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THE SECRETARY OF THE AIR FORCE

AIR FORCE TACTICS, TECHNIQUES  
AND PROCEDURES 3-42.57



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*Tactical Doctrine*

EN ROUTE PATIENT STAGING SYSTEM

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**PURPOSE:** The Air Force Tactics, Techniques and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. 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 the Air Force Records Disposition Schedule (RDS) in the Air Force Records Information Management System (AFRIMS). This publication applies to all Air Force personnel, including Air Force Reserve Command (AFRC) and Air National Guard (ANG). For the purpose of this TTP, ANG is included in the term Major Command (MAJCOM). The doctrine in this document is authoritative but not directive. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, *Recommendation for Change of Publication*. Route AF Form 847 through the appropriate chain of command and parent MAJCOM. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. This Instruction requires collecting and maintaining information protected by the Privacy Act of 1974, System of Records Notices (SORN), F033 AF B, Privacy Act Request File, and F036 AF PC Q, Personnel Data Systems (PDS) apply and are available at: <http://dpclo.defense.gov/Privacy/SORNs.aspx>. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

**SUMMARY OF REVISIONS:** This document reflects the transition from the Mobile Aeromedical Staging Facility (MASF)/Contingency Aeromedical Staging Facility (CASF) building block approach to the ERPSS modular building approach.

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## Chapter 1

### GENERAL

**1.1. Purpose.** This document describes command relationships and publishes general guidance for the development of ERPSS capabilities supporting the Aerospace Expeditionary Force (AEF) in contingency operations; theater operation plans (OPLANs) and humanitarian assistance/disaster relief (HA/DR). Specific information to amplify and tailor guidance contained in this TTP is included in Technical Orders (TOs), OPLANs, or other regional guidance. This TTP: (a) identifies and defines ERPSS responsibilities; (b) ensures ERPSS tasks, functions, and responsibilities are properly assigned; (c) describes the resources available to support global military operations associated with regional plans; and (d) provides a source document for developing standardized ERPSS policies, operating procedures, training programs and allowance standards (AS).

### 1.2. Background.

1.2.1. An AEF is a package of aerospace capabilities that provides tailored forces to meet theater requirements across the full spectrum of military operations. AEF forces respond to sustainment and crisis action contingency operations. The Air Force Medical Service (AFMS) provides medical capabilities to the AEF identified in unit type codes (UTCs) to support needed requirements. As such, medical UTCs are assigned and deployed as the mission dictates.

1.2.2. Regarding medical capability, the Expeditionary Medical Support/Air Force Theater Hospital (EMEDS/AFTH) system is designed to provide essential care in a theater of operations to include deployment scenarios, war operations, deterrence and contingency operations, peacetime engagement, crisis response, and HA/DR. Aeromedical Evacuation (AE) is necessary for patients who require definitive care not available in the EMEDS/AFTH.

1.2.3. Patient staging is a key component of ensuring timely AE. Patient staging is designed to temporarily stage patients and prepare them for flight and aircraft loading while reducing the amount of time an AE aircraft is on the ground. Prior to the ERPSS concept, staging patients for AE had historically been accomplished via MASFs, CASFs or Disaster Aeromedical Staging Facilities (DASFs).

1.2.4. In 2010, HQ AMC/SGX proposed re-structuring the CASF/MASF missions into the ERPSS. In doing so, the UTCs have been combined into force modules (FM) to meet mission requirements. Utilizing the ERPSS FMs, HQ AMC is able to accomplish patient staging from bare base operations to a 200-bed patient staging capability at fixed facilities and allow flexibility with ever changing operations. The primary mission of the ERPSS is to provide personnel and equipment necessary for 24-hour staging operations for patients entering and transiting the Air Force components of the global AE system. The ERPSS coordinates and communicates with medical and AE elements to accomplish patient care and patient movement (PM), including ground transportation. It provides patient reception, complex medical/surgical nursing, limited emergent intervention, and ensures patients are medically and administratively prepared for flight.

**1.3. Threat.** The ERPSS ability to function within a Medical Counter- Chemical, Biological, Radiological, Nuclear (MC-CBRN) environment is very different than that of the EMEDS. There are no collectively protected ERPSS packages. The AFMS has the capability to move one or two contagious “index” patients utilizing the Patient Isolation Unit (PIU). This capability should not imply the need to have a collectively protected ERPSS package.

#### 1.3.1. Medical Threat Implications.

1.3.1.1. Disease and Non-Battle Injury (DNBI). Historically, DNBI accounted for over 80 percent of personnel admitted to hospitals during contingency operations. The medical community is exposed to a unique class of threats mitigated by infection control practices, which include, sharp needle/scalpel sticks, and exposure to infection through careless infection control procedures or neglect. Personnel and patients, from high threat areas, may show signs of suspected or known highly infectious agents. ERPSS personnel must be aware of possible signs and symptoms of these diseases as well as the appropriate public health response in these instances. Proper emphasis of infection control practices should keep this threat to a minimum, but will require firm and sustained enforcement. Safety is paramount in an environment where small injuries can become serious due to austere conditions. Appropriate training of medical personnel during peacetime should mitigate these potential threats.

1.3.1.2. Conventional Weapons. These weapons, including precision guided munitions, antipersonnel/vehicle mines, tube and rocket artillery, aerial bombs, cruise and ballistic missiles, and others carry the potential to inflict personal injury in widely varying degrees. Treatment of injuries caused by these weapons is enhanced through advanced diagnostic capability, specialty consultation, medical information access, AE, and the ability to process tests and data rapidly. ERPSS offers no protection from conventional (kinetic) weapons and requires protective shelters from Expeditionary Combat Support (ECS) sources.

1.3.1.3. Weapons of Mass Destruction (WMD). For definitive guidance on biological and chemical agents, and nuclear weapons and their effects, see JP 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear Environments*. Refer to AFTTP 3-42.22, *Contagious Casualty Management*, for the guidance regarding movement of contaminated/contagious casualties/personnel.

1.3.1.3.1. Biological and Chemical Weapons (BW/CW). The possibility of biological or chemical attack poses a significant threat to deployed forces. While there are EMEDS packages fitted with collective protection components to allow for continued operations in a contaminated environment, these same measures are not available for ERPSS packages. Large scale PM does not normally occur in a contaminated environment.

1.3.1.3.2. Nuclear/Radiological Weapons. These weapons range greatly in size and energy yield and are employed by a variety of means. While blast and thermal injury will account for most casualties, radiation effects will also be significant. A nuclear

incident has the potential to produce a very large number of casualties instantaneously, severely burdening the medical evacuation and treatment system. ERPSS packages do not protect against radiation.

1.3.2. Information Warfare (IW). Our heavy reliance on information systems makes them attractive targets to potential adversaries. The threats to these systems are worldwide, technically diverse, and growing rapidly. Network Control Center (NCC) Information Assurance (IA) programs provide information systems security support for the ERPSS. The medical facility abides by the Air Force Forces/Air Expeditionary Task Force (AFFOR/AETF) Network Operation and Security Center–Deployed (NOSC-D) and NCC communications design architectures, operational rules of engagement, and MAJCOM preferred product lists to minimize the threat.

## Chapter 2

### DESCRIPTION

**2.1. Mission.** The ERPSS has a two-fold mission: provide support and continuity of medical care for PM and serve as an integral patient interface to the Air Force components of the Global AE system. The Global AE system consists of unregulated movement via Casualty Evacuation (CASEVAC), Medical Evacuation (MEDEVAC), and/or AE from the point of patient injury, illness, or wounding, through successive roles within the theater, to include evacuation to definite care when warranted. The ERPSS provides personnel and equipment necessary for 24-hour patient staging operations, administrative processing and patient ground transportation between the staging facility and the aircraft.

### **2.2. Essential Care.**

2.2.1. The ERPSS is designed to temporarily hold patients as they transit the AE system while providing short-term complex medical-surgical nursing care and limited emergent intervention. The length of stay in an ERPSS facility may be from two to 72 hours. Holding times differ depending on the size of the staging facility. At the 10-bed initial stage, holding times are limited by the amount of space and supplies in this initial package. Two to four hours is the preferred hold time; not to exceed six hours. At the larger staging facilities (50-100 bed), holding times will vary depending on the operational capability of the location and the flight schedules, but should be limited to no more than 72 hours.

2.2.2. Complex medical/surgical nursing is defined as utilizing multiple skill sets when caring for patients with wide-ranging traumatic injury, cardiac, respiratory, gastrointestinal, genitourinary, neurological and multi-system pathologies. Skill sets include, but are not limited to, managing multiple intravenous (IV) or central lines; administering numerous IV medications and blood products; performing wound irrigations and dressing changes; and assisting with placement and management of chest tubes. Additionally, knowledge of flight considerations for trauma and medical patients and the stresses of flight are important in this environment.

2.2.3. Complex care does not represent critical care. Critically ill patients will be cared for at the nearest/supporting Military Treatment Facility (MTF). The co-located or supporting inpatient MTF is responsible for holding/staging all patients with medical care requirements outside the scope of the ERPSS. In the event that the ERPSS cannot be geographically co-located with a supporting MTF and the MTF Chief of Medical Staff determines the distance to be significant, emergent care personnel, such as a Critical Care Air Transport Teams (CCATT), may be co-located with the ERPSS to assist in stabilizing patients.

2.2.4. All ERPSS facilities (with the exception of the ERPSS-10) should be co-located with a theater hospital level MTF to support patient treatment and movement. It can be a stand-alone facility with providers, nursing personnel and flight surgeons assigned to assist in stabilizing patients for movement in the Global AE system. If the ERPSS facility is not co-located with an MTF that can provide the required clinical support, arrangements must be in

place to meet the clinical support levels needed for patients transiting the facility (host nation, local civilian authorities, or Joint Service counterparts).

### **2.3. Assumptions.**

2.3.1. Populations-at-risk (PAR) represent contingency/disaster support personnel or international military and civilian personnel in a coalition operation. US military population supported will have predeployment medical screening, prophylaxis, immunizations and will be trained in Self Aid Buddy Care (SABC).

2.3.2. Airlift is available.

2.3.3. Patients are evacuated IAW the theater evacuation policy.

2.3.4. AE capabilities support rapid movement of stabilized patients.

2.3.4.1. Patient Evacuation. IAW AF directives and Combatant Commander directives, patient medical supplies and patient movement items (PMI) may be prepositioned to meet patient movement requirements. If not prepositioned, the originating facility will be responsible for providing these items and should provide a one-day minimum of supplies for PM within the Continental United States (CONUS) or three-day minimum of supplies for outside the CONUS (OCONUS) moves.

2.3.5. Deployed medical forces may not be able to depend on host-nation medical support.

2.3.6. ECS, including but not limited to communications, fuel, potable water, ice, electrical power, transportation, living quarters for medical personnel, food service, base security, protective shelters, site preparation, pallet movement, wastewater disposal, and human and medical waste disposal, is provided.

**2.4. ERPSS FM Builds/Doctrine.** ERPSS is a medical war reserve materiel (WRM) supply and equipment asset, with a building construct that allows medical planners to right size the facility requirements based on PM requirements. The ERPSS builds from a 10-bed mobile facility (FFEPS). As workload changes, or is projected to change, UTC packages (personnel and equipment) may be deployed in small increments and combined with previously deployed ERPSS UTCs to increase capability.

**2.5. Incremental Build of the ERPSS from 10 to 200 Beds.** Figures 2.1 and 2.2 demonstrate the incremental build from a 10-bed to 200-bed ERPSS FM. What follows are descriptions of the UTCs contained within the ERPSS FM. It is important to note vehicles (HMMWVs, AMBUS, M1078 Truck and 10K Forklift) must be tasked separately in support of ERPSS operations, as they are not part of the UTC AS (per the Mission Capability Statement [MISCAP]).

2.5.1. ERPSS-10. This UTC is the first increment in building all ERPSS assemblages. The staging facility maintains the flexibility to be a mobile or fixed capability.

2.5.1.1. ERPSS-10 Personnel UTC (FFEPS). This UTC is a 13-person, ten-bed capability that provides rapid response patient staging of ten patients at a time, a maximum flow of 40 patients in a 24-hour period, and a maximum six hour patient hold time. Team should be able to sustain this tempo for 72 hours without augmentation.

**Table 2.1. ERPSS Modular Build.**

			UFMPR	UFMPR X 2
		UFMPR	UFMT4	UFMT4 X 2
		UFMT4	UFM81 X 3	UFM81 X 6
	UFMVH X 2	UFM81 X 2	FFPS4 X 2	FFPS4 X 4
UFMVH X 2	FFPS7 <sub>2</sub>	FFPS4	FFPS3 X 2	FFPS3 X 4
FFPS7 <sub>2</sub>	FFPS8 <sub>1</sub>	FFPS3	FFPS2	FFPS2 X 2
FFPS8 <sub>1</sub>	FFPS1	FFPS2	FFHPS	FFHPS X 2
FFPS1	FFPPS	FFPPS	FFPPS	FFPPS X 2
FFQCR	FFQCR	FFPPS	FFPPS	FFPPS X 2
FFEPS	FFEPS	FFEPS	FFEPS	FFEPS X 2
10 Bed Stage	10 Bed Med Aug/Dr	50 Bed	100 Bed	200 Bed
15 personnel	25 personnel	51 personnel	74 personnel	148 personnel
<sub>1</sub> Re-supply				
<sub>2</sub> Environmental Control Unit (ECU)	RED = Pax	Green = Cargo	Black = vehicle	

**Table 2.2. ERPSS UTC Build.**

ERPSS 10 (13 PAX)	ERPSS 50 (28 PAX)	ERPSS 100 (23 PAX)
FFEPS	FFPPS	FFHPS
Nursing, MSC	Nursing, Med Tech, FS, MSC,	Nursing, Med Tech, FP, MSC,
Med Tech, Med Admin	Med Admin, Med Log, Nut Med	BMET

Pharmacy			
ERPSS Clinical Augmentation (10 PAX) FFPS FS/PA, Nursing, Med Tech, Med Log			
<u>FFPS1</u> Equipment Pkg: Rapid Response (2 x UFMVH-packed), 7 – Day Supply, Tents & Communications Deploys with FFEPS			
<u>FFPS2</u> Equipment Pkg: Computers, Radios, Generator, Essential Med Equip & Supplies (Deploys with FFFPS)			
<u>FFPS3</u> Supply Pkg: 30 Day Supply of Pharmacy & Treatment Supplies (Resupplies FFFPS)			
<u>FFPS4</u> Equipment Pkg: Tentage, ECU, Electrical, Durable Med Equip, Patient Beds (Deploys with FFFPS)			
<u>ERPSS 10</u> 2 x UFMVH (HWMMV)	<u>ERPSS 50/100/200</u> 2x/3x/6x UFM81 (AMBUS)	<u>ERPSS 50/100/200</u> 1x/1x/2x UFMT4 (5 Ton Cargo Truck)	<u>ERPSS 50/100/200</u> 1x/1x/2x UFMPR (10K Forklift)
<u>FFPS7</u> Equipment Pkg: Environmental Control Unit, Generator (Optional for deployment with FFPS1)			
<u>FFPS8</u> Supply Pkg: 15-Day Supply of Pharmacy & Treatment Supplies (Expands FFPS1 to a 22-day Capability)			

2.5.1.2. ERPSS-10 Equipment UTC (FFPS1, AS 904F). Provides equipment necessary to establish a rapid response ERPSS-10. The FFPS1 provides for an initial seven days of supplies. If operations are anticipated to exceed seven days it is vital a re-supply (FFPS8) is immediately requested or sent with the initial UTC tasking. This UTC can be deployed

as rolling stock (if the UFMVH UTC is tasked) or on aircraft pallets (463L). If this UTC is not deployed as rolling stock, it cannot be considered mobile. This UTC comes with heating capability; however, the ERPSS-10 Environmental Control Unit (FFPS7) UTC must be tasked to add a cooling capability.

2.5.1.3. ERPSS-10 AE Communication Team (FFQCR). For the ERPSS-10, this two person AE communication team (FFQCR) must be tasked separately for communications support. This UTC does not normally deploy with the 50, 100, or 200 bed ERPSS packages. For the 50, 100, or 200 bed ERPSS packages, communications support is an ECS responsibility.

2.5.1.4. ERPSS-10 Vehicle Support (UFMVH), High Mobility Multi-purpose Wheeled Vehicle (HMMWV). These two light, highly mobile, diesel-powered, four-wheel-drive vehicles are equipped with an automatic transmission and are required for the ERPSS-10 to deploy as rolling stock. These vehicles must be tasked in addition to the ERPSS-10 (FFPS1) equipment package, per the MISCAP.

2.5.1.5. ERPSS-10 Environmental Control Unit (ECU) (FFPS7, AS 904J). Provides an ECU and augmentation equipment/generator to provide basic heating/cooling environment capability to the ERPSS.

2.5.1.6. ERPSS-10 Re-supply (FFPS8, AS 904K). Provides 15-day re-supply for employed ERPSS-10 based on 40 patients per 24 hours. When combined with ERPSS-10 Equipment UTC (FFPS1), this package provides an initial 22 day capability to support PM. Re-supply arrives on 463L pallets. If package is repositioned, receiving unit is required to have ground support (10K forklift) to transport re-supply package to new location.

2.5.2. ERPSS-P Personnel UTC (FFPPS). This 10-person UTC provides clinical providers, additional nursing staff, and logistical support to enhance the clinical capability for any ERPSS UTC. Serves as a clinical interface capability between forward medical care and the ERCC. Can be deployed with or as a follow on to the ERPSS-10. The ERPSS-P can deploy independently to support the EMEDS where staging is deliberately planned. Larger builds require deployment of this UTC in combination with other UTCs to form the various packages.

2.5.3. ERPSS-50 thru 200 Bed Capabilities. The ERPSS-50/100 UTCs provide staging capabilities for 50 and 100 bed stages. Patient stays at this level should be limited to 72 hours or IAW theater operations policy. When supporting an EMEDS, other service theater hospitals, or CONUS MTFs, patients can remain in the facility as space and staging requirements allow, depending on the casualty flow, nature of the injuries, availability of AE resources, and requirements of the mission. For robust AE and staging missions, patient stays are reduced to 12 hours, thereby increasing throughput capability due to projected use of retrograde airlift, civilian hospitals, air ambulances, and other-than-AE lift options.

2.5.3.1. These configurations have more complete services than the ERPSS-10 and the ERPSS-P. Physician, biomedical equipment repair, administration, and logistics services

are components of larger personnel packages. ERPSS-50/100 requires MTF support for nutritional medicine, pharmacy, mental health and intensive care nursing. If an ERPSS-50/100 is located with an MTF that does not have in-house food service, a support agreement is to be established with base food service for patient feeding, addressing specific therapeutic food items required for patients.

#### 2.5.4. ERPSS-50.

2.5.4.1. ERPSS-50 Personnel UTC (FFFPS). This 28-person UTC is used as a bed extension/augmentation package for patient staging. It administratively and clinically prepares patients for flight and ensures patients are clinically supported while in the ERPSS. This UTC assists with the transportation of patients to and from the aircraft. Builds with other ERPSS UTCs, or can be tasked to augment PM at other echelons of care. If ECS is limited, planners should add provisions for personnel with expertise in Aerospace Ground Equipment (AGE) setup and management for generator, electrical grid and lighting.

2.5.4.2. ERPSS-50 Equipment UTC (FFPS2, AS 904G). This UTC provides operational equipment, computers, radios, C2, generator and essential medical equipment and advanced cardiac life support medications. It is used to build from the 50-bed capability to the 200-bed capability. One ERPSS - 50 equipment package supports the ERPSS-50/200. The UTC is used in conjunction with the ERPSS Expendables (FFPS3) and ERPSS Facility (FFPS4) packages to complete the initial ERPSS-50 (See Figures 2.1 and 2.2, pages 9 and 10). ECS or Host Nation base support is required for medical equipment repair, bioenvironmental engineering (BE), security, petroleum/oil/lubricants (POL), and civil engineering (CE).

#### 2.5.4.3. ERPSS-50 Vehicle Support.

2.5.4.3.1. UFM81, Ambulance Bus (AMBUS). This UTC is required to safely move patients and support the ERPSS system. Planning should include consideration for adequate maneuvering and parking for a bus 36 feet in length. This UTC is required to support PM.

2.5.4.3.2. UFMT4, Vehicle, 5 Ton Cargo Truck. UFMT4 provides a six-wheel drive, 5 ton cargo truck/prime mover capability. This UTC is required to support equipment and ERPSS.

2.5.4.3.3. UFMPR, 10K Forklift. This UTC provides a 10K standard forklift capability. This UTC is required to support ERPSS FM equipment packages.

2.5.4.4. ERPSS-50 Expendables (FFPS3, AS 904H). Provides expendable supplies, pharmacy and treatment supplies for patient care. ERPSS bed size as follows: 1 for ERPSS-50, 2 for ERPSS-100, and 4 for ERPSS-200. Must be utilized in conjunction with the ERPSS-10 equipment package and ERPSS-50 Facility Package to complete the capability of the ERPSS. This package also serves as a re-supply package for the ERPSS FM.

2.5.4.5. ERPSS-50 Facility (FFPS4, AS 904I). Package contains tentage, ECUs, electrical assembly, oxygen, durable medical equipment and operating equipment. Package includes patient beds, field cots, litters and other durable patient care items. This UTC is used to build from the 50 bed capability to the 200 bed capability. It can also be used in conjunction with the ERPSS equipment and expendable UTCs to complete the ERPSS FM capability.

#### 2.5.5. ERPSS-100.

2.5.5.1. ERPSS-100 Personnel UTC (FFHPS). This 23 person UTC is used as a bed extension/augmentation package for the ERPSS FMs. It can deploy independently or as a staging augmentation package to an existing MTF with limited staging function. It administratively and clinically prepares patients for flight and ensures patients are clinically supported while in the ERPSS. Also assists with the transportation of patients to and from the aircraft.

**Table 2.3. ERPSS Personnel AFSCs by UTC.**

FFEPS 13 PAX	ERPSS-10 Bed	4-046N3, 1-4A071, 4-4N051, 3-4N071, 1-041A3
FFPPS 10 PAX	ERPSS-Provider/Support Staff	1-048R3, 1-042G3, 2-046N3, 1-4A171, 4-4N051, 1-4N071
FFFPS 28 PAX	ERPSS-50 Bed	1-041A3, 5-046N3, 1-048R3, 1-4A271 1-4A051, 1-4A071, 8-4N051, 4-4N071, 1-4D071, 1-4A151, 1-4P071, 1-046A3, 1-4N091, 1-4A091
FFHPS 23 PAX	ERPSS-100 Bed	2-041A3, 2-046N3, 2-4A051, 1-4A071, 10-4N051, 4-4N071, 1-044F3, 1-4A251

**Table 2.4. ERPSS Building Block Concept.**

<p>FFEPS 10 Bed 13 Med Pers 2 Comm Pers</p> <p>Bare Base Expeditionary Stage</p>	<p>FFFPS Provider/Support Staff Augmentation 10 Med Pers</p> <p><u>Introduces</u> - Flt Doc &amp; PA - Med Logistics</p> <p>No Increase in Throughput</p>	<p>FFFPS 50 Bed 28 Med Pers</p> <p><u>Introduces</u> - Nurse Manager - Superintendent - BMET - Pharmacy Tech - Dietary Tech</p> <p><u>Increases</u> -Through-put -Nursing -Admin Functions</p>	<p>FFHPS 100 Bed 23 Med Pers</p> <p><u>Introduces</u> - Family Physician</p> <p><u>Increases</u> - Through-put - Nursing - Admin Functions - BMET</p>
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## Chapter 3

### OPERATIONS

**3.1. Introduction.** Medical operations occur within five distinct phases: deployment, employment, generation/sustainment, redeployment, and reconstitution. Each phase is delineated by mission objectives, PAR, and operational objectives. Overall, the health services support objective is to enhance force protection by providing a modular, clinically enhanced, tailored and more life-saving capability while reducing the medical footprint.

#### **3.2. General Policies.**

3.2.1. The ERPSS UTCs are postured against sourced units in the UTC Availability Tool (UTA). ERPSS equipment/facility infrastructure packages may be pre-positioned in theater based on Geographic Combatant Commanders (GCC) and AFFOR requirements.

3.2.2. The ERPSS is employed according to the requirement dictated by the Joint component surgeon, in support of (ISO) the Combatant Commander's (CCDR) OPLAN. The ERPSS is considered a Combat Services Support (CSS) function when deployed in a Joint environment, the same category as user service medical elements. The ERPSS needs to be positioned to fulfill its mission at the same time the user service is positioning its own CSS medical elements. Delivery methods used by user services for positioning combat support elements vary. CSS elements may be inserted via air/land delivery when the airfield is considered secured enough for placing these elements. They may also follow combat forces via ground convoy, according to the CCDR's plan. Determining the insertion method of the ERPSS is a responsibility of the AF planner, as dictated by the Joint component surgeon, and in keeping with the ERPSS's operational function, and support requirements.

3.2.3. ERPSS personnel are required to be knowledgeable of Joint service operations and are employed at operating locations where forward resuscitative capability and fixed/rotary wing airfields are available. Members should be familiar with all references to the Global AE system as referenced in Joint Publication 3-17, *Air Mobility Operations*, and Joint Publication 4-02, *Health Service Support*. The ERPSS supports medical elements of the US Army, US Navy, US Marine Corps, US Air Force, other coalition force medical elements and may be tasked ISO HA/DR and DSCA operations. The Medical Service Corp Officer (41A) and Medical Admin (4AO) assigned to FFEPS will complete the following Federal Emergency Management Agency (FEMA) courses: IS-100, Introduction to Incident Command System, IS-700, National Incident Management System – An Introduction and IS-800, National Response Framework or the Air Force Response Operations, Introduction (AERO) web-based training. The training is located at <http://training.fema.gov/IS/crslst.aspx>. satisfies this requirement. Other ERPSS personnel in leadership positions are recommended, but not required, to complete the same FEMA training.

**3.3. ERPSS Support for the Global Patient Movement Plan (GPMP).** The GPMP may be activated to facilitate significant global PM. In many instances, an existing MTF will need staging and holding capability and be able to support a small staging component through existing resources such as physician support, nutritional medicine, logistics, mental health, and pharmacy.

### 3.4. Deployment.

3.4.1. Deployment planning and preparation is essential to support ERPSS operational objectives during contingencies and must afford sufficient command emphasis to ensure unit readiness. The deployment can include a movement of troops, cargo, weapons systems, or a combination of these elements, utilizing multiple types of transport. ECS must provide the goods and services to sustain the operations of a deployed ERPSS force package for the duration of a deployment. The planners and initial ERPSS UTC personnel arrange messing, billeting, petroleum oil lubricants (POL), real estate and other support requirements for deployed medical elements.

3.4.1.1. The Time Phased Force Deployment Data (TPFDD) is built by the air component and flowed through the MAJCOMs to the Wing plans and operations centers for action. Local installation Deployment Control Centers (DCC) establishes local schedules to prepare units, personnel, and cargo IAW required delivery dates in theater. Schedules are developed by working backward from an “aircraft commander briefing” or “station” time to include the essential steps in the deployment process (i.e., manifesting, subsistence palletizing, marshaling, personnel processing, and assembly of personnel and cargo at unit assembly areas).

3.4.1.2. Deployment Timelines.

3.4.1.2.1. Regular Air Force (RegAF) ERPSS-10 and the ERPSS-P UTCs have the ability to rapidly deploy within 24 hours of notification.

3.4.1.2.2. Once all mobilization actions have been completed, ARC forces must be ready for deployment within 72 hours.

3.4.2. Cargo Processing. The processing of ERPSS cargo begins immediately after a unit is tasked for deployment (notification stage), and continues until the cargo arrives at the deployed destination. The DCC will publish the Deployment Schedule of Events (DSOE) which demonstrates the unit’s deployment process, detailing critical deployment actions required to meet movement departure times.

3.4.3. Equipment Preparation. When notified of a deployment tasking, equipment and supplies must be ready and prepared for transport. Units should have checklists and/or flowcharts to assure procedures are followed for deployment of personnel and cargo. Equipment mobility paperwork packages contain load and packing lists, hazardous materials declarations, and hazardous cargo placards IAW AFI 41-209, *Medical Logistics Support*. It is essential that all man-portable equipment for the ERPSS is kept in the “ready mode” at all times.

3.4.4. Personnel Preparation. Personnel assigned to the ERPSS should be fully trained and ready to deploy prior to entering their deployment “band” or continuously ready for those assigned as an “enabler.” Upon notification of deployment, the deploying team leader will coordinate with their assigned MTF medical readiness office staff, schedule a predeployment conference, and then review key documents and responsibilities. Key documents include:

deployment orders, TPFDD, force protection threats, medical intelligence reports, and overall intelligence reports. Please refer to Chapter 9 of this TTP for an inclusive list of training requirements.

3.4.5. Medical Intelligence. During the deployment phase, the team will obtain a detailed medical intelligence assessment for deployment briefings and inclusion in the force protection plan from the Base Public Health Office. Sources for this information may include the MAJCOM medical and AE Plans and Readiness divisions, host base and theater intelligence, Air Force Office of Special Investigations (AFOSI), National Center for Medical Intelligence (NCMI), Medical Environmental Disease Intelligence and Countermeasures (MEDIC) CD-ROM data base, airfield surveys reports, Joint Lessons Learned Information System (JLLIS), published lessons learned/after action reports, Department of State, and any in-country US embassy or consulate.

### **3.5. Employment:**

3.5.1. The ERPSS personnel should have a plan for rapidly setting up and taking down all equipment. Pack equipment like radios/antenna and tents where they will be quickly assessable when arriving at the deployed site. This allows the element to become operational and begin casualty flow at the earliest possible time. Equipment UTC pack-out guides (if applicable) are available in the MEFPAK Playbook located at <https://cs3.eis.af.mil/sites/27468/default.aspx>.

3.5.2. Upon arrival at a deployed location, an ERPSS representative should immediately make contact with supporting organizations command elements, medical commanders, Contingency Response Groups (CRG) or Combat Control Team (CCT), airfield managers and brief the ERPSS capabilities, function, and ECS requirements. Final site selection, operating perimeter, air base security plans are extremely important and must be reviewed and coordinated with supporting authorities.

#### **3.5.2.1. ERPSS-10/ERPSS-P Employment.**

3.5.2.1.1. The ERPSS-10/ERPSS-P are employed within a defined Area of Operations (AO) ISO contingency operations. These UTCs are capable of relocating in a minimal amount of time as contingency operations dictate. Leadership is required to interface with all local and host activities that provide ancillary support services. This relationship is critical to ensure that the UTC's can provide effective PM support to user service medical teams, and that reciprocal support needed to sustain operations is provided.

3.5.2.1.2. Initial Operational Capability (IOC) for the ERPSS-10 and ERPSS-P should be achieved within one hour of arrival at the assigned location. IOC is defined as the initial ability to provide immediate reception of patients and establishment of a communication link to the supporting Air Operations Center (AOC), AE Control Team (AECT) and servicing Patient Movement Requirement Center (PMRC) to coordinate PM.

3.5.3. General Site Survey and Selection. Aspects of site survey/selection process apply to all deployed elements. A crucial step in the establishment of any airfield operation is determining where to establish the site, tent orientation and equipment placement. Proper assessment of the terrain and physical surroundings is critical and is required to be accomplished correctly to avoid setting up operations on an unsuitable site. At the operating location, the ERPSS-10 should be physically located to afford ready access to active taxiways/runways as feasible, while the ERPSS-50 to ERPSS-100 UTCs should be located in close proximity to the nearest medical facility. This promotes rapid patient enplaning operations and supports the overall air mobility mission by minimizing aircraft ground-times and delays. Guidance for airfield safety clearances when operating near active taxiways or runways can be found in Attachment 8. The team chief appoints the site survey team to survey those areas of the proposed site based on their expertise. **Note:** Prior to beginning the site survey/selection process, the team chief needs to first coordinate with airfield management authorities or supporting units. See ERPSS-10 SITE ESTABLISHMENT Attachment 6 for additional guidance, to include the criticality of good drainage for tents.

3.5.3.1. Personal/Site Camouflaging. When camouflaging is deemed necessary for Force Protection (FP), personnel need to take into consideration the threat, time of year, climate, and the natural surroundings. Skin should be covered using camouflage face paint, paint sticks, mud, or any other suitable material. All areas of the head, neck, face, hands, throat, ears, and any other exposed skin areas are to be covered. Sleeves will be rolled down. Shiny areas of the face, which includes the forehead, nose, cheekbones, and chin, should be subdued using darker colors like dark green, brown, and black. Personnel should remove or cover all reflective items such as rings, watches, earrings, etc. Personnel should use branches, leaves, or other local vegetation to break up outlines for themselves and their equipment. Vehicles and equipment should be dispersed to the maximum extent possible. Vehicle windows and mirrors will need to be appropriately covered or concealed to avoid reflections from the sun, moon, and other light sources. Camouflaged netting should be used to the maximum extent possible. Commanders must understand that if personnel, facilities and equipment are camouflaged, any protection these would receive under the Geneva Conventions as “marked” medical personnel, facilities or equipment is forfeited. While not a war crime to camouflage – there may be a operational reasons for doing so – it does not then equate to a LOAC violation if an adversary strikes those being unaware of any protected status.

3.5.3.2. Hardening Assets and Building Safe Defensive Fighting Positions and Bunkers. Tents, POL, and generators should be hardened as much as possible, when FP conditions require. Generators should be located at least 50 feet from the work/sleeping areas. The generator power cable should be buried in the ground. Generators should be shielded on all sides with sandbags to a height equal with the uppermost portion of the generator. This shielding or revetment should be big enough to allow free air ventilation and movement around the generator. Tents should be bunkered a minimum 3 ft. high by 3 ft. deep with 3 ft. of clearance between the tent and sandbags. This allows for additional cover for personnel outside, adequate cover for personnel inside the tent, free air ventilation and helps suppress light from the bottom of the tent during blackout conditions. The tentage doorways should have a protective barrier in front approximately

8 to 10 feet from the entrance/exit. This allows for some protection from blasts and small arms fire while providing space for litter casualty movement. The ratio of bunkers to personnel should be at least one bunker for every five to seven personnel. Whether it is provided by the user service or built by UTC personnel, the quantity of fighting positions and bunkers should be adequate to support all personnel. Assignments to them should be made to prevent overcrowding. Defensive fighting positions should be dug armpit deep. Bunker walls should be at least three feet wide by four feet high. To increase the height of the interior space, dig into the ground. Use available resources to cover the bunker. These need to be supported by dunnage or interior walls built into the bunker. A protective layer of sandbags at least two bags thick will be placed on the roof. The placement of a protective wall in front of the doorway will further protect against blasts or debris.

3.5.3.3. Initial Site Security. Security for ERPSS personnel and resources within the immediate area of each deployed location is the responsibility of the host installation. ERPSS-10/ERPSS-P should arrive at a forward operating location with the expectation that it may be a semi-secure airfield and be prepared to set-up area defense prior to establishing the facility. There may be little or no time to prepare for hostile action in the area. Every situation will be different and actions will be determined by all available information, such as intelligence reports and personal observation. Threats should dictate actions taken. Personnel should always use good judgment, err on the side of caution, and maintain a tactical posture whenever deployed. Guards should be posted for adequate safety and defense.

3.5.3.3.1. Defensive Fighting Position. When an area defense must be quickly established, personnel should post a guard or guards; immediately prepare hasty fighting positions (shallow depressions or holes roughly 18 inches deep and long enough for the body), and identify fields of fire. Continue to refine fighting positions, increasing survivability with more advanced positions as situation, mission, and time dictate.

3.5.3.3.2. ERPSS personnel engaged exclusively in medical duties are non-combatant; however, personnel may be armed as dictated by theater instructions. Facility security for asset protection, entry control, personal protection, and patient protection is performed by armed ERPSS personnel IAW the Law of Armed Conflict and Geneva Conventions. Though ERPSS personnel are armed IAW theater requirements, the ERPSS does not have forces assigned for security, other than installation security limited to protection of assets, regulation of access, and Unexploded Explosive Ordnance (UXO) sweeps. Security for personnel and patients against enemy aggressors is primarily the responsibility of, and should be provided by, the host installation commander. Security for patients and personnel resources within the immediate area at each deployed medical site is a medical responsibility. Enemy Prisoner of War (EPW) patients are the responsibility of security forces personnel, not medical personnel. Medical personnel are issued small arms IAW AFI 31-117, *Arming And Use Of Force By Air Force Personnel*. Deployed medical site assets, such as narcotics, are protected as a controlled area IAW AFI 31-101,

*Integrated Defense.* Additional force protection measures should be determined by the Deployed Medical Commander (DMC) or Senior Medical Officer (SMO) based upon Force Protection Condition (FPCON) and the advice of the Defense Force Commander (DFC).

3.5.3.3.3. Entry Control Points (ECPs). ECPs should be established in the same manner as those on the flight line. They are not designed to keep people out but to give controlled access to authorized personnel. Anyone entering the ERPSS area not using an ECP should be considered “unfriendly” until proven otherwise.

3.5.3.3.4. Code Words. Sign/Countersign, authentication codes and duress words should be used at all ECPs as the FP conditions dictate. The host installation FP Office is responsible for generating these requirements; however, ERPSS personnel may need to establish these items upon arrival until the host installation FP Office is functional. Follow AFPAM 10-100, *Airman’s Manual*, for further guidance. A duress code should be established. This is a word or phrase used during the challenge/reply sequence to alert the guard that the member is under duress from an enemy, e.g., gun pointed at member by enemy, but is out of sight of the guard. Numbers equal to an established sum may also be used. All challenge/responses should be given in a clear voice, just loud enough to be heard.

3.5.3.3.5. Running Passwords. A running password should be made for times of emergencies when the conventional challenge/reply would be too time consuming. A running password is used when a "friendly" member is being pursued by enemy forces into the compound. The running password identifies the "friendly" and alerts the guards the enemy is right behind them. It requires no reply from the guards and should be shouted repeatedly by the incoming "friendly". The guards will immediately take up defensive positions and fields of fire once the "friendly" has entered the camp area. Make sure the camp is quickly alerted by any means available.

3.5.3.3.6. Buddy System. ERPSS personnel, who transit outside the area’s defined security perimeter, will not do so alone. ERPSS personnel who transit outside the area’s defined security perimeter will do so in compliance with established force protection measures. The ERPSS leadership may consider implementation of a ‘wingman concept’ that requires personnel to travel outside the security perimeter in pairs as threat conditions warrant/require.

3.5.3.4. General Evasive Plan of Action (Bug-out). During contingency operations, escape and evasion routes and procedures will need to be established with other elements at the deployed location to ensure all personnel are prepared in case of an emergency. All PM elements will coordinate with the supporting collocated user service to see if an evasive plan of action has been established. The ERPSS personnel need to be identified and included in the plans. The team chief will ensure the security of personnel and equipment are taken into consideration by the user service. If one has not been developed, assure a simple and direct plan is communicated. Disseminate this to all

personnel on what items to take, which vehicles or aircraft to go in, and make sure routes are specifically drawn out. Map, compass, Global Positioning Satellite (GPS) training is highly desirable for all personnel.

3.5.3.4.1. Fire Evacuation Plan. Each deployed element will develop a fire evacuation plan. This plan will include, at a minimum, a plan to egress the physical structure or location, assembly point, and personnel accountability. Additionally, the plan will address the accountability for classified documents, encryption devices and weapons.

3.5.3.4.2. Base Recovery after Attacks. Designate specific sweep areas, sector assignments, and marking procedures for your recovery teams. Assure processes are in place to quickly notify your area control element on the status of recovery assessments and accountability of all personnel.

3.5.3.5. Survivability/Separation of Assets. A crucial step in the survivability of all elements in a hostile environment is the separation of all assets and/or the location and protection of manpower and resources. It is important to remember that to survive in austere and hostile environments, effectively separating your assets and properly camouflaging them will limit the amount of collateral damage sustained in the event of an attack. All assets, such as tents, generators, vehicles, personnel, POL, food, water, supplies, and equipment should be separated as much as possible when threat conditions warrant such actions to minimize loss of resources and personnel from a hostile action, such as mortar or artillery attack, or individual sabotage. All supplies, medical and non-medical, should be kept, stored, concealed, and secured at all times.

3.5.4. Emergency Communications. ERPSS team members should coordinate with user service regarding the type of communications available for early warning of changes in chemical and FPCON conditions (i.e. flags, Land Mobile Radios (LMR), sirens, horns, whistles, voice levels) as well as phones installed in the bunkers for emergency use (when bunkers are required). When personnel are required to gather in one or more bunkers, an emergency communication system is essential to ensure all personnel are accounted for. The team chief of the element should establish procedures of notification, accounting, and evacuation of personnel.

3.5.5. AGE. AGE includes generators and heaters. Electrical power sustains our vital communication links, medical equipment, lighting, computers, and other equipment as needed. In order to operate AGE equipment safely, team members need to have knowledge about placement, set up and operation of the equipment, recognize gauge reading and know normal and emergency shutdown procedures. Obtaining these skills creates a safe working environment for equipment and personnel. It is the team chief's responsibility to ensure all ERPSS-10/ERPSS-P personnel are trained on the equipment utilized prior to deployments or participation in an exercise.

3.5.6. Fuel Storage and Safety. Proper fuel storage is critical to the continuing operations of any given UTC. The POL site should be a minimum of 50 feet from any semi-permanent

structure and should meet the same shielding criteria as generators. There should be a physical separation between full and empty fuel containers and the area should be clearly marked.

### 3.5.7. Personnel Responsibilities.

#### 3.5.7.1. Chief of Medical Staff. Supporting MTF responsibility.

3.5.7.1.1. Provides oversight to flight medicine, pharmacy, and nutritional medicine. (There are no credentialed providers in an ERPSS-10).

3.5.7.1.2. Coordinates with the validating flight surgeon to recommend whether patients should be admitted to the supporting MTF, or are authorized to remain overnight (RON) in the staging facility.

3.5.7.1.3. Ensures appropriate clinical/surgical/ancillary support services are available as required to meet the patient care needs for patients in RON status in the staging facility.

#### 3.5.7.2. ERPSS Team Member Responsibilities.

3.5.7.2.1. Team Chief. The Team Chief is either established as Commander on G Series orders, Operations Order (OPORD) or appointment by the supporting MTF or is the senior medical officer of the team assembled regardless of AFSC.

3.5.7.2.1.1. Establish communications with the deployed base commander and airfield manager. The ERPSS leadership team should also develop a relationship with the Air Terminal Operations Center (ATOC), CE, communications, transportation, dining facilities (DFAC), flight safety, fire and force protection units. These units should be notified of the presence of an ERPSS on the base and the mission support requirements inherent in the ERCC.

3.5.7.2.1.2. Develops and coordinates plans with the supporting MTF, Wing, MAJCOM, supporting PMRC, and AECT to support peacetime and contingency operations.

3.5.7.2.1.3. Coordinate with the supporting MTF to establish administrative, ancillary service, and clinical support requirements.

3.5.7.2.1.4. Establish communications with the appropriate PMRC.

3.5.7.2.1.5. Establish communications with all supported service tactical evacuation assets/units.

3.5.7.2.1.6. Establish communications with all MTFs moving patients to the ERPSS to ensure transportation and continuity of patient care is maintained.

3.5.7.2.1.7. Ensures staff training is provided to all assigned personnel for environmental and any specific geographic issues of concern at the deployment location. Coordinates with supporting MTF to ensure clinical/ancillary support requirements over and above the capability of the assigned ERPSS personnel are met.

3.5.7.2.1.8. Assesses overall personnel demands against authorized/allocated resources.

3.5.7.2.1.9. Ensures funding and accountability by submitting requirements to MTF or co-located medical facility for budget and financial planning.

3.5.7.2.1.10. Supports and oversees personnel management of unit.

3.5.7.2.1.11. Ensure anti-hijacking procedures are followed IAW AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*, AFI 48-307 V1, *En Route Care and Aeromedical Evacuation Medical Operations*, and Federal Aviation Administration (FAA) directives.

3.5.7.2.1.12. Ensure handling and storing of weapons and ammunition, perimeter and entry control procedures are be accomplished IAW AFI 31-101, *Integrated Defense*, and Area of Responsibility (AOR) Commanders' local policies and directives.

3.5.7.2.1.13. Ensure UXO sweeps and perimeter maintenance are accomplished IAW AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear and High-Yield Explosive (CBRNE) Environment*.

3.5.7.2.1.14. Ensure handling, securing and processing EPWs and detainees is IAW Geneva Convention rules and Laws of Armed Conflict (LOAC).

3.5.7.2.1.15. Team chiefs need to consider operating without operational IM-IT connectivity; therefore hard copy documentation work-arounds must be considered.

3.5.7.2.2. Flight Surgeon. The flight surgeon will review the patient's record, prescribe treatment, diet and address any current medical complaints upon arrival with appropriate documentation on the patient's AF Form 3899, *Patient Movement Record*, approved electronic health record, or DD Form 602, *Patient Evacuation Tag*. The flight surgeon will determine if the patient can begin or continue travel in the AE System and coordinate status with the appropriate PMRC. A flight surgeon will evaluate and document the patient's condition every 24 hours, consult with medical specialists as needed and will be available on a 24-hour basis. Make rounds with the staging nurse, at least every 24 hours, and update the AF Form 3899. In the event of a patient status change, report the change through staging facility leadership and/or

PMRC for updating the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES).

3.5.7.2.2.1. Credentialed Provider's Orders. Physicians will order en route treatment on the AF Form 3899 or approved electronic charting, and sign the order.

3.5.7.2.2.2. With assistance of the supporting MTF Chief of Medical Services and PMRC validating flight surgeon (VFS), determine whether each patient can remain in the staging facility or must be transferred to the MTF for medical care.

3.5.7.2.2.3. Placing patients on medical hold. In the event of changes in the patient's condition, the flight surgeon may place a patient on medical hold, not to exceed 72 hours. Patients with severe conditional changes may require admission to an MTF whereupon the flight surgeon will arrange for hospitalization.

3.5.7.2.3. Family Physician/Physician Assistant. The family physician/physician assistant will review the patient's record, prescribe treatment, diet and address any current medical complaints with appropriate documentation on the patient's AF Form 3899. Neither the family physician nor the physician assistant is authorized to clear patients for flight.

3.5.7.2.4. Nursing Services.

3.5.7.2.4.1. Nursing services will document all patient care on AF Form 3899 or other AF approved computer based charting. All entries will be recorded in ZULU time (example: 1837Z or 0245Z). At a minimum, charting is required upon admission, once a shift and upon discharge from an ERPSS. Triage starts with a review of the patient manifest and Patient Movement Request (PMR) and continues through the patient's arrival and nursing report.

3.5.7.2.4.2. Ensure all patients have a patient identification (ID) bracelet. The ID bracelet will be printed or typed with the last name, first name, middle initial, date of birth and TRAC2ES cite number.

3.5.7.2.4.3. Medication Management.

3.5.7.2.4.3.1. Nurses are responsible for daily accountability of patient narcotics on each applicable AF Form 3899 for all inpatients and non-self-medicating outpatients..

3.5.7.2.4.3.2. Outpatients deemed compliant and competent to self-medicate, may self-medicate with controlled/non-controlled medications if determined by the sending provider as being competent to self-medicate and when designated by the clearing flight surgeon. Self-medication orders will be documented on the AF Form 3899 by the nurse on duty. The Pharmacy/nurse will provide an adequate supply of medications and an AF Form 3899I,

*Patient Movement Medication Record*, for identifying dosages and schedules for self-administered medication. The pharmacy technician will provide instruction and information regarding their prescribed medication. Education will be documented on the AF Form 3899 by the staging nurse.

3.5.7.2.4.3.2.1. Provider order for self-administration of medications (SAM).

3.5.7.2.4.3.2.2. “Will self-medicate” boxes must be marked on the front and back of the AF 3899.

3.5.7.2.4.3.2.3. The following statement written and signed by the verifying provider or nurse stating that the patient is compliant and competent to self-medicate.: “*Patient is hand-carrying medication(s): has been instructed on self-medication of (list medication name[s] and verbalizes understanding)*”.

3.5.7.2.4.3.2.4. At a minimum, SAM patients will be reassessed at every hand-off for continued competency and compliance.

3.5.7.2.4.3.2.5. If an outpatient is deemed not compliant and/or not competent for SAM at any point of the patient movement process, the respective care provider (e.g. Medical Crew Director (MCD), Flight Nurse (FN), ERPSS personnel, etc.) will:

3.5.7.2.4.3.2.5.1. Immediately assume responsibility for and administration of that patient’s medication(s).

3.5.7.2.4.3.2.5.2. Clearly document the change in the patient's SAM status on the AF Form 3899.

3.5.7.2.4.3.2.5.3. Verbally communicate that change in status to the accepting provider at the next patient hand-off.

3.5.7.2.4.3.2.5.4. Initiate a DD Form 2852, *AE Event and Near Miss Report* and submit to AMC/SG Patient Safety representative.

3.5.7.2.4.3.6. Inpatients medications, both controlled and non-controlled will be managed by en route care medical personnel. Patient Controlled Analgesia (PCA) will be managed through physician orders.

3.5.7.2.4.3.7. When patient medical supplies and PMI are coordinated with the AE system in advance, most items can be provided from the AE staging base. The originating facility will be responsible for providing these items and should provide a one-day minimum of medical supplies. The originating facility will provide supplies; for intra-theater movement, a three-day supply; for inter-theater movement, a two-three day minimum supply is required.

During time of war, intra and inter-theater medication supply levels will be based on command directives.

3.5.7.2.4.3.8. It is the responsibility of the medical personnel in each patient care area (user service, staging facility, AE crews, and destination MTF) to administer controlled medications to their patient population as prescribed on the AF Form 3899.

3.5.7.2.4.3.9. Unaccompanied controlled medications (schedule II, III, IV) will be turned into the pharmacy and documented on AF Form 3859, *Turn-In of Unaccompanied Narcotics*.

3.5.7.2.4.3.10. If controlled medication is stored at a remote location other than a pharmacy (i.e. a nurse's station), a nurse and another qualified person must count narcotics at change of shift and document on AF Form 579, *Controlled Substances Register* or in automated equipment logs (e.g. Pyxis ® log), as appropriate.

3.5.7.2.4.3.11. Controlled medications issued to patients and under patients' control may not be returned to pharmacy. They must be destroyed IAW local policies.

3.5.7.2.4.3.12. Providers must use electronic order entry for prescriptions whenever available, IAW AFI 44-102, *Medical Care Management*. If not using electronic order entry, use AF Form 781, *Multiple Item Prescription*, or equivalent computer-generated means via an AF approved system.

3.5.7.2.4.4. If a patient arrives without an AF Form 3899, for example, arrives with a DD Form 1380, *US Field Medical Card*, information from those documents will be transcribed onto an AF Form 3899 and the original documentation will be attached to the AF Form 3899 and will become a permanent part of the patient's medical records.

3.5.7.2.4.5. Prior to departing the staging facility for the aircraft, the patient will be assessed for pain and, if required, administered medication within one hour of departure from staging area. If medically acceptable, delay administering diuretics until after flight.

3.5.7.2.4.6. Chief Nurse/Nurse Manager.

3.5.7.2.4.6.1. Provides clinical oversight and management of Nursing Services.

3.5.7.2.4.6.2. Assesses nursing personnel demands against authorized/allocated resources.

3.5.7.2.4.6.3. Assesses clinical level and experience of assigned nursing personnel and identifies and provides for additional clinical training needs as applicable.

3.5.7.2.4.7. Aerospace Medical Service Superintendent. Provides oversight and supervision for all assigned Aerospace Medical Service Journeyman/Craftsman.

3.5.7.2.4.8. Clinical Nurse and Aerospace Medical Service Journeyman/Craftsman. Clinical nurses and Aerospace Medical Service Journeyman/Craftsman make up the ERPSS patient care team. They receive reports on incoming patients, prepare patients for flight IAW AFI 48-307 V1, *En Route Care and Aeromedical Evacuation Medical Operations*, complete patient assessment and treatment documentation, keep patients informed concerning the status of their care, and ensure anti-hijacking measures are accomplished for all patients prior to enplaning.

#### 3.5.7.2.5. Administration.

3.5.7.2.5.1. Maintain, IAW AF and local directives, a comprehensive events log documenting activities, correspondence, communications and facility issues. The events log provides historical documentation of all activities within the facility and can be used to verify activities, as well as actions taken by unit personnel.

3.5.7.2.5.2. Maintain a status board displaying appropriate information, such as mission, Estimated Time of Arrival (ETA), Estimated Time of Departure (ETD), patient loads, and aircraft data in appropriate area out of view for protection of information.

3.5.7.2.5.3. Verify mission information, including patient information, load data, special equipment requirements and aircraft information with appropriate agencies as directed by higher headquarters and local directives. Coordinate patient and mission changes with appropriate PMRC and AECT to ensure lift and crews are appropriate for mission.

3.5.7.2.5.4. Coordinate mission requirements with appropriate personnel, such as census, launch and recovery times/staffing needs, to include drivers or vehicles, appropriate clinical points of contact at other MTFs and supporting agencies.

3.5.7.2.5.5. Establish procedures to ensure the physician at the originating facility initiates appropriate documentation and signs the AF Form 3899, or AF approved electronic patient documentation, recommending movement of patients and attendants. The clinical staff will document patient assessment and care, while the administrative staff will ensure documentation is available for use. Patient Administration or Medical Regulating Office will provide appropriate documentation from TRAC2ES to meet mission requirements, such as PMRs, patient manifest, patient baggage list, and any other additional paperwork.

3.5.7.2.5.6. Information in TRAC2ES is subject to change on short notice based on current operational requirements. Changes are updated as quickly as possible, but the PMR may not reflect the most current information available. The facility control center will be in contact with the PMRC to ensure the latest information is provided to staff, but some changes will not get communicated until a flight arrives on station. The control center will communicate directly with the Officer in Charge (OIC) of any changes to the patient manifest or patient condition to ensure the most current medical information is available to the AE crew.

3.5.7.2.5.7. Ensure patients and attendants are briefed regarding AE and staging policies and procedures, including at a minimum, force protection issues, unauthorized items in the facility, as well as on aircraft and anti-hijacking requirements. Unauthorized items will be confiscated and documented on AF Form 1297, *Temporary Issue Receipt*. Weapons and ammunition, should be given to the patient's unit Liaison Officer (LNO) for storage and/or return to home station, with appropriate documentation in the Events Log or on an AF Form 1297.

3.5.7.2.5.8. Ensure patient accountability is maintained at all times. Only patients and medical/non-medical attendants identified with a current automated Information System (AIS) allowing Intransit Visibility (ITV) will be staged. This can be maintained on status boards or log sheets, provided they are compliant with the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d et seq, and personnel are briefed on use, maintenance and compliance issues.

3.5.7.2.5.9. Releasing Patients from the AE System. See AFI 48-307 V1, *En Route Care and Aeromedical Evacuation Medical Operations*. This AFI provides the current guidance on policies and procedures. **Note:** patients who are removed from the AE System may not resume travel on their original TRAC2ES cite number.

3.5.7.2.5.10. All patients RONing in the MTF or other agency are census assets of the ERPSS (if co-located with MTF). If patients need to RON in the MTF or other agency while transiting the AE System, they may be formally admitted to the MTF. The MTF flight surgeon or designee will manage the medical care of such patients and will reaffirm their readiness for flight. Patients in RON status at a civilian medical facility may be admitted, but the ERPSS will retain them as ERPSS RON patients.

3.5.7.2.5.11. Health Services Administration Officers. The Medical Service Corps (MSC) officers assigned are responsible for ensuring all necessary coordination is made with medical organizations requesting AE support. Acts as principle liaison with organizations sending patients to the ERPSS and ensures all required reporting is completed. Remains familiar with all communications equipment and assists the AE Communications Team personnel if needed.

3.5.7.2.5.12. Health Services Management Superintendent. Provides oversight and supervision for all assigned health services management journeyman/craftsman.

3.5.7.2.5.13. Health Services Management Journeyman/Craftsman. The Health Services Management Journeyman/Craftsman are responsible for managing and accounting for patient records. Initiates all necessary in-flight documentation; ensuring paperwork is complete and accurate. Additionally, work with the supporting user service to verify AE mission arrival and departure times. May assist with anti-hijacking measures. Personnel need to be familiar with all communications equipment and assist the AE Communications Team personnel if needed.

3.5.7.2.5.14. Medical Materiel Journeyman/Craftsman. Medical logistics support is essential to the ERPSS mission success. The logisticians manage, provide guidance, technical support, and coordinate re-supply support channels.

3.5.7.2.5.15. Biomedical Equipment Craftsman. Is responsible for all medical equipment maintenance activities.

3.5.7.2.6. Diet Therapy Craftsman. Informs Nutritional Medicine at the MTF of any unique food requirements. In the event of altered transportation plans, shall obtain adequate nutritional provisions for patients and provide three-day feeding supply for intra-theater PM and five-day supply for inter-theater PM.

3.5.7.2.6.1. Nutritional Medicine Support. Supporting MTF responsibility unless nutritional medicine personnel are assigned to staging facility.

3.5.7.2.6.1.1. Nutritional Medicine coordinates patient feeding requirements with Base Operating Support (BOS) elements. Nursing service orders patient meals three to four times a day on AF Form 1094, *Diet Order*. The form is completed by Nursing Services, and all patient meals must be annotated on the diet order form. The patient meal tally is to be presented to the DFAC no later than two hours prior to the start of meal preparation. Patient nutritional requirements are coordinated with the DFAC, flight kitchen, and Nutritional Medicine. The AF Form 129, *Tally In/Out*, is used to transfer rations from an AF DFAC or MTF. The AF Form 79, *Head Count Record*, is used to account for patient meals prepared in an AF DFAC.

3.5.7.2.6.1.2. The ERPSS provides meals to patients transiting the ERC System Attendants (medical and non-medical) are authorized to use the MTF DFAC when available, at their own expense. The staging facility provides meals to patients using local DFAC or Meals Ready to Eat (MRE). Refer to AFI 41-307 for additional information regarding meals.

3.5.7.2.7. Pharmacy. Supporting MTF responsibility unless pharmacy personnel are assigned to Staging Facility.

3.5.7.2.7.1. Prepares patients' medications for departure from the staging facility.

3.5.7.2.7.2. Obtains and provides pharmaceuticals within the approved staging formulary which may or may not be augmented by medications provided by the MTF or other available resources.

3.5.7.2.7.3. Assures or provides patients with an adequate supply of medications to reach their prescribed destination. Deployed locations should send a one-day supply from a Role II to Role III facility in a combat operations theater and a two-day supply from a Role III to a theater hospital out of the combat operations theater. When inpatients are moving OCONUS to the CONUS, a two - three day supply is required depending on if the inpatient is going to port or past port. All outpatients moving OCONUS to CONUS should receive a five-day supply. When moving within the CONUS, a one-day supply is adequate.

3.5.7.2.7.4. Outpatients may carry their own supply of controlled substances, if determined by the sending provider to be competent to self-medicate. Note: Outpatient mental health patients (5C) will only be cleared to self-medicate after consultation with a provider licensed or credentialed in mental health. Prior to flight, a registered nurse must personally interact with the patient to verify the patient understands and provides additional education as appropriate, on proper self-administration of medications. Healthcare professionals must remain cognizant of potential abuse and misuse of controlled medications and must follow the below guidance as applicable.

3.5.7.2.7.5. Originating MTF will ensure patient medication education for any prescribed pharmaceuticals. If geographically possible, patient education for "new" medications dispensed at en route stops will be done by the dispensing facility.

3.5.7.2.7.6. Physicians are required to have AF Form 2383, *Prescriber's Information*, on file (one at MTF pharmacy, one with ERPSS pharmacy tech). Nurses are required to have AF Form 2383 on file in the ERPSS pharmacy.

3.5.7.2.7.7. Provide AF Form 579 to dispense narcotics to different nursing stations (a separate form is needed for each controlled substance and dosage).

3.5.7.2.7.8. Reviews the AS and formulary; tailor according to local requirements and/or IAW local policy. The formulary must be approved by the Medical Group Commander (MDG/CC) and the MTF Pharmacy and Therapeutics Committee/Function.

3.5.7.2.7.9. Pharmacy Craftsman. Prepares patient medications for departure from the staging facility. Assures or provides patients with an adequate supply of medications to reach their destination.

3.5.7.2.8. Patient Safety Manager. The ERPSS Team Chief shall appoint a Patient Safety Manager (PSM) and an alternate. Typically the primary role is performed by the senior nurse assigned to the ERPSS. The PSM will review all DD Form 2852s, Near Miss Reports, and ensure submission into the TRAC2ES system in the Patient Movement Quality Report (PMQ-R) tab. The PSM advises the local leadership on all matters related to patient safety, tracks and trends data, and initiates and facilitates completion of significant event root cause analysis when indicated, assists with Medical Incident Investigations, provides patient safety related in-services as needed, and maintains a current TRAC2ES account. The PSM will provide a quarterly report and an annual report (end of calendar year) to the ERPSS senior leadership and associated EMEDS/MTF leadership as to the status of open reported trends, resolutions, open events, and other patient safety issues, assessments or initiatives. The local leadership will send reports through associated MAJCOM to HQ AMC/SGK Patient Safety.

3.5.7.2.8.1. The focus of a patient safety program is to keep staff current on patient safety practices/initiatives, identify issues and trends for improvement, and take action to plan and implement improvements. A more detailed description of this role and responsibilities and further information/guidance can be found in the “Deployed Patient Safety Guide” and “AE Patient Movement Patient Safety Program Guide” located on the Knowledge Exchange (see link below) under ‘Guidance & Policy’ and then select ‘Patient Safety Guides’. Knowledge Exchange Link:  
<https://Kx2.afms.mil/kj/kx2/CQMPatientSafety/Pages/home.aspx>

3.5.7.2.9. Vehicle Control Officer/NCO. The ERPSS Team Chief shall appoint a Vehicle Control Officer/Non-Commissioned Officer (VCO/VCNCO) in writing. The VCO/VCNCO will manage the vehicles IAW AFI 24-302, *Vehicle Operations*, and local directives. The VCO/VCNCO’s ensure appropriate personnel are trained to operate assigned vehicles, verify certification for flight line vehicle operations, and prepare and submit vehicle reports according to local directives.

### **3.6. Generation/Sustainment of ERPSS Operations.**

#### **3.6.1. Staging Facility Personnel Will.**

##### **3.6.1.1. Stage, enplane and deplane patients.**

3.6.1.1.1. Staging facilities at strategic hubs are responsible for the transportation of patients between their MTF and/or the evacuation asset/aircraft. The appropriate vehicle support UTCs must be tasked in addition to the ERPSS personnel and equipment UTCs. Fixed staging facilities must have adequate AMBUS assets assigned to support PM requirements.

3.6.1.1.2. Depending upon the patient’s needs, a nurse, medical technician, and health services management technician (in addition to the driver), plus emergency equipment (i.e. Defibrillator/ Monitor, portable O2, portable medications kit {not an

all inclusive list}) will accompany patients in an AMBUS, ambulance or vehicles of opportunity according to patient requirements. Staging Facility personnel are also required to load and unload patients on and off aircraft or other evacuation asset. Additional medical personnel may be required due to patient acuity. Additional manpower will be necessary to facilitate large patient loads (i.e. baggage handling, litter movement, etc.).

3.6.1.1.3. Occupational Safety. All staff involved in patient movement must exercise extreme caution during enplaning and deplaning procedures. A high accident potential exists because of the noise level, vehicle activity around the aircraft, and possibility of inclement weather.

3.6.1.1.4. All personnel in the immediate area of an operating aircraft must wear ear plugs. All vehicles moving within 10 feet of the aircraft will use a spotter. The spotter will preposition wheel chocks to prevent the vehicles from damaging the aircraft. Chocks will remain in position until the vehicle(s) are ready for movement.

3.6.1.1.5. All vehicles will approach parked aircraft with the driver side of the vehicle toward the aircraft.

3.6.1.1.6. Only vehicles required to deplane patients/passengers or service the aircraft will be permitted to approach after aircraft block in. All vehicles will stand clear until directed to proceed.

3.6.1.2. Receive regulated/unregulated patients and provide continuing and supportive care.

3.6.1.3. Prepare and clear patients for flight to ensure suitability for movement under the guidance of the PMRC VFS.

3.6.1.4. Brief patients and accomplish appropriate documentation and TRAC2ES inputs.

3.6.1.5. Provide ground transportation between the staging facility and the aircraft.

3.6.1.6. Provide facility security for the protection of assets, personnel and entry control.

3.6.2. Mission Launch and Recovery. ERPSS Commander/Team Chief will ensure Plans, Policies, Procedures and Processes (P4) will be in place to include the following:

3.6.2.1. Management and control of medical attendants.

3.6.2.2. Stresses of flight.

3.6.2.3. Billeting and recall.

3.6.2.4. Attendant responsibility for assigned patients.

3.6.2.5. Inventory and management of PMI equipment.

- 3.6.2.6. Delivery and recovery of patient to and from aircraft.
- 3.6.2.7. Medical and medication documentation to MCD.
- 3.6.2.8. Special diet, patient medical records, X-rays, SF 600.
- 3.6.2.9. Proper handling of litters, North Atlantic Treaty Organization (NATO) carriers and attire.
- 3.6.2.10. Management of administrative processes including:
  - 3.6.2.10.1. Reviews of AF Form 3899 and TRAC2ES PMR.
  - 3.6.2.10.2. Preparation of baggage list provided by TRAC2ES and patient baggage tag (DD 600).
  - 3.6.2.10.3. Anti-hijacking process and presentation.
    - 3.6.2.10.3.1. All patients, attendants and baggage to be placed aboard AF aircraft or HQ AMC contract aircraft must be anti-hijack checked by staging facility personnel. A staging facility representative will provide the MCD with a signed statement listing the names of the individuals searched and that anti-hijacking measures have been accomplished. This statement will be: “Anti-hijacking accomplished per AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*.”
    - 3.6.2.10.3.2. During contingencies, when performing anti-hijacking procedures, personnel will wear personnel protective equipment (i.e. helmet, flack vest, etc.). When possible, anti-hijacking procedures should be accomplished in an area away from the facility.
    - 3.6.2.10.3.3. Inspect patients and attendants either with a hand held or walk through metal detector, X-ray machine or by a physical check. **WARNING:** Electromagnetic interference from hand held and stationary surveillance systems interferes with implantable cardiac pacemakers and implantable cardioverter-defibrillators. Changes in pacing rates, shock, and possible cardiac arrest may occur. Use alternate anti-hijacking procedures for patients and passengers with these medical devices.
    - 3.6.2.10.3.4. Notify security forces if suspicious items are found.
    - 3.6.2.10.3.5. Restrict inspected patients and attendants to a holding area.
    - 3.6.2.10.3.6. Inspect all hand-carried items.
    - 3.6.2.10.3.7. Honor requests for visual/physical inspection instead of using X-ray or metal detectors.

- 3.6.2.10.3.8. Identify any patients or attendant showing suspicious behavior.
- 3.6.2.10.3.9. Ensure guards have been arranged to accompany prisoner patients to their destination.
- 3.6.2.10.3.10. Conduct all inspections with the highest standard of military courtesy.
- 3.6.2.10.3.11. Exempt classified materials held by official couriers from inspections.
- 3.6.2.10.3.12. Inform passengers they can't carry weapons or explosives aboard. Notify aircrew if authorized weapons are carried onboard.
- 3.6.2.10.4. Vehicle control including drivers.
- 3.6.2.10.5. Flight line authorization, chocks and radios.
- 3.6.2.10.6. Configuration of AMBUS's, ambulance or opportune conveyance.
- 3.6.2.10.7. Vehicle mechanical and security checks.
- 3.6.2.10.8. Flight line safety and security.
- 3.6.2.11. Management of patient documentation.
  - 3.6.2.11.1. Completion of AF Form 3899A-L or AF approved computer based charting, to include vital signs, ensure medication requirements are properly documented.
  - 3.6.2.11.2. Complete other forms as necessary, including:
    - 3.6.2.11.2.1. AF Form 3899E, *Patient Movement Intake & Output*.
    - 3.6.2.11.2.2. AF Form 3899B, *Patient Movement Physician Orders*.
    - 3.6.2.11.2.3. AF Form 3899I, *Patient Movement Medication Record*.
    - 3.6.2.11.2.4. All special diets will be ordered by the physician and documented on the AF Form 3899. Ensure all patients are allocated a meal for flight.
    - 3.6.2.11.2.5. Patient classification changes on PMR (can only be changed by flight surgeon).
    - 3.6.2.11.2.6. Complete AF 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*, if required.

- 3.6.2.11.3. Place all medical records (clinical records, outpatient treatment records, X-rays, and any other pertinent patient information) in an envelope. The following information is required to be printed on the outside of each patient envelope: patient name, rank or status, patient classification, Self-Administering Medications (SAM) or Non-SAM Status, allergies, last five numbers of Social Security Number (SSN), cite number for patients without SSN, nationality (if not a US citizen), organization, date of departure, and destination. The cite number is a TRAC2ES system specific number that is utilized to track a patient/individual in the system without providing personal identifying information (PII) description of the cite number. Consists of 10 Characters: Positions 1-2 = last 2 digits of year, Positions 3-5 = Julian date, Position 6 = PMRC designation, (1=TPMRCA; 2=TPMRCE; 3=TPMRCP; 4=JPMRC) Positions 7-10 = system sequence number for one day. All medical records, X-rays, medications and supplies will be placed in a secure records container carried and transported to and from the aircraft. This carrier will be exchanged with the MCD at origin and each end of the mission. All information regarding patient information must follow AFI 33-332, *Air Force Privacy and Civil Liberties Program*.
- 3.6.2.12. Ensure adequate medication supply for patient.
- 3.6.2.13. Brief patients scheduled for departure to include:
- 3.6.2.13.1. Potential for unscheduled overnight stops.
  - 3.6.2.13.2. Possession of authorized/unauthorized articles.
  - 3.6.2.13.3. Use of restrooms.
  - 3.6.2.13.4. Hand carrying luggage, X-rays, medical records and medications.
  - 3.6.2.13.5. Sequence and order of patient loading.
  - 3.6.2.13.6. Procedure and patient requirements during transport to aircraft.
- 3.6.2.14. Patient Handoff. When preparing patients for departure, the nurse will include the I-SBAR (Identify, Situation, Background, Assessment, and Recommendation/Request) format for all outpatient handoffs (Attachment 16) and all inpatients handoffs (Attachment 17). These forms are available in TRAC2ES under "Documents".
- 3.6.2.15. Patient Death in the ERPSS. If a patient death occurs in the ERPSS, the individual remains will be transported to the Host MTF with all records and appropriate documentation, i.e. "Death Certificate." If at an ERPSS-10, individual remains are to be transported back to the providing user service facility IAW AFI 48-307.
- 3.6.2.15.1. Fill out a DD Form 2852 to report all deaths within the ERC system into the Patient Safety Reporting System (TRAC2ES/PMQ-R).

### 3.6.3. Conducting Anti-Hijacking Procedures and Security.

#### 3.6.3.1. Baggage Restrictions.

3.6.3.1.1. Inform all passengers regarding baggage restrictions and prohibitions, to include the current FAA provisions on liquids, and the general prohibition on bringing weapons and explosives onboard the aircraft.

3.6.3.1.2. IAW DoD 1415.13R, *Air Transport Eligibility*, Patients are authorized 70 pounds of personal baggage. This 70 pound limit does not include issue items (i.e. body armor or mobility bags).

3.6.3.1.3. Patients being moved via small aircraft (i.e. C-21) are only authorized one small bag IAW AFI 11-2AE Vol. 3. Additional baggage must be sent via other methods to the patient's final destination.

## 3.7. Redeployment.

3.7.1. Redeployment or Notification. The CCDR's redeployment order authorizes the redeployment of medical resources. ERPSS team chief needs to ensure the command element Aeromedical Evacuation Squadron (AES/CC and MDG/CC) are aware of the orders, and are involved in the coordination to ensure PM capability, as required for operations. The ERPSS team chief will actively participate in redeployment planning, including preparing time-phased reduction in medical services consistent with the deactivation of the deployed location. Associated activities will include inventory/re-pack of deployed medical assets, transportation planning, transition planning (if required) and preparation of debriefs and after-action reports.

3.7.2. Redeployment to Home Station. Team members will inventory and re-pack all assets according to the pack-out list. At least one ERPSS staff member must be Hazardous Materials (HAZMET)/Hazardous Materials Declaration (HAZDEC) certified and one person should be load plan certified. Familiarity with pallet building and airlift procedures are significant for shipping equipment. Any hazardous items will require appropriate documentation. All personal gear will be packed in personal bags only.

3.7.3. Forward Deployment. Personnel assigned to the ERPSS-10 will either redeploy or role into an ERPSS-50 if directed.

## Chapter 4

### COMMAND AND CONTROL (C2)

**4.1. HQ AMC/SG Responsibility.** HQ AMC/SG maintains MEFPAC responsibility and has overall responsibility for ERPSS policy. As the UTC MEFPAC Responsible Agency (MRA), HQ AMC/SG will designate medical units to support ERPSS teams. HQ AMC/SG is also responsible for the UTC coordination and validation process. The AEF Center will source units to support ERPSS deployment taskings.

4.1.1. AMC. Inter-Theater AE forces normally remain under the Operational Control (OPCON) of United States Transportation Command (USTRANSCOM), delegated downward within AMC to 18th Air Force (18 AF) with planning, tasking and execution accomplished by the 618th Air and Space Operations Center (Tanker Airlift Control Center) (618 AOC (TACC)). Intra-Theater AE forces are normally under the OPCON of the CCDR, delegated downward to the Theater Air Operations Center (AOC) with planning, tasking and execution accomplished by the AE Control Team (AECT) and AOC.

4.1.2. Pilot Unit. The pilot unit is responsible for assisting in the development of and maintenance of standard manpower and logistics detail for all ERPSS UTCs IAW AFI 10-401 Chapter 5, *Air Force Operations Planning and Execution*. The goal is a uniform and capable package for all ERPSS teams.

4.1.3. MDG/CC. For Medical Groups with the assigned ERPSS teams, the MDG/CCs and affiliated Air Reserve Component (ARC) units are required to maintain the approved AFTTPs to ensure team members are appointed, trained, and ready for deployment. The MDG/CC is required to provide support to ensure successful training, predeployment planning, deployment and redeployment, and after action reporting.

4.1.4. MTF Medical Readiness. The Medical Readiness office staff is responsible for identifying personnel shortages and reporting readiness of UTCs assigned as directed in AFI 41-106, *Medical Readiness Program Management*.

### 4.2. Command and Control (C2).

4.2.1. C2 is the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. For definitive guidance reference AFI 13-103, *AFFOR Staff Operations, Readiness and Structures*. C2 functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations for mission accomplishment.

### 4.3. Joint Force Structure.

4.3.1. Unified Command Surgeon. The Unified Command Surgeon establishes theater medical policy, theater evacuation policy, requirements, and medical Concepts of Operations (CONOPs) and communicates these matters through the AFFOR Surgeon to the deployed

medical units. The chain of command for expeditionary medical units is through the Line of the Air Force (LAF).

4.3.2. Commander Air Force Forces (COMAFFOR). The COMAFFOR provides unity of command. To a Joint Force Commander, the COMAFFOR provides a single face for all Air Force issues. Within the Air Force Service component, the COMAFFOR is the single commander who conveys commander's intent and is responsible for operating and supporting all Air Force forces assigned or attached to that joint force.

4.3.2.1. A medical officer is a member of the COMAFFOR special staff and is the director of AF health services operations. This medical officer may be known as the AFFOR Surgeon and is responsible for overall health resources management and provides information on health surveillance and risk assessments, sustainment, and other force health protection issues. In coordination and planning for overall health service support, the AFFOR Surgeon will engage with both LAF and SG assets to ensure integrated PM and staging processes. The AFFOR Surgeon does not exercise command authority over deployed medical assets but provides a planning, coordinating, and oversight role.

4.3.3. Multinational or United Nations (UN) Operations C2. C2 of medical operations in multinational or UN operations are defined in the warning, execution, and operations orders. Service component planners establish medical requirements and relay them through existing tasking messages/mechanisms to MAJCOMs and wings.

#### **4.4. C2 Relationships.**

4.4.1. Aeromedical Evacuation Liaison Team (AELT). If assigned, the AELT works with the user MTF (AF Expeditionary Medical Support, Army Combat Support Hospital or Navy Fleet Hospital for example) to facilitate patient staging and assists/inputs patient information into a PMR via TRAC2ES in preparation for PM. The AELT directs patient on-load activities (in the absence of an AE Operations Team), provides AE related support services, and interfaces with all local and host activities that provide ancillary AE mission support services. The AELT possesses a vehicle and can move with the supported MTF to a new operating location.

4.4.2. Air Mobility Division (AMD). The Theater AMD generates the aircraft and aviation crews in preparation for PM.

4.4.3. Patient Movement Requirement Center (PMRC). Provides clinical and administrative validation for PM via the VFS. They coordinate PM by matching patients to the most effective AE mission.

4.4.4. Aeromedical Evacuation Operations Team (AEOT). Provides management and direction of assigned, attached and transiting AE crews, CCATTs and associated equipment. The team works directly with the AOC and PMRC to coordinate AE missions and ensure on-time launch and recovery.

4.4.4.1. The ERPSS will communicate with the AEOT to coordinate PM.

4.4.5. ERPSS-10/ERPSS-P.

4.4.5.1. When the ERPSS-10 and ERPSS-P are deployed, they may fall under the OPCON and Tactical Control (TACON) of the Joint Force Air Component Commander (JFACC)/Commander Air Force Forces (COMAFFOR) exercised through the Director of Mobility Forces-Air (DIRMOBFOR-AIR) and may be assigned to a deployed AE element. During exercise participation, OPCON/TACON will be outlined in the EXPORD or OPORD describing exercise command and control.

4.4.5.2. When deployed in support of AMC AE operations, the ERPPS-10 and ERPSS-P, fall under the OPCON or TACON of the 618 AOC (TACC).

4.4.6. ERPSS-50 through ERPSS-100.

4.4.6.1. The ERPSS-50/ERPSS-100 UTCs will fall under TACON of the Air Expeditionary Wing (AEW)/Air Expeditionary Group (AEG) commander.

4.4.6.2. If there is no AF presence, the UTCs may align under TACON of the local MTF IAW the OPORD, which defines specific command relationships. OPCON remains with the theater COMAFFOR. These UTCs may be designated a squadron under the expeditionary or fixed MDG/CC.

4.4.6.3. If the UTCs are located on other than AF locations, the UTCs will be under the OPCON of the AEW MDG/CC and TACON of host base commander unless otherwise specified in the OPORD.

4.4.6.4. When deployed to a location with a peacetime ERPSS, the ERPSS-50/ERPSS-100 UTCs may be merged with the peacetime assets and the commander will be identified prior to deployment from the senior administrator, flight surgeon, and nurse, with command and/or ERPSS-50/ERPSS-100 UTC experience. If the assets are not merged, the UTCs may become a squadron and will report to the host AF medical facility commander.

## Chapter 5

### INTELLIGENCE, NATIONAL AGENCY AND SPACE SUPPORT

**5.1. Intelligence.** Accurate medical intelligence is critical to threat identification and application of appropriate preventive medicine measures. Prior to deployment, units, groups, and/or individuals tasked to support an operation require deployment briefings IAW AFI 41-106, and AFI 10-402, *Mobilization Planning*. During the employment stage of an operation, ERPSS personnel require periodic briefings for their deployed location and for areas transited while conducting medical operations. The AFFOR Surgeon is responsible to ensure periodic medical/environmental intelligence updates are provided to all assigned units. Wing and Group commanders, in IAW with operational directives, coordinate communication of medical intelligence information with other base agencies.

**5.2. National Agency.** The Defense Intelligence Agency (DIA) and the National Center for Medical Intelligence (NCMI) <https://www.intelink.gov/ncm>, are primary sources for current medical intelligence prior to deployment. In the deployed environment, the Aerospace Expeditionary Task Forces (ASETF)/AFFOR Surgeon is the primary source for dissemination of theater/regional medical intelligence.

**5.3. Space Support.** Space-derived intelligence, weather updates, and troop movements are examples of valuable information that are primarily acquired through base support units/organizations. Accurate medical intelligence is crucial to threat identification and application of appropriate preventive medicine measures. The AFFOR Surgeon is responsible for ensuring assigned units receive periodic medical/environmental intelligence updates. Space-based communication systems, linked with terrestrial C2 systems, give the theater surgeon and deployed medical commander the ability to more effectively and efficiently direct, monitor, and employ the deployed medical forces and resources.

## Chapter 6

### COMMUNICATIONS AND INFORMATION SYSTEM SUPPORT

**6.1. Communication Requirements.** The communication systems/equipment used must be interoperable to optimize joint communications and frequency management operations. Communication planners must coordinate frequency requirements through appropriate frequency management channels (e.g. installation, MAJCOM, and theater) to ensure all radiating equipment is spectrum certified and frequency supportable.

6.1.1. Host nation coordination must be initiated before a full-scale deployment. ERPSS requires ECS for deployed NCC functionality, supplying networking core services (e.g. Wide Area Network (WAN) network access, information protection, Network Operating System (NOS) domain architecture, and Transmission Control Protocol/Internet Protocol (TCP/IP) addressing).

**6.2. Air Force C4 Policy.** AFI 33-108, *Compatibility, Interoperability, and Integration of Command, Control, Communications, and Computer (C4) Systems*, establishes guidance and responsibilities to ensure compatibility, interoperability, and integration for new and modified C4 systems, including automated information systems (AIS).

**6.3. Network Operations.** AFI 33-115, *Air Force Information Technology (IT) Service Management*, identifies the responsibilities for training, equipping, and supporting AF communications and information network users primarily through the use of Workgroup Managers (WM), NCC and MAJCOM Network Operations and Security Centers (NOSC). AF network management adheres to the Defense Information Infrastructure Control Concept (DIICC) consisting of areas of distributed responsibility at global, regional, and local levels.

**6.4. Information Assurance (IA) Policy.** The ERPSS personnel must understand and follow IA procedures, to include Communications Security (COMSEC) and computer security (COMPUSEC), IAW AFI 33-200, *Information Assurance (IA) Management*, and associated AF IA guidance. Deploying ERPSS personnel must have current AF IA certification.

**6.5. Communication Equipment.** The ERPSS deploys with organic computer hardware and software. While the ERPSS-10 does contain some limited self-sustaining communications, longer-term and more robust systems support will be required from base and/or ECS communication resources.

6.5.1. Communication Personnel (FFQCR). An FFQCR will be tasked in conjunction with the ERPSS-10 to provide initial communication personnel support, set-up and initiate communication between elements, process and track requests for AE, follow mission progress, and maintain situational awareness.

6.5.2. Satellite/Local Area Network (LAN) Connectivity. Satellite Communication (SATCOM) assets deploy with the ERPSS packages. Though satellite connectivity is the preferred connection, factors such as bandwidth availability and CCDR priorities may dictate other than SATCOM usage. Theater Deployable Communications (TDC) provides other

methods for theater communications. Telemedicine, medical logistics support, video transmission, and electronic mail require SATCOM capability when there is no LAN/WAN connectivity or a TDC network available. Satellite communications may be military or DOD approved commercial systems. Secondary communications links, such as LAN are obtained upon arrival in theater (via ECS) depending on the maturity of the theater communications infrastructure and the availability of commercial or military service provided circuits.

### 6.5.3. Communication Systems.

6.5.3.1. Laptops. The ERPSS deploys with standard laptops containing the DOD Standard Desktop Configuration (SDC) and Theater Medical Information Program (TMIP)-AF software. Both are capable of word processing, database management, store-forward telemedicine, tele-maintenance, message text formatting, graphics, and LAN/WAN interface capability.

6.5.3.2. Radio Systems. The AE system uses organic Very High Frequency (VHF) and SATCOM radio assets as a means of providing secure/non-secure communications capability. Radio equipment will be the AF current model and type with appropriate encryption capability as supported by the CCDR. This radio system is operationally focused to manage intra-ERPSS communications and support flight line PM operations. Communication requirements and frequency allocation issues need to be coordinated prior to deployment. The radio equipment is interoperable with a wide variety of DOD and commercial radios. Use of these radio sets in operations OCONUS, needs to be approved through the appropriate theater leadership.

6.5.3.3. Iridium Phones with secure sleeve. Iridium phones are handheld satellite phones that work anywhere in the world. It is larger than a typical mobile phone, but still small enough to carry in a backpack, is very simple to use, and provides secure/unsecure voice telephone capabilities through satellites. For secure communications, a secure sleeve must be attached to the phone handset. Each Unit will use their local Program Designator Code (PDC) for the purchase and activation of Subscriber Identity Module (SIM) cards for training and exercises. WRM SIM cards *will not* be used for unit training or exercises. When iridium phones are deployed, the WRM SIM card will be activated using the appropriate contingency operation consolidated PDC.

6.5.3.4. Broadband Global Area Network (BGAN). Portable and easy to setup the BGAN is another satellite phone that uses satellites located around the earth for worldwide telephone capabilities. This system can also interface with the Secure Terminal Equipment (STE) to provide secure communications. Each Unit will use their local Program Designator Code (PDC) for the purchase and activation of SIM cards for training and exercises. WRM SIM cards will not be used for unit training or exercises. When BGAN phones are deployed, the WRM SIM card will be activated using the appropriate contingency operation consolidated PDC.

6.5.3.4.1. All applicable information for the Iridium and International Marine/Maritime Satellite/(INMARSAT) can be found at the activation website: <https://www.disadirect.disa.mil/products/ASP/welcome.ASP>

**6.6. Medical Reports and Communication.** ERPSS UTCs are required to provide a daily SITREP and OPREP-3 when necessary. All medical reports are submitted IAW AFI 10-206, Chapter 4, *Operational Reporting*, specific Joint Task Force (JTF), and COMAFFOR guidance. These reports are communicated to the AFFOR Surgeon, contributing MAJCOM Surgeons, and the AF Surgeon General. See Attachment 11 for SITREP and OPREP-3 Formats.

6.6.1. SITREP. SITREPs are completed by the deployed medical Team Chief (senior medical officer) to provide daily medical input for inclusion in the deployed wing's SITREP. They are used to report the status of readiness of the element to the chain of command within the theater. All AE elements will provide SITREPs to the Aeromedical Evacuation Command Cell (AECS) as directed, generally on a 24-hour basis, or when a major change in mission capability occurs. The reports are normally submitted no later than 0200Z, reflecting data current as of 2359Z. The AECS, then compiles the SITREPs and will provide daily status report on the operational status of the AE System and PM mission data to Higher Headquarters (HHQ) per AF directives.

6.6.2. OPREP-3. AF OPREP-3s are used to immediately notify HHQ of any significant event or incident that rises to the level of DoD, CJCS, combatant command (CCMD), or Service Level interests. The Command Post will submit the applicable AF OPREP-3 regardless of whether or not the event is being reported through other channels. AF OPREP-3 reports do not replace the requirement for more detailed reports such as the Commander's SITREP.

**6.7. Classification of Information.** Any classified information must be transmitted by secure means: i.e. SITREPs, site locations, and flight information.

6.7.1. Physical Security. Protect classified equipment and documents against compromise or loss by using proper accounting and storage procedures. Classified information that is not under the personal control and observation of an authorized person is to be guarded or stored in a General Services Administration (GSA) approved field safe. One or two-drawer light containers must be securely fastened to the structure or under constant surveillance to prevent theft. If the need arises for equipment/COMSEC destruction, see Attachment 15, Radio Equipment Destruction.

6.7.2. COMSEC Re-supply. The AE Communications Team will deploy with the current months COMSEC material plus 90 day supply. The AE Communications Team will have to establish a COMSEC account within the AOR if the operation will require secure communications beyond 90 days.

**6.8. Message Precedence.** General Messages are all other message traffic with the precedence being designated by the message originator. All message traffic transmitted via High Frequency (HF) communications is normally assigned precedence. It serves as a guide to communication personnel to indicate the order of handling and notifies the addressee of the significance or

urgency of the content of the message. All messages are sent as soon as possible; however, the one with the higher precedence is sent first.

6.8.1. FLASH. This precedence is reserved for alerts, warnings, and other emergency actions having immediate bearing on national, command, or area security. FLASH messages are hand carried, processed, transmitted, and delivered immediately ahead of all other messages.

6.8.2. Immediate. This precedence is reserved for vital communication having immediate operational effect on tactical operations; communications directly concerning safety or rescue operations; and communications affecting the intelligence community operational role.

6.8.3. Priority. This precedence is reserved for calls that require prompt completion for national defense and security, the successful conduct of war, or to safeguard life or property. Normally, priority is the highest precedence that may be assigned to administrative matters for which speed of handling is of vital importance. Maximum delivery time is 24 hours.

6.8.4. Routine. This precedence is reserved for all official communications to which all of the above listed precedence does not apply. Routine messages are handled in the order received and after all messages of a higher precedence have been sent. Maximum delivery time is 72 hours.

## 6.9. Software Applications.

6.9.1. TMIP-AF. TMIP-AF provides the medical information systems needed to support health care delivery, medical logistics, and medical C2 functions in theater.

**Table 6.1. TMIP-AF Applications.**

APPLICATION	PURPOSE
Armed Forces Health Longitudinal Technology Application – Theater (AHLTA-T)	Electronic health record (EHR) for theater environments  <b>Note:</b> AHLTA-T is based on the EHR system used at MTFs in CONUS and sustaining bases.
Defense Medical Logistics Standard Support (DMLSS)	Medical logistics management
Defense Occupational and Environmental Health Readiness System (DOEHRS)	Occupational and Environmental Health (OEH) exposure tracking and surveillance
Joint Medical Workstation (JMeWS)	Medical C2

Medical Situational Awareness in the Theater (MSAT)	Medical surveillance
Patient Movement Items Tracking System (PMITS)	AE medical equipment tracking
Theater Medical Data Store (TMDS)	Theater medical record database  <b>Note:</b> AHLTA-T uploads medical data to TMDS when network communications are available. TMDS updates the central Clinical Data Repository (CDR) in CONUS so that records can be retrieved electronically at the member's home MTF.
TMIP Composite Health Care System (CHCS) Cache (TC2)	Ancillary services
TRAC2ES	Medical regulating and PM tracking

**6.10. Help Desk Support.** The TMIP-AF help desk, Maxwell AFB, Gunter Annex, AL provides configuration control, technical, and help-desk support for AFMS UTCs. The help desk is available 24/7 and can be reached at the following telephone numbers and email address:

DSN: 312-596-5771 - options 1, 1, 3

Toll Free: 877-596-5771 - options 1, 1, 3

Commercial: 334-416-5771 - options 1, 1, 3

Email: [team1@gunter.af.mil](mailto:team1@gunter.af.mil)

## Chapter 7

### LINE INTEGRATION AND INTEROPERABILITY

**7.1. Integration and Interoperability With Other Systems.** Integration and interoperability of deployed assets in an AOR are critical for successful medical operations. Potential ERPSS deployments include the full spectrum of deployed scenarios. This requires that medical integration and interoperability occur with line elements of an AEF, components of the ERCC, joint medical counterparts, Special Operations Forces (SOF), SOF medical components, and other federal and civilian support systems. In some instances, theater planners may request an ERPSS to support Army or SOF bed down locations not associated with typical AEF or ECS infrastructure. Coordinating logistics, integrating with other organic medical assets, and understanding/clarifying command and control are essential to support a seamless casualty care continuum.

**7.2. ECS Requirements.** Integration with the line counterparts is particularly critical for ECS and PM. ECS requirements include, but are not limited to, messing and other consumable materials, water, ice, fuels, billeting, latrines, showers, laundry, mortuary affairs, public affairs, chaplain, linguist, waste management, transportation (to include ambulance-type vehicles), vehicle maintenance support, vehicle decontamination, equipment maintenance, general supplies, contracting, information and communications systems support and maintenance, personnel decontamination and security. This is applicable to ERPSS support for the entire spectrum of AEF operations.

## Chapter 8

### SECURITY AND FORCE PROTECTION

**8.1. Security.** Medical personnel and equipment are non-combatant assets as defined by Geneva Conventions and the Law of Armed Conflict (LOAC). Medical personnel are authorized arms IAW AFI 31-117. Security within the immediate area for patients and personnel resources at each deployed medical site is a medical responsibility.

**8.2. Operations.** In most deployment scenarios the ERPSS deploys to secure locations. The DFC has overall responsibility for security operations, including physical security, and force protection issues. Current threat assessments provided by the combatant commander and local threat conditions established by the AEW commander (or equivalent) dictate all local security measures. ERPSS personnel are required to provide site security within the immediate area of their facilities. Protection of ERPSS patients and personnel is the responsibility of the ERPSS Team Chief.

**8.3. Physical Security.** Medical assets (personnel and WRM assemblages) are protected in accordance with AFI 31-101, *Integrated Defense*. ERPSS personnel are responsible for following all personal protective measures as outlined in AFI 31-101, AOR security briefings, established force protection requirements, and other guidance. The DFC and security forces provide technical advice and recommendations on physical plant protection issues for the ERPSS. The ERPSS medical control center must maintain direct radio contact with the AEW/AEG Expeditionary Operations Center (EOC) and the Base Defense Operations Center (BDOC).

8.3.1. The ERPSS Team Chief is responsible for ensuring force protection measures are taken to protect his/her unit and the Team Chief may request support personnel from security forces, depending upon threat and AOR requirements. The DFC will provide security for ERPSS only if he/she deems it necessary as part of the overall base defense plan. The security at deployed locations is specifically sized. If the threat changes, the DFC may appoint an augmented security detail to provide the ERPSS with the required personnel for force protection, entry control points and sentries.

**8.4. OPSEC.** OPSEC requirements will be adhered to IAW AFI 10-701, *Operations Security*. To prevent an adversary from gaining a military advantage, ERPSS staff must control mission critical information from inadvertent disclosure.

**8.5. COMPUSEC.** COMPUSEC requirements will be adhered to IAW AFI 33-201V2, *Communication Security (COMSEC) User Requirements*, and AFI 33-332, *The Air Force Privacy and Civil Liberties Program*. ERPSS staff will protect systems against sabotage, tampering, denial of service, espionage, fraud, misappropriation, misuse, or release to unauthorized persons.

**8.6. Security of Weapons and Ammunition.** All members shall comply with AFI 31-207, and local procedures when securing weapons and ammunition. To minimize the threat to patients and staff, a weapons clearing barrel should be placed outside the main entrance to the ERPSS

when threats require personnel to carry loaded weapons. Personnel, other than Security Forces responding to a request for assistance, should not be allowed to enter the ERPSS with a loaded weapon.

8.6.1. Staff Weapons. ERPSS personnel may be issued weapons/ammunition and authorized by the ERPSS facility commander at the direction of the AEW/AEG commander (or equivalent) and IAW the Law of Armed Conflict and the Geneva Conventions to carry these weapons during the performance of their duties. Weapons and ammunition need to be secured.

8.6.2. Patient Weapons. Normally, patient weapons/ammunition arriving at the ERPSS facility will be transferred immediately to a member of the patient's unit. When not possible, the ERPSS may temporarily store the weapons until the patient's unit or AEW/AEG armory can accept responsibility. Properly clear all weapons before securing them.

## Chapter 9

### ERPSS TRAINING

**9.1. Education Programs.** Education programs improve Airman's skills and knowledge across the full range of military operations. Unit training requirements will be maintained IAW AFI 41-106. The staging mission is a unique role integral to the successful movement of patients. Corporate knowledge and expertise of PM issues are the responsibility of the team leader. Smaller personnel packages supporting expeditionary operations will require personnel to perform a variety of functions (multi-tasking), which may not be in their specific AFSC responsibilities (i.e. Readiness Skill Verifications [RSVs] or Career Field Education and Training Plans (CFETP)). Accordingly, training shall emphasize a breadth of talents and skills.

**9.2. Training Environment.** Training should be conducted in an environment that permits assigned personnel to exercise with the actual equipment and supplies of the ERPSS UTCs. Educating and training as a UTC permits personnel to learn and support the duties of other team members. Some sustainment training and RSVs may be completed at operational exercises, provided the exercise meets the criteria. Readiness training will be conducted in conjunction with sponsored or local training exercises, or in conjunction with operational deployments.

**9.3. Cross-Functionality.** Training to enhance multi/cross-functionality between AFSCs is encouraged as it provides maximum capability and ensures all assigned personnel can function throughout the ERPSS, regardless of AFSC. Joint training is encouraged to foster relationships and enhance capabilities of each service. When the opportunity exists, it is highly beneficial for all units to coordinate with co-located AE Squadrons to accomplish ERPSS UTC training. This cooperative training will serve to enhance team members overall ERCC knowledge, enhance tasking and patient reporting skills, and will provide an opportunity for the AELT/AE Communications Team and AEOT members to train with the ERPSS UTCs. Familiarity with CCATT and AE operations is also essential.

**9.4. Home Station Training Responsibility.** At home station, the MDG/CC is responsible to ensure appropriate time is allowed to conduct and complete specific UTC training and that it is properly documented (maintained within the unit Medical Readiness Office). Personnel assigned to the ERPSS should be fully trained and ready to deploy prior to entering their deployment "band" or continuously ready for those assigned as an "enabler." ERPSS personnel should also be aware that they may be performing strenuous work in an austere environment, so maintaining physical fitness is a necessity. The Medical Readiness Officer (MRO) is responsible for reporting the training statistics to their parent MAJCOM using the MAJCOM prescribed format.

**9.5. Training Categories.** Medical Readiness training is grouped as Category I, II or III. Medical personnel must complete all required Category I and II training upon initial assignment to a UTC, before entering their deployment vulnerability period and ensure completed training remains current for the duration of the vulnerability period or associated deployment. UTC team integrity should be maintained to the maximum extent possible during all training forums, that is, medics who deploy together will have trained together prior to deploying.

9.5.1. Category I. Individual training is required for all medical personnel, and in some cases assigned non-medical personnel, civilians, and contractors, regardless of their deployment status.

9.5.1.1. Readiness Skills Verification Program (RSVP). Training must be completed prior to deployment. Exceptions to this policy must be approved by the specialty consultant or Career Field Manager. RSVP checklists can be accessed on the Air Force Medical Service Knowledge Exchange (AFMS Kx) at: <https://kx2.afms.mil/kj/kx9/RSVP>

9.5.1.2. Personnel must complete RSVP training for their Career Air Force Specialty Code (CAFSC) for enlisted and Duty Air Force Specialty Code (DAFSC) for officers.

9.5.1.3. Personnel who are utilized as authorized substitutes on a standard UTC must complete RSVP training for the AFSC they are filling on the UTC, as well as their own. Exceptions to this policy must be approved by the specialty consultants or Career Field Managers (CFM) of both AFSCs.

9.5.2. Category II: Training required for medical personnel assigned to standard deployable UTCs.

9.5.2.1. Initial Formal Training. UTC formal training is to be accomplished in accordance with AFI 41-106, unless otherwise directed by the MRA or higher authority. Personnel assigned to the ERPSS UTCs: FFEPS, FFPPS, FFFPS, and FFHPS will complete the Aeromedical Evacuation and Patient Staging (AEPS) formal course at Camp Bullis, TX and complete the Aeromedical Evacuation and Patient Staging (AEPS) Computer Based Training (CBT), located on MedLearn, through the ADLS Gateway within 12 months of assignment. These courses are designed to ensure ERPSS personnel are proficient in the ERPSS UTC Mission Essential Tasks (METs). Once initial training is complete, ERPSS personnel will remain on that UTC for a minimum of 24 months or until they permanently change stations (PCS). The unit commander may waive the 24-month assignment requirement. The waiver will identify why the individual was removed from the position and when the 24-month period is completed. The waiver will be maintained in the MRO until the end of the 24-month period. This requirement for a 24-month UTC waiver is not applicable to the ARC. ARC sustainment training requirements are every 48 months.

9.5.2.1.1. Recurring Formal/Sustainment Training. FFEPS and FFPPS personnel will attend sustainment training every 24 months and personnel assigned to all other ERPSS UTCs (FFFPS/FFHPS) will, after initial training, attend sustainment training every 48 months. This will occur by either participation in MET-driven exercises, local exercises, and joint exercises approved by a Readiness Training Oversight Committee (RTOC) or MRA (HQ AMC/SG), or they will go back to the formal AEPS course. Contact the HQ AMC/SGX MEPAK branch for information on MRA approved sustainment training exercises. Personnel assigned to fixed ERPSS facilities will complete AEPS course one time, within 12 months of assignment,

unless assigned to an ERPSS UTC that requires sustainment training as described above.

#### 9.5.2.2. Miscellaneous/Mandatory Deployment Training.

9.5.2.2.1. Passport. All members, upon assignment to the ERPSS-10/ERPSS-P enabler teams, will obtain official military passports. The US State Department no longer provides “blanket” approval waivers for official passports, thus team members will need to identify one of the following countries, all of which require official passports, with an estimated deployment date six months from the date of assignment to the Enabler UTC: Azerbaijan, United Arab Emirates, Egypt, Libya, Saudi Arabia, Jordan, Iraq, Uganda, Burkina Faso, Thailand, Honduras, Mali or Oman. Members assigned to Enabler teams are required to have official passports prior to employment/deployment.

9.5.2.2.2. Secret Internet Protocol Router Network (SIPRNET) Access/Account. The ERPSS team chief will identify the team members who will be required to establish current SIPRNET accounts and receive required training through their MRO per AMCI 10-403, *Air Mobility Command (AMC) Force Deployment*.

#### 9.5.3. Category III. This training consists of unit level training.

9.5.3.1. Sustainment Training. ERPSS personnel training will cover the entire spectrum of deployed PM operations and all phases of deployment, employment, and redeployment. Specific ERPSS training will be incorporated into regular UTC sustainment training at the unit level.

9.5.3.2. Required Quarterly/Annual Training Topics. Quarterly training of ERPSS operations is required to include training identified below. The team chief will develop an annual, team specific training agenda to ensure team members are fully trained. Participation in a MAJCOM approved exercise can be utilized to meet this quarterly training requirement.

Units with ERPSS personnel and equipment UTCs will ensure an operational test of the associated equipment allowance standards are completed annually (e.g. pack equipment into High Mobility Multipurpose Wheeled Vehicles( HMMWVs), drive HMMWVs to on-base location, unpack/set-up/test all equipment, tear-down/repack equipment into HMMWVs, inventory IAW AFI 41-201, and return allowance standards to storage.

##### 9.5.3.2.1. Pallet Build-up.

9.5.3.2.2. Hazardous Material/ Hazardous Materials Declaration (HAZMAT/HAZDEC). Each unit should have a currently certified hazardous cargo courier trained to deploy with each ERPSS increment.

9.5.3.2.3. Vehicles. All personnel assigned to an ERPSS are required to have a government driver’s license with Ambulance Bus (AMBUS), HMMWV, and truck

cargo 5-ton capability. Note: For bases that do not have an AMBUS, training on the 44-PAX vehicle will meet this requirement as this vehicle can provide the same familiarization with regard to handling, minus the seating configuration. For the ERPSS-P, ERPSS-50 and ERPSS-100 UTCs, any AF medic with their own government issued driver's license, officer or enlisted, can train for licensure. Each ERPSS module will contain multiple qualified drivers to provide 24/7 coverage at the deployed location.

9.5.3.2.4. Required training areas: The ERPSS Team Chief will designate team members to be trained annually in the following areas:

9.5.3.2.4.1. Forklift operation.

9.5.3.2.4.2. Generators identified on the ERPSS Allowance Standards.

9.5.3.2.4.3. Providing Oxygen Support.

9.5.3.2.4.4. Vehicle Pack-out.

9.5.3.2.4.5. Communication Equipment Operation (overview/awareness).

9.5.3.2.4.6. Map/Compass/GPS training.

9.5.3.2.4.7. Heaters identified on the ERPSS Allowance Standards.

9.5.3.2.4.8. Tent Erection and Site Camouflage.

9.5.3.2.4.9. Security and terrorism response training.

9.5.3.2.5. Weapons Training. All medical personnel are required to receive weapons training. Weapons qualification and currency will be annotated on AF Form 522, *USAF Firearms Qualification*. Category B personnel are those who would not ordinarily be issued a weapon in peacetime operations, but may be issued a weapon for designated hostile areas. All assigned FFEPS team members are required to be dual qualified in both M-16/M-4 and M-9. Those personnel assigned to the UTC FFEPS/FFPPS as "enablers", are required to be current at all times.

9.5.3.2.5.1. Weapons training requirements are outlined in AFI 31-117 and AFI 41-106. The theater Combatant Commander may levy additional requirements, which are generally specified in the operation's Execution Order (EXORD) or reporting instructions. See the *Weapons and Munitions Forecasting Table for AFMS UTCs* on the AFMS Medical Readiness site for more information. Therefore, maximum weapons training for personnel assigned to standard UTCs is highly encouraged.

9.5.3.2.5.2. At least two personnel assigned to each ERPSS UTC are needed to qualify as a weapons courier for each ERPSS UTC. Units will coordinate with

their local Combat Arms personnel for additional weapons qualifications requirements for personnel on alternate deployment UTC positions. Failure to qualify does not automatically remove an individual from deployment status. All medical personnel who qualify may be issued a weapon.

9.5.3.3. Specialized Training. Personnel may be identified to accomplish the following training as applicable; Advanced Trauma/Critical Care Clinical, TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES), Theater Medical Information Program (TMIP), Aeromedical Evacuation Electronic Health Record (EHR), and/or Armed Forces Health Longitudinal Technology Application – Theater (AHLTA-T).

## Chapter 10

### LOGISTICS

**10.1. Medical Re-Supply.** The ERPSS-10 deploys with an initial seven day supply and the ERPSS-50 and ERPSS-100 a 30-day supply of expendable items. Expeditionary Medical Logistics provides timely re-supply of ordered items to deployed medical units. Upon deployment notification, medical logistics personnel should contact the Air Force Medical Logistics Operations Center (AFMLOC) to receive re-supply guidance for specific destination/location at DSN (312) 343-4172/2883/4294. The Air Force expeditionary medical logistics reachback program provides timely, single point re-supply of ordered medical items to initially deployed medical unit until the Theater Lead Medical Materiel (TLAMM) is operational. Interim to TLAMM support, deployed units will place orders through the Operations Group to AFMOA/SGALW at Port San Antonio, Texas. AFMOA/SGALW receives orders from deployed units and takes necessary actions to ensure 100% of all orders are transmitted to vendors/depots, are immediately purchased, packed, marked, and shipped so that the materiel is received by the deployed unit. Once the theater has sustained operations, the TLAMM system will become the source for all joint medical supply needs. Fixed ERPSS's will be supported by the base MTF Medical Logistics Account. For further guidance, refer to AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System*.

10.1.1. Re-supply UTCs. The ERPSS has two re-supply UTCs (a) FFPS8, AS 904K, which provides 15 day re-supply to the ERPSS-10 and (b) FFPS3, AS 904H, which can be used to re-supply the ERPSS-50. Additional FFPS3 UTCs can be tasked to provide re-supply for ERPSS 100 and 200 bed facilities.

### 10.2. Medical Equipment.

10.2.1. Maintenance/Repair. A Biomedical Equipment Technician does not become a part of the ERPSS until the 50-bed stage. Medical Equipment Maintenance or Repair may be coordinated with the EMEDS/AFTH/host MTF.

10.2.2. Patient Movement Items. HQ AMC/SG is the MRA for the Global PMI Program. AMC/SG will provide funding, management direction and oversight in support of PMI Centers, PMI operational support and training platforms, and will develop and maintain the PMI CONOPS. All Medical personnel must be familiar with the many aspects of the theater's PMI program, to include obtaining, storing, maintenance, tracking, and recycling practices of the PMI commodity. The PMI Tracking System (PMITS) is the Joint tool for asset visibility and essential for timely AE equipment recycle support to prevent degradation of forward element medical capability. Personnel must work with the AE community in tracking assets for optimal utilization. Guidance for PMI is located in AFI 41-209, *Medical Logistics Support*.

10.2.2.1. All personnel working in PMI Centers, theater PMI Cell, and AE units will scan all PMI equipment in their area of responsibility as READY/OUT/QA as applicable. PMI Equipment must be scanned each time it moves or changes category.

10.2.2.2. Personnel with questions regarding the PMI program should contact HQ AMC/SGXM at 1-877-286-1931 / DSN: (312) 779-6952 or email hqamcpmi@us.af.mil.

**10.3. ECS Supported Capabilities (see Attachment 5).** Support services such as billeting, food service, sewage and waste disposal, potable water, power, transportation and vehicle maintenance will be provided by ECS to support the ERPSS needs.

10.3.1. Non-Medical Equipment Maintenance. Base Civil Engineering (CE) is responsible for major maintenance of equipment (e.g., generators and Heating, Ventilation and Air Conditioning (HVAC) systems). Support will be provided using Basic Expeditionary Airfield Resources (BEAR) assets or similar components.

10.3.2. Electrical Power. Deployed base electrical power systems provide prime and backup power for the ERPSS facilities and equipment. Initial support will be provided using power generators. High voltage primary power will be provided once installed, and the tactical generators allocated for emergency backup power. Ground power equipment specialists will be provided to connect Power Distribution Panels (PDPs) to commercial or bare base power.

10.3.3. Fuel. Ground fuels support will normally be obtained on a contract basis. Fuels for the ERPSS vehicles, generators, etc., will be included with other base requirements.

10.3.4. Medical Gases/Oxygen. Refill of oxygen storage systems will be part of ECS requirements. This can also be accomplished by utilizing the EMEDS, Expeditionary Deployable Oxygen Containment System (EDOCS), Mobile Oxygen Storage Tank (MOST), or the deployable oxygen package (FFOX2). For staging facilities that are over 100 beds, recommend adding a dedicated FFOX2 for additional oxygen refill capability.

10.3.5. Potable Water. Potable water must be readily available either as a secure piped supply, water buffalo, or bladder. Since the ERPSS does not have its own Bioenvironmental Engineer, water testing and guarantee of a constant uncontaminated supply of water needs to be assured by the host facility IAW AF standards for initial and ongoing water testing/verification.

10.3.6. Sanitary Sewer. Sewer and toilet facilities need to be provided either as part of a building of opportunity, or as serviced port-a-potties for patients; control is essential.

10.3.7. Communications Infrastructure. Communications with the host facility and PMRCs are crucial. Radio or land-line (such as telephone or field phone) may be used, but is required to be reliable and secure as the CCDR mandates.

## 10.4. Facility Requirements.

10.4.1. Physical Location. The location of an ERPSS should be on or very near the flightline, especially in a contingency. If located adjacent to the flightline, planners have to take prop wash into consideration. Operational requirements for airfield storage, command space, maintenance, supply, etc. might force the location of an ERPSS away from the airstrip; however, the distance from the flight line will directly and proportionally affect requirements for personnel, vehicles, and time required for planning and processing missions. Ideally, location for the ERPSS should be 200-500 feet from aircraft parking. A distance of more than one mile will adversely affect the ability of the ERPSS to complete its mission.

10.4.2. Flightline Access. The ERPSS requires clear access to the flight line, unencumbered by natural barriers or excessive unfinished roadways. If not bordering the aircraft parking ramp, the road access to the ERPSS needs to be flat and either gravel or hard-surfaced since the AMBUS can operate only on level flat surfaces and does not have 4-wheel drive capability. Heavy rain or snow could potentially shut down an ERPSS not appropriately serviced with an all-weather road.

10.4.3. Building of Opportunity Requirements. In cases where there is availability of an appropriate building(s) of opportunity, there are minimum standards and requirements that must be met for safe conduct of ERPSS operations.

10.4.3.1. Decontamination of Site/Building of Opportunity/Vehicles. Support may be provided using BEAR, Air Force Contract Augmentation Program (AFCAP) or commercial assets. In contaminated environments, base support may be required for decontamination of deployed medical facility infrastructure and vehicles to include decontamination of the site location when necessary.

10.4.4. Size. The ERPSS facility requires floor space as given in Figure 10.1. It may be partitioned or open as in a hangar or gymnasium. Larger ERPSS's will require buildings of proportionately more floor space as calculated by the number and type of additional UTCs deployed. The ERPSS-10 utilizes the Utilis Tent System®. Tentage requirements for the ERPSS-50 to 200 use an Alaska Small Shelter System® (32 feet long x 20 feet wide). If other type of tents, such as temper tents, are substituted, similar floor space needs be provided. Modular facilities or other buildings of opportunity should be of equivalent size.

**Table 10.1. Requirements for ERPSS Operational Space.**

Facility Requirements for Tentage				
	ERPSS 10	ERPSS 50	ERPSS 100	ERPSS 200
Admin Tents		2	4	8
Clinical Tents	2	6	12	16
Total Tents	2	8	16	24
Total Sq. Ft.	1,300	5,120	10,240	15,360

10.4.5. Tent Requirements. If an appropriate building is not available, tentage must be used. If tents are required, there are minimum requirements for their location and set up. Location selected should be level, unobstructed and of sufficient elevation to prevent flooding. To allow for incremental building of the ERPSS UTC's correct initial placement of the ERPSS is critical. Adequate space on both ends of the ERPSS should be available to allow for the addition of more tents if the ERPSS is required to incrementally increase in size. Due to the length of the electrical cables in the ERPSS AS, the following items are required to be considered for initial placement of the ERPSS-10. When increasing an ERPSS-50 to an ERPSS-100, the additional tents should be attached to the generator end of the facility. When placing the ERPSS adjacent to a flight line or roadway the entrance doors of the ERPSS should face the direction the patients will be transported to or from the facility.

10.4.6. Fire Safety. Approval of the shelter by the local fire chief authority should be accomplished prior to patient use. Adequate exits, alarms, smoke detectors, and fire extinguishers are critical. Briefings regarding use and planned evacuation routes will be routinely provided to patients and staff.

10.4.7. Evacuation. Secondary and tertiary locations for evacuating are required to be coordinated in advance. These locations are required to be communicated to all members and emergency response organizations. The facility manager is responsible for maintaining and updating evacuation plans.

10.4.8. Utilities. Electricity and lighting are essential and are required to be 110-120 Volts, 50-60Hz, with adequate outlets for servicing electronic patient equipment. At least 12 outlets for each 25 beds is a minimum. Batteries for AE missions may be charged during patient holding time in the ERPSS. Lighting is required to be adequate to assure safe movement of patients and personnel in the facility.

10.4.9. Drainage. The facilities should be on slightly crowned ground to facilitate drainage. A ramp to the buildings is acceptable. Steps into the buildings are hazardous. A second floor location is an unacceptable location.

10.4.10. Contamination/Exposure. The facility must be free of toxic contamination from previous use. Consideration should be given to carbon monoxide exposure from engines running near the facility. Proximity to fuel and petroleum products should be avoided since patient movement is difficult during a flight line emergency or fire.

10.4.11. Thermal. Safe heating/cooling is required to maintain the facility temperature within a temperature range, between 68-80 degrees F (approximate range).

10.4.12. Security and Safety. Security and safety should be the highest priority when identifying a location. Hardening of the facility can be accomplished if necessary. Windows, glass, high-unsupported ceilings, and wood construction are a liability.

10.4.13. Roof. The roof must be waterproof, the floor hardened and without risk of flooding. If tentage is used, a rain fly is required to be affixed.

10.4.14. Hardening/Force Protection. Based on the situational environment, hardening should be considered for any ERPSS structure.

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***Adopted Forms***

DD Form 600, *Patient Baggage Tag*

DD Form 601, *Patient Evacuation Manifest*

DD Form 1300, *Report of Casualty*

DD Form 1854, *US Customs Accompanied Baggage Declaration*

DD Form 2064, *Certificate of Death Overseas*

DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*

AF Form 146, *Death Tag*

AF Form 3829, *Summary of Patients Evacuated by Air*

AF Form 3836, *Aeromedical Mission Management, part II*

AF Form 3838, *Do Not Resuscitate (DNR) Certification for AE*

AF Form 3841, *Certificate of Release*

AF Form 3851, *Patient Baggage Data*

AF Form 3854, *Receipt for Patient's Valuables*

AF Form 3858, *C-130 Aeromedical Evacuation Mission Offload Message*

AF Form 3859, *Turn-In of Unaccompanied Narcotics*

AF Form 3860, *Aeromedical Patient Record Data*

AF Form 3899, *Patient Movement Record*

AF Form 3899A, *Patient Movement Record Progress Note*

AF Form 3899B, *Patient Movement Physician Orders*

AF Form 3899C, *Patient Movement Physical Assessment*

AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flow sheet*

AF Form 3899E, *Patient Movement Intake/Output*

AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*

AF Form 3899G, *Patient Movement Restraint Observation Flow sheet*

AF Form 3899H, *Patient Movement Neurological Assessment*

AF Form 3899I, *Patient Movement Medication Record*

AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*

AF Form 3899K, *Patient Movement/In-flight Resuscitation Flow Sheet*

AFTO 350, *Repairable Item Processing Tag*

Worksheet - Aeromedical Evacuation Outpatient Handoff Report Form

Worksheet - Aeromedical Evacuation Inpatient (I-SBAR) Handoff Report Form

Blank Patient ID Bands

***Abbreviations and Acronyms***

**ACLS** - Advanced Distributive Learning System

**ADLS** - Advanced Distributive Learning System

**AE** – Aeromedical Evacuation

**AECS** - Aeromedical Evacuation Command Cell  
**AECT** - AE Control Team  
**AEF** - Aerospace Expeditionary Forces  
**AEG** - Air Expeditionary Group  
**AELE** - Aeromedical Evacuation Liaison Team  
**AEPS** - Aeromedical Evacuation Patient Staging  
**AES** - Aeromedical Evacuation System  
**AEOT** - Aeromedical Operations Team  
**AETF** - Air Expeditionary Task Force  
**AEW** - Air Expeditionary Wing  
**AF** - Air Force  
**AFB** - Air Force Base  
**AFCAP** - Air Force Contract Augmentation Program  
**AFFOR** - Air Force Forces  
**AFOSI** - Air Force Office of Special Investigations  
**AFMAN** - Air Force Manual  
**AFMLOC** - Air Force Medical Logistics Operations Center  
**AFMS** - Air Force Medical Service  
**AFSC** - Air Force Specialty Code  
**AFTH** - Air Force Theater Hospital  
**AGE** - Aerospace Ground Equipment  
**AHLTA-T** - Armed Forces Health Longitudinal  
**AIS** - Automated Information Systems  
**AMBUS** - Ambulance Bus  
**AMC** - Air Mobility Command  
**AMD** - Air Mobility Division  
**AO** - Area of Operations  
**AOC** - Air and Space Operations Center  
**AOR** - Area of Responsibility  
**ARC** - Air Reserve Component  
**AS** - Allowance Standard  
**ASETF** - Air and Space Expeditionary Task Force (USAF)  
**ATOC** - Air Terminal Operations Center  
**BDOC** - Base Defense Operations Center  
**BE** - Bioenvironmental Engineering  
**BEAR** - Basic Expeditionary Airfield Resources  
**BGAN** - Broadband Global Area Network  
**BOS** - Base Operating Support  
**BW/CW** - Biological Warfare/Chemical Warfare  
**C2** - Command and Control  
**C4** - Critical Care Combat Casualty Course  
**CAC** - Common Access Card  
**CAFSC** - Career Air Force Specialty Code  
**CASF** - Contingency Aeromedical Staging Facility  
**CASEVAC** - Casualty Evacuation  
**CBRN** - Chemical, Biological, Radiological, and Nuclear

**CBT** - Computer Based Training  
**CCT** - Combat Control Team  
**CCATT** - Critical Care Air Transport Team  
**CDR** - Clinical Data Repository  
**CCDR** - Combat Commander  
**CE** - Civil Engineering  
**CFETP** - Career Field Education and Training Plans  
**CFM** - Career Field Manager  
**CHCS** - Composite Health Care System  
**CN** - Chief Nurse  
**COMAFFOR** - Commander Air Force Forces  
**COMSEC** - Communications Security  
**COMPUSEC** - Computer Security  
**CONOPS** - Concept of Operations  
**CONUS** - Continental United States  
**CRG** - Contingency Response Group  
**CSS** - Combat Services Group  
**DAFSC** – Duty Air Force Specialty Code  
**DCC** - Deployment Control Centers  
**DFAC** - Dining Facility  
**DFC** - Defense Force Commander  
**DIA** - Defense Intelligence Agency  
**DIICC** - Defense Information Infrastructure Control Concept  
**DISA** - Defense Information Systems Agency  
**DIRMOBFOR-AIR** - Director of Mobility Forces-AIR  
**DMC** - Deployed Medical Commander  
**DMLSS** - Defense Medical Logistics Standard Support  
**DNBI** - Disease Non Battle Injury  
**DNR** - Do Not Resuscitate  
**DOD** - Department of Defense  
**DOEHRS** - Defense Occupational and Environmental Health Readiness System  
**DSCA** - Defense Support to Civil Authorities  
**DSOE** - Deployment Schedule of Events  
**ECAS** - Electrical Cable Assembly Set  
**ECP** - Entry Control Point  
**ECS** - Expeditionary Combat Support  
**ECU** - Environmental Control Unit  
**EDOCS** - Expeditionary Deployable Oxygen Containment System  
**EHR** - Electronic Health Record  
**EMEDS** - Expeditionary Medical Support  
**EML** - Expeditionary Medical Logistics  
**EOC** - Expeditionary Operations Center  
**EPW** - Enemy Prisoner of War  
**ERCC** - En Route Care Capability  
**ERPSS** - En Route Patient Staging Capability  
**ETA** - Estimated Time of Arrival

**ETD** - Estimated Time of Departure  
**EXORD** - Execution Order  
**FAA** - Federal Aviation Administration  
**FDECU** - Field Deployable Environmental Control Units  
**FEMA** - Federal Emergency Management Agency  
**FM** - Force Module  
**FN** - Flight Nurse  
**FP** - Force protection  
**FPCON** - Force Protection Condition  
**GCC** - Geographic Combatant Commanders  
**GPMP** - Global Patient Movement Plan  
**GPS** - Global Positioning Satellite  
**GSA** - General Services Administration  
**HA/DR** - Humanitarian Assistance/Disaster Response  
**HAZDEC** - Hazardous Materials Declaration  
**HAZMAT** - Hazardous Material  
**HF** - High Frequency  
**HHQ** - Higher Headquarters  
**HIPAA** - Health Insurance Portability and Accountability Act  
**HMMWV** - High Mobility Multipurpose Wheeled Vehicles  
**HSS** - Health Support Services  
**HRT** - Health Response Team  
**HVAC** - Heating, Ventilation and Air Conditioning  
**IA** - Information Assurance  
**IAW** - In Accordance With  
**ID** - Identification  
**INMARSAT** - International Marine/Maritime Satellite  
**IOC** - Initial Operational Capability  
**ISO** - In Support Of  
**I-SBAR** - Identify, Situation, Background, Assessment, and Recommendation  
**IV** - Intravenous  
**IW** - Information Warfare  
**JFACC** - Joint Force Air Component Commander  
**JLLIS** - Joint Lessons Learned Information System  
**JTF** - Joint Task Force  
**JMEWS** - Joint Medical Workstation  
**KW** - Kilowatt  
**LAF** - Line Air Force  
**LAN** - Local Area Network  
**LMR** - Land Mobile Radios  
**LNO** - Liaison Officer  
**LOAC** - Law of Armed Conflict  
**MAJCOM** - Major Command  
**MASF** - Mobile Aeromedical Staging Facility  
**MC-CBRN** - Medical Counter- Chemical, Biological, Radiological, Nuclear  
**MCD** - Medical Crew Director

**MDG** - Medical Group  
**MEDIC** - Medical Environmental Disease Intelligence and Countermeasures  
**MEDEVAC** - Medical Evacuation  
**MEFPAK** - Manpower and Equipment Force Packaging System  
**MERC** - Medical Equipment Repair Center  
**MET** - Mission Essential Task  
**MHE** - Materiel Handling Equipment  
**MISCAP** - Mission Capability Statement  
**MOST** - Mobile Oxygen Storage Tank  
**MRA** - MEFPAK Responsible Agency  
**MRE** - Meals Ready to Eat  
**MRO** - Medical Readiness Officer  
**MSAT** - Medical Situational Awareness in the Theater  
**MSC** - Medical Service Corps  
**MTF** - Medical Treatment Facility  
**NATO** - North Atlantic Treaty Organization  
**NCC** - Network Control Centers  
**NCMI** - National Center for Medical Intelligence  
**NCOIC** - Non Commissioned Officer In Charge  
**NIMS** - National Incident Management System  
**NOS** - Network Operating System  
**NOSC** - Network Operations and Security Center  
**OCONUS** - Outside Continental United States  
**OCO** - Overseas Contingency Operations  
**OIC** - Officer In Charge  
**OEH** - Occupational and Environmental Health  
**OPCON** - Operational Control  
**OPLAN** - Operations Plan  
**OPORD** - Operation Order  
**OPR** - Office of Primary Responsibility  
**OPREP** - Operational Reports  
**OPSEC** - Operations Security  
**PAR** - Population at Risk  
**PCA** - Patient Controlled Analgesia  
**PCS** - Permanent Change Of Station  
**PDC** - Program Designator Code  
**PDP** - Power Distribution Panels  
**PIU** - Patient Isolation Unit  
**PM** - Patient Movement  
**PMI** - Patient Movement Item  
**PMITS** - Patient Movement Items Tracking System (PMITS)  
**PMQ-R** - Patient Movement Quality Report  
**PMR** - Patient Movement Request  
**PMRC** - Patient Movement Requirements Center  
**POC** - Point of Contact  
**POL** - Petroleum Oil Lubricants

**PSS** - Patient Staging System  
**PSM** - Patient Safety Manager  
**P4** - Plans, Policies, Procedures and Processes  
**RDS** - Records Disposition Schedule  
**RON** - Remain Over Night  
**RSV** - Readiness Skills Verification  
**RSVP** - Readiness Skills Verification Program  
**RTOC** - Readiness Training Oversight Committee  
**SABC** - Self-Aid Buddy Care  
**SAM** - Self-Administering Medications  
**SATCOM** - Satellite Radio  
**SDC** - Standard Desktop Configuration  
**SG** - Surgeon General  
**SIM** - Subscriber Identity Module  
**SIPRNET** - Secret Internet Protocol Router Network  
**SITREP** - Situation Report  
**SMO** - Senior Medical Officer  
**SOF** - Special Operations Forces  
**SSN** - Social Security Number  
**STE** - Secure Terminal Equipment  
**TACC** - Tanker Airlift Control Center  
**TACON** - Tactical Control  
**TC2** - TMIP Composite Health Care System (CHCS) Cache (TC2)  
**TCP/IP** - Transmission Control Protocol/Internet Protocol  
**TDC** - Theater deployable communications  
**TLAMM** - Theater Lead Agent for Medical Materiel  
**TMDS** - Theater Medical Data Store  
**TMIP** - Theater Medical Information Program  
**TO** - Technical Order  
**TPFDD** - Time Phases Force Deployment Data  
**TTP** - Tactics, Techniques and Procedures  
**TR** - Telecom Request  
**TRAC2ES** - TRANSCOM Regulating and Command & Control Evacuation System  
**UN** - United Nations  
**USTRANSCOM** - United States Transportation Command  
**UXO** - Unexploded Ordinance  
**UTC** - Unit Type Code  
**VCO** - Vehicle Control Officer  
**VCNCO** - Vehicle Control Non Commissioned Officer  
**VFS** - Validating Flight Surgeon  
**VHF** - Very High Frequency  
**WAN** - Wide Area Network  
**WM** - Workgroup Managers  
**WMD** - Weapons of Mass Destruction  
**WRM** - War Readiness Materiel

## Attachment 2

**EQUIPMENT PREDEPLOYMENT CHECKLIST**

The following items are required in preparation for deployment of the ERPSS - 10:

**Table A2.1. Equipment Predeployment Checklist.**

	<b>Obtain LOGDET from unit mobility office to determine equipment requirements</b>
	<b>Are MRE's/Water required for deployment</b>
	<b>Aerospace ground equipment (AGE). Check equipment for:</b>
	Appropriate power cords
	Appropriate heater fuel tank match
	Fuel cans/Jerry cans for emersion heater
	Purged
	Damage free/empty/no smell
	Required to be plastic for international deployment
	Ensure gasket in place
	Appropriate spouts
	Oil cans
	Motor oil
	<b>Transportation</b>
	Identify qualified drivers for appropriate vehicles
	Vehicle tie down straps (s-hooks).
	Obtain title for fuel procurement, fuel key, servo card
	<b>Vehicles</b>
	Clean, inside and out, no fuel leaks
	Battery cleaned and secured
	Fuel tanks (not to exceed 1/2)

	Vehicle equipment secured
	Spare tire
	Fire extinguisher, first aid kit.
	Hazardous cargo declarations (Dash 2) as needed
	Hazardous placards as needed
	Weight and center of gravity posted
	<b>Logistic – Pallets</b>
	Serviceable, no rust, tears or missing rings, and warp-free.
	Appropriate serviceable netting amount (one top netting, two side netting)
	Pallet bag
	Cargo tie-down straps as needed
	Three (3) pieces of dunnage per pallet (adequate amount)
	<b>Administrative</b>
	Forms Pack list – hard copy of each form required to operate without operational IM IT connectivity
	<b>ERPSS – 10</b>
	Tentage and liners
	Tent pole sets
	Tent pegs
	Field desk
	Roll of Plastic
	Speed tape
	Tent repair kit
	550 cord, band cutters, entrenching tools / shovels
	Replacement tent ropes
	Camouflage netting appropriate for area deployed

	Sandbags (adequate amount)
	<b>Medications</b>
	Controlled medications obtained and inventoried
	Appropriate narcotics control forms obtained
	Nurses assigned as narcotics couriers
	Appropriate means for securing narcotics available
	Lock box or tool chest
	Lock
	Keys
	All medication's (controlled and routine) expiration dates checked and current throughout deployment length
	Packaging and contents free from damage or contaminants
	<b>Medical Equipment</b>
	Inspection stickers checked and current
	All component parts present
	Operational check of
	Cardiac monitor's battery accessory pack and batteries
	Portable suction
	Bag-valve mask resuscitator
	MOST
	Electrical cable assembly set (ECAS).
	Pulse oximetry (when available)
	Laryngoscope, light bulbs batteries
	Otoscope light bulbs, batteries
	Oxygen monitor
	<b>Medical Supplies</b>

	Expiration dates and lot numbers checked and current
	Packaging and contents free from damage and contaminants
	Mission kit (publications, to include drug book, advance cardiac life support [ACLS] algorithms) stocked
	Infection control items stocked
	Biohazard bags
	Sharps containers
	Hand washing, antimicrobial solutions, or decontamination agents
	<b>IRIDIUM and INMARSAT (BGAN) Activation Note:</b> The satellite phones are not activated while stored in the UTC package

## Attachment 3

## PERSONAL PACKING PREDEPLOYMENT CHECKLIST

Table A3.1. Personal Packing PreDeployment Checklist.

	<b>"A" BAG (Issued by Base Mobility when required) *Depends on Orders</b>
	A-3 Bag or Ruck
	First Aid Kit
	Canteen (2), Cup, CW Cap, Cover
	Helmet
	Flak Vest*
	Poncho and Liner * (Sub Gortex)
	Mess Kit w/Accessories
	Sleeping Bag
	Sleeping Pad
	Goggles, Sun/Dust
	Reflective Belt
	Gloves, Work, Leather
	Ammo Pouch (9mm)
	Load Bearing Vest (LBV)*
	<b>Unit A Bag Augmentation Pkg - Suggested Issue Items (ESP Coded for Overseas Contingency Operations (OCO))</b>
	Rucksack
	Load Bearing Gear
	Steel Toed Boots
	Camel Back
	Black Work Gloves
	Leatherman
	Flashlight
	*Gortex Rain Coat/Pants
	Overshoes, Rubber
	<b>"B" BAG (Issued by Base Mobility when required) *Depends on Orders</b>
	A-3 Kit Bag
	Lined Field Cap
	Mitten Set
	Mukluks / Inserts
	N3B Parka
	Wool, Socks / Sweater
	Long Underwear Top / Bottom
	<b>"C" BAG (Issued by Base Mobility when required) *Depends on Orders</b>
	Waterproof Bag

	MCU2-P Filter Canister *
	Hood , Chemical*
	Gloves, Chemical *
	Cotton Inserts*
	GVO Boots *
	M8 Paper
	M9 Tape
	MCU2-P Mask, Chemical
	Carrier Chemical Mask
	M258 Decon Kit *
	MCU2-P Filter *
	Chemical Suit *
	Helmet Cover (shower cover) *
	<b>Personal Bag (Suggested Items, not inclusive)</b>
	Chap stick
	Sunscreen/Insect Repellant
	ABUs and Cap
	T-Shirts
	Undergarments
	PT Gear
	Reflective Belt
	Sunscreen
	Foot Powder
	Gloves
	Socks (ABUs and PT Gear)
	Towels
	Handkerchiefs
	Rucksack
	Sewing Kit
	Nail Clippers
	Clothesline/Pins
	Can Opener
	Laundry Bag/Soap
	Padlock
	Cards/Games
	Sunglasses
	Hearing Protection
	Shaving Kit
	Deodorant
	Soap, Shampoo, Conditioner
	Tooth Paste, Toothbrush w/ Container
	Comb or Brush
	Feminine Hygiene Items (Females Only)

## Attachment 4

## ERPSS ECS REQUIREMENTS

Table A4.1. ERPSS ECS Requirements.

	<b>FFEPS Inc. FFQCR (Comm UTC)</b>	<b>FFPPS Provider Augmentation</b>	<b>FFFPS 50 Bed</b>	<b>FFHPS 100 Bed</b>	<b>200 Bed</b>
Staff Members	15	25	51	74	148
Patients	40	40	50	100	200
Total Personnel	55	65	101	173	348
<b>BASIC EXPEDITIONARY AIRFIELD RESOURCES (BEAR) REQUIREMENTS</b>					
Site Requirements with slight grade (sq. ft.)	5200	5200	36,400	62,400	124,800
Work Shelter (sq. ft.)	1,300	1,300	5,120	10,240	15,360
Latrines staff (patients) 1:15 (latrines: people)	1 (3) =4	2 (3) =5	4 (3) =7	5 (7) =12	11 (14) =25
Showers staff (patients) 1:20 (showers: people)	1 (2) =3	2 (2) =4	3 (3) =6	4 (5) =9	8 (10) =18
Lodging (staff only beds)	15	25	51	74	148
Meals, Regular staff (patients) (per day)	45 (108)=153	75 (108)=183	159 (135)=294	225 (270)=495	474 (540)=1014
Meals, Liquid (patients) (per day)	12	12	15	30	60
Laundry staff (patients) (pers/wk.=32 lbs.)	480 (1280) =1760	608 (1280) =1888	1696 (1600) =3296	2400 (3200) =5600	5056 (6400) =11456
Ice staff (patients) (lbs./day) =4.4 lbs.	66 (176) =242	110 (176) =286	234 (220) =454	330 (440) =770	696 (880) =1576

Power (kW) 3 phase	0	0	1 – 100 kw Generator	1 – 100 kw Generator	2 - 100 kw Generator
ECU Requiring Support (# of Units)	0	0	8	16	32
Potable water staff=10 (patients=65) (gal/day)	150 (2600) =2750	250 (2600) =2850	530 (3250) =3780	750 (6500) =7250	1580 (13000) =14580
<b>MEDICAL / BIOHAZARD WASTE</b>					
Waste, Liquid staff (patients) (gal/day) =.7x water	10.50 (28) =38.5	17.5 (28) =45.5	37.10 (35) =72.1	52.50 (70) =122.5	111 (140) =251
Waste, Solid staff (patients) (lbs./day=4 lbs.	60 (160)=220	100 (160)=260	212 (200)=412	300 (400)=700	632 (800)=1432
<b>LOGISTICS REQUIREMENTS</b>					
POL (gal/day)	50	50	50	50	50
Diesel (gal/day)	50	50	20	20	20
<b>VEHICLES</b>					
Vehicle Maintenance	TBD	TBD	TBD	TBD	TBD
Vehicle Requirements	2-UFMVH (HMMWV)	2-UFMVH (HMMWV)	2- UFM81 (Ambus), 1 UFMT4 (M1078 Truck, 1UFMPR (10K Forklift)	3- UFM81 (Ambus), 2 UFMT4 (M1078 Truck, 2 UFMPR (10K Forklift)	6- UFM81 (Ambus), 2 UFMT4 (M1078 Truck, 2UFMPR (10K Forklift)
Equipment Movement	Rolling Stock	Personnel only no equipment added	Pallet load	Pallet Load	Pallet Load
<b>COMMUNICATIONS REQUIREMENTS</b>					
SIPRNET ACCESS	YES	YES	YES	YES	YES
NIPRNET ACCESS	YES	YES	YES	YES	YES
Phone	12 (8 CELL 4 LAND)	12 (8 CELL 4 LAND)	12 (8 CELL 4 LAND)	12 (8 CELL 4 LAND)	12 (8 CELL 4 LAND)
Satellite (Iridium)	1	1	1	1	1

Land Mobile Radios (organic) requiring Comm network support	9	9	18	18	36
Secure Telephone Equipment Maintenance (Organic)	1	1	1	1	1

**NOTE: IAW AFI 10-219, Vol 5 & 6 where applicable and data provided**

## Attachment 5

### ERPSS-10 SITE REQUIREMENTS

**1.1.** Contact installation commander/airfield manager/Civil Engineer to coordinate ERPSS-10 establishment. Brief commander on ERPSS-10 function and requirements.

**1.2.** Determine site selection using the following guidelines:

1.2.1. Area Setup Requirements:

**Table A5.1. Area Setup Requirements.**

<i>Tent</i>	<i>Length</i>	<i>Width</i>	<i>Height</i>
UTILIS®	34ft	20ft	10.5ft

**Note:** Allow room for tent pegs and rope extensions.

1.2.2. ERPSS-10 tent distance from taxiway edge or runway centerline will depend on the type of aircraft that will be using the airfield. **Note:** When setting up the ERPSS-10 at airfields, carefully coordinate with the airfield authorities. If at all possible, avoid set-up next to an active runway. At forward landing strips (FLSs) the runway and taxiway are often the same in that the runway is also the taxi way and the turnaround area. If this is encountered contact the Combat Control Team or Contingency Response Group/Element.

**1.3. Determine billeting requirements using the following guidelines if not using ERPSS-10 tent as billet:**

1.3.1. Tented billeting or hard quarters

1.3.2. Tented billeting supplies

1.3.3. Assigned ERPSS - 10 personnel plus additional personnel in attached air crews or manpower augmentation package:

1.3.3.1. Male Officers/Enlisted

1.3.3.2. Female Officers/Enlisted

1.3.3.3. Bathing and shower requirements along with hours of operation

**1.4. Latrine requirements:**

1.4.1. Portable latrines

1.4.1.1. Amount needed

1.4.1.2. Who procures

1.4.2. Can trenches be dug if no portable latrines

1.4.3. Other latrine sources

**1.5. Messing requirements:**

1.5.1. Number of ERPSS-10 personnel given to appropriate Point of Contact (POC) for Food Services

1.5.2. Location of messing facility

1.5.3. Field kitchen

1.5.4. Meals ready-to-eat (MRE). If MREs, identify POC for issuing and location of issue

1.5.5. Dining Facility. If dining facility, hours of operation

1.5.6. Water point location

**1.6. Vehicle requirements:**

1.6.1. Your vehicles or someone else's

1.6.2. Where are keys to vehicles

1.6.3. When can they be picked up

1.6.4. Crew bus available

1.6.5. Shuttle bus service

1.6.6. Hours of operation

1.6.7. Type and number of vehicles required:

1.6.7.1. Pickup truck

1.6.7.2. Van

1.6.7.3. Step van

1.6.7.4. M1008 tactical pick-up truck

1.6.7.5. M35 2.5-ton truck

1.6.7.6. HMMWV

- 1.6.7.7. Water Trailer (buffalo).
- 1.6.7.8. M105 trailer
- 1.6.7.9. Bus (number of passengers).
- 1.6.7.10. Forklift
- 1.6.7.11. M1078 Truck
- 1.6.7.12. M1097 HVY HMMWV

1.6.8. Check vehicles for operability and maintenance requirements

1.6.9. Vehicle fueling location and hours of operation

**1.7. Communication requirements** (For sustainment operations):

- 1.7.1. Class A phones
- 1.7.2. Class B phones

**1.8. Fuel requirements** (approximate):

1.8.1. Ensure adequate fuel will be available for ERPSS - 10 operation using the following guidelines:

1.8.2. Generators:

- 1.8.2.1. Three kilowatt (KW) requires 25 gallons of fuel and one pint of oil per day
- 1.8.2.2. Five KW requires 35 gallons of fuel and one pint of oil per day
- 1.8.2.3. Ten KW diesel requires 36 gallons of fuel and one pint of oil per day
- 1.8.2.4. Thirty KW diesel requires 40 gallons of fuel and one pint of oil per day
- 1.8.2.5. Sixty KW diesel requires 55 gallons of fuel and one pint of oil per day.

1.8.3. Identify fuel re-supply point (Note: Source re-supply at base located):

- 1.8.3.1. Hours of operation
- 1.8.3.2. Type of fuels available: Diesel; MOGAS; JP8
- 1.8.3.3. Fuel key required

1.8.3.4. Where will we get one? Note: If JP8 fuel is available instead of diesel, automatic transmission fluid is to be added to fuel tanks to keep seals on engines from drying out. Where will we get this additive, and how much is required per gallon.

**1.9. Power requirements:**

1.9.1. Commercial power available (host), and what voltage

1.9.2. Who will do work to tap in to commercial power

1.9.3. Power carts available

1.9.4. ERPSS-10 generators required

1.9.5. How many tents will be powered

**1.10. Potable/NonPotable Water requirements:**

1.10.1. Commercial water available

1.10.2. Water buffalo trailer required? Identify re-supply point

1.10.3. Bottled water? Identify re-supply point

**1.11. Temporary storage requirements:**

1.11.1. Warehouse storage. POC

1.11.2. Contingency exercise storage. POC

**1.12. Ramp services equipment available:**

1.12.1. 10K Forklift

1.12.2. K-loader

1.12.3. Identify POC and location of Material Handling Equipment (MHE) at site

1.12.4. If no MHE at site, can aircraft do combat offloads of pallets

**1.13. Oxygen re-supply and refill capabilities:**

1.13.1. Is a Liquid Oxygen (LOX) cart or plant available to refill patient LOX units? Forty liters per day minimum requirement

1.13.2. If not, is a re-supply available for oxygen tanks? Trade used ones for full ones

1.13.3. Does ERPSS-10 have other means of re-supply LOX units or oxygen tanks

1.13.4. Does the AECS have the means of re-supply LOX units or oxygen tanks

1.13.5. Are oxygen concentrators available

1.13.6. Should they be taken to supplement or replace Mobile Oxygen Storage Tank (MOST) or oxygen tanks

**1.14. Transportation to ERPSS-10 set-up site (if not already at location):**

1.14.1. Obtain sufficient transportation to transport personnel and baggage. Note: ERPSS-10 vehicles do not provide enough room for movement of all personnel.

1.14.2. Obtain following information before departure:

1.14.2.1. Maps of route, as applicable

1.14.2.2. Identify primary and alternate routes

1.14.2.3. Refuel locations

1.14.2.4. Convoy procedures required by local authorities or other services

1.14.2.5. Local threat levels and what type

1.14.3. Review convoy routes and procedures with ERPSS-10 personnel

1.14.4. Identify projected break times or places. Note: Remember M35 drivers will usually require frequent breaks

1.14.5. Assign personnel to specific vehicles

## Attachment 6

### ERPSS-10 SITE ESTABLISHMENT

**1.1. Contact the installation commander /airfield manager/Civil Engineer to coordinate ERPSS-10 establishment. Brief commander on ERPSS-10 function and requirements.**

**1.2. Determine site for ERPSS-10 set-up using the following guidelines:**

- 1.2.1. Find level ground high enough for good drainage and large enough for all tents. If necessary, trench around tents.
- 1.2.2. Avoid getting too close to streams, lakes or rivers. Ensure site is above high water marks or levels and not in the pathway of a stream emptying into a potable water holding area.
- 1.2.3. Avoid placing ERPSS-10 in canyons or near dry creek beds. Look at the slope of the ground and determine water runoff direction. Avoid placing tents in a potential flood area.
- 1.2.4. In hot weather, find shady area free of underbrush.
- 1.2.5. Avoid placing tents under dead trees.
- 1.2.6. In snow covered areas ensure snow is not concealing any crevices.

**1.3. Layout ERPSS-10 site using the following guidelines:**

- 1.3.1. Appropriate distance from taxiway/runway. Do not set up beyond the "HOLD" line on taxiway/runway.
- 1.3.2. Twelve feet between pegs of nearest tent to allow for vehicle passage.
- 1.3.3. Short side of tent away from generators or vehicle traffic, if possible.
- 1.3.4. Short side of tents facing each other, if using two tents. This keeps heater fuel cans and power cords in a protected area.
- 1.3.5. Generators placed with mufflers facing away from tents and grounded. Note: All electrical equipment must be grounded.
- 1.3.6. Fuel storage area 50 feet away from generators, antenna and ERPSS-10. Store in an open area free from brush and debris. Fire extinguisher available at storage site.
- 1.3.7. Bury antenna cables and generator power lines.
- 1.3.8. Latrine and latrine screen set up 100 feet from water source and messing facility.
- 1.3.9. Install power cords for medical equipment (i.e., suction unit, ventilators, cardiac monitors, pulse oximeters, etc.).

1.3.10. Ensure site is secure from loose items, packing materials, cargo nets/straps, pallets, dunnage etc., before aircraft arrival at site. Secure all items to prevent foreign object debris (FOD) damage and improve safety around ERPSS-10 site.

1.3.11. Identify vehicle access roads and parking areas. Secure vehicles.

1.3.12. Establish daily duty schedule and post.

1.3.13. Establish hand-washing facilities.

Attachment 7

ERPSS-10 AIRFIELD CLEARANCES

Figure 7A.1. Airfield Clearances (Taxiway/Helo).

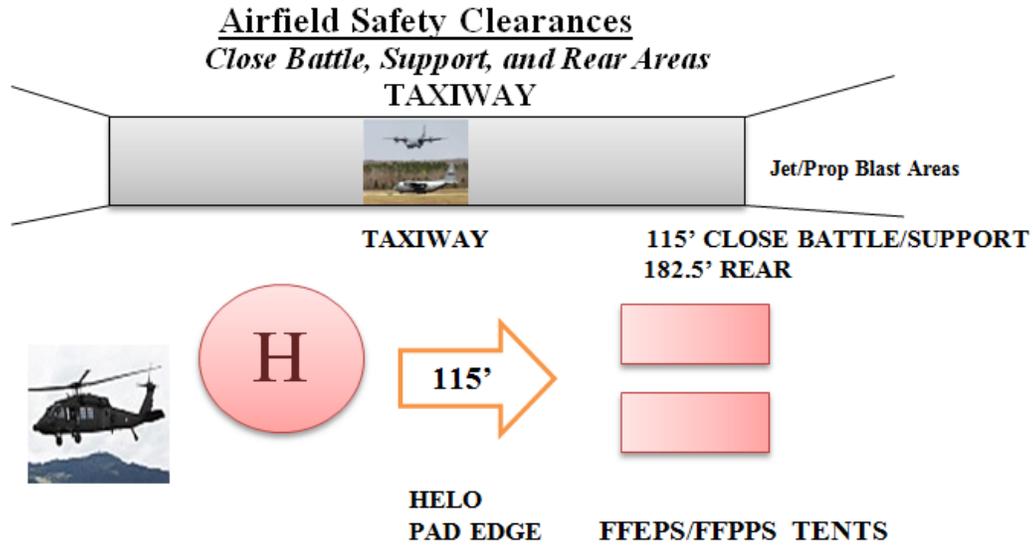
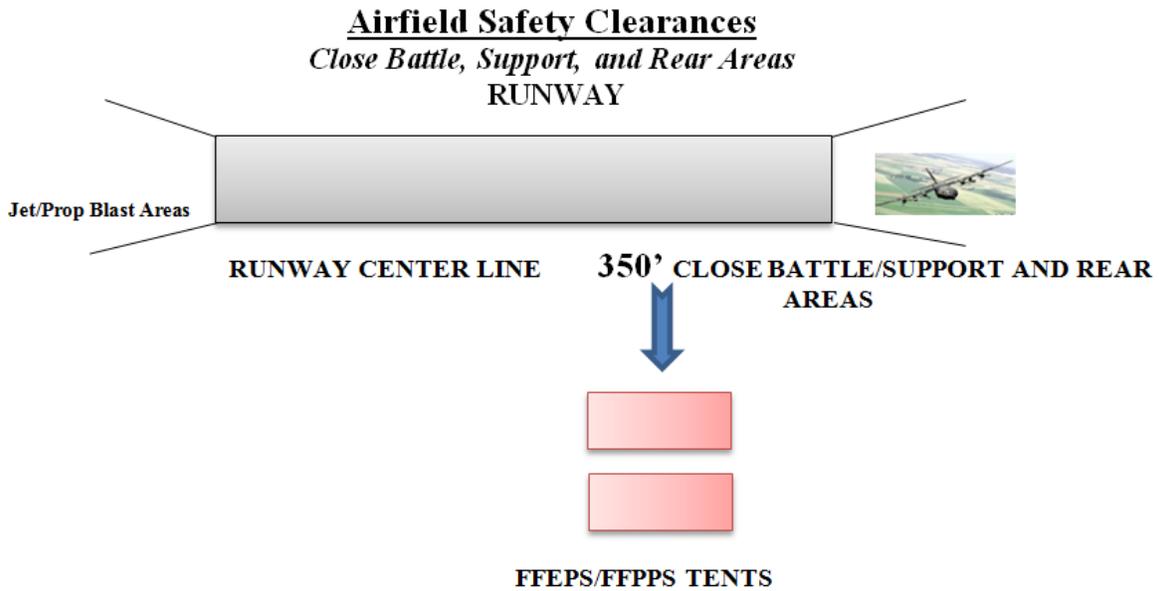


Figure 7A.2. Airfield Clearances (Runway).



**Note:** Runway/Taxiway/Helo Pad Safety margins Airfield authorities (CRG/CRE etc.) are to be consulted prior to element establishment.

Attachment 8

ERPSS-10 LAYDOWN CONSIDERATIONS

Figure A8.1. ERPSS 10 Laydown Considerations.

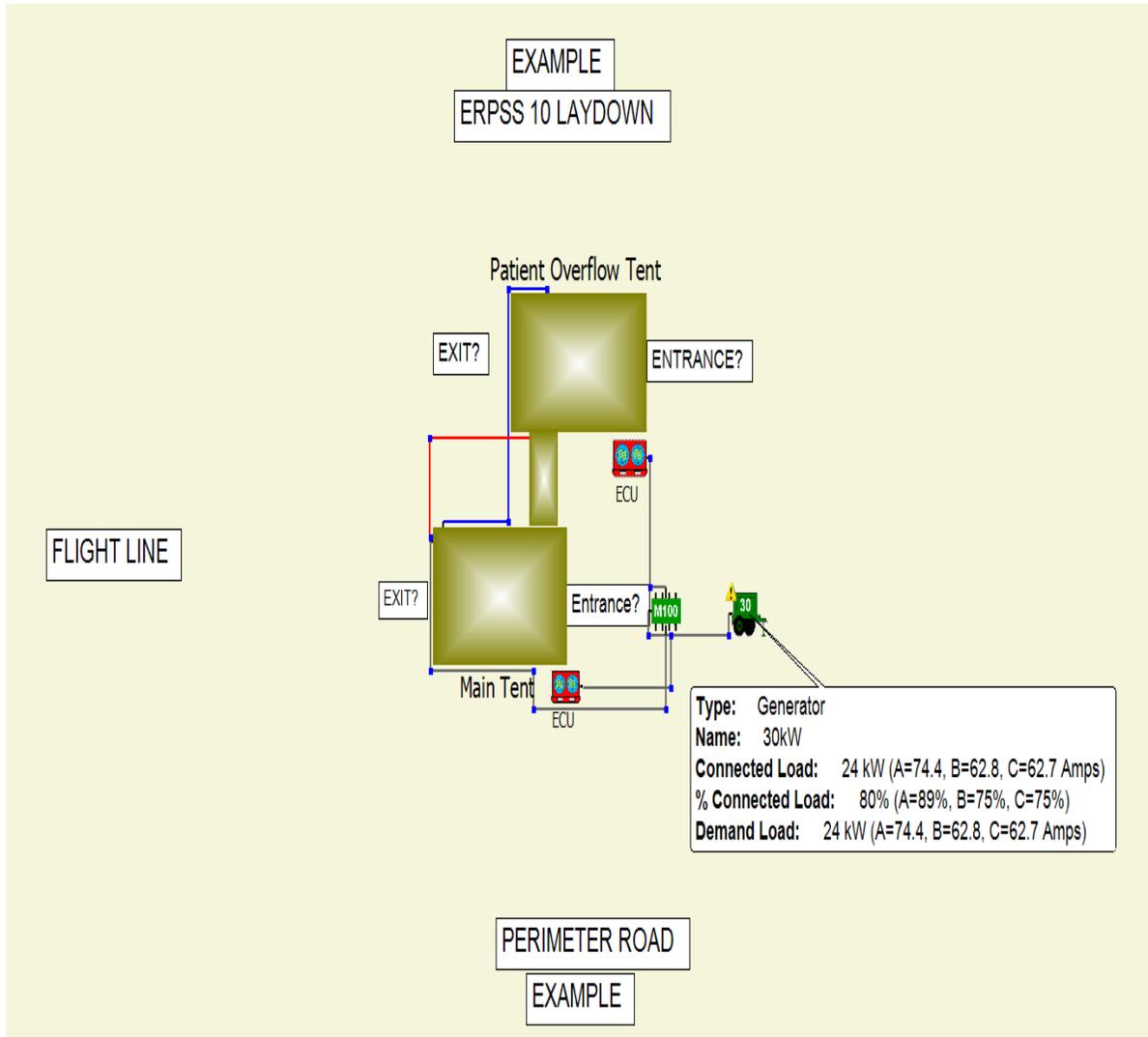


Figure A8.2. ERPSS 10 Main Tent.

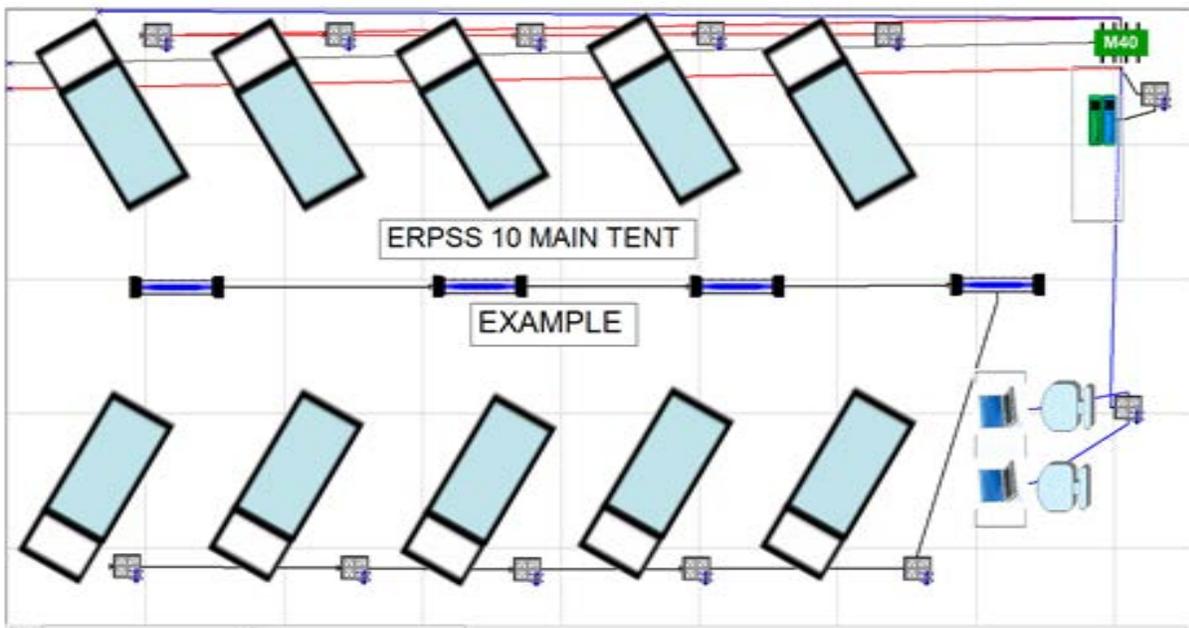
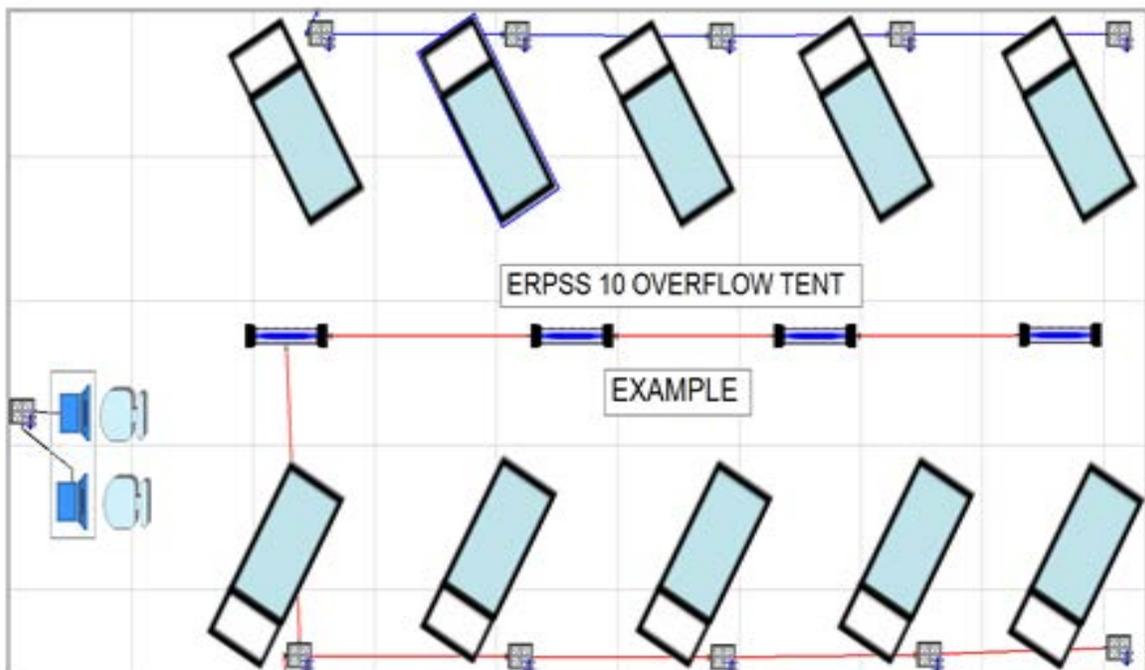


Figure A8.3. ERPSS 10 Overflow Tent.



Attachment 9

ERPSS-50 TENT CONFIGURATION/SET-UP

Figure A9.1. ERPSS 50 Tent Configuration/Set up.

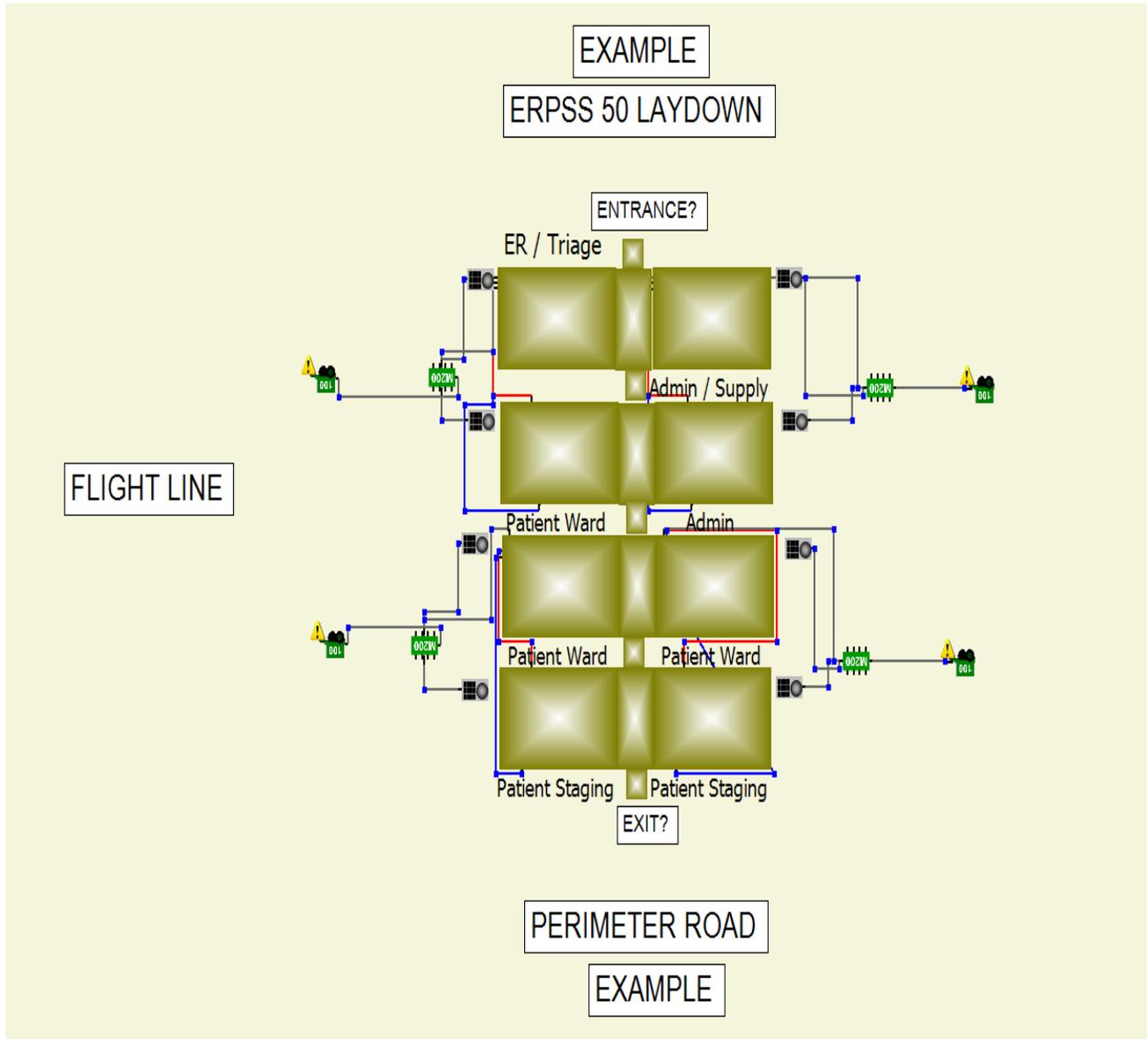


Figure A9.2. ERPSS 50 Supply Admin Tent.

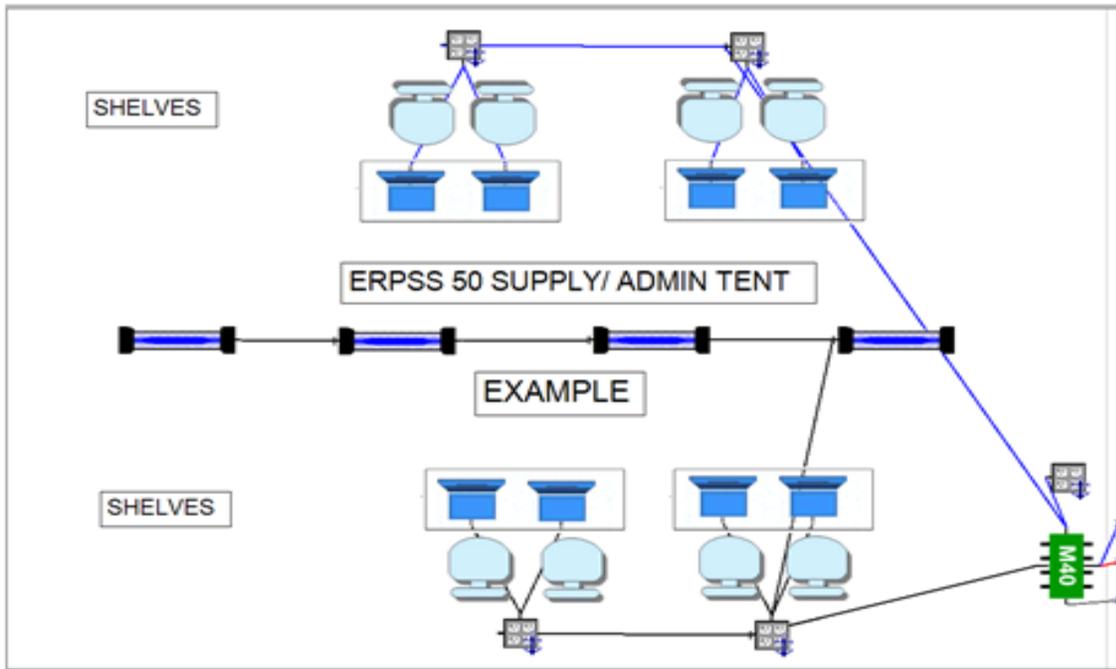


Figure A9.3. ERPSS 50 Admin Tent.

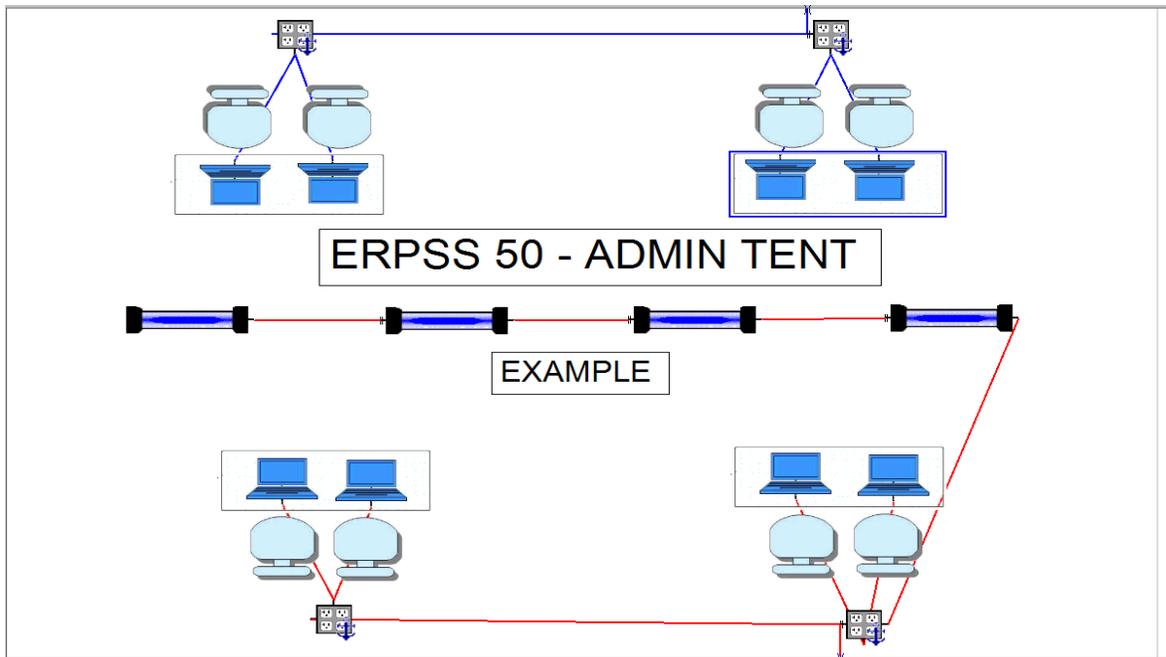


Figure A9.4. ERPSS 50 ER/Triage Tent.

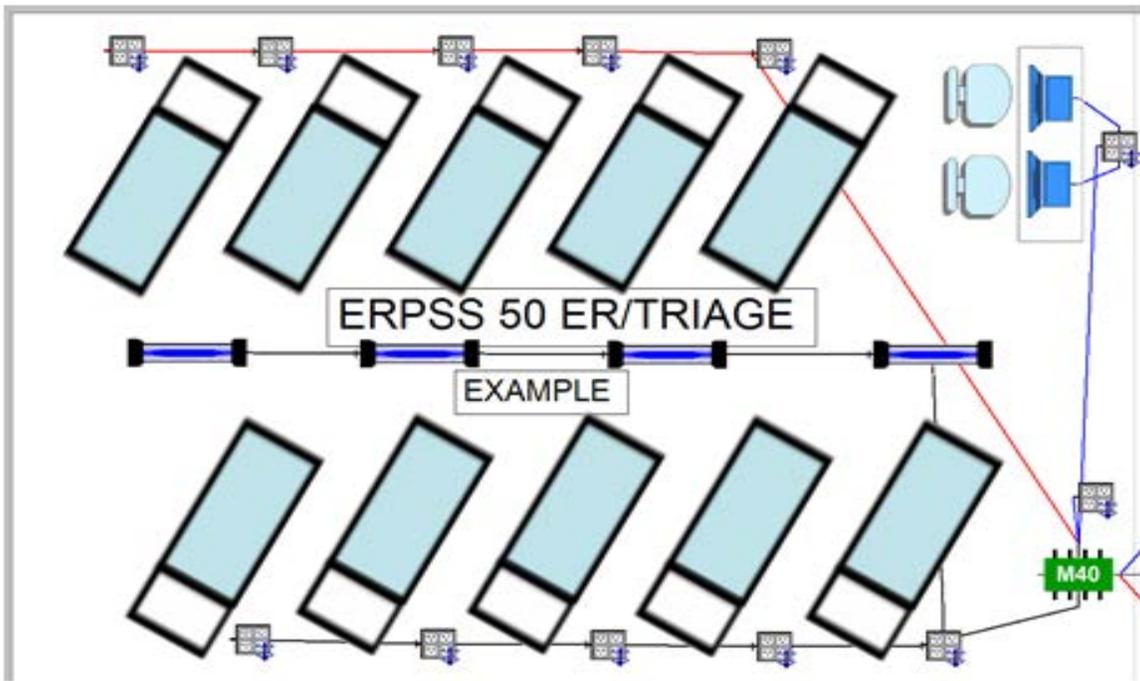
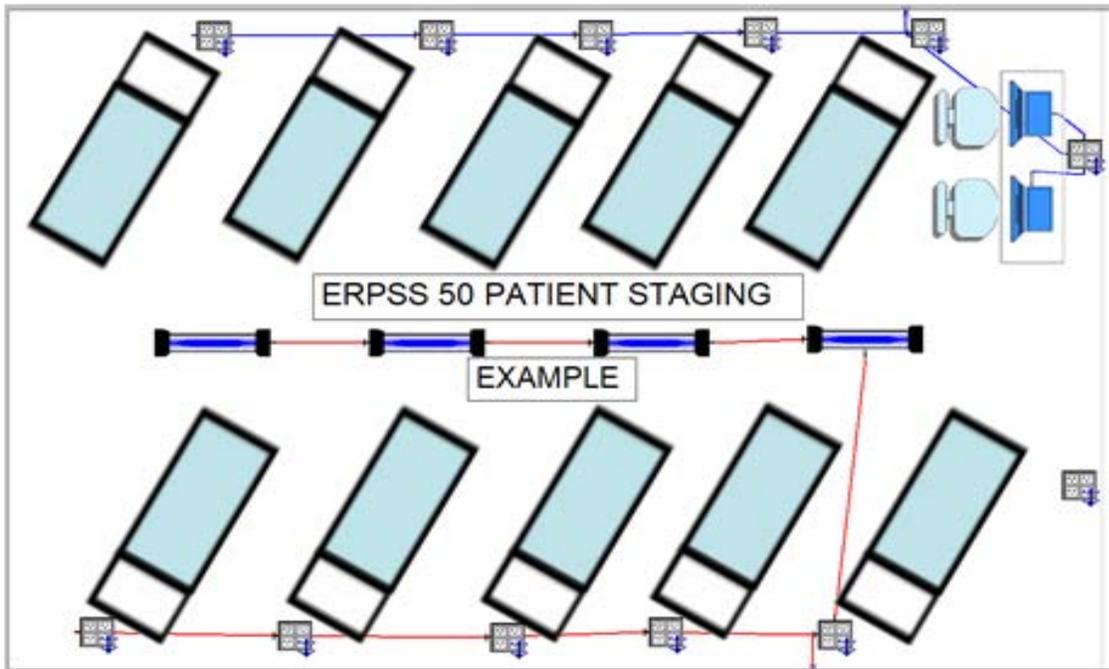


Figure A9.5. ERPSS 50 Patient Staging.



## Attachment 10

## EXAMPLE SITREP AND OPREP-3 GUIDE

**SITREP**

- Item 1 Identity and Type of unit.
- Item 2 Operating location of unit.
- Item 3 List number of assigned personnel by AFSC.  
Note any gains or losses since last report.
- Item 4A Patients evacuated since last report, as: (U.S) - (ALLIED) - (EPW)
- Item 4B Patients evacuated since last report, as:  
BI / L /A+ Att  
NBI / L /A+ Att
- Item 4C Patients waiting for evacuation, as: L /A+ Att
- Item 5 Equipment status (vehicles, AGE, radios, admin, medical) to be listed as:  
Green: Fully mission capable.  
Yellow: Operational, but needs parts, repair or re-supply within 24 hours.  
Red: Not operational, but expected to be within 24 hours.  
Black: Not operational, and not expected to be within 24 hours.

**Note:** List “green” equipment on the Operational Employment (first) report only. For all other colors list exact problem and any corrective actions underway.

- Item 6 Comments or remarks section. List any factors that may adversely affect mission effectiveness.

**OPREP-3**

- Item 1 Number of Medical Personnel impacted.
- Item 2 Infrastructure impact as a result of the incident or natural disaster.
- Item 3 Impact to operational capability as a result of the incident or natural disaster.
- Item 4 Detailed medical equipment issues/requirements.

- Item 5 Detailed Class VIII medical materiel issues/requirements, with separate reporting for Class VIIIA medical supplies and Class VIIIB Blood and blood products.
- Item 6 Detailed information on additional medical forces required.
- Item 7 Medical unit commander's narrative, as needed to provide more detail, clarification of mission impact, corrective action/resolution and estimated get-well date.

**\*\*\* Classification: SITREPs/OPREP-3s are classified SECRET or EXERCISE SECRET!**

**Attachment 11**

**MESSAGE FORMATS**

MESSAGE NUMBER DATE TIME GROUP

(MSG NR DTG)

03 R 090011Z OCT 12

MSG NR PREC. DATE Z TIME MTH YEAR

Z=FLASH: LESS THAN 10 MINUTES.

O=IMMEDIATE: NO LONGER THAN 1 HOUR

P=PRIORITY: NO LONGER THAN 6 HOURS

R=ROUTINE: WITHIN 24 HOURS

TIME OF RECEIPT (TOR) / TIME OF DELIVERY (TOD)

TOR - WHEN A MESSAGE FROM ANOTHER STATION IS RECEIVED BY YOUR LOCATION

TOD - WHEN A MESSAGE, TRANSMITTED TO ANOTHER STATION, IS ACKNOWLEDGED AS RECEIVED BY THAT STATION.

10 1337Z OCT 04 //LL// WD

DATE Z TIME MTH YEAR FQ PERSONAL SIGN

GENERAL MESSAGE WORKSHEET

MESSAGE NUMBER DTG: \_\_\_\_\_

FROM: \_\_\_\_\_

TO: \_\_\_\_\_

INFO: \_\_\_\_\_

BT

BT

TOR / TOD

RE-SUPPLY REQUEST

NR: \_\_\_\_\_

FROM: \_\_\_\_\_

TO: \_\_\_\_\_

INFO: \_\_\_\_\_

BT

DRILL / EXERCISE

LITTERS: \_\_\_\_\_

TENTAGE: \_\_\_\_\_

RATIONS: (Number of Meals): \_\_\_\_\_

WATER: (Gallons): \_\_\_\_\_

FUEL: (Type & Gallons): \_\_\_\_\_

OTHER (Specify): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

REMARKS: \_\_\_\_\_

\_\_\_\_\_

TOR / TOD \_\_\_\_\_ RELEASER: \_\_\_\_\_

EXPLANATION: Delta Message. An optional re-supply request that can be added onto the SITREP or sent separately to AECS on a daily basis, as needed.

## Attachment 12

## WHEELS UP MESSAGE FORMAT

Table A12.1. Wheels Up Message Format.

<i>AEROMEDICAL MISSION WHEELS-UP MESSAGE</i>			
1. FROM:			
2. TO:			
3. DTG:			
4. A/C TYPE:		5. MISSION #:	
6. PRECEDENCE:		7. CALL SIGN:	
8. AE CREW:			
9. CCATT:			
10. ONLOAD INFORMATION			
a. AFLD ICAO	b. ATA	c. ATD	
d. LITTER	e. AMBULATORY	f. ATTENDANT	
11. REMARKS (#CCATT , #Vented pts. & Altitude Restrictions)			
RELEASER:			

**Note: THIS INFORMATION IS REQUIRED BY EACH ERPSS TO BE TRANSMITTED TO THEIR ASSOCIATED AEOT FOR ONWARD REPORTING PURPOSES. INFORMATION SHOULD BE GATHERED IN THE ERPSS BY THE ADMINISTRATIVE STAFF AND TRANSMITTED BY THE FFQCR PERSONNEL AS REQUIRED, BUT NO LATER THAN 10 MINUTES AFTER TAKEOFF. INFORMATION GOES TO ASSOCIATED AEOT, AND/OR CRE. IF NO CONTACT IS MADE WITH THE AEOT, THIS INFORMATION WILL BE PHONED INTO THE 618 AOC (TACC) AT COMMERCIAL NUMBER 1-618-229-4967 OR DSN (312) 779-4967.**

**Attachment 13****WHEELS-UP MESSAGE COMPLETION GUIDE**

1. **FROM:** ERPSS Unit Call sign
2. **TO:** Receiving Unit (i.e. AEOT Call Sign, AECS Call Sign)
3. **DTG:** Date Time Group, message Number, Day, Time, Local or Zulu, Month and year (01140923Z APR 13)
4. **A/C TYPE:** C-130, C-17, KC-135, KC-10, C-5, C-21.
5. **MISSION NUMBER:** Aircraft Mission # (i.e., JLWGK220F095)
6. **PRECEDENCE:** Precedence of the mission (**U** – Urgent, **P** – Priority, **R** – Routine, **O** – Immediate)
7. **CALL SIGN:** Aircraft Call sign
8. **AE CREW:** Medical Crew Director (MCD) name
9. **CCATT:** Yes or No/If Yes, Annotate Physicians Name
10. **ONLOAD INFORMATION:**
  - a. **AFLD ICAO:** Airfield designator for the ERPSS's deployed location
  - b. **ATA:** Actual time of Aircrafts Arrival
  - c. **ATD:** Actual time of Aircrafts Departure
  - d. **Litter:** Number of Patients on litters
  - e. **Ambulatory:** Number of Ambulatory Patients
  - f. **Attendant:** Number of Non-medical/Medical Attendants
11. **Remarks**
  - Number of CCATT-** Number of CCATT Patients on Board
  - Number of Vented Patients** – Number of Vented patients on Board
  - General Remarks** – i.e. altitude restrictions

**Releaser:** ERPSS appointed primary or alternate message releaser's written name/initials

## Attachment 14

### RADIO EQUIPMENT DESTRUCTION

**1.1. Types of Destruction.** The ranking official on site will determine whether the nature and circumstances involved in the threat to the material requires precautionary destruction or total destruction.

1.1.1. Precautionary Destruction. Precautionary destruction would include the destruction of administrative documents, files and other material not required for continued operation. Under no circumstances will equipment be destroyed under the precautionary destruction order. Insure that records indicate what material has been destroyed when precautionary destruction is implemented. Retain all equipment, all operational and maintenance documents, and a 90-day supply of COMSEC material.

1.1.2. Total Destruction. Total destruction includes the destruction of key tapes, documents, and equipment. This plan is implemented when the commander decides forces and facilities are no longer adequate to protect classified and COMSEC material from impending capture or loss. Normally, other individuals are empowered to put the plan into effect on their own if conditions prevent contact with the commander. The person most familiar with the amount and significance of COMSEC material on-hand must prepare a clear and concise plan. Planners should consider the options available when preparing for hostile actions. Where and when capture or overrun could be imminent; the plan should always be directed toward using the most expeditious means consistent with insuring total destruction.

**1.2. Precedence of Destruction.** Destroy assets in the following descending order:

1.2.1. TOP SECRET-CRYPTO and TOP SECRET simultaneously.

1.2.2. SECRET-CRYPTO.

1.2.3. SECRET.

1.2.4. CRYPTO CONTROLLED ITEMS (CCI).

1.2.5. Remaining classified material and equipment that could benefit the enemy.

**1.3. Zeroing.** The term "zeroized" is used to describe the action taken to remove stored information from the memory of electronic equipment. The Secure Terminal Equipment (STE), Iridium sleeve and loaded PSC-5 and PRC-150 must be erased in order to ensure complete destruction. (Consult equipment-operating instructions for zeroizing procedures.)

**1.4. Methods of Destruction.** There are three basic methods of destruction:

1.4.1. Burning. If using thermite or sodium nitrate on equipment, use proper safety procedures. Make sure the burn is complete and paper or plastic products are completely destroyed.

1.4.2. Smashing. Completely destroy integral components to render the equipment inoperable and beyond repair.

1.4.3. Shredding. Always use COMSEC approved cross cutting shredders to prevent reconstruction of documents.

Attachment 15

AE INPATIENT HANDOFF CHECKLIST

Figure A15.1. AE Inpatient Hand-off Checklist (Page 1 of 2).

PATIENT MOVEMENT INPATIENT HANDOFF REPORT WORKSHEET	
<b>I</b>	DATE/TIME: _____ CITE #: _____ PATIENT NAME: _____ CURRENT SENDING FACILITY: _____ RECEIVING FACILITY: _____ PATIENT CLASSIFICATION: _____
<b>HANDOFF TO AE CREW BY FACILITY REPORT BY:</b>	
<b>S</b> <i>(Situation)</i>	Diagnosis: _____ Date of surgery: _____ Date of injury/admission: _____ Current status: <input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Responds to verbal <input type="checkbox"/> Responds to pain <input type="checkbox"/> Unconscious Patient on/oad method: <input type="checkbox"/> Unassisted <input type="checkbox"/> Crutches/cane <input type="checkbox"/> Litter Code status: <input type="checkbox"/> DNR <input type="checkbox"/> Medical <input type="checkbox"/> Non-medical Attendant: _____
<b>B</b> <i>(Background)</i>	Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List: _____ Medications: <input type="checkbox"/> None <input type="checkbox"/> Self-Administered <input type="checkbox"/> Given to Flight Nurse <input type="checkbox"/> See 3899 for list Recent: Pain Meds/Route/Time Given (zulu) _____ Antiemetic/Route/Time Given (zulu) _____ Antibiotics/Route/Time Given (zulu) _____ Other Meds/Route/Time Given (zulu) _____ Other pertinent information/history: _____
<b>A</b> <i>(Assessment)</i>	Vitals: BP _____ P _____ R _____ SpO2 _____ T _____ Pain level: _____/10 Location: _____ Airway: <input type="checkbox"/> No devices <input type="checkbox"/> Trach <input type="checkbox"/> Other: _____ Breathing: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Labored <input type="checkbox"/> Assisted Oxygenation: <input type="checkbox"/> Room Air <input type="checkbox"/> NC <input type="checkbox"/> NRB Rate: _____ LPM Circulation: <input type="checkbox"/> Adequate <input type="checkbox"/> Altered (location): _____ Skin: <input type="checkbox"/> Skin Intact/No Pressure Ulcers (PU) or concerns <input type="checkbox"/> Braden Scale score: _____ <input type="checkbox"/> Skin Issue/Location: _____ IV: <input type="checkbox"/> 0.9% NS <input type="checkbox"/> LR <input type="checkbox"/> D5W <input type="checkbox"/> Other: _____ Rate: _____ mL/hour <input type="checkbox"/> Packed RBCs <input type="checkbox"/> Saline Lock Location: _____ <input type="checkbox"/> Fluids brought onboard w/ patient <input type="checkbox"/> Tubing/Fluids/medications labeled Devices: <input type="checkbox"/> Suction <input type="checkbox"/> Orthopedic device <input type="checkbox"/> NG tube <input type="checkbox"/> Pr Monitor <input type="checkbox"/> Restraints <input type="checkbox"/> Foley <input type="checkbox"/> Chest tube <input type="checkbox"/> IV pump <input type="checkbox"/> Cast <input type="checkbox"/> Neg Pressure Wound Therapy Device(s) x _____ <input type="checkbox"/> SCDs <input type="checkbox"/> Feeding tube <input type="checkbox"/> Drain <input type="checkbox"/> Epidural <input type="checkbox"/> PCA pump <input type="checkbox"/> Peripheral Nerve Block <input type="checkbox"/> Other: _____ Pain equipment safety check: <input type="checkbox"/> Site: _____ <input type="checkbox"/> Line patent <input type="checkbox"/> Pump functional <input type="checkbox"/> Right Medication/concentration <input type="checkbox"/> Right infusion rate/settings <input type="checkbox"/> Tubing unclamped Wound vtc safety check: <input type="checkbox"/> Site(s): _____ <input type="checkbox"/> Tube unclamped <input type="checkbox"/> Pump functional Abnormal labs: <input type="checkbox"/> H/H <input type="checkbox"/> Cardiac enzymes Other pertinent information: _____ Specific inflight orders/instructions for AE Crew (AF 3899, Section III: Other Orders): _____
<b>R</b> <i>(Recommendation/Request)</i>	Standard Patient Preparation Items Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>** See back of checklist**</b> As of 20140430 (page 1 of 2)
<b>HANDOFF BY AE CREW REPORT BY:</b>	
	<input type="checkbox"/> No change in status/situation Status change: <input type="checkbox"/> A/O <input type="checkbox"/> Confused <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unconscious Pt offload method: <input type="checkbox"/> Unassisted <input type="checkbox"/> Crutches/cane <input type="checkbox"/> Litter Other information: _____
	<input type="checkbox"/> No change in medication Inflight: _____ Last Pain Meds/Route/Time Given (zulu) _____ Last Antiemetic/Route/Time Given (zulu) _____ Last Antibiotics/Route/Time Given (zulu) _____ Other Meds/Time Given (zulu) _____ Other information: _____
	Last Vitals: BP _____ P _____ R _____ SpO2 _____ T _____ Pain level: _____/10 Location: _____ Airway: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Breathing: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Oxygenation: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ LPM Circulation: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Skin: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ mL/hour IV: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ mL/hour Devices: <input type="checkbox"/> No change <input type="checkbox"/> Changed to/Issues during flight: _____ Device safety checks completed: <input type="checkbox"/> Yes <input type="checkbox"/> No* * If "No" is checked, please explain why below. Other information: _____
	<input type="checkbox"/> Inflight orders/instructions accomplished Other information: _____

\* This form is not a part of the patient's permanent medical record  
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Figure A15.2. AE Inpatient Hand-off Checklist (Page 2 of 2).

<b>AEROMEDICAL EVACUATION (AE) INPATIENT HANDOFF CHECKLIST (BACKSIDE)</b> <b>STANDARD AE PATIENT PREPARATION ITEMS</b> <b>(TO BE COMPLETED BY THE ORIGINATING FACILITY/CASF/ASF PRIOR TO ARRIVING AT THE AIRCRAFT)</b>		
<b>TASK</b>	<b>DESCRIPTION</b>	<b>SUPPORTING REGULATION</b>
<p><b>Medication</b>    <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Adequate supply of medications given to the patient or flight nurse</p> <p><input type="checkbox"/> Patient is pre-medicated prior to flight</p> <p><input type="checkbox"/> Patient medication verified</p>	<p>Role 2 to Role 3 (i.e. Bastion to Bagram) movements in combat operations theater: <b>1-day minimum</b>; Role 3 to Role 4 (i.e. Bagram to LRMC) movements: <b>2-day minimum</b>; inpatients from OCONUS MTF to port of entry MTF CONUS (i.e. LRMC to Bethesda): <b>2-day minimum</b>; inpatients from OCONUS MTF to other locations in CONUS with RON: <b>3-day minimum</b>; all outpatient movements OCONUS to CONUS: <b>5-day minimum</b>; CONUS to CONUS movements: <b>1-day minimum</b>.</p> <ul style="list-style-type: none"> <li>• Pain medication within 1 hours of departure (if applicable)</li> <li>• Antiemetic (if applicable)</li> <li>• Medication that would be scheduled to be given during patient loading and through 1 hour after takeoff (if applicable)</li> <li>• Medication delivered to the aircraft is for the right medication for the right patient with the right time/frequency of administration annotated, and is the correct form/route</li> <li>• All medications are verified with order on AF Form 3899/DD Form 602</li> <li>• All medications have been documented and timed on MAR/PMR</li> </ul>	<p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.5.3., 2.10.3.1., 2.10. 2.10.4, 2.10.7., 2.12.5; USTRANSCOM Memorandum, <i>Medication Administration, Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement System</i>, dated 17 May 2010.</p>
<p><b>Equipment</b>    <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Working condition confirmed</p> <p><input type="checkbox"/> Approved for flight</p> <p><input type="checkbox"/> Equipment waiver obtained</p> <p><input type="checkbox"/> All auxiliary parts present</p> <p><b>Supplies</b>    <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Adequate amount of supplies given to the patient or flight nurse</p>	<p>Equipment must work properly and battery must be fully charged prior to leaving facility. Originating MTF must use only flight-certified medical equipment for use on AE missions. All "approved equipment" questions must be directed to GPMRC or appropriate theater AFCC/TPMRC. Power cords/adapters, canisters, litter brackets/securing device, tubing</p> <p>Role 2 to Role 3 (i.e. Bastion to Bagram) movements in combat operations theater: <b>1-day minimum</b>; Role 3 to Role 4 (i.e. Bagram to LRMC) movements: <b>2-day minimum</b>; inpatients from OCONUS MTF to port of entry MTF CONUS (i.e. LRMC to Bethesda): <b>2-day minimum</b>; inpatients from OCONUS MTF to other locations in CONUS with RON: <b>3-day minimum</b>; all outpatient movements OCONUS to CONUS: <b>5-day minimum</b>; CONUS to CONUS movements: <b>1-day minimum</b>.</p>	<p>AFI 41-307, <i>Aeromedical Evacuation Patient Considerations and Standards of Care</i>, AFI 10-2909, <i>Aeromedical Evacuation Equipment Standards</i>.</p> <p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.6.3., 2.10.7.; USTRANSCOM Memorandum, <i>Medication Administration, Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement System</i>, dated 17 May 2010.</p>
<p><b>Documentation</b></p> <p><input type="checkbox"/> Documentation verified</p>	<ul style="list-style-type: none"> <li>• Physician has signed the AF 3899/DD Form 602</li> <li>• Flight surgeon has cleared the patient; documented on form</li> <li>• AF Form 3899/DD Form 602, medical record, x-rays placed in an envelope affixed with completed DD Form 2267 or with the following information: patient's name, rank/status, SSN, nationality (if not a US citizen), organization, date of departure, and destination)</li> <li>• Military ID card with the patient or in envelope listed above</li> <li>• ID bracelet on patient with last name, first name, middle initial, cite #, and date of birth</li> </ul>	<p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.2.8.1.5., 2.5.3., 2.9., 2.10.7., 2.12.5; USTRANSCOM Policy Letter, dated 9 October 2009.</p>
<p><b>Anti-hijacking/Baggage</b></p> <p><input type="checkbox"/> Completion confirmed</p>	<ul style="list-style-type: none"> <li>• Patients, attendants, and their baggage are inspected with a hand-held or walk-through metal detector, x-ray machine, or physical check for weapons or explosives.</li> <li>• All baggage is tagged appropriately and baggage manifest is provided to the AE crew.</li> </ul>	<p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.8.2.1, 2.8.1.5., 2.12.4.2., 2.13.</p>

**Attachment 16**

**AE Outpatient Handoff Checklist**

Figure A16.1. AE Outpatient Handoff Checklist.

PATIENT MOVEMENT OUTPATIENT HANDOFF REPORT WORKSHEET

MSN CALENDAR DATE/JULIAN DATE: \_\_\_\_\_

<p>Pt Name: _____ Classification: _____ Cite# _____                  Deplane ICAO: _____ Diagnosis: _____ Age: _____ DOB: _____                  Allergies: _____ Medical Attendant: <input checked="" type="checkbox"/> Y/N Non-medical Attendant: <input checked="" type="checkbox"/> Y/N                  Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____                  Inpt Records: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> Outpt Records: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> CD: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> Is patient a SAM? <input checked="" type="checkbox"/> Y/N Narcotics: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> 3899 signed by FS: <input checked="" type="checkbox"/> Y/N                  3899I created for medications: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> Pt has all ordered medications: <input checked="" type="checkbox"/> Y/N Pt &amp; Bags Anti-Infected: <input checked="" type="checkbox"/> Y/N <input checked="" type="checkbox"/> Pt ID Band On: <input checked="" type="checkbox"/> Y/N                  Next Medication(s) due: _____ Last dressing change: _____                  Date of injury/surgery &amp; procedure: _____ O2 requirements _____                  Saline Lock: <input checked="" type="checkbox"/> Y/N Location: _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____                  Equipment: Litter / IV pump / suction / backrest / glucometer / other _____                  Ambulatory Device: crutches / cane / walker / walking can boot / other _____                  If applicable: date last seizure / chest pain / ETOH intake / Glucose _____                  Other pertinent info/treatments/labs: _____</p>	<p>Handoff by AE CREW  <input type="checkbox"/> NO CHANGE  <input checked="" type="checkbox"/> CHANGE SUMMARY                  (Refer to patient record).                  _____                  _____                  _____</p>
<p>Pt Name: _____ Classification: _____ Cite# _____                  Deplane ICAO: _____ Diagnosis: _____ Age: _____ DOB: _____                  Allergies: _____ Medical Attendant: <input type="checkbox"/> Y/N Non-medical Attendant: <input type="checkbox"/> Y/N                  Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____                  Inpt Records: <input type="checkbox"/> Y/N <input type="checkbox"/> Outpt Records: <input type="checkbox"/> Y/N <input type="checkbox"/> CD: <input type="checkbox"/> Y/N <input type="checkbox"/> Is patient a SAM? <input type="checkbox"/> Y/N Narcotics: <input type="checkbox"/> Y/N <input type="checkbox"/> 3899 signed by FS: <input type="checkbox"/> Y/N                  3899I created for medications: <input type="checkbox"/> Y/N <input type="checkbox"/> Pt has all ordered medications: <input type="checkbox"/> Y/N Pt &amp; Bags Anti-Infected: <input type="checkbox"/> Y/N <input type="checkbox"/> Pt ID Band On: <input type="checkbox"/> Y/N                  Next Medication(s) due: _____ Last dressing change: _____                  Date of injury/surgery &amp; procedure: _____ O2 requirements _____                  Saline Lock: <input type="checkbox"/> Y/N Location: _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____                  Equipment: Litter / IV pump / suction / backrest / glucometer / other _____                  Ambulatory Device: crutches / cane / walker / walking can boot / other _____                  If applicable: date last seizure / chest pain / ETOH intake / Glucose _____                  Other pertinent info/treatments/labs: _____</p>	<p>Handoff by AE CREW  <input type="checkbox"/> NO CHANGE  <input type="checkbox"/> CHANGE SUMMARY                  (Refer to patient record).                  _____                  _____                  _____</p>

As of 20140910

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