2, or equivalent plans/annexes/checklists for LRC units, according to requirements outlined in Chapter 4 of this Instruction.

3.2.2. Develop, coordinate and maintain copies of medical response support MOU/MOA/MAA. See Chapter 4 of this Instruction for additional planning guidance.

3.2.3. Review all installation plans to ensure medical unit roles and capabilities are included.

3.3. MRDSS ULTRA Unit System Administrator. This individual will: (T-2)

3.3.1. Create user accounts, review and drop/delete unit-level user accounts no longer requiring access, and ensure positive control of sensitive information contained within the system.

3.3.2. Maintain MR Office accounts. Recommend issuing each member of the MR Office staff an individual account.

3.3.3. Create and maintain Education and Training (E&T) office accounts. Larger facilities should consider designating a second MRDSS ULTRA Unit System Administrator in the E&T office to specifically manage E&T accounts. The MRDSS ULTRA Unit System Administrator will provide AFSC functional training managers, MCRP team chiefs, and Graduate Medical Education (GME) directors with MRDSS ULTRA accounts to enter training data for their personnel as necessary.

3.3.4. Provide assistance to unit users. Contact the parent MAJCOM MRDSS ULTRA representative for assistance or guidance. The MRDSS ULTRA Unit System Administrator will contact the Help Desk only if the MAJCOM representative is unable to provide assistance.

3.3.5. Provide recommendations for updates or changes to MRDSS ULTRA to the parent MAJCOM MRDSS ULTRA representative for consideration by the MRDSS CCB.

3.4. Medical Readiness Training Manager. This individual will: (T-2)

3.4.1. Schedule, track and document readiness training in MRDSS ULTRA. Medical Readiness Management Course (MRMC) and formal UTC training are scheduled and documented using the Formal Training Management Scheduler (FTMS) function within MRDSS. Unit FTMS schedulers are designated by their parent MAJCOM/SGX training scheduler. Reference Chapter 5 of this Instruction and the Category III Training Guide, provided on the AF Medical Readiness SharePoint Site, for scheduling guidance.

3.4.2. Ensure all medical readiness training is properly documented in MRDSS ULTRA in accordance with this Instruction. Document UTC sustainment training credit for MRA-approved exercise participation using the exercise end date as the completion date for associated training items.
3.5. Unit Deployment Manager (UDM).

3.5.1. UDMs have primary responsibility for managing personnel assigned to UTC positions and ensuring those personnel are trained and equipped to accomplish the missions of the UTCs to which they are assigned. Medical UDMs will (T-2):

3.5.1.1. Identify personnel to fill UTC positions, in coordination with the unit AFSC functional manager and unit commanders, using the Control AFSC (CAFSC) for enlisted personnel and Duty AFSC (DAFSC) for officers.

3.5.1.1.1. Ensure the best AFSC, grade, and skill level matching accordance with the UTC Mission Capability Statements (MISCAPs), AFI 10-403, Deployment Planning and Execution, and other applicable guidance or reporting instructions. Prior to assigning personnel to UTCs and/or selecting individuals to deploy:

3.5.1.1.2. Verify individual duty status and deployment availability (DAV) codes to determine if the individual is present for duty or can be recalled, and that there are no discriminating legal, security, medical, or administrative factors that may render the member ineligible to deploy. Update MRDSS ULTRA with any duty status changes. Units will run the MRDSS ULTRA expired DAV code report at the end of each month, to coincide with monthly resource and capability readiness reporting, verifying personnel availability.

3.5.1.2. Assign personnel to UTCs using MRDSS ULTRA and update deployment preparedness information.

3.5.1.3. Provide newly assigned UTC members with a copy of applicable UTC Tactics, Techniques and Procedures (TTP), MFEL, training requirements and allowance standards (AS) (electronic is acceptable).

3.5.1.4. Conduct pre-deployment activities.

3.5.1.4.1. Upon receipt of a deployment tasking, enter tasked members’ anticipated deployment date and estimated tour length in MRDSS ULTRA. Update the data if/when changes occur (e.g. if the individual ultimately deploys on a different date or does not deploy).

3.5.1.4.2. Schedule and monitor completion of pre-deployment training.

3.5.1.5. Conduct post-deployment activities.

3.5.1.5.1. Obtain deployment training documentation from deployers.

3.5.1.5.2. Update MRDSS ULTRA to reflect individual/WRM deployment return date.

3.5.1.5.3. Notify AFSC functional training managers and MCRP team chiefs of returning deployers.

3.5.2. Follow applicable UDM requirements as outlined in AFI 10-401, Air Force Operations Planning and Execution, AFI 10-403 and the Installation Deployment Plan (IDP).
3.6. Additional MR Office Functions.

3.6.1. Develop or provide input to the MRC/EMC meeting agenda. (T-3) Minimum required agenda topics are listed in Table 3.1.

Table 3.1. Minimum Required MRC/EMC Agenda Topics.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion Items</th>
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| Training Update              | - Category I, Clinical Currency, and Category II, Readiness Skills Training, including a review of CMRP training gaps and solutions for each assigned specialty annually. Completion dates of annual gap analyses will be tracked for each AFSC by the MRC and documented in meeting minutes.  
- Category III, UTC readiness training  
- Category IV, MCRP team training, at a minimum  
- Other training, as necessary |
| Installation Medical Response Update | - Status of installation medical response teams (MCRP or equivalent) manning, equipment and supplies (include HSMR assets), inventory results, degradation in capability and potential impact to response capabilities and get-well plan |
| Readiness Status Update      | - Update on MRL changes (when applicable)  
- UTC vacancies  
- Response team status |
| Medical Logistics Update     | - Status of assigned WRM, including force protection assets such as anti-malaria/cholera program and biological/chemical warfare antidotes, facility expansion assets, etc.  
- Status of other assigned assets |
| UDM Update                   | - Deployment taskings and activities  
- DAV code review |
| Plans Update                 | - Annual review of the MCRP, or equivalent plans/annexes/checklists  
- Review and approval of medical input to installation plans (e.g. IEMP, IDP, etc.) |
| Exercise Update              | - Status of unit and installation exercise requirements  
- Results of exercises conducted since last meeting  
- Exercise credit for real world response |
| After Action Report Update   | - Lessons learned and corrective actions from AARs related to in-garrison exercises and real world events since the last meeting. |
3.6.2. Conduct medical readiness in-processing and out-processing in MRDSS ULTRA for assigned personnel. (T-2)

3.6.2.1. Establish standardized in-processing procedures for all newly assigned personnel. Develop an orientation checklist to include: installation medical response plan (MCRP or equivalent) review; UTC assignment and deployment requirements; MCRP team assignment and training requirements; names and duty sections of MCRP and UTC team chiefs and AFSC Functional Training Manager; and review of current training status and requirements.

3.6.2.2. Establish standardized out-processing procedures for personnel permanently changing station, separating or retiring. Provide printed hard copies if necessary.

3.6.3. Provide oversight and support to MCRP Team Chiefs. Assign MCRP team chiefs and assign team members using MRDSS ULTRA. (T-2)

3.6.4. Manage weapons authorizations for assigned medical UTCs using the Weapons and Munitions Forecasting Table for AFMS UTCs provided on the AF Medical Readiness SharePoint Site. (T-3)

3.6.5. For MTFs with pilot unit responsibilities, maintain pilot unit program management oversight and act as liaison to the MRA. (T-2)

3.6.6. Provide oversight of the implementation of Response Training and Assessment Program (RTAP). (T-3) The assessment provides the foundation for establishing preparedness priorities and developing exercises that assess capability-based objectives.

3.6.7. Develop the Medical Readiness Training and Exercise Schedule (MRTES), incorporating all training and exercise requirements described in this Instruction, including all AFSC and UTC readiness training, for example, in an executable format and timetable. Include unit developed readiness training programs under local purview and Wing training schedules as available. (T-2) This planning tool may be adjusted as training and exercise opportunities become available or are rescheduled. The RTAP TDs may be used in the development of training objectives for the MRTES. A sample MRTES format is provided on the AF Medical Readiness SharePoint Site.

3.6.8. Manage the utilization of MC-CBRN program funds in conjunction with medical logistics and the resource management office and in accordance with guidance in AFMAN 41-120, Medical Resource Management Operations, and AFTTP 3-42.32, Home Station Medical Response to Chemical, Biological, Radiological and Nuclear (CBRN) Events. (T-1)

3.6.9. For units that maintain HSMR assets (886 allowance standards (AS) for AFRC and AD units, 976 AS for ANG), report HSMR as a generation mission in MRDSS ULTRA and in capability readiness reports in DRRS. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.01)

3.6.10. Units that maintain HSMR assets are not authorized to decrease AS levels but may enhance local capabilities based on threat assessments, medical capabilities and limiting factors. Increases to AS levels must be approved by the MRC/EMC and documented in the minutes, and forwarded to the parent MAJCOM/SGX for final approval. (T-2) Exception: LRC units may modify 886 AS to provide appropriate capability through coordination with HQ ACC/SGXH and submitted to parent MAJCOM/SGX for approval.
3.6.11. ANG units that maintain the HSMR response assets (976 AS) will: (T-2)

3.6.11.1. Provide ANG manpower consisting of full-time installation staff members who are certified by on-site, formal DoD school, or other training programs through NGB/SGAX to support installation medical response.

3.6.11.2. Execute LAF PE 58036F to fund the ANG MC-CBRN program and coordinate sustainment requirements with NGB/SGX.

3.6.11.3. Report inventory results to NGB/SGX annually. ANG unit HSMR requirements are listed in Table 3.2.

3.6.11.4. ANG units may modify 976 AS to provide appropriate capability, with NGB/SGX approval.

Table 3.2. ANG HSMR Requirements.

<table>
<thead>
<tr>
<th>Team</th>
<th>Assemblage</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Decontamination Team</td>
<td>976A</td>
<td>Must have one full-time medic POC and 11 full-time non-medical personnel, as a minimum</td>
</tr>
<tr>
<td>BE Team</td>
<td>976H</td>
<td>Will consist of all full-time bioenvironmental personnel</td>
</tr>
<tr>
<td>Triage</td>
<td>976K</td>
<td>Has no full-time manning requirements</td>
</tr>
<tr>
<td>Public Health Team</td>
<td>976P</td>
<td>Will consist of one full-time Public Health member</td>
</tr>
</tbody>
</table>

3.6.12. AFRC units that maintain the HSMR Bioenvironmental Engineering (886H) assemblage will (T-2):

3.6.12.1. Designate the full time Bioenvironmental Engineering office, assigned to the MSG, to maintain the assemblages (N/A to Ft. Worth NAS and Pope AAF). Funding for 886H equipment/supplies and training is provided through PE 58211F.

3.6.12.2. For non-collocated AFRC units, work with host AD MTFs on maintenance of the 886H assets in Defense Medical Logistics Standard Support (DMLSS). The host MTF is responsible for establishing the account, ordering supplies and equipment, inputting receivables, and documenting inventory results in DMLSS. The supported unit will appoint a unit property custodian (normally BE personnel assigned to the MSG) for the assemblage. The property custodian ensures required inventories are conducted and forwards inventory documentation to the AFRC unit for completion of the inventory cycle within 30 days. (T-0: DoDI 3020.52) The property custodian monitors the assemblage status in MRDSS ULTRA. See AFI 41-209 for additional asset management guidance.

3.6.12.3. Ensure personnel assigned to the Bioenvironmental Engineering response team designated to use 886H assets are trained based on command guidance and execution of AFTTP 3-42.32 for the 886H AS. The response force may consist of a combination of BE, public health, civil engineers, or other designated personnel. Individuals identified for response will also be trained to perform health risk assessments and to enter the warm/hot zone using Self-contained Breathing Apparatus (SCBA).
3.6.12.4. For AFRC non-collocated units, provide the commander adequate information to make decisions - initial identification and basic assessment only (MOU/MOA/MAA with the local agencies may provide additional capability). Collect, package, ensure chain-of-custody, and transport biological samples.

3.7. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA).

3.7.1. MRDSS ULTRA provides enhanced global visibility of medical materiel, personnel, and their training to allow for the efficient management and deployment of those assets. MRDSS ULTRA is the official system of record for the management of expeditionary medical personnel and resources for the AFMS. It is the single authoritative source for medical readiness training for medical personnel and the authoritative medical document for UTC apportionment prior to entry into UTA. The governing directive for MRDSS ULTRA is this Instruction.

3.7.1.1. Access. Only authorized medical personnel and units, and others requiring access for official use, are granted access to MRDSS ULTRA. The data it contains will not be released nor provided outside the AFMS or supporting agencies without prior approval by appropriate level command authorities. The MRO/MRNCO/MRM and MRDSS ULTRA Unit System Administrator contact the MAJCOM MRDSS ULTRA representative to obtain an account, as well as MAJCOM-specific usage guidance. Other unit personnel, including E&T, unit Functional Training Managers, UDMs, and MCRP team chiefs contact the MRDSS ULTRA Unit System Administrator to obtain accounts. Note: The MRDSS Help Desk does not establish user accounts without MAJCOM or higher headquarters authorization.

3.7.1.2. Classification. The data contained within MRDSS ULTRA is for official use only (FOUO). Although it contains the raw statistical data used to compile classified operational readiness reports, it does not contain, report, collect, or display all the data elements for a UTC, nor does it include supporting remarks or allow for unit commander assessments of the ability of a UTC or MCRP team to perform its specific mission.

3.7.1.3. Data Currency. The MR Office will ensure the currency of MRDSS ULTRA data at all times and update it as events or changes occur. (T-2) Waivers for this requirement must be coordinated with the parent MAJCOM/SGX prior to submission, in accordance with AFI 33-360. Updates include the following, at a minimum: annotating training events, UTC assignments, MCRP team assignments, DAV codes, and unit information such as contact information for medical readiness and Medical Logistics staff (phone numbers, e-mail addresses, classified communication device numbers, and 24-hour contacts).

3.7.1.4. MRDSS ULTRA Functions. Units use MRDSS to:

3.7.1.4.1. Designate appointed positions, such as MRO/NCO/MRM, UDM, MEM, PHEO, Unit Functional Training Managers, team chiefs, etc.

3.7.1.4.2. Track E&T training for military members, civilians and contractors.

3.7.1.4.3. Assign personnel to UTCs and MCRP teams.

3.7.1.4.4. Schedule and track readiness training completion.
3.7.1.4.5. Track deployments of personnel and WRM.
3.7.1.4.6. Track CMRP training gaps.
Chapter 4

MEDICAL CONTINGENCY RESPONSE PLAN

4.1. Medical Contingency Response Plan (MCRP).

4.1.1. The MCRP is the medical unit commander’s plan, establishing procedures for the unit’s installation medical response missions identified in the IEMP 10-2. The MR Office will manage the preparation, coordination, publication, and distribution of the MCRP. (T-2)

4.1.2. The MCRP will be designed to address the results of the All-Hazards Risk Management Process and the installation’s vulnerability assessment. All MCRPs will include the areas listed in Table 4.1 in the basic plan and the annexes in Table 4.2. (T-1) Additional annexes and guidance may be included as necessary, based on the MTF’s mission, capabilities, and vulnerabilities/threats specific to the installation.

4.1.3. To capitalize on common efficiencies and optimize planning, MCRP annexes and appendices should mirror the installation’s IEMP 10-2, as closely as possible. The tasks and OPR(s) in the appendices are derived from specifically assigned response actions.

Table 4.1. Basic Plan.

<table>
<thead>
<tr>
<th>Title</th>
<th>Describes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Instructions</td>
<td>Include organizational structure, conditions of execution, references, assumptions.</td>
</tr>
<tr>
<td>Planning Factors</td>
<td>Include a description of the factors used in planning for a medical response. Some of items that maybe included are Population at Risk, clinic designation (inpatient/outpatient) and other things such as capability and hours of operation. Also, include how your unit is organized within the community as part of the hospital coalition or consortium. Reference the HVA for additional planning factors.</td>
</tr>
<tr>
<td>Preparedness/Mitigation</td>
<td>Outline established procedures for augmenting supplies, equipment and personnel during emergencies. Outline actions the unit will undertake to mitigate or the retrofitting measures before disasters to lessen the severity or impact a potential disaster may have on its operation.</td>
</tr>
<tr>
<td>Internal &amp; External Coordination</td>
<td>Include MTF-internal coordination and installation response partners. Identify existing MOU/MOA/MAA and other pre-coordination activities with local hospitals and community response partners.</td>
</tr>
<tr>
<td>Command and Control</td>
<td>Identify the organizational structure used for response (AFIMS and Incident Command System) and key elements.</td>
</tr>
<tr>
<td>Communication</td>
<td>Outline information flow and procedures for key C2 nodes including internal/external communication, maintaining situational awareness, operating log of events and Common Operating Picture (COP).</td>
</tr>
<tr>
<td>Recovery</td>
<td>Outline how the unit will return to normal operations. Team recovery will be outlined in their respective team checklists.</td>
</tr>
</tbody>
</table>
Recalls: Outline procedures for activation, assembly and 24-hour operations.

Medical COOP: Outline procedures for continuity of operations. Do not include potentially classified information, such as specific relocation sites.

<table>
<thead>
<tr>
<th>Annex</th>
<th>Describes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Major Accidents</td>
<td>Procedures for response to major accidents, such as nuclear weapons accidents, HAZMAT spills, aircraft accidents, fires, etc. as appropriate based on local vulnerabilities/threats specific to the installation. Activation of teams such as: MCC, FRT, ESF, and BEEs.</td>
</tr>
<tr>
<td>B – Natural Disasters</td>
<td>Procedures for response to natural disasters, such as earthquakes, wildfires, extreme heat and cold, hurricanes, tornadoes, floods, etc. as appropriate, based on local vulnerabilities/threats specific to the installation. Activation of teams such as: MCC, FT, and ESFs.</td>
</tr>
<tr>
<td>C – Enemy CBRNE Attack</td>
<td>Procedures for units in medium and high threat areas (MTAs, HTAs). Not applicable to units in low threat areas (LTAs) unless MAJCOM directed.</td>
</tr>
<tr>
<td>D – All Hazards</td>
<td>Actions based on the All Hazards Risk Management Process. Reference AFI 10-2501 for more information.</td>
</tr>
<tr>
<td>E – MTF Internal Emergencies</td>
<td>Procedures for responding to internal facility emergencies, such as fire, power outage, structural damage, flooding, active shooter, hostage/combative person, evacuation, shelter-in-place, hazmat spill, patient surge, infant/child abduction, and bomb threat. Refer to Medical COOP procedures outlined in the Basic Plan.</td>
</tr>
<tr>
<td>Annex</td>
<td>Describes</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F – Patient Support and Casualty Management</td>
<td>Maximum anticipated patient population during contingencies, projected changes in availability of medical services, including curtailment of routine services, and patient redistribution. For inpatient MTFs, casualty management procedures for specific work centers, to include casualty flow within the facility and transportation of casualties to the MTF. Additionally, detail patient administration tracking procedures for patients transferred/sent to other facilities. For outpatient units, field treatment/expedited transfer procedures from the incident site and patient administration tracking procedures for patients dispersed to downtown facilities. Procedures for use of the 886L and 886D assemblages for HSMR response, SG05 Pandemic Influenza Supplies, and SG10 Ebola Virus Defense assemblages. Procedures for Pandemic or Disease outbreaks. The facility’s AE role, including procedures to be used in the event of an unanticipated diversion of AE missions to the base, or the unplanned requirement to support patients, both inpatient and outpatient, remaining overnight.</td>
</tr>
<tr>
<td>Z – Distribution</td>
<td>See para 4.7.</td>
</tr>
</tbody>
</table>

4.1.4. Establish MCRP teams based on local capabilities and mission requirements. (T-2) A list of suggested MCRP teams and their roles is provided in Table 4.3. Include a functional description of the MCRP teams assigned to your unit. Additional teams may be created based on unique unit capabilities, threats and roles. If the unit possesses 886 AS assets, they must form and maintain the corresponding team, as listed in Table 4.4.

4.1.4.1. Team chiefs will develop and maintain individual team response checklists. (T-2) These checklists will be prepared and maintained separately from the MCRP to facilitate future updates, and will be reviewed annually, as part of the annual plan review. Reference the AF Medical Readiness Guide for additional information.

4.1.4.2. Units will develop and maintain current medical response checklists in support of installation plans, addressing unit control center activation, All-Hazards response, and casualty management, at a minimum. (T-2)
<table>
<thead>
<tr>
<th>Team</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Control Center (MCC)</td>
<td>Medical unit communication and coordination focal point; Maintains events and casualty status logs; Tracks casualties, patients, manpower, equipment and supplies through the entire event lifecycle, as required.</td>
</tr>
<tr>
<td>Information Services Disaster Response Team (ISDRT)</td>
<td>Supports Medical COOP operations by reacting to disasters or downtime, preventing, and detecting data loss or compromise from further intrusion, recovering and maintaining IS, and coordinating with outside agencies to restore critical systems. Team responsibilities include assessing damage to IS hardware, software, and data; notifying various agencies (Air Force Computer Emergency Response Team (AFCERT), MAJCOM, Legal, Public Affairs, etc.); ensuring the MTF meets current Information Operations Condition (INFOCON) levels checklists; denying access to or shutting down vulnerable systems; and maintaining and prioritizing a list of critical systems and associated administrators of those systems. Note: This team may be combined with the MCC.</td>
</tr>
<tr>
<td>Field Response</td>
<td>Initial medical response and any follow-on medical response to the scene as requested by the incident commander; Responsible for assessing the situation, requesting additional medical support as necessary, and providing triage, treatment and stabilization on-scene; Utilize the 886J assemblage for HSMR.</td>
</tr>
<tr>
<td>Laboratory Biological Defense Team (LBDT)</td>
<td>Identify biological agents of operational concern in environmental and clinical samples (not applicable to units that do not maintain AS 886I); Utilize the 886I assemblage for HSMR.</td>
</tr>
<tr>
<td>Triage Team</td>
<td>Primary team - provide triage of patients arriving at the MTF Secondary team - provide re-triage after patient decontamination, when activated; Utilize the 886K assemblage for HSMR.</td>
</tr>
<tr>
<td>Clinical Team</td>
<td>Provides patient support and casualty management. Team receives and provides/arranges for medical treatment of patients. Establishes procedures to manage patients throughout the facility in a safe, effective manner. In facilities where there is adequate staffing to support separate Minimal, Delayed and Immediate teams, separate teams may be formed. In this situation, the immediate team chief is responsible for the 886D, AS 886L and SG05 and SG10 assemblages.</td>
</tr>
</tbody>
</table>
Team | Functions
---|---
Patient Decontamination Team | Provides patient decontamination prior to entry into the MTF or transport to another medical facility. Utilize the 886A assemblage for HSMR.
Patient Administration Team | Provides patient tracking and status reporting of casualties within the facility and those transported to other area medical facilities during contingency operations, in accordance with AFI 41-210, *TRICARE Operations and Patient Administration*.
Disaster Mental Health (DMH) Team | Provides mental health services to patients and families, hostage negotiation consultation as well as support for First and Emergency Responders; Reference AFI 44-153, *Disaster Mental Health Response & Combat And Operational Stress Control*, for additional guidance.
Manpower and Security Team | Support wing/installation terrorist threat response and carry out Force Protection Condition actions within and around the facility; Deployment and management of manpower team members during an emergency; Manpower and Security Decontamination Support Team is a sub-team of the Manpower and Security team, specifically designated and trained to support patient decontamination operations; Utilize the 886M assemblage for HSMR.

### 4.2. Home Station Medical Response (HSMR) Teams.

4.2.1. The teams listed in Table 4.4 provide HSMR and maintain equipment and supplies that exceed those necessary for normal day-to-day operations (see AFTTP 3-42.32, *Home Station Medical Response to CBRN Incidents*).

4.2.2. If a unit maintains an assemblage (based on the unit’s MRL), they must appoint the corresponding team chief and team members, and address team response functions in the MCRP and response checklists. The corresponding team chiefs are responsible for maintaining assigned assemblage in accordance with AFI 41-209, *Medical Logistics Support*. The assets must be stored in ready status and in locations that are easily accessible during duty and non-duty hours. (T-2) Table 4.5 applies to ANG units only. **Note:** Assemblages listed in the Unit HSMR AS Applicability Table on the AF Medical Readiness SharePoint site provide a baseline capability for identified unit types.

#### Table 4.4. Allowance Standards with Associated MCRP Teams.

<table>
<thead>
<tr>
<th>HSMR Assemblage</th>
<th>Installation Medical Response Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>886A, Patient Decontamination¹</td>
<td>Patient Decontamination Team</td>
</tr>
<tr>
<td>886D, Inpatient Medical Follow-on</td>
<td>Clinical Team</td>
</tr>
<tr>
<td>886E, Pharmacy Response</td>
<td>Pharmacy</td>
</tr>
</tbody>
</table>
A minimum of 12 trained medical personnel are required to staff the patient decontamination system and perform decontamination. Minimum training requirements are provided in chapter 5. Ensure sufficient additional personnel are trained as augmentees to perform patient decontamination to allow for continual operations and team member work/rest cycles. The 886A AS has sufficient PPE for up to 24 personnel.

2 A Manpower/security decontamination support team may be established to provide support to the decontamination process if necessary.

Table 4.5. ANG Medical Teams and Associated AS.

<table>
<thead>
<tr>
<th>HSMR Assemblage</th>
<th>Responsible Team Chief</th>
<th>Located at</th>
<th>Composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>976A, Patient Decontamination¹</td>
<td>Patient Decontamination Team Chief</td>
<td>ANG Non-Collocated units. Collocated units will be assigned to teams under their AD host as needed</td>
<td>1 full-time medical AFSC and 11 full-time non-medical AFSCs</td>
</tr>
<tr>
<td>976H, Bioenvironmental Engineering</td>
<td>Bioenvironmental Engineering Flight Chief or Team Chief</td>
<td>ANG Medical Units who have BE Staff</td>
<td>Full-time Bioenvironmental Engineering Staff</td>
</tr>
<tr>
<td>976K, Triage</td>
<td>Triage Team Chief</td>
<td>materiel only</td>
<td>No manpower, materiel support to responders only</td>
</tr>
<tr>
<td>976P, Public Health</td>
<td>Public Health Flight Chief or Team Chief</td>
<td>ANG Medical Units who have PH Staff</td>
<td>Full-time Public Health Staff</td>
</tr>
</tbody>
</table>
4.3. Special Planning Considerations.

4.3.1. LRC and Deployed MTFs are not required to prepare an MCRP. However, these units will conduct a realistic assessment of their contingency response capabilities (including HSMR) and incorporate them into the IEMP 10-2, or sister service equivalent. (T-2) Use the MCRP annex framework in table 4.2 as a guide in preparing the unit’s installation medical response input. Clearly identify the unit’s capabilities, roles and responsibilities in support of a collaborative installation response, including support provided via MOU/MOA/MAA, as appropriate. Ensure assigned personnel are trained and record this training in MRDSS ULTRA utilizing existing MCRP team names as applicable. Local MCRP team training requirements may be added to allow for tracking of unit-unique training. Contact the MRDSS Help Desk for assistance.

4.3.2. ARC and Aeromedical Evacuation (AE) units collocated with an AC MTF are considered available medical resources and may be, with prior coordination, included in the AC MTF’s MCRP as such.

4.3.3. Depending on local capabilities, particularly for OCONUS units, support may be provided by another AF MTF.

4.3.4. Units in multi-service or multi-unit areas, e.g. San Antonio or Colorado Springs, will develop an integrated MCRP, addressing a unified response to a citywide event or incident, as well as interaction between units and with local emergency management officials. (T-2)

4.3.5. FCCs will identify where the FCC PRA plan is maintained through an MCRP Annex labeled “FCC PRA Plan”.

4.4. Medical Continuity of Operations (COOP).

4.4.1. Medical COOP involves the evacuation and dispersal of patients from the MTF as rapidly and safely as possible, staging them in a pre-designated location and providing necessary medical care only until dispersal activities are complete. Medical COOP does not involve relocating vast amounts of supplies and personnel to an alternate location for the purpose of continuing routine patient care, although units that have the capacity or responsibility to continue to provide services to AD base populations may plan to do so.

4.4.2. For Medical COOP, the core mission essential functions (MEF) to be addressed in the MCRP include: 1) medical command and control for the evacuation and dispersal; 2) patient support, to include facility evacuation, dispersal, transportation, tracking, and pandemic response, at a minimum; 3) staff support, to include evacuation, dispersal, and accountability; 4) medical response activities, to include critical installation support; 5) Command, Control, Communications, Computers and Information (C4I), to include relocation and continuity of medical command and control, as well as information sharing with beneficiaries, staff, and higher headquarters. Units may add additional MEFs based on their unique missions, capabilities, and beneficiary population needs. List and prioritize all MEFs in the MCRP.

4.4.3. See AFI 10-208, Air Force Continuity of Operations (COOP) Program, for additional non-medical specific guidance.

4.5. MCRP Coordination.

4.5.1. All offices and agencies tasked to provide any kind of support in the MCRP must coordinate on the plan, specifically approving their roles and responsibilities. (T-2)
4.5.2. If unable to obtain coordination with an off-base agency, develop a memorandum for record (MFR) and attach all correspondence (e-mails, memos, phone records, etc.) to document their attempts to gain formal coordination.

4.5.3. Submit a copy of the draft MCRP to the parent MAJCOM/SGX for review after full coordination with applicable agencies and MRC/EMC approval, but prior to publication. MAJCOM/SGXs will accomplish plan reviews within 60 days; concurrence is implied if no comments are received within that period.

4.6. MCRP Review.

4.6.1. Units will review the MCRP and supporting checklists annually for currency and make changes as necessary. (T-3) Coordinate changes with all affected agencies and distribute according to the original plan distribution.

4.6.2. The MCRP will be rewritten when there is significant change in the wing's mission or unit capabilities. The plan must be reviewed annually by Team Chiefs and the MRC and documented in MRC minutes. (T-2) If changes are made, ensure they are coordinated with all impacted agencies. Update the MCRP publication date in MRDSS ULTRA whenever the plan is re-published.

4.7. MCRP Distribution.

4.7.1. Distribute copies of the MCRP and appropriate checklists to each office that plays a role in its execution.

4.7.2. The MR Office will maintain additional copies for transfer to the shelter, Medical Continuity of Operations (COOP) alternate command and control (C2) location, and the installation EOC, as applicable. (T-3)

4.8. Memoranda of Understanding (MOUs), Memoranda of Agreement (MOA), and Mutual Aid Agreements (MAAs).

4.8.1. Support to the MTF from off-base agencies must be coordinated in writing, in the form of an MOU, MOA, or MAA, in accordance with AFI 25-201, Support Agreements Procedures. (T-2) Do not duplicate existing agreements and contracts, such as the TRICARE contract.

4.8.2. Approval of an MOU/MOA/MAA constitutes agreement with the MCRP contents; therefore, an additional staff summary sheet is not required.
Chapter 5
MEDICAL READINESS TRAINING

5.1. Training Philosophy.

5.1.1. All medical personnel must be fully trained to meet the task requirements associated with globally integrated operations (GIO). Leaders at all levels have an inherent responsibility to ensure their personnel receive the full spectrum of required training, from individual level through collective and unit level readiness training.

5.1.2. The Comprehensive Medical Readiness Program (CMRP) divides medical readiness training into categories to support targeted application of requirements for specific specialties, personnel, and missions across the full spectrum of AF military medical operations. Category I, Clinical Currency, and Category II, Readiness Skills Training, are levied using CMRP checklists developed by specialty consultants, corps directors and CFMs. Category III, UTC Training, is levied by the Category III Training Guide maintained on the AF Medical Readiness SharePoint Site. Category IV, MCRP Team Training, consists of standardized training required for all like teams across the AFMS as well as unit-specific training requirements.

5.1.3. Recognizing all medical personnel must maintain a baseline training standard, medical personnel assigned to non-medical units will complete the Category I (if applicable) and II training requirements in this chapter, as well as any specialized training for their unique medical missions. (T-1)

5.2. Initial Medical Readiness Training.

5.2.1. Airmen are trained to initial proficiency upon entry into the Air Force, or join the Air Force with verifiable AFSC-specific credentials. Enlisted personnel receive initial medical readiness training through Expeditionary Medical Readiness Course (EMRC) or Basic Expeditionary Medical Readiness Training (BEMRT) in conjunction with their AFSC-awarding courses. Officers receive initial medical readiness training as part of COT or Reserve Commissioned Officer Training (RCOT) courses, or through a commissioning program such as a service academy, Reserve Officer Training Corps (ROTC) or Officer Training School (OTS).

5.2.2. Curricula for these courses provide the initial medical readiness training elements listed in Table 5.1., at a minimum.

Table 5.1. Initial Medical Readiness Training Topics.

<table>
<thead>
<tr>
<th>Training Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEF Concept/Structure</td>
<td>Familiarization of current Air Expeditionary Force concepts</td>
</tr>
<tr>
<td>The Deployment Cycle</td>
<td>Phases of deployment, pre-deployment, initial deployment, build up, sustainment, termination/re-deployment</td>
</tr>
<tr>
<td>Training Element</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AFMS Concepts of Operations (CONOPS)</td>
<td>AFMS Mission, DoD Medical Service Capabilities, Joint operating concepts, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), threats and potential battlefield environments (including site security to include Law of Armed Conflict and Geneva Conventions, force protection, anti-terrorism measures), and awareness of home station response mission</td>
</tr>
<tr>
<td>Combat Stress Control</td>
<td>Signs and symptoms of stress, treatment and assistance</td>
</tr>
<tr>
<td>Casualty Movement</td>
<td>Casualty evacuation concepts, litter carries, AE familiarization</td>
</tr>
<tr>
<td>Shelter Assembly</td>
<td>Procedures for unpacking the shelter system, erecting the shelter system, procedures for re-packing the shelter system, procedures for site clean-up</td>
</tr>
<tr>
<td>Field Sanitation and Hygiene, Disease Prevention</td>
<td>Occupational and environmental hazards, disease types and countermeasures, types of waste and their disposal, force health surveillance</td>
</tr>
</tbody>
</table>

5.3. **Non-standard Training Situations.**

5.3.1. **Training While Deployed.** Personnel are required to be fully trained prior to deployment. Therefore, deployed units are not expected to conduct medical readiness training. However, personnel should take full advantage of any training opportunities provided, to include joint training with coalition partners, sister services, and host nation medical forces. Upon return to home station, members may request credit for training accomplished during deployment, with appropriate documentation, in accordance with this Instruction.

5.3.2. **Students.** Members in a formal training or student status are exempt from all medical readiness training requirements, including Comprehensive Medical Readiness Program (CMRP) training. Training or student status includes but is not limited to students, interns, residents, fellows, and those enrolled in Health Professions Scholarship Program (HPSP) or similar programs. Participation in local readiness training venues and exercises is highly recommended whenever available.

5.3.3. **Medical Institutional Forces (IF).** Personnel assigned to higher headquarters, such as MAJCOMs, certain Field Operating Agencies (FOA) and the Air Staff will complete the CMRP requirements identified in this chapter when assigned to a standard deployable UTC or when tasked to deploy.

5.4. **Training Documentation.**

5.4.1. All medical readiness training, including equivalency training credit (as applicable), is documented in MRDSS ULTRA for: (T-2)

5.4.1.1. Assigned unit personnel.
5.4.1.2. IMAs that are attached to the unit. Assign IMAs to the FFAZZ Associate UTC in MRDSS ULTRA for tracking purposes. They do not count against unit training statistics.

5.4.1.3. Other medical personnel on or off base who do not work within the medical facility (e.g. Squadron Medical Element (SME) personnel). These individuals are tracked by associating their unit’s Personnel Accounting System Code (PASCODE) with the MTF within MRDSS ULTRA. Doing so will ensure personnel do not affect MTF training statistics. For remotely located medical personnel (e.g. recruiters), the nearest MTF will assume responsibility for tracking their training. (T-3) Obtain the PASCODE for the unit to be associated and contact the MAJCOM/SGX MRDSS Administrator for assistance. If coordination of training events or dates with these units is not successful, document associated communications in a memorandum for record. **Exception:** AF Special Operations Command (AFSOC) Operational Support Medicine (OSM) flights and AFSOC medical personnel assigned to Special Tactics Groups/Squadrons (STG/STS) track their own training in MRDSS ULTRA.

5.4.2. Air Force Training Record (AFTR). AFSC functional managers will review and print CMRP checklists and AF Forms 1098 from MRDSS ULTRA, ensuring all training requirements have been completed and properly documented prior to an enlisted member’s deployment. (T-1) Upload these documents into the member’s AFTR following the review. Upon the member’s return to home station, the functional manager will determine if any relevant training was accomplished during the deployment and, if so, document it in AFTR and upload any AF Forms 1098/AF Forms 623a provided. (T-3)

5.5. Training Equivalency.

5.5.1. Formal Courses. A list of training requirements that may be met through attendance of formal courses, such as EMRC, BEMRT and Commissioned Officer Training (COT), is provided on the Medical Readiness Training Equivalency Matrix on the AF Medical Readiness SharePoint Site in the AFI 41-106 Toolbox.

5.5.2. Exercises. A list of exercises the MRAs have approved for sustainment training credit may be found on the MRA’s SharePoint Site. Sustainment training credit may also be approved by the appropriate MRA for local UTC Mission Essential Task-driven exercises validated by a qualified team not to include exercise participants (i.e. WIT, MR office members, other medics not participating, etc.). Local exercises must use UTC equipment packages and follow the checklists and timelines found on the MRA’s SharePoint site to qualify for sustainment training credit. Upon completion of the exercise, an exercise AAR listing personnel and equipment UTCs utilized in the exercise and a list of participants must be submitted within 30 days to the appropriate MRA for sustainment training approval. When approved, the MRA will update the sustainment training in MRDSS ULTRA using the exercise end date as the training completion date.

5.5.3. Deployments. Members may request UTC sustainment training credit for participation in real world operations and/or deployments. Members who have deployed and performed duties consistent with their assigned UTC, utilizing the UTC’s assigned war reserve materiel (WRM) equipment assemblages in an expeditionary (Bare Base) environment may request UTC sustainment training credit. Requests will be forwarded through the parent MAJCOM/SGX to the appropriate MRA for approval.
5.6. CMRP Category I, Clinical Currency for Readiness.

5.6.1. Clinical Currency for Readiness is defined as the fundamental clinical skills of an Airman, usually obtained through medical education and in-garrison care that form a foundation on which to build readiness skills. It is the foundation of the Comprehensive Medical Readiness Program (CMRP) and applies to all medical personnel with clinical specialties who are required to have up-to-date clinical skills in a practice environment. Clinical currency tasks are defined by specialty consultants and CFMs and may involve tracking the level of patients/procedures (volume, acuity, and diversity) to advance along the currency continuum. There are multiple venues for maintaining clinical currency including, but not limited to, local TAAs, SMART, and C-STARS. Unit Functional Training Managers will document Category I training using the CMRP checklist in MRDSS ULTRA and update the clinical currency verification date in accordance with consultant or CFM guidance.

5.6.2. All Category I training will be current prior to entering a deployment vulnerability period (DVP). Any clinical currency training that will expire during the DVP must be reaccomplished prior to entry into the DVP. Personnel who are considered deployed in place and those who are required to maintain a high state of readiness (assigned an AEFI of YR) must be current on Category I training at all times. (T-1)

5.6.3. Privileged providers and non-privileged medical professionals will also follow the policies in AFI 44-119, Medical Quality Operations, pertaining to licensure, credentials, privileges, and certification requirements. In addition, personnel holding certain clinical AFSCs may be required to maintain currency in Basic Life Support (BLS), Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), National Registry of Emergency Medical Technicians (NREMT), Prehospital Trauma Life Support (PHTLS), or other life support training, in accordance with AFI 44-102, Medical Care Management.

5.6.3.1. Education and Training (E&T) office personnel will validate requirements for each specialty and track this training for military members, civilians, and contractors in MRDSS ULTRA. (T-1) Representatives from the E&T office will be given MRDSS ULTRA accounts for this purpose. Larger facilities may designate a second MRDSS ULTRA Unit System Administrator in the E&T office specifically to manage E&T accounts.

5.6.3.2. For personnel tasked to deploy, licensure, credentials or certifications with expiration dates during the projected deployment vulnerability period must be reaccomplished prior to departure. Certifications expiring during unplanned deployment extensions may be waived until the individual returns to home station. (T-1)

5.7. CMRP Category II, Readiness Skills Training (RST).

5.7.1. Readiness Skills Training is defined as the skills specific to an AFSC, which allow an Airman to perform within the full scope of their AFSC in a deployed setting. There are multiple venues for accomplishing RST, including but not limited to local training, C-STARS, and the Emergency War Surgery Course. Refer to the CMRP matrix on the AF Medical Readiness SharePoint Site and CMRP checklists for additional guidance. Unit Functional Training Managers will document Category II training using the CMRP checklist MRDSS ULTRA and update the clinical currency verification date in accordance with consultant or CFM guidance.
5.7.2. Personnel will complete Category II training for their Control AFSC (CAFSC) for enlisted or Duty AFSC (DAFSC) for officers. (T-1) Contact the appropriate specialty consultant, corps director or CFM to determine Category II training requirements for commanders on G series orders.

5.7.3. Personnel who are utilized as authorized substitutes on a standard UTC must complete Category II training for the AFSC they are filling on the UTC, as well as their own AFSC. (T-1) Waivers or exemptions to this policy must be approved by the specialty consultants, corps directors or CFMs for both AFSCs. **Exception:** For UTCs that allow AFSC neutral substitutions (e.g. FFGLB and FFHSR), authorized substitutes complete RST for their own AFSC only.

5.7.4. For personnel required to complete Category II, training will begin as soon as individuals report to their first duty station, after completing technical training or professional education. Category II training is required as follows:

5.7.4.1. All personnel assigned to a standard deployable UTC will be current on Category II training prior to entering their deployment vulnerability period (DVP) and remain current for the duration of the DVP.

5.7.4.2. Personnel not assigned to a standard deployable UTC, but who are assigned to specific Specialty Currency Platform MTFs and possess a critical operational medical specialty, as listed on the CMRP Training Matrix available on the AF Medical Readiness SharePoint Site, will be current on Category II training prior to entering their DVP.

5.7.4.3. Personnel not assigned to a standard deployable UTC, but who are assigned to a Currency Platform MTF and possess an AFSC that is required on a UTC postured at that unit, will be current on Category II training prior to entering their DVP. For exceptions, see CMRP Training Matrix on the AF Medical Readiness SharePoint Site.

5.7.4.4. Personnel who do not meet the criteria described in paragraphs 5.7.4.1. through 5.7.4.3. above may accomplish Category II training just in time, upon receipt of a deployment tasking, unless directed otherwise by the by the specialty consultant, Corp Director, or CFM.

5.7.5. Category II training may be waived by the unit commander for individuals who will be non-deployable for the duration of their deployment vulnerability period (DVP), when appropriate. Waived individuals must complete required training once they are returned to deployable status. (T-3)

5.8. **CMRP Category III, UTC Readiness Training.**

5.8.1. UTC Readiness Training is defined as training specific to a UTC to which an Airman is assigned. UTC formal course curricula will include the medical readiness training elements listed in Table 5.2., at a minimum, in accordance with DoDI 1322.24, *Medical Readiness Training.*
<table>
<thead>
<tr>
<th>Training Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats and potential battlefield environments.</td>
<td>Includes disease prevention and field sanitation and hygiene</td>
</tr>
<tr>
<td>Operational concepts of operation.</td>
<td>AFMS Mission, DoD Medical Service Capabilities, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), Threats and Potential Battlefield Environments, Awareness of home station response (MCRP) mission</td>
</tr>
<tr>
<td>Operational command, control, and communications.</td>
<td>Activities that use information and business management systems to facilitate day-to-day operations in support of operational missions, including the use of radio communications, Information Management/Information Technology (IM/IT). Reference AFTTP 3-4, <em>Airman’s Manual</em>.</td>
</tr>
<tr>
<td>Preventive medicine, including field sanitation and hygiene.</td>
<td>Personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities. Operational measures for countering endemic disease, prevention of non-battle injuries, mental health, countering disease vectors in field and urban environments, environmental health threats, and force health surveillance will be covered.</td>
</tr>
<tr>
<td>Occupational and environmental hazard recognition, mitigation, and reporting.</td>
<td>Public Health/Bioenvironmental personnel accomplish site selection surveys and travel to off-site locations to evaluate a market setting and village setting to conduct surveys on food, water, and health concerns.</td>
</tr>
<tr>
<td>Combat stress control (CSC)</td>
<td>Familiarization with basic principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment.</td>
</tr>
<tr>
<td>Identification and treatment of endemic infectious diseases.</td>
<td>Public Health personnel review Medical Intelligence Report on deployed location and make recommendations to commander and medical staff on immunizations and prophylaxis prior to deployment. International Health Specialists (IHS) may also advise on endemic infectious diseases, partner nation medical systems, and local resources.</td>
</tr>
<tr>
<td>Identification and treatment of traumatic injuries.</td>
<td>Clinical aspects of medical management of casualties and disease non-battle injuries, particularly triage and initial evaluation; gunshot wounds; vascular, neurological, orthopedic, maxillofacial, and hypo/hyper thermal stress injuries; burns, bandaging, and splinting; hypovolemic shock; eye injuries; and use of blood products.</td>
</tr>
<tr>
<td>Training Requirement</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Medical support of stability operations, humanitarian assistance activities, homeland defense and defense support of civil authorities.</td>
<td>AFMS Mission, DoD Medical Service Capabilities, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), Threats and Potential Battlefield Environments, Awareness of home station response (MCRP) mission</td>
</tr>
<tr>
<td>Recognition and medical management of chemical, biological, radiological, nuclear, and explosive injuries.</td>
<td>Clinical staff is trained to recognize types of injuries/illnesses during triage, upon presentation to the field clinic, and then establish procedures to manage the patient throughout the facility in a safe, effective manner during a field exercise.</td>
</tr>
</tbody>
</table>

5.8.2. All personnel assigned to standard deployable UTCs will complete Category III training in accordance with the following paragraphs and the Category III training guide maintained on the AF Medical Readiness SharePoint Site. (T-0: DoDI 1322.24) All required Category III training will be current prior to entering a DVP and must be current for the duration of the DVP. Any training that will expire during a DVP must be reaccomplished prior to entering the DVP. Personnel required to maintain a high state of readiness (assigned an AEFI of YR) will complete training no later than six months after assignment to the UTC. (T-1)

5.8.2.1. For UTCs that have formal UTC courses, credit for initial and one-time-only Category III training is granted by attending the appropriate UTC formal course. However, in the case where a member has an opportunity to participate in an exercise prior to initial attendance of the course, credit may be requested through the parent MAJCOM/SGX to the appropriate MRA for approval. The exercise end date will be entered as the sustainment training completion date in MRDSS ULTRA.

5.8.2.2. Sustainment training for courses with recurring training requirements is completed every 36 months by AC personnel and every 48 months by ARC personnel, except as noted in the TTP. Sustainment training consists of participation in an RTOC-sponsored exercise or an MRA-approved UTC MET-driven exercise, is accomplished between formal course attendance, and is designed to keep UTC members’ skills current.

5.8.2.3. Personnel who are not assigned to a standard deployable UTC but are tasked to deploy in a standard UTC, must complete all appropriate Category III training for the tasked UTC position prior to deployment.

5.8.2.4. Personnel assigned to a standard UTCs who have attended a UTC formal course should remain on that UTC for a minimum of one training cycle (36 months for AC or 48 months for ARC).

5.8.2.5. For UTCs that do not have formal UTC courses, Category III training will consist of reviewing the UTC Tactics, Techniques and Procedures (TTP), Mission Capability Statements (MISCAPS), Mission Essential Task (MET) Lists, and allowance standards (AS).

5.8.2.6. Individuals assigned to FFCCT and FFTCT UTCs will meet all requirements outlined in AFTTP 3-42.51. (T-1)
5.8.3. Units will use the Category III Training Guide, provided on the AF Medical Readiness SharePoint site, for training requirements and comply with the scheduling process described therein. (T-1)

5.9. CMRP Category IV, Installation Medical Response Training.

5.9.1. Installation medical response training is part of the readiness currency continuum conducted at the unit and is designed to ensure members understand their roles and responsibilities, are proficient with assigned equipment, necessary skills, and can execute associated medical response procedures. Training is required for all members assigned to an MCRP team or, for LRC units, members identified to support installation medical response, and will be tailored to the mission and unit capabilities. (T-1) At a minimum, training will include familiarization with plans and procedures, response checklists, and assigned equipment. (T-1) Sustainment training is accomplished annually and includes hands-on refresher training with assigned equipment.

5.9.2. HAZMAT training requirements established by AFI 10-2501, Air Force Emergency Management Program, and Occupational Safety and Health Administration (OSHA) Best Practices is required for First Receivers/Responders on an annual basis. (T-1) This HAZMAT training is implemented in the AFMS as follows:

5.9.2.1. Enhanced First Responder Awareness: This training is a HAZMAT First Responder Awareness course designed specifically for the Field Response Team and ambulance drivers.

5.9.2.2. First Receiver Awareness: This training is a HAZMAT First Responder Awareness course designed specifically for medical first receivers. First Receiver Awareness training is required for all personnel who work in the medical facility who may have contact with contaminated patients, their belongings, equipment, or waste. The commander may use discretion in deciding if personnel who aren’t likely to come in contact with patients, require this training. BE personnel are not required to accomplish this training.

5.9.2.3. Combined First Receiver Awareness and Operations Training: This training is the combined HAZMAT First Receiver Awareness and Operations course. This training is required for all personnel who have a designated role in or around the decontamination zone outside the medical facility. Members need to successfully complete both the didactic and hands-on training with the PPE to meet the initial training requirement. Annual requirements can be met with a demonstration of competencies during an exercise, tactical drill or real-world response.

5.9.2.4. HAZMAT First Responder Operations: All Bioenvironmental Engineering personnel require HAZMAT Operations level training and DoD certification.

5.9.3. Respiratory Protection: All personnel required to utilize respiratory protection will comply with the requirements of AFI 48-137, Respiratory Protection Program, as applicable. (T-0: 29 CFR 1910.134)

5.9.4. Patient Decontamination Training: The Patient Decontamination Team Chief and NCOIC will attend and successfully complete the Patient Decontamination Course (L3ORP4XXX 00DA) or the mobile Patient Decontamination Course one-time only, within
six months of assignment to the team. (T-1) Within 90 days of completion of the course, the team chief and NCOIC will train the remaining team members using the assigned patient decontamination assemblage, AS 886A. (T-1) **Note:** For team chiefs and NCOICs stationed at remote locations, attendance of the course is not required as long as they are trained locally by an individual who has attended the formal course. This training must occur within 30 days of assignment. If no formally trained individual is available, the team chief and NCOIC must attend the formal course. (T-2) Training can be also accomplished through other courses, as approved by HQ ACC/SGX.

5.9.5. **JBAIDS Training:** Laboratory Biological Detection Teams (LBDT) maintaining JBAIDS or other LBDT equipment will have at least 2 members of the team current in the requirements for each assigned asset. (T-1) Requirements for each asset include completion of the respective formal course (one-time only) and compliance with the corresponding proficiency/competency program every 12 months by each member.
Chapter 6

EXERCISES

6.1. Exercise Requirements.

6.1.1. Non-medical exercise requirements may be met by participating in wing/installation exercises. If the wing/installation does not accomplish all exercises listed in AFI 90-201, the MTF/LRC unit is not expected to accomplish them independently. However, if wing exercises that are conducted do not adequately test the unit’s capabilities (for example, the exercise stops at the entrance to the medical facility), units will develop internal scenarios to supplement or extend the exercise.

6.1.2. Units should make every effort to maximize participation in exercises while minimizing disruptions to patient care.

6.1.3. The following are medical-specific exercise requirements:

6.1.4. Recalls. Recall exercises demonstrate the unit’s ability to return to duty in response to a contingency situation. Acceptable response standards are generally established by the wing. If no wing standard exists, the MRC must establish the standard and include it in the Basic Plan of the MCRP. Conduct each of the following recall types at least once annually: MCRP Teams, UTCs, deployment support teams, and one unit-wide recall. The unit-wide recall may alternate between telephonic voice or text only and report-to-duty each year and may be combined with other exercises, as appropriate. (T-2)

6.1.5. Installation Medical Response. Units that publish MCRPs are required to conduct installation medical response exercises. (T-0: The Joint Commission (TJC) Emergency Management Standards) At the commander’s discretion, annexes may be exercised together, as part of a comprehensive exercise, as functionally appropriate to support realistic scenarios and response, while minimizing impact to wing operations and patient care. Units that do not publish MCRPs, but provide input to the IEMP 10-2 or sister service equivalent IEM plans, must also exercise this capability annually. (T-0: TJC Emergency Management Standards) Emergency response exercises will include an influx from outside the organization of volunteer or simulated casualties. Enough casualties should be used to adequately test the organization's resources and reactions under stress.

6.1.6. Comply with reporting and documentation requirements in this Instruction for all exercises. (T-1)

6.1.7. Additional information is provided in the AF Medical Readiness Guide.

6.2. Exercise Credit.

6.2.1. Medical units may take exercise credit for a real world response of similar scope and magnitude to the exercise requirements. For example, a response to a bus accident with multiple casualties utilizing numerous MCRP teams may satisfy a major accident exercise requirement.

6.2.2. Credit may be taken only when objectives are met for the specific exercise type or subsequent corrective action is successful.
6.3. Special Exercise Considerations.

6.3.1. LRC units will work with their wing/base/installation IG (or equivalent) to determine the best way to conduct required exercises. Exercises should be combined with sister service or wing/base/installation exercises to the greatest extent possible. Exercise scenarios must be developed collaboratively to test medical response capabilities as they would realistically be employed. In addition, LRC units will conduct each of the following recall types annually: installation medical response teams, UTCs, deployment support team(s), and one unit-wide recall. The unit-wide recall may alternate between telephonic only and report-to-duty each year and may be combined with other exercises, as appropriate. (T-2) LRC units may also be required to participate in host unit/service exercises.

6.3.2. Deployed MTFs should participate in the host wing/base/installation’s exercise program, as mission requirements permit, especially major accident response. Deployed MTFs are not expected to plan or conduct large-scale exercises on their own; however, deployed MTFs will conduct a unit-wide recall, or personnel accountability exercise, every three months. (T-2)
Chapter 7

MEDICAL READINESS REPORTING

7.1. Readiness Reports.

7.1.1. Resource and capability readiness reports provide higher headquarters and other interested organizations, up to and including the Office of the Secretary of Defense and National Command Authority, necessary information to make critical decisions with regard to deployments and resource requirements.

7.1.2. The first two reports described below are updated at the unit level each month, giving commanders the opportunity to assess and report their unit resources and capabilities. The remaining reporting processes are accomplished as needed to relay vital information to higher headquarters before, during, or after a deployment or major event, as directed in this Instruction and referenced governing directives.

7.2. Resource Readiness Reporting.

7.2.1. Resource readiness reporting is accomplished using the AF Input Tool (AF-IT) in Defense Readiness Reporting System (DRRS). Personnel (total and critical), training, equipment and supplies on-hand are reported in accordance with the AF Tables in DRRS. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.02)

7.2.1.1. Reference AFI 10-201, Force Readiness Reporting, for reporting guidance.

7.3. Capability Readiness Assessments.

7.3.1. Capability readiness assessments are accomplished in DRRS and focus on the full scope of the unit’s core mission capabilities assessed against mission essential tasks (METs), which are informed by the resource readiness report and UTC readiness assessments (ART). Medical unit commanders will assess unit mission capabilities in accordance with AFI 10-201, and the following: (T-0: DoDI 6055.17, DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.02)

7.3.1.1. For deployment missions, consider the deployability, availability, and training of personnel assigned to applicable UTCs, and critical percentages for assigned contingency materiel. Contingency materiel maintained for other units will be assessed by the “owning/using” units.

7.3.1.2. For in-place/generation/homeland response missions, consider all assigned unit personnel, to include military members, civilians, and contractors, and their required training (e.g. UTC and MCRP team training), when assessing mission capability.

7.3.1.3. Consider mission manning, training, resources, as well as results of exercises and inspections when assessing the unit’s mission capabilities.

7.3.1.4. Units with more than one “copy” of a UTC will assess the mission as a whole. (T-2)

7.3.1.5. For units with fragmented (shared/split) UTCs, the parent/supported unit, as the “owner” of that mission, assesses the fragmented mission capability as a whole. Supporting units (those providing manpower to another unit’s UTCs) will not assess their
portion(s) of that mission in their capability assessment. (T-2) **Note:** This is different from resource readiness reporting, in which a unit is reporting the readiness of assigned resources, rather than assigned missions.

7.3.1.6. Assessment of the All-hazard Installation Medical Response MET should be informed by RTAP TDs, wing/medical response plans, exercise AARs, team status, and equipment availability to assess the unit’s overall unit installation medical response capability against likely hazards and threats.

7.3.1.6.1. Annually, brief capability assessment to the MRC (or EMC) and to the installation’s Emergency Management Working Group (EMWG). (T-0: DoDI 6055.17) **Note:** This briefing will be classified SECRET.

7.3.1.6.2. Reference the Medical Readiness Guide for additional information on Capability Assessment Factors.

7.3.2. All reporting medical units will include a monthly overall Unit Mission Assessment Comment in the capability assessment, comparing the unit’s resource readiness C-level to the capability readiness assessment. If the resource readiness C-level aligns with the capability readiness assessment level (e.g., resource readiness is C-1 and capability readiness is Y-Green) state so in the comment. If resource readiness C-level does not align with capability readiness assessment (e.g. resource readiness is C-3 and capability readiness is Y-Green) provide rationale for the difference in ratings in layman’s terms.

7.3.3. Once the AFMS Core METL template has been copied to the unit’s core METL, non-applicable METs and performance measures may be deleted only after obtaining MAJCOM FAM approval. Update the unit’s core METL anytime the unit’s MRL or mission changes. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.02) Units will make no other alterations or modifications to the unit’s core METL, but may submit recommendations for updates or changes to the parent MAJCOM FAM. (T-2)

7.4. **Medical Report for Disasters, Emergencies and Contingencies (MEDRED-C).**

7.4.1. The MEDRED-C provides information on USAF Medical Service unit operational readiness status, availability, and patient care activities during in-garrison and deployed contingency operations. MEDRED-Cs also apply to medical units influenced by unusual occurrences (e.g., natural disasters or other emergencies). MEDRED-Cs are completed using the input tool provided on the AFMS DRRS Dashboard (T-1).

7.4.1.1. Part A – Deployed Units. Deployed units will complete a MEDRED-C Part A within 24 hours of establishing initial operations and provide updates on a daily basis thereafter. MEDRED-C updates will cover the PREVIOUS 24-hour period (0001-2359Z).

7.4.1.2. Part B – In-Garrison Units. In-garrison AF medical units complete a MEDRED-C Part B during all exercises and real-world events that adversely impact the unit’s normal operations, capabilities, or otherwise impairs the unit’s ability to carry out its mission. Submissions are required within two hours of initial impact from the event. Significant MTF events include, but not limited to, natural disasters, prolonged power outages, technological disasters, covert attack, active shooter, and/or a CBRN event that affects the unit. Follow-on MEDRED-Cs providing status updates will be accomplished
every 24 hours for as long as the event persists, and a final submission will be accomplished upon resuming normal operations. Notify the parent MAJCOM upon submission of a Part B MEDRED-C.

7.4.2. Additional guidance for completing the MEDRED-C is provided on the AF Medical Readiness SharePoint Site.

7.5. After Action Report (AAR).

7.5.1. Accomplish AARs after deployments, contingencies, and exercises, in accordance with AFI 90-1601, Air Force Lessons Learned Program. (T-3) After action reports will document observations, which have or can result in improvements to military operations at the strategic, operational, or tactical level. AAR observations should describe how the mission could be/was improved, potential risks to mission degradation/how to mitigate those risks, and include recommended Doctrine, Organization, Training, Materiel, Leadership, Personnel, Facilities and Policy (DOTmMLPF-P) changes and corrective actions, as appropriate. Examples may be found on the AF Medical Readiness SharePoint Site. Additional information, including submission guidance is provided in the AF Medical Readiness Guide.

7.5.1.1. Deployment After Action Reporting.

7.5.1.1.1. All deploying AFMS personnel will complete a post-deployment questionnaire concerning deployment preparation and training. Instructions for completing the questionnaire can be found in the Medical Readiness Guide.

7.5.1.1.2. Deployed medical unit commanders will collect input from their unit personnel and compile a consolidated AAR covering the time period of their command prior to return to home station. After action reports will be submitted in AF-Joint Lessons Learned Information System (JLLIS) at the appropriate classification level (NIPRNET or SIPRNET); AFMSA/SG3X; and the organization sponsoring the deployment. (T-2) Instructions for using AF-JLLIS and sample after action reports can be found on the AFMS Kx lessons learned page.

7.5.1.2. In-Garrison After Action Reporting. Medical units will compile after action reports after each exercise or real world incident. AARs will be compiled by the MR office within 30 days of the event if medical inputs are not fully incorporated into a Wing AAR. AARs for real world incidents will be submitted in AF-JLLIS. Examples of in-garrison after action reports can be found on the AFMS Kx lessons learned page.

7.5.2. The MRC will review AARs, identify best practices, lessons observed, and corrective actions from AARs. Unit commanders will elevate issues that cannot be resolved at the installation level to the parent MAJCOM/SGX.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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AF Form 1098, Special Task Certification and Recurring Training

Abbreviations and Acronyms
AAR—After Action Report
AC—Active Component
ACC—Air Combat Command
ACLS—Advanced Cardiac Life Support
AE—Aeromedical Evacuation
AEF—Air and Space Expeditionary Force
AETC—Air Education and Training Command
AF-JLLIS—Air Force—Joint Lessons Learned Information System
AFEMSI—Air Force Expeditionary Medical Skills Institute
AFIA—Air Force Inspection Agency
AF-IT—AF Input Tool
AFMAN—Air Force Manual
AFMOA—Air Force Medical Operations Agency
AFMSA—Air Force Medical Support Agency
AFMS—Air Force Medical Service
AFPC—Air Force Personnel Center
AFRC—Air Force Reserve Command
AFSC—Air Force Specialty Code
AFTH—Air Force Theater Hospital
AFTR—Air Force Training Record
AFTTP—Air Force Tactics, Techniques and Procedures
AOR—Area of Responsibility
ARC—Air Reserve Component (includes Air National Guard and Air Force Reserve Command)
ART—AEF Reporting Tool; also Air Reserve Technician
AS—Allowance Standard
AT—Annual Training; also Annual Tour (ARC)
ATLS—Advanced Trauma Life Support
BEE—Bioenvironmental Engineer
BEMRT—Basic Expeditionary Medical Readiness Training
C2—Command and Control
C4I—Command, Control, Communications, Computers and Information
CAF—Combat Air Forces
CAFSC—Control AFSC
CASF—Contingency Aeromedical Staging Facility
CBD—Consultant Balanced Deployments
CBRN—Chemical, Biological, Radiological and Nuclear
CBRNE—Chemical, Biological, Radiological, Nuclear, and High Yield Explosive
CCAT—Critical Care Air Transport
CCATT—Critical Care Air Transport Team
CCB—Configuration Control Board
CCDR—Combatant Commander
CDM—Constant Deployer Model
CERFP—ANG Chemical Biological Radiological Nuclear and High Yield Explosive Enhanced Response Force Packages
CFM—Career Field Manager
CMRP—Comprehensive Medical Readiness Program
CONOPS—Concept of Operations
COOP—Continuity of Operations
COT—Commissioned Officer Training
CPM—Contingency Preventive Medicine
CRG—Contingency Response Group
CSC—Combat Stress Control
CSDC—Consolidated Storage and Deployment Center
C-STARS—Centers for Sustainment of Trauma and Readiness Skills
DAFSC—Duty Air Force Specialty Code
DAV—Deployment Availability
DHP—Defense Health Program
DMLSS—Defense Medical Logistics Standards Support
DOC—Designed Operational Capability
DRRS—Defense Readiness Reporting System
DRU—Direct Reporting Unit
DSCA—Defense Support to Civil Authorities
DVP—Deployment Vulnerability Period
E&T—Education and Training
EMC—Executive Management Committee
EMEDS—Expeditionary Medical Support
EMRC—Expeditionary Medical Readiness Course
EOC—Emergency Operations Center
EOWG—Exercise Oversight Working Group
EPRC—Emergency Preparedness and Response Course
ERPSS—En-route Patient Staging System
FAM—Functional Area Manager
FCC—Federal Coordinating Center
FOA—Forward Operating Area; also Field Operating Agency
FOUO—For Official Use Only
GIO—Globally Integrated Operations
HAF—Headquarters Air Force
HAZMAT—Hazardous Material
HRF—Homeland Response Force
HSMR—Home Station Medical Response
HSS—Health Services Support
IDMT—Independent Duty Medical Technician
IDP—Installation Deployment Plan
IEM—Installation Emergency Management
IEMP—Installation Emergency Management Plan
IF—Institutional Force
IHS—International Health Specialist
IMA—Individual Mobilization Augmentee
IM/IT—Information Management/Information Technology
IS—Information Systems
ISDRT—Information Services Disaster Response Team
JBAIDS—Joint Biological Agent Identification Diagnostic System
JCS—Joint Chiefs of Staff
JLLIS—Joint Lessons Learned Information System
Kx—Knowledge Exchange
LAF—Line of the Air Force
LBDT—Laboratory Biological Detection Team
LOAC—Law of Armed Conflict
LRN—Laboratory Response Network
LRC unit—Limited Readiness Capability Medical Treatment Facility
MAA—Mutual Aid Agreement
MAF—Mobility Air Forces
MAJCOM—Major Command
MCC—Medical Control Center
MC-CBRN—Medical Counter—CBRN
MCRP—Medical Contingency Response Plan
MEFPAK—Manpower and Equipment Force Packaging System
MEM—MTF Emergency Manager
MET—Mission Essential Task
METL—Mission Essential Task List
MICT—Management Internal Control Toolset
MISCAP—Mission Capability
MOA—Memoranda/um of Agreement
MOU—Memoranda/um of Understanding
MR—Medical Readiness
MRA—MEFPAK Responsible Agency
MRC—Medical Readiness Committee
MRDSS—Medical Readiness Decision Support System
MRDSS ULTRA—Medical Readiness Decision Support System Unit-level Tracking and Reporting Application
MRL—Medical Resource Letter
MRM—Medical Readiness Manager
MRMC—Medical Readiness Management Course
MRNCO—Medical Readiness Noncommissioned Officer
MRO—Medical Readiness Officer
MTF—Medical Treatment Facility
NAF—Numbered Air Force
NCMI—National Center for Medical Intelligence
NDMS—National Disaster Medical System
NGB—National Guard Bureau
NREMT—National Registry of Emergency Medical Technicians
O&M—Operations and Maintenance
OCONUS—Overseas Continental United States
OPLAN—Operation Plan
OPR—Office of Primary Responsibility
OTS—Officers Training School
PAR—Population at Risk
PEM—Program Element Manager (Monitor)
PHEO—Public Health Emergency Officer
PHNCO—Public Health Non-commissioned Officer
PHO—Public Health Officer
PHTLS—Prehospital Trauma Life Support
PMI—Patient Movement Item
POC—Point of Contact
POM—Program Objective Memorandum
PPBES—Programming, Planning and Budgeting Execution System
PPE—Personal Protective Equipment
PRA—Patient Reception Area
PRC—Primary Receiving Center
RCOT—Reserve Commissioned Officer Training
RST—Readiness Skills Training
RTAP—Response Training and Assessment Program
RTOC—Readiness Training Oversight Committee
SEI—Special Experience Identifier
SFS—Security Forces Squadron
SMART—Sustained Medical and Readiness Training
SME—Squadron Medical Element; also Subject Matter Expert
SOF—Special Operations Forces
SSC—Secondary Support Center
TAA—Training Affiliation Agreements
TCCET—Tactical Critical Care Evacuation Team
TPFDD—Time—Phased Force Deployment Data
TTP—Tactics, Techniques and Procedures
UDM—Unit Deployment Manager
ULTRA—Unit-Level Training and Reporting Application
UMD—Unit Manning Document
USAFSAM—US Air Force School of Aerospace Medicine
UTA—UTC Availability (replaced the AFWUS); also Unit Training Assembly
UTC—Unit Type Code
UTM—Unit Training Manager
VA—Veterans Administration
WMP—War and Mobilization Plan
WRM—War Reserve Materiel

Terms

Aeromedical Evacuation (AE)—AE provides time-sensitive en-route care of regulated casualties to and between medical treatment facilities using organic and/or contracted aircraft with medical aircrew trained explicitly for that mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full spectrum of globally integrated operations (GIO), and in all operating environments. Specialty medical teams may be assigned to work with the AE aircrew to support patients requiring more intensive en-route care.

Community Recovery—The process of assessing the effects of an Incident of National Significance, defining resources, and developing and implementing a course of action to restore and revitalize the socioeconomic and physical structure of a community.

Core requirements—Those essential individual training requirements needed to accomplish the AFMS mission.

Critical Infrastructure—Systems and assets, whether physical or virtual, so vital to the US that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

Defense Support of Civil Authorities (DSCA)—Refers to DoD support, including Federal military forces, DoD civilians and DoD contractor personnel, and DoD agencies and components, for domestic emergencies, and for designated law enforcement and other activities.

Disease Prevention—Encompasses the anticipation, prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological,
chemical, physical or psychological threats or stressors found at home station and during deployments.

Emergency Operations Center (EOC)—The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be located in a permanent or temporary location. EOCs may be organized by major functional disciplines (fire, law enforcement, medical services, etc.), by jurisdiction (Federal, State, regional, county, city, tribal), or by some combination.

Emergency Responders (medical)—Disaster Response Force members who deploy after first responders and provide additional support. They include follow-on medical personnel including additional ambulances, physicians, nurses, technicians, and other specialized teams. Teams such as radiology, laboratory, pharmacy, surgery, and nutritional medicine would not ordinarily leave the facility and are therefore not considered emergency responders. Examples of MCRP teams in the emergency responder category would be the Field Response Team, Triage Team, the Public Health Team, and the Nursing Services Team.

Emergency Support Function—A grouping of government and certain private sector capabilities into an organizational structure to provide the support, resources, program implementation, and services to help communities recover following domestic incidents.

Federal Coordinating Center (FCC)—A facility located in a metropolitan area of the United States, and Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). Note: The main difference between the FCC and the Primary Receiving Center (PRC) mission is FCCs coordinate planning, training, exercising, and operations of one or more NDMS PRAs. PRCs receive; triage, stage, transport, and track patients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care.

Homeland Security Exercise and Evaluation Program (HSEEP)—Provides a set of guiding principles for exercise programs, as well as a common approach to exercise program management, design and development, conduct, evaluation, and improvement planning. HSEEP principles are applicable for exercises across all mission areas—prevention, protection, mitigation, response, and recovery. HSEEP principles should be utilized in the development, assessment, and review of all exercises.

Installation Medical Response—Term that encompasses the full spectrum of installation medical response activities, including medical contingency response, defense support of civil authorities, civil support, and disaster response.

The Joint Commission—Previously called the Joint Commission on Accreditation of Healthcare Organizations. The name change reflects the Joint Commission’s continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care in all organizations.

Patient Reception Area (PRA)—A geographic locale containing one or more airfields, bus stations, or airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to pre-identified, non-Federal, acute care NDMS hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these hospitals are within a 50-mile radius.
Primary Receiving Center (PRC)—A Military Treatment Facility (MTF) or Veterans Administration (VA) Medical Center (VAMC) designated for coordinating and/or providing treatment to sick and wounded military personnel returning from armed conflict or national emergency. The main difference between the FCC and the PRC mission is FCC’s coordinate planning, training, exercising and operations of one or more NDMS Patient Reception Areas. FCCs receive; triage, stage, transport and track already-inpatients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care. The patients may not be eligible for care in a Federal treatment facility. The mission of a PRC is to receive and treat sick and wounded military personnel returning from armed conflict or national emergency.

Secondary Support Center (SSC)—Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated to accept transfers from, or sharing resources with, a Primary Receiving Center (DoD or VA Only) to maximize health care services support to the DoD.

Wound and Casualty Management—Wound management refers to those medical skills that are needed to care for trauma and disease non-battle injury patient conditions. Casualty management refers to those skills that are needed to triage and regulate casualties, to include land and air medical evacuation, and staging.
Attachment 2

APPLICATION OF THE LAW OF ARMED CONFLICT

A2.1. General.

A2.1.1. As a matter of Air Force policy, medical personnel may deploy as either noncombatants or combatants. The protections afforded under the Geneva Conventions are different for each category, and therefore, medical personnel should verify their status and the consequences of that status prior to deployment.

A2.2. Noncombatants.

A2.2.1. Medical personnel are considered noncombatants if they are exclusively engaged in performing medical duties. This includes supporting duties such as medical records, administration, disease prevention, and the variety of missions performed by Bioenvironmental Engineering personnel for the purposes of prevention of disease/sickness through health risk assessment and control. Noncombatants may carry weapons for self-defense, defense of patients, or defense of other noncombatants such as their co-workers. However, medical personnel may not engage in actions that are harmful to lawful enemy combatants, such as offensive military operations, convoy operations, or laying minefields, without losing their noncombatant status for the duration of their deployment and subjecting themselves to being targeted by the enemy. If captured, true non-combatants are considered retained personnel and not prisoners of war.

A2.3. Combatants.

A2.3.1. Medical personnel may deploy as combatants and as such are prohibited from appearing as noncombatants while deployed in a combatant capacity. This means that while serving in a combatant role:

A2.3.2. Medical personnel will not wear the large Red Cross armband.

A2.3.3. Medical personnel will not carry a common access card (CAC) displaying a red cross.

A2.3.4. Medical personnel are not entitled to special protection against enemy attacks. (In this scenario, medical personnel are lawful targets.)

A2.3.5. Upon capture, medical personnel in combatant roles are considered prisoners of war rather than retained personnel. However, the capturing force may elect to use the captured medical personnel in their medical capacity instead. In that event, the medical personnel would be entitled to the same treatment as retained personnel.

A2.4. Disclaimer.

A2.4.1. This section is not intended to answer all of the possible scenarios for medical-legal issues relating to combatants and noncombatants. The Air Force Judge Advocate General should be consulted for answers to specific questions. Also, AF/JAO has published specific legal reviews for medical personnel and those documents should be reviewed (see AF/JAO Memorandums dated 08 Sep 08 at on the AF Medical Readiness SharePoint Site assessable through the AF Portal.)