BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE TACTICS, TECHNIQUES, AND PROCEDURES 3-42.6

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Tactical Doctrine

USAF MEDICAL SUPPORT FOR SPECIAL OPERATIONS FORCES

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The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. This document, AFTTP 3-42.6, provides an overview of special operations and the United States Air Force (USAF) medical tactics, techniques, and procedures (TTP) that support all SOF and missions. It describes the organization, capabilities, planning, logistics, training, and operations of the AFSOC Medical Forces and primarily pertains to deployed operations. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFI 33-322, *Records Management and Information Governance Program*, and disposed of in accordance with the Air Force Records Disposition Schedule located at https://www.my.af.mil/afrims/afrims/afrims/rims.cfm. 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 IMT 847 through the appropriate chain of command and parent Major Command (MAJCOM).

SUMMARY OF CHANGES

This publication has been significantly revised and must be completely reviewed. This revision updates and clarifies information throughout the document including roles, responsibilities, and relationships at all levels. It updates United States Special Operations Command (USSOCOM) special operations forces (SOF) operational priorities and core tasks and revises the Air Force Special Operations Command (AFSOC) medical unit type code (UTC) narratives. It expands and clarifies medical doctrine and policy as applied to operational employment of AFSOC medical assets at home station and deployed. It expands the medical logistics, operational planning, and communications sections.

APPLICATION: This publication applies to all Air Force military and civilian personnel including Air Reserve Components (ARC). This document is authoritative but not directive.

SCOPE: Special operations missions are conducted by specially organized, trained and equipped military forces to achieve military, political, economic, or psychological objectives by unconventional means in, to include but not limited to hostile, denied, or politically sensitive areas. Whether operating from a contingency location (CL), cooperative security location, enduring location (EL), forward operating site (FOS), initial CL, or main operating base, AFSOC medical assets provide medical Expeditionary Combat Support (ECS), trauma care and casualty evacuation

(CASEVAC) during operational missions for Air Force Special Operations Forces (AFSOF) and other SOF. AFSOC medical teams and designated line units support SOF by providing both mission operations support as well as SOF base operations support. These capabilities include comprehensive medical mission planning, Global Health Engagement, small unit care, damage control resuscitation, damage control surgery, advanced trauma life support, CASEVAC, prolonged casualty care, as well as more routine preventive and acute medical care for deployed SOF personnel.

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Chapter 1

SOF OVERVIEW

1.1. Overview. Special operations are military operations conducted by specially trained, equipped, and organized Department of Defense forces against strategic or tactical targets in pursuit of national military, political, economic, or psychological objectives. These operations are often conducted in hostile, denied, or politically sensitive environments and are characterized by one or more of the following elements: time sensitive, clandestine, low visibility, conducted with and/or through indigenous forces, requiring regional expertise, and/or a high degree of risk. Special Operations Forces are those active and reserve component forces of the services designated by the Secretary of Defense (SecDef) and specifically organized, trained, and equipped to conduct and support special operations.

1.2. SOF Truths. The SOF truths guide day-to-day activities as well as strategic planning and vision.

- Humans Are More Important Than Hardware
- SOF Cannot Be Mass Produced
- Competent SOF Cannot Be Created After Emergencies Occur
- Quality Is Better Than Quantity
- Most Special Operations Require non-SOF Assistance

1.3. SOF Core Activities. USSOCOM organizes, trains, and equips SOF for special operations core activities and other such activities as may be specified by the President and/or SecDef. These core activities reflect the collective capabilities of all joint SOF rather than those of any one Service or unit. It is important to note that core activities are mutually supporting and interoperable in most cases. Rarely, if ever, will a special operation occur that does not support, include, or impact multiple core activities.

- Direct action (DA)
- Special reconnaissance (SR)
- Counter-proliferation of Weapons of Mass Destruction
- Counterterrorism (CT)
- Unconventional warfare
- Foreign internal defense (FID)
- Security force assistance
- Hostage rescue and recovery
- Counterinsurgency
- Foreign humanitarian assistance
- Military information support operations
- Civil affairs operations

Chapter 2

ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

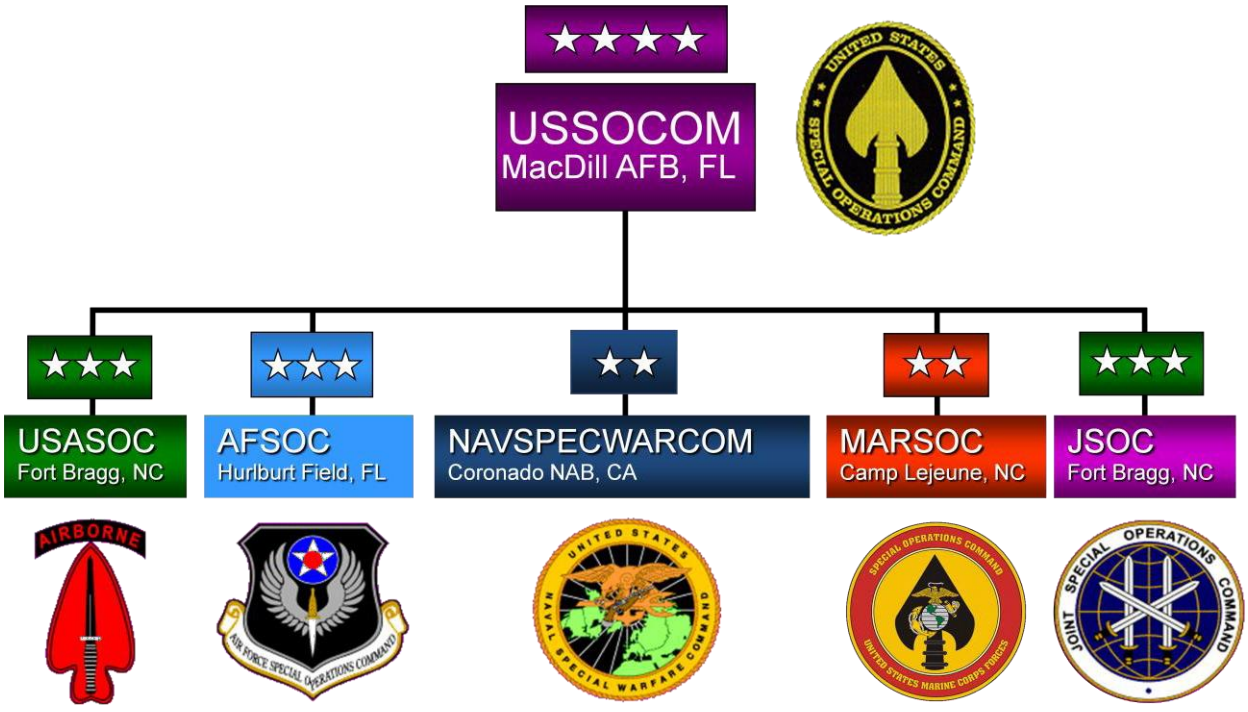
2.1. United States Special Operations Command (USSOCOM).

2.1.1. USSOCOM Mission. USSOCOM develops, and employs the world's finest SOF to conduct global special operations and activities as part of the Joint Force, in concert with the U.S. Government Interagency, Allies, and Partners, to support persistent, networked, and distributed combatant command operations and campaigns against state and non-state actors all to protect and advance U.S. policies and objectives.

2.1.2. Headquarters. USSOCOM is headquartered at MacDill AFB, Florida, and is one of the combatant commands directly responsible to the President and SecDef. As a functional combatant command, USSOCOM has been given lead responsibility with waging war on terrorism and plays a supporting role in Great Power Competition. Its duties in connection with this responsibility include planning, directing, and executing special operations. USSOCOM also provides SOF to support the Combatant Commander's theater security cooperation plans. The designation of Special Operations as a Major Force Program makes USSOCOM unique among the combatant commands in that it has service-like responsibilities to organize, train, and equip its forces for special operations missions.

2.1.3. Component Commands. USSOCOM has four component commands and one sub-unified command: the US Army Special Operations Command (USASOC), Fort Bragg, North Carolina; the Naval Special Warfare Command (NAVSPECWARCOM), Coronado, California; the Air Force Special Operations Command (AFSOC), Hurlburt Field, Florida; the Marine Corps Forces Special Operations Command (MARSOC), Camp Lejeune, North Carolina and the sub-unified command Joint Special Operations Command (JSOC), Fort Bragg, North Carolina. (see Figure 2.1.)

Figure 2.1. USSOCOM Component Commands



2.1.4. Theater Special Operations Commands (TSOCs). TSOCs are sub-unified commands established within each combatant command (CCMD). The function of the TSOC is to ensure that SOF is fully integrated into the combatant commanders (CCDR) collective security plans and contingency operations. The TSOC commander plans and conducts joint special operations, ensuring that SOF capabilities are matched to mission requirements while advising component commanders in theater on the proper employment of SOF. Additionally, TSOCs provide the core element for establishing a Joint Special Operations Task Force (JSOTF) or Special Operations Joint Task Force (SOJTF), a quick reaction command and control element that can respond immediately to regional emergencies. There are joint service medical planners assigned to TSOCs. The seven TSOCs supporting CCDRs worldwide are: Special Operations Command Central (SOCCENT), Special Operations Command Europe (SOCEUR), Special Operations Command Pacific (SOCPAC), Special Operations Command South (SOCSOUTH), Special Operations Command Korea (SOCKOR), Special Operations Command Africa (SOCAFRICA), and Special Operations Command U.S. Northern Command (SOCNORTH).

2.2. Air Force Special Operations Command (AFSOC).

2.2.1. AFSOC Mission. AFSOC organizes, trains, and equips forces to conduct SO across the full range of military operations in support of joint force commanders and interagency partners, to meet theater and national objectives.

2.2.2. AFSOC Lead Component (LC) and Specified Responsibilities. USSOCOM designates Service Components as lead for an activity as assigned in USSOCOM D 10-1. Designation as LC is based on the recognition of subject matter expertise within the assigned activity. Below are the assigned special operations activities where AFSOC serves as the LC:

- Operations of unmanned aircraft system and forces capable of supporting national and regional objectives
- Fixed-wing and tilt-rotor mobility to include non-standard aviation
- Rapid, global, specialized aerial refueling of aircraft to increase their range, endurance, and flexibility
- SOF geospatial intelligence imagery processing, exploitation, and dissemination
- Development and management of SOF Intelligence, Surveillance and Reconnaissance Tactical Controller program TTPs and training course
- Agile combat support of AF SOF in austere environment to ensure uninterrupted support to SOF
- Role 2 Surgical Support to include medical support to standard and non-standard casualty evacuation

2.2.3. Headquarters. AFSOC is headquartered at Hurlburt Field, Florida, and functions as both an Air Force MAJCOM and as the air component of USSOCOM. As a MAJCOM, AFSOC retains Title 10 responsibilities to organize, train, equip, administer, and maintain special operations forces for worldwide deployment and assignment to unified commands. As the air component of USSOCOM, AFSOC provides AFSOF to accomplish assigned special operations mission activities. Also, as the Air Force component, the AFSOC commander exercises command authority consistent with operational control (OPCON) over all Continental United States-based active and reserve AFSOF assets.

2.2.4. AFSOC Command Surgeon. The AFSOC/SG functions as a MAJCOM/SG and as the air component surgeon to USSOCOM. As a MAJCOM/SG, the AFSOC surgeon is responsible for establishing, coordinating, and sustaining a health care system for AFSOC personnel and for organizing, training, and equipping AFSOC medical forces for contingency medical support. As the air component surgeon to USSOCOM, the AFSOC/SG plans execution of all Air Force medical support for AFSOF and serves as the principal Air Force medical service advisor to USSOCOM.

2.2.5. Organizational Structure. AFSOC medical units and line units with medical responsibilities are currently organized into a Wing, Group, Squadron, and Flight configuration.

2.2.5.1. AFSOC Supported Units. AFSOC provides leadership and oversight for the 1st Special Operations Wing (SOW), 24 SOW, and 492 SOW at Hurlburt Field, FL, the 27 SOW at Cannon AFB, NM, the 352 SOW at RAF Mildenhall, United Kingdom, and the 353 SOW at Kadena AB, Japan. The 352 and 353 SOWs are Primary Subordinate units to AFSOC/CC. Additionally, AFSOC has Air Force Reserve Component (AFRC) and Air National Guard (ANG) units: the 137 SOW of the ANG at Will Rogers ANG base, Oklahoma City, OK, the 193 SOW of the Pennsylvania ANG at Harrisburg Airport, Middletown PA, and the 919 SOW of the AFRC at Duke Field, FL. (see Figure 2.2.)

Figure 2.2. AFSOC Command Structure

2.2.5.2. AFSOC Medical Groups. AFSOC has two fixed health care facilities: the 1st Special Operations Medical Group (1 SOMDG), Hurlburt Field, Florida and the 27th Special Operations Medical Group (27 SOMDG), Cannon AFB, New Mexico. These units operate outpatient clinics that offer primary care, aerospace medicine, optometry, pediatrics, health promotion,

bioenvironmental engineering, public health, physical therapy, behavioral health, women's health, and dental services. Their primary mission is to support the warfighter's medical readiness requirements and beneficiary care.

2.2.5.3. Operations Support Medical (OSM) Flights. OSM flight personnel are specifically trained and equipped, based on their assigned UTC, to support both the AFSOC flying mission as well as the medical support needs of deployed SOF units. For specific in-garrison mission information, please reference AFSOCI 48-1010, Aeromedical Special Operations.

2.2.5.3.1. As a Squadron Medical Element, OSM personnel fall under the command and control (C2) of Line of the Air Force Commanders of special operations units. At home station, OSM personnel report to the Special Operations Support Squadron (SOSS) commander or Wing A-Staff (if outside continental United States), or as a Special Operations Forces Medical Element (SOFME) to flying squadron Commander if embedded in the aviation units. While deployed, OSM personnel report through Special Operations Task Group (SOTG) and/or task force commanders to the TSOC to the CCDR. AFSOC mission commanders maintain operational control of AFSOC medical personnel to support short notice and/or highly specialized missions and to ensure OSM personnel have the required training prior to being tasked to support such operations.

2.2.5.3.2. OSM flights can have a combination of flight surgeons, physician assistants, medical administrators, Independent Duty Medical Technicians (IDMT), public health and bioenvironmental engineering technicians, plans/operations officers, and organic medical logisticians. OSM flights vary depending on location but may have several complimentary medical components.

2.2.5.4. Special Operations Surgical Team (SOST). SOST is AFSOC's only Role 2 Light Maneuver capability. These teams fall under the command and control of the 720th Operational Support Squadron (OSS) inside the 24 SOW. While deployed, SOST personnel report through Special Operations Task Group (SOTG) and/or task force commanders to the TSOC to the CCDR.

2.2.5.5. Special Tactics (ST) Squadron Medics. ST Medical Personnel fall under the command of the Special Tactics unit they are embedded in. In-garrison, the ST medical element provides full-spectrum medical care to members within the unit, to include acute care, Individual Medical Readiness, and Flight PHAs.

2.3. AFSOC Medical Preparedness and Force Protection.

2.3.1. Force Preparation. The medical groups supporting AFSOC units, with the assistance of personnel in the OSM, provide critical support to the AFSOC mission by preparing the force for deployed operations. SOF must be in a continual state of readiness to support minimal-notice tasking. More explicit information is contained in AFSOCI 48-1010, *Aeromedical Special Operations*.

2.4. AFSOC Medical System. Special Operations Forces are required to operate in remote, austere, and/or far-forward environments, which may not be adequately supported by conventional medical personnel. AFSOC/SG is tasked with providing a medical system that can provide health care to the supported SOF personnel who may be deployed in these environments. The overall AFSOC medical system may be divided into the base medical groups, operational medics, and STS and pararescue specialist (PJ) assets.

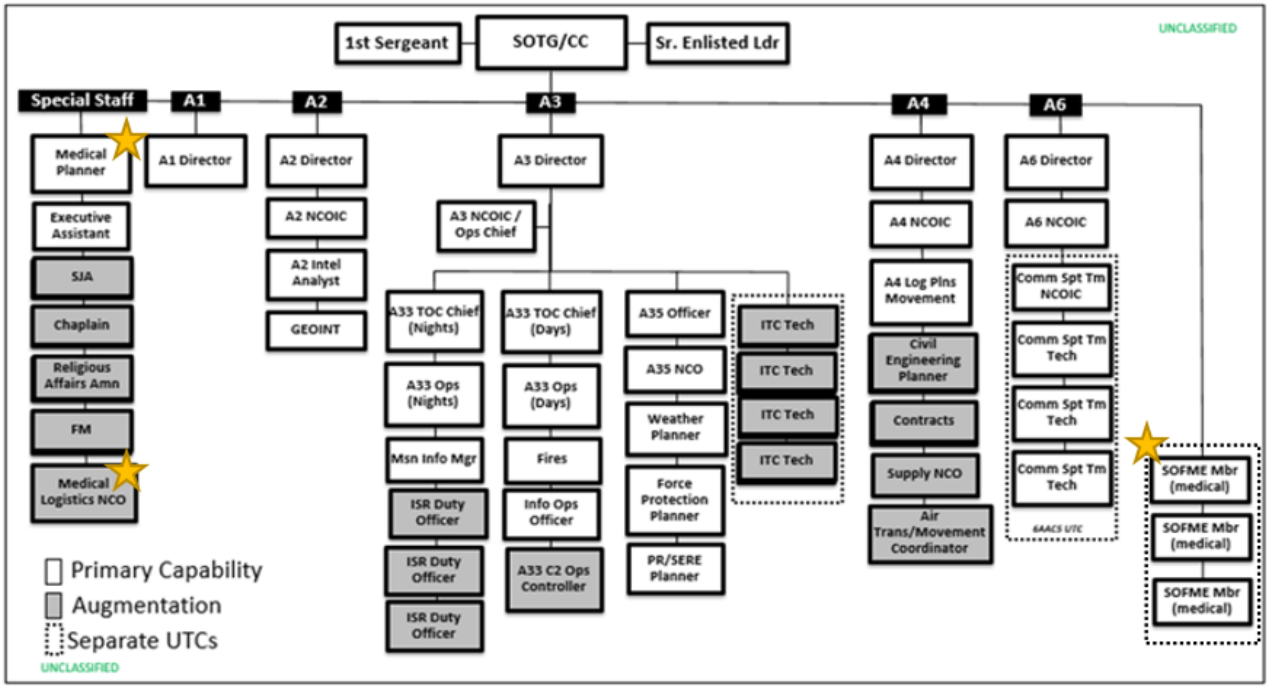
2.4.1. Home Station Health Support. Home station health care supports the AFSOC mission through programs that promote force fitness and performance, preventive and acute care, and managed health care for active-duty personnel and non-active duty beneficiaries. Medical service efficiency is optimized through sound business practices, effective utilization management/review, and cost-effective resourcing.

2.4.2. AFSOC Medical Pilot Units. AFSOC medical pilot units are responsible for the unit program management oversight and act as liaison to the AFSOC/SG. Pilot Units should appoint team chiefs and alternate team chiefs for their pilot UTCs in Medical Readiness Decision Support System (MRDSS). If required, pilot units should participate in the development of TTPs for their UTCs. Pilot units for UTCs can be found in MRDSS.

2.4.3. Deployed Medical Care Responsibility. Deployed SOF medical support provides a continuum of medical care from point of injury to entrance into the conventional medical system. AFSOC medical capability includes BOS medical support, Tactical Combat Casualty Care (TCCC), battlefield surgery, and unregulated patient movement to all component SOF units deployed in support of special operations missions.

2.4.3.1. Special Operations Task Group (SOTG). The SOTG and Special Operations Task Unit (SOTU) C2 construct will better organize and prepare AFSOC Airmen in garrison and more clearly present AFSOF capabilities to the joint community. SOTG health service support (HSS) will include one medical operations planner and one medical materiel noncommissioned officer (NCO). These medical assets will be deployed and located with the SOTG. SOFMEs will be assigned to the SOTG for support to the aviation SOTUs. SOFME can provide medical care to the SOTG HQ staff. When the SOTG HQ deploys independent of subordinate Aviation SOTUs, HQ medical care will be provided by organic medical teams with the ST or Mission Sustainment Team (MST) SOTUs. Refer to Figure 2.3. for the SOTG organizational chart.

Figure 2.3. SOTG Org Chart

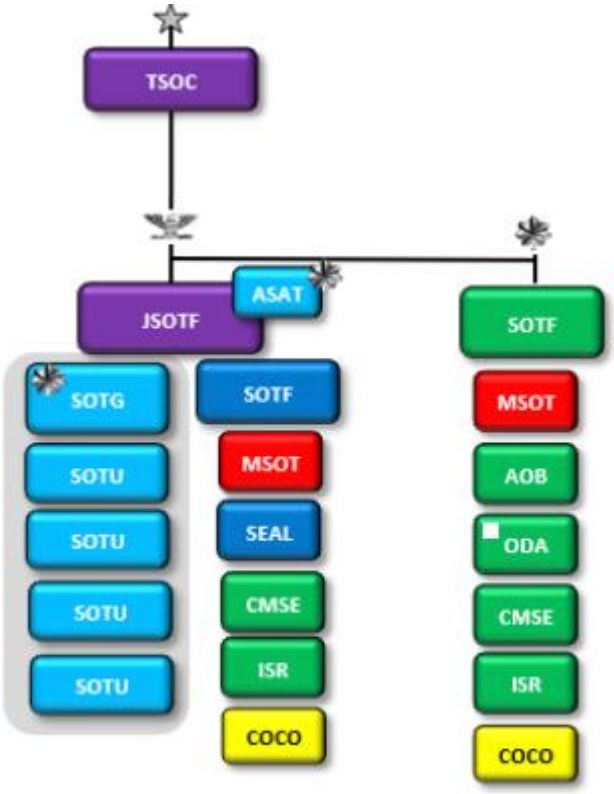


Chapter 3

COMMAND AND CONTROL

3.1. Deployed Lines of Communication. AFSOC operational medical personnel fall under the command and control of AFSOC Line of the Air Force commanders. While they report to a line commander, they are a part of the overall medical capability of the home station base or deployed operating location. AFSOC medics are responsible to their parent line units for the welfare of their unit. AFSOC medical personnel may fall under the professional oversight of a conventional medical commander, i.e., when deployed alongside non-SOF medical support units or when SOFMEs are deployed to a location with an established military treatment facility. In these instances, the AFSOC senior medical officer will establish the framework for cooperative effort. Unless otherwise directed, AFSOC will deploy under the Air Force Force Generation (AFFORGEN) deployment tempo in a SOTG concept (see Figure 3.1.).

Figure 3.1. SOTG Command Structure



3.2. AFSOC UTC Assignment. AFSOC medical personnel are UTC-specific trained and equipped to support both the AFSOC flying mission as well as the medical support needs of deployed SOF units. Members are assigned to operational units to fill UTCs that are assigned based on operational need, such as number of flying units or SOCOM generated requirements.

3.2.1. ARC Medical Units. AFSOC UTCs assigned to the AFRC-supported or ANG units are coordinated between AFSOC/SG and AFRC/SG or ANG/SG to ensure support to the AFSOC mission while maintaining the parent Wing medical support capability.

3.3. Medical Command and Control.

3.3.1. Operational Medical C2. Operational medical personnel fall under the C2 of Line of the Air Force Commanders of special operations units. While deployed, personnel report through SOTG and/or task force commanders to the TSOC to the CCDR. AFSOC mission commanders maintain operational control of AFSOC operational medical personnel in order to support short notice and/or highly specialized missions and to ensure operational medics have the required training prior to being tasked to support such operations.

3.3.1.1. Non-combatant Status. AFSOC medical personnel deploy in accordance with (IAW) appropriate Geneva Conventions/Law of Armed Conflict directives as members of a USSOCOM or TSOC task force.

3.3.1.2. The AFSOC medics are an operational aeromedical support entity for the special operations air component rather than a conventional healthcare support element. As such, the AFSOC medics primarily deploy under the OPCON of the SOTG commander.

3.4. Concept of Medical Oversight. Medical oversight must be maintained during daily operations, joint exercises, preventive medicine programs, and certification training program management. It is imperative to the success of SOF medicine that everyone involved in response and treatment of casualties is trained and proficient to maintain the stated capabilities within this document.

3.4.1. Deployed Medical Oversight. Deployed Medical Oversight ensures appropriate medical care is provided for SOF and complements line-side Commanders. Typically, direct deployed medical oversight is provided by the task force SG. Additional support can come from the TSOC and/or CCMD/SG. AFSOC medical personnel may fall under the professional medical oversight of a conventional medical commander (Expeditionary Medical Support [EMEDS], Field Hospital [FH], etc.) when SOFMEs are deployed with non-SOF medical support units or when SOFMEs are deployed to a location with an established military treatment facility. AFSOC medical personnel will remain under the OPCON/Tactical Control (TACON) of SOTG, task force, or TSOC commanders and will not change OPCON to support non-SOF medical requirements. Furthermore, AFSOC medical personnel will redeploy with AFSOC forces when SOF missions and SOF requirements are completed.

3.4.2. Cooperative Medical Oversight. CMO allows commanders to maintain effective medical coverage while utilizing forces efficiently. Joint training, standardized practices, and policies enhance the interoperability of AFSOC medical forces. Commanders must be aware and informed of the medical capabilities needed and how to employ these support forces effectively and efficiently.

3.4.3. Medical Data Collection. The senior deployed SOFME medical officer has the responsibility to establish a system for the collection of data from all caregivers rendering care to assigned or attached forces. The deployed SOST lead similarly has the responsibility of establishing a system of data collection for all care delivered by SOST members. Medical record keeping will be IAW theater policy. All mission reports will be reviewed, and lessons learned will be reported through SOTG and/or task force report channels to the SOFME's or SOST's command chain (SOSS, Special Operations Group (SOG), etc.) with parallel reporting through the chain of command to

AFSOC/SG via the AFSOC Operations Center. Situation Reports should be accomplished IAW the timelines prescribed by their chain of command or AFSOC/SG.

3.4.4. Relationship with Theater Medical Authorities. The AFSOC medics have a relationship with theater medical authorities. Although the AFSOC medics maintain command relationships through operational chains of command, they adhere to theater medical policies and requirements as established by the CCMD/SG and TSOC/SG.

Chapter 4

EMPLOYMENT OF MEDICAL SUPPORT FOR SOF

4.1. Deployment Concept and Capabilities. The AFSOC medical UTC employment concept is to deploy appropriate UTCs in support of AFSOC/SOF missions. As a part of the AFFORGEN concept, AFSOC medical UTCs are deployed in support of the SOTG model. Additional medical deployment requirements may be aligned against line-side UTCs. Conventional medical and/or aeromedical evacuation (AE) assets may also be integrated with organic medical capabilities of special operations units to enhance the medical and AE support as needed.

4.1.1. Modular Employment Concept. The AFSOC medical UTC employment concept is based on a modular building block approach that allows for the desired capability to be employed at the correct time and place in support of AFSOC missions. AFSOC medical personnel may be collocated with other SOF Joint Task Force (JTF) medical assets to ensure full spectrum health support for deployed AFSOF and/or other assigned/attached forces.

4.1.2. SOF Medical Element – UTC FFQEK. The SOFME is a three-person UTC, AFSOC's primary deployable medical element, and the core AFSOC field medical team. The SOFME normally consists of one flight surgeon and two Special Operations Independent Duty Medical Technicians (SOIDMT) who are awarded the 455 Special Experience Identifier. However, this UTC may be tailored to meet operational mission requirements and may include SOF-trained physician assistants (PAs) or Nurse Practitioners (NPs) in place of an SOIDMT/SOF trained enlisted medic. Internal to the SOFME, the flight surgeon, regardless of rank, is ultimately the medical decision-making authority. In the tactical environment, the ranking team member acts as the tactical team leader for the SOFME.

4.1.2.1. SOFME Capability. SOFME personnel have extensive medical training focused on combat health service support, trauma care, aeromedical decision making, and bare-base preventive medicine support. The key capability that the SOFME provides is deployed aerospace medicine support for AFSOC aircrews and special duty personnel (PJs, Combat Control Team [CCT], SR, and Tactical Air Control Parties [TACP]). The SOFME provides medical ECS and CASEVAC for AFSOF and other SOF. Medical ECS includes but is not limited to: preventive/occupational healthcare, routine healthcare, urgent/emergent point-of-injury trauma care, forward resuscitative/stabilization, aeromedical decision making, aircraft mishap investigation, CASEVAC of injured/ill personnel, Prolonged Casualty Care (PCC), and medical support for core SOCOM activities. Additionally, SOFME personnel utilize all sources of medical intelligence to develop medical threat assessments and advise SOF commanders on how to mitigate potential medical threats. The SOFME is specifically trained and equipped to provide SOF mission support and to establish bare-base operations in austere, forward and/or sensitive locations.

4.1.2.2. When deployed in conjunction with AFSOC equipment UTCs, a SOFME can provide medical support to a deployed AFSOC unit for up to 30 days without resupply. Additionally, the SOFME can provide casualty holding and staging for up to 24 hours and forward CASEVAC support via any appropriate platform of opportunity to include SOF and non-standard vehicles, vessels, and aircraft.

4.1.2.3. SOFME personnel receive extensive training. Please reference the AFSOCI 48-1010, *Aeromedical Special Operations* for a complete list of required and recommended trainings.

4.1.2.4. AFSOC Medical WRM assemblages provide the SOFME with medical supplies and equipment required to support SOF combat operations. All AFSOC WRM assemblages are packed to an allowance standard (AS) that ensures interoperability among AFSOC units and interoperability with sister service SOF units. The SOFME individual medical kit is comprised of a medical packs or small lightweight modules (carried by each SOFME member) and medical supplies to support Advance Trauma Life Support (ATLS) level care for 2-3 severely injured casualties. The SOFME Rapid Response Deployment Kit (RRDK) provides medical equipment and supplies required to support a deployed population at risk (PAR) of 200. The SOFME CASEVAC kit includes equipment/supplies necessary to evacuate injured/ill personnel.

4.1.2.5. The SOFME provides casualty and disease management during SOF operations to stabilize injured or ill patients while moving them to/towards definitive care. If movement by air is immediately available and/or rendered urgent by the tactical situation and/or medical condition of the patient/casualty, stabilization/treatment may occur during CASEVAC.

4.1.2.5.1. RRDK – UTC FFQEM. The RRDK package contains trauma, sick call, preventive medicine, and emergency medical treatment resources for short term tactical deployment of special operations forces to an austere location. The RRDK is composed of four modules: Advanced Resuscitation Module, Trauma Module, Environmental Module, and Medical Module. The Advanced Resuscitation Module is comprised of medical supplies and equipment to support advanced cardiac life support. The Trauma Module provides supplies and equipment for Advanced Trauma Life Support, both at the base level and during CASEVAC missions. The Environmental Module encompasses equipment and supplies utilized for conducting public health threat assessments at a deployed location. The Medical Module is packed with medical equipment and supplies to provide routine (clinical/sick call) patient care.

4.1.2.5.2. CASEVAC Kit – UTC FFQEN. This UTC provides additional equipment for SOFMEs supporting extended bare base operations. The CASEVAC equipment module is designed to provide in-flight casualty treatment, sustainment, and monitoring, as well as the ability to transport and store blood and blood products. The CASEVAC Kit adds a communication suite that enables the SOFME to transmit secure voice/data in support of casualty management and disease non-battle injury (DNBI) tracking. This kit complements the RRDK and supports CASEVAC of two critical patients per mission.

4.1.2.5.3. SOF Air Transportable Treatment Unit (ATTU) – UTC FFQEL. The SOF ATTU is a mobile medical treatment facility for establishing an environmentally controlled shelter that is complete with generators, environmental control unit, and tents. It may be deployed with the SOFME to provide shelter for primary care and emergency medical operations. Additionally, ATTU contains a laptop computer and other administrative supplies for a deployed SOFME. It provides temporary holding and staging shelter for AE. SOFMEs supported with an ATTU can be self-sufficient for short periods but requires BOS for extended duration operations.

4.1.2.5.4. SOF Medical Element Augmentation – UTC FFQE8. SOF Medical Element Augmentation Team: This 4-member team consists of a PA, Bioenvironmental Engineering technician, Public Health technician, and a medical liaison officer. SOF Medical Element Augmentation is designed to augment bare base operations that are serviced by a SOFME. The

package enhances capability to perform food safety, long-term hygiene sustainability, environmental protection surveillance, communicable disease control tasks, medical logistics, and operational planning. Additionally, it provides chemical, biological, radiological, nuclear, and environmental threat detection, limited patient decontamination capability. It is important to note that this element is not staffed or equipped to perform overall base wide decontamination. Close coordination with the deployed base commander must be maintained to prevent any misinterpretation of this specific capability.

4.1.2.5.5. SOF Medical Augmentation Equipment Package – UTC FFQEG. This package provides enough equipment and supplies for limited bare base support for force health protection surveillance and decontamination activities.

4.1.3. Special Operations Surgical Team (SOST) – UTC FFQE3. The six-person SOST is composed of a General Surgeon (45S3), an Emergency Services Physician (44E3A), an Advanced Practice Nurse – Certified Nurse Anesthetist (046Y3M) (substitutable with an Anesthesiologist [45A3]), a critical care nurse (46N3E), a Surgical Services Craftsman (4N171), and a respiratory therapy technician (4H171). The SOST comprises the core of AFSOC's advanced surgical capability. Once on location, the team's equipment and personnel can be tailored to provide immediate on-scene trauma response and far-forward surgical resuscitation utilizing shelters of opportunity or full surgical stabilization from a forward operating base depending on the needs of the mission. The six-member team and accompanying supply and equipment increments (UTCs FFQEF/E/S) can be airlifted in any aircraft. Ground transportation can be accomplished in a single High Mobility Multi-Wheeled Vehicle, field ambulance, or larger sized vehicle. The equipment package to support the SOST is organized such that it can be palletized as personal or professional gear. Majority of supplies and equipment are maintained in man-portable field packs. The team requires shelter and potable water to be operational. Once operational, it can be self-sufficient for 48 hours and then requires normal base operating support.

4.1.3.1. SOST Capability. The SOST is designed to be a lightweight, rapidly deployable far-forward surgical team that can provide advanced emergency medical and surgical care to combat and other casualties within 15 minutes from the time of infiltration to a usable shelter of opportunity. The SOST can provide damage control surgical stabilization and emergency medical care to injured or critically ill patients in any environment and on multiple airframes. SOST can perform up to two surgical cases with four resuscitation cases utilizing the primary equipment package. Sustainment increment packages add a potential capability for 30 additional patients. Laboratory data is restricted to a handheld clinical lab analyzer. Radiographic imaging is limited to chest and portable sonography. Medications are limited to those essential for emergency resuscitative care, resuscitative surgery, and immediate post-operative critical care. SOST members can provide CASEVAC or MEDEVAC care during patient movement. Capability is limited to the primary deployment package unless medical resupply is readily available. As such, SOST capability can be expanded modularly for larger scale operations of longer duration.

4.1.3.2. SOST Equipment. The SOST equipment packages are modular and composed of three complementary assemblages. The first increment can stand alone for initial care but all three are required to provide patients with optimal medical care.

4.1.3.2.1. SOST Surgical Primary Response Equipment – UTC FFQEF. This primary equipment package is contained in portable field packs and holds supplies for up to 10 resuscitative surgeries.

Personnel will deploy with four portable packs.

4.1.3.2.2. SOST Surgical Electric Equipment Augmentation – UTC FFQEE. The second increment is designed to augment the first increment and includes the electronics package and part of the communications package.

4.1.3.2.3. SOST Critical Care Initial Response Equipment – UTC FFQEB. The third increment is critical care initial response. Provides equipment for trauma resuscitation and casualty evacuation.

4.1.4. SOTG HQ Medical – UTC FFQE1. This UTC provides a command medical staff element for deployed AFSOF headquarters command for contingency operations. The two personnel include Health Services Administrator (41A3) and Medical Materiel Craftsman (4A171). Suitable substitutes for the 41A3 can be any trained medical operations personnel, such as a Health Service Management (4A0) or a PA (42G3P). It provides oversight of deployed medical assets, medical programs, and medical force health protection measures. They provide medical input to required briefings and reports and serves as liaison with other medical elements and host nation (HN) medical agencies.

4.1.5. SOF Mission Sustainment Team (MST) Medical. Medical personnel will also deploy as part of the MST. This team provides HSS to the expeditionary MST. These medical assets will be deployed and collocated with the MST. The medical care provided will be focused on acute care of the deployed personnel, site surveys, basic preventative medicine, and small unit and point of injury care. This team is not trained to conduct paramedic skills, CASEVAC, PCC, and Damage Control Resuscitation (DCR).

4.1.6. SOF Medical Augmentation – UTC FFQE9. This UTC provides additional medical support personnel to an operational AFSOC unit or SOTG. Deploys in conjunction with UTCs FFQEK and FFQEM. It can provide primary care and aerospace medicine to a deployed AFSOC unit for durations up to 30 days without resupply.

4.1.7. AFSOC Global Health Engagement (GHE) and International Health Specialists. AFSOC/SG GHE and International Health Specialists supports the overall Air Force and AFSOC Irregular Warfare program. GHE helps shape a theater and provide access employment vectors in support of a TSOC. They can also build partner nation (PN) military and government medical capacities. AFSOC will continue to expand their current medical capabilities and develop new capabilities as needed to allow AFSOC to perform the GHE missions. AFSOC/SG has established three personnel UTCs (FFQE6 and FFQET) specifically for GHE missions.

4.1.7.1. SOF GHE Team – UTC FFQE6. This UTC provides support to the CCDRs' theater security cooperation goals and objectives by building partnership capacity in health and medical services and infrastructure. It is primarily intended to deploy and collocate with US SOF forces. This UTC can be deployed in total or increments to meet operational mission requirements.

4.1.7.2. SOF GHE Augmentation – UTC FFQET. This UTC provides additional medical personnel to execute missions in support of security cooperation and International Health Specialist operations.

4.2. Advantages. A major benefit derived from the development of AFSOC medical modules is incremental deployment flexibility. As a result, medical deployment packages are tailored to the specific task/operation. Medical kits can be deployed in whole or in part, allowing deploying medics to hand carry the initial medical response package on any organic aircraft or to palletize the medical kit with other mobility equipment. Follow-on medical equipment can be transported as airlift availability permits.

4.3. Core Concepts of AFSOC Medicine in the Battlespace.

4.3.1. BOS. Provides foundational medical support for normal day to day operations. These capabilities include, but are not limited to:

- Small Unit Care
- Aeromedical Dispositions
- Preventive Medicine
- Aircraft Mishap Investigations
- Medical Intelligence
- Medical Planning
- Deployment Related Health Assessments

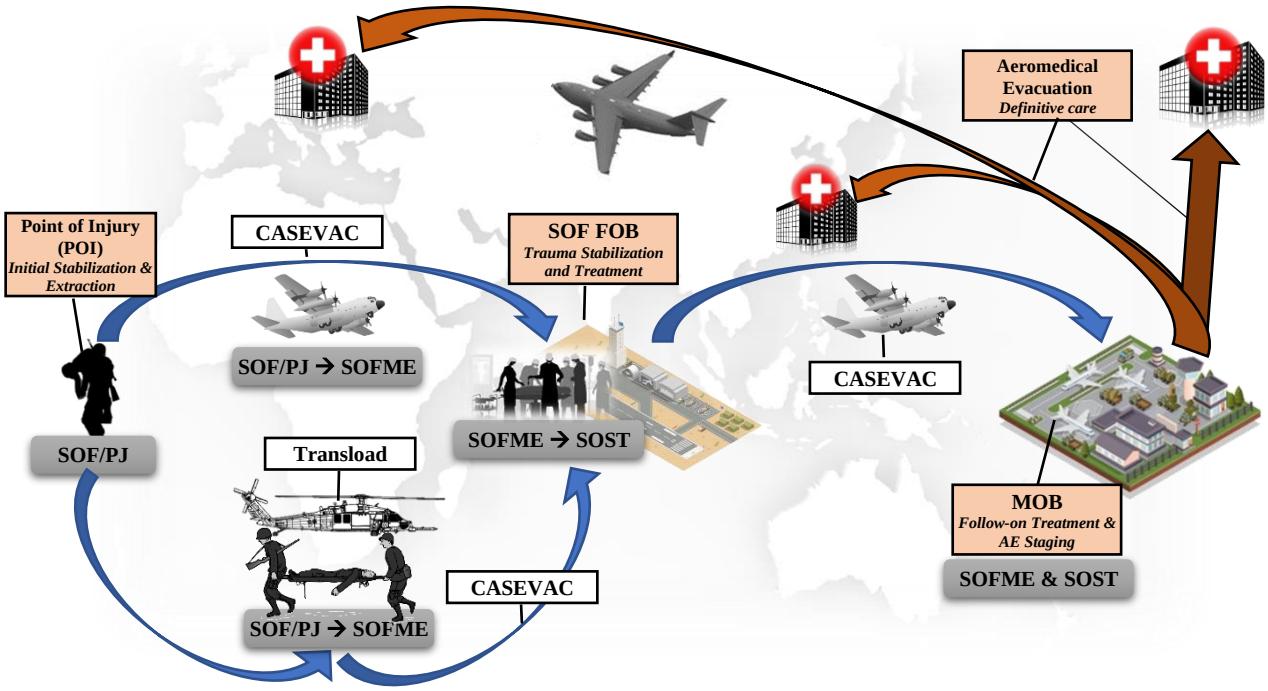
4.3.2. CASEVAC. AFSOC medical personnel, specifically SOFME and SOST, are trained in CASEVAC operations and can move patients that require advanced medical interventions in any platform of opportunity. This can provide the SOTG the capability to move a casualty to a higher echelon of care.

4.3.3. PCC. The SOFME team provides advanced monitoring, sedation/pain management, airway control, ventilator management, nursing care for an extended period (dependent on limitations placed by the mission environment,), and patient packaging. Additionally, the element can provide ongoing resuscitation and critical care management, including but not limited to, blood transfusion, invasive hemodynamic monitoring, and laboratory testing.

4.3.4. DCR/Damage Control Surgery (DCS). SOST can provide DCR/DCS, to include blood product administration, advanced airway placement/management, pharmacological treatment, invasive monitoring, point-of-care ultrasound assessment, and surgery for hemorrhage control. SOST is the only capability that can provide both DCR and DCS. Other AFSOF medical personnel can provide only DCR. Resuscitation capabilities can be performed throughout all phases of care.

4.4. Casualty and Disease Management in SOF Operations. AFSOC deployed capability for management of disease and injury can be characterized by four phases: 1) Point of Injury Care; 2) initial response; 3) stabilization and treatment; and 4) CASEVAC. Phases two through four may overlap and/or occur simultaneously to varying extents, depending on the scenario. The patient movement and casualty management process are outlined in Figure 4.1.

Figure 4.1. SOF Casualty Management



4.4.1. PHASE I – TCCC. TCCC is the foundation of the medical care system. Properly trained and equipped non-medical personnel are able to provide initial lifesaving first aid in the absence of trained medical professionals or assist medical professionals during a mass casualty situation. TCCC is especially critical for AFSOC forces due to the limited number of AFSOC medics. All AFSOC personnel receive TCCC training IAW Department of Defense Instruction (DoDI) 1322.24, *Medical Readiness Training*.

4.4.2. PHASE II – Initial Response. AFSOC ST PJs perform advanced battlefield trauma care and emergency medical treatment while in the performance of special operations missions. ST PJs are specifically trained for combat surface operations either independently or in conjunction with Special Forces, Combat Control, Rangers, and Sea-Air-Land (SEAL) Teams. Although they do not hold a medical Air Force Specialty Code, the medical care rendered by AFSOC Pararescue personnel falls within the professional purview and oversight of AFSOC/SG, through the 24 SOW/SG. Additional AFSOC Pararescue capabilities include:

- Functioning as initial responders in support of far forward personnel recovery operations.
- Conducting casualty collection operations during DA missions or in hostile/denied areas.
- Providing the vital link in the transition process from Personnel Recovery – Combat Search and Rescue (PR – CSAR) field missions to the casualty evacuation system.

4.4.2.1. Transload. Pararescue specialists provide the vital link in the transition from direct actions or PR-CSAR field missions to definitive care platforms. Whenever possible this phase is rapid and short term. When recovery/rescue operations are conducted over large geographical distances, pararescue resources must be returned to action rapidly. If advanced medical transport care is required, transition of patients to a CASEVAC mission may have to be conducted. This transition is defined as a transload and can only be accomplished through concise pre-coordination with medical

and operational planners. Transload operations must be coordinated and exercised to ensure the highest level of patient safety and clinical care. It is important to note that care must be taken to ensure accurate patient information is passed along. The PJ team leader should ensure that all pertinent patient information is passed to any subsequent care provider and to appropriate command and control agencies.

4.4.2.2. Medical Personnel Utilization. In intermediate situations where tactical extraction and initial stabilization are necessary under high threat but less than active combat conditions, PJs in combination with SOFME assets, can be used to provide greater monitoring and treatment capability as well as a high level of medical capability immediately to the casualties. Environments where extended transport time (over two hours) are expected, there is a known disease component along with the trauma, or other complicating medical factors may be part of the injury scenario, SOFME assets should be considered.

4.4.3. PHASE III – Casualty Stabilization and Disease Treatment. Stabilization surgery, performed by the SOST, is aimed at achieving a stable airway, controlling hemorrhage/internal bleeding, and stabilizing orthopedic injuries. Stabilization begins with the first responders and continues as the casualty is transferred to the care of the SOFME and moved towards definitive care. Serious disease requiring evacuation is stabilized and moved in the same fashion. Stabilization can become a prolonged phase lasting over 24 hours if host-nation care is unacceptable and strategic aeromedical evacuation is not immediately available. SOFMEs manage less serious disease amenable to treatment in the forward setting.

4.4.4. PHASE IV – CASEVAC. CASEVAC is defined as the unregulated movement of patients from either the point of injury or a transload site to a point where they enter the regulated patient movement system or definitive medical care system. Special operations security considerations and mission constraints may preclude the establishment of traditional AE and medical regulating systems far forward. AFSOC has organized, trained, and equipped SOFME and SOST assets to meet this requirement. AFSOC medics will provide definitive circulation and airway management (i.e., hemorrhage control, fluid and blood resuscitation, and ventilator management) as well as detailed medical monitoring and administration of medications during transport. Responsibility for the planning and coordination of CASEVAC and AE of SOF rests with the supported commander and task force SG. Conventional AE mission will require patient regulation through the Patient Movement Requirements Center (PMRC) assigned to the operational Area of Responsibility (AOR).

4.4.5. Casualty Movement. SOFME and SOST flight personnel are trained in contingency patient movement procedures and are qualified to provide casualty evacuation support. If the tactical situation permits and with the approval of the senior AFSOC line commander, AFSOC medical flight personnel can provide casualty evacuation support on AFSOC weapon systems or other opportune air, land, and sea modes of travel from secured objective locations to SOF operating bases.

4.4.5.1. Aircraft Familiarization. SOFME and SOST personnel have the capability to configure AFSOC aircraft and other aircraft of opportunity and provide enroute medical stabilization support and intervention until a transition to the established conventional medical and AE systems can be accomplished. Aircraft familiarization should be conducted prior to deployment and upon arrival at a deployed location. The SOFME and SOST should accomplish regular configuration training while deployed.

Chapter 5

PLANNING CONSIDERATIONS

5.1. SOF Operational Environment Medical Planning Considerations.

5.1.1. Comprehensive Medical Planning. The SOF casualty care system begins with pre-deployment activities that include identification of the PAR and the medical requirements and medical intelligence gathering required to support the PAR. The AFSOC medical operations planner, particularly in the SOTG model, translates the requirements into a plan by recognizing mission resource requirements, identifying HN or PN medical facility capabilities, coordinating support with the AE system, coordinating with the Combatant Command Trauma System (CTS), and coordinating with HSS agencies or deployed medical assets.

5.1.2. Medical Intelligence. AFSOC medical planners have access to multiple intelligence resources and gathering methods, to include Public Health resources, Pre-deployment site surveys (PDSS), National Center for Medical Intelligence, Defense Intelligence Agency, and coordination with theater medical planners.

5.1.3. Medical Integration. AFSOC medical forces are not organically equipped to perform extended medical operations or medical logistics support. Situations may mandate the close integration, coordination, and cooperation between AFSOC medical personnel and those within the established operational theater. As mission requirements allow, and with the approval/coordination of the AFSOC line commander, AFSOC medical forces will integrate with other deployed medical resources to maximize the overall base medical readiness posture.

5.2. AFSOC Interface with Medical Contingency Ground Support Systems.

5.2.1. Aerospace Medical Contingency Ground Support System. This system includes the Squadron Medical Elements and IDMTs assigned to operational units or remote sites and represents the cornerstone of medical support to Air Expeditionary Force forces deployed in any worldwide contingency. Any special operations medic assigned or attached unit to a SOTU will coordinate with the lead SOFME or medical operations planner assigned to the SOTG. Medical oversight and coordination are required to ensure efficient use of limited medical assets in theater.

5.2.2. AFSOC Medical and EMEDS Integration. It is imperative that all AFSOC medical personnel and planners understand the capabilities inherent with each component, and specifically the HSS capability available during each phase of the EMEDS buildup. This will typically be the first interface point with medical units possessing enhanced clinical capabilities and inpatient beds. Components of the Aerospace Medical Contingency Ground Support System are utilized to provide essential medical/dental care, deferring definitive care as dictated by theater medical Concept of Operations.

5.2.3. SOF Casualty Management. Once admitted to the medical treatment facility, SOF casualties are not always managed, regulated, or evacuated similar to conventional forces. SOF personnel normally have a separate evacuation policy to prevent personnel with critical specialties from being evacuated out of theater. SOF missions are often politically sensitive, there may be a requirement to safeguard the patient's identity, to prevent any compromise of the unit's presence or

jeopardize the operational mission. If requirements to safeguard patients' identities exist, prior coordination with the JTF/SG should occur to determine appropriate AE procedures.

5.3. Interface with the Aeromedical Evacuation (AE) System.

5.3.1. Movement of SOF Casualties. Evacuation procedures employed are dependent on the special operations mission and the presence of a developed HSS system. The techniques, procedures, and equipment used to evacuate and/or extract casualties are consistent with the nature of SOF missions both principal and collateral.

5.3.2. AE/SOF Planning Considerations. Planning should also address the interface with the AE system for patient movement requirements. AE for SOF may be difficult because of far forward operating location. AE mission requirements should be coordinated through the theater PMRC. It is important to note that patient movement planning is complicated by the nature of special operations missions that require operational security measures precluding immediate patient movement to eliminate the signature of forces in sensitive areas or compromise mission accomplishment. AFTTP 3-42.5, *Aeromedical Evacuation (AE)* may also be used as a reference for planning considerations.

5.3.3. AFSOC AE Planning. AFSOC does not possess organic conventional AE capability and must identify requirements for and obtain conventional AE support. Contingency planning should include the movement of patients from forward or remote areas back to military or HN’s medical treatment facilities that have the capabilities to provide the appropriate level and standard of care.

5.3.3.1. AE/SOF Integration. Integration of SOF and the AE system is very likely. Contingency and crisis action planning match SOF missions to SOF and conventional AE capabilities. SOF missions require a flexible response. Therefore, conventional AE units tasked to support SOF missions may occasionally be required to modify or adjust their operational concepts to meet SOF mission requirements. An AE planner may be an active participant in the planning process. The task force or SOTG HQ medical operations planner will develop and coordinate all patient movement support requirements with AE planners. Conventional AE units need not obtain SOF type equipment. Proficiency in their Mission Essential Tasks List and UTC Mission Capability Statements (MISCAPs) will be the basis for developing roles and missions IAW AFMAN 11-2AEV1, *Aeromedical Evacuation Aircrew Training*.

5.3.3.2. AE/SOF Doctrinal Differences. Doctrinal differences from SOF and AE will be addressed in the planning process. SOF does not organically have patient movement items (PMI) assets and provides limited documentation on casualties. Predetermined PMI may need to be strategically placed at forward locations or brought by AE teams. There may be no medical regulating of patients from forward areas and patients may be moved to pre-designated military treatment facilities (MTFs). SOF medical equipment is limited and may not move with the patient. Little or no medications will accompany patients.

5.4. Mission Planning.

5.4.1. Medical Operations Planner. Mission planning is paramount to the successful execution of exercises, deployments, and operations. Due to the diversity of the geographic areas of responsibility that SOF operate in, each OSM and SOTG has a designated medical operations planner to ensure the needs of the mission are met. The medical operations planner coordinates the

SOF casualty care system, logistics, and operational support with headquarters, joint, and theater planners. PJ team leaders play a vital role in operational planning and can offer guidance to medical operations planner as to care available, transport options, operational environment, and ongoing operations.

5.4.2. Risk Management. Since AFSOC medical assets are limited, task force surgeons and commanders must carefully consider available resources when assigning personnel to CASEVAC roles and other forward contingency taskings. Appropriate risk management processes must be considered when determining the optimal utilization of the AFSOC medical assets. Appropriate tailoring of force size and composition during the pre-deployment planning phases will greatly assist in ensuring availability of the required medical resources to meet operational requirements.

5.4.3. Medical Mission Constraints and Risk Mitigation. AFSOC aircraft configuration and mission profiles limit the extent of medical care which can be provided during flight from an objective area to more definitive care.

5.4.3.1. CASEVAC Mission Support. SOFMEs are specifically trained and may be tasked to support CASEVAC missions, as determined by the designated deployed SOF medical commander and the mission commander.

5.4.3.2. CASEVAC Mission Planning. IDMTs should be considered first when planning to execute a CASEVAC mission. Some missions may dictate utilization of a physician or physician extender in addition to or in lieu of an IDMT. Commanders must evaluate the risk and mission requirements to determine the best team composition to accomplish a tasking.

5.4.4. Non-combatant Assets. Medical personnel and equipment are non-combatant assets. However, AFSOC operational medical personnel train in small unit tactics, weapons use, and all appropriate combat skills for the SOF environment. They deploy armed to defend themselves and their patients according to mission requirements. AFSOC medics should be tactically sound, so as not to degrade the capability of the operation. Overall security for the AFSOC medics and their patients is the responsibility of the forces securing the forward operating location or the supported team. Medical site assets and patients will be protected as a controlled area in accordance with DAFI 31-101, *The Air Force Installation Security Program*. Medical personnel should never be placed in an offensive role.

Chapter 6

MEDICAL LOGISTICS SUPPORT AND WRM

6.1. Medical Logistics Support for Special Operations UTCs and Medical WRM.

6.1.1. Purpose. AFSOC WRM assemblages provide medical supplies and equipment needed to support combat casualty initial treatment, transport, and the prevention of DNBI. All AFSOC WRM assemblages are packed to a standardized AS to ensure interoperability between AFSOC medical personnel. AFSOC logisticians working with line and medical operations planners have the requirement base to plan and predict the acquisition and flow of supplies and maintenance of WRM that special operations medics will require. Their knowledge allows essential strategies to be formulated to ensure adequate equipment and supplies for the deployed SOF medical assets.

6.1.2. Deployment Planning. During initial deployment planning, theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies. For AFSOC units, the deployment load will vary based on mission requirements and operational constraints. To determine medical logistic requirements, medical operations planners must consider the mission and its duration, the availability of supplies at the mission location, and the alternate medical supply sources available in the event the conventional supply system breaks down.

6.1.3. AFSOC Medical Logistics. AFSOC medical forces currently possess limited logistical support capabilities. In many SOF operations, the nature of the operation (clandestine, short-term, etc.) will not allow or require a resupply mechanism to be established. During clandestine operations, adequate medical supplies and equipment are deployed with AFSOC medical units to ensure capability exists to support operational requirements. When resupply is required, SOF medical operations planners establish resupply through a variety of mechanisms to include: (1) support from a host medical treatment facility; (2) in-country Department of State assets; and (3) home station or main operating base. When deployed in support of a major regional conflict, AFSOC medical logistics support is provided by the conventional HSS system. Prior coordination with host medical treatment facility or task force SG will help ensure adequate medical logistics support is available.

6.1.4. Medical Logistics Planning. Medical involvement in all phases of mission planning is essential for mission success. Medical resupply requirements are driven entirely by the planned mission. Consequently, such operations may require coordination to ensure resupply when and if necessary. AFSOC medical logistics should be coordinated by the medical operations planner or medical logistics NCO through task force SG and TSOC. Cost estimates should be provided in the preliminary planning process to ensure reconstitution of all AFSOC WRM assets. Resupply must be addressed in the pre-deployment planning process. AFSOC medical supply costs are funded by the supported unit(s), and reimbursed, when possible, from operations, exercise, or contingency funds.

6.1.4.1. Medical Logistic Objectives. Logistical objectives are to reduce the physical footprint for deployment without degradation of medical capability, reduction of portability, or loss of logistics support to ensure responsive sustainment. In many SOF operations, the short term, clandestine, or low-visibility nature of the operation will not permit the establishment of a standard resupply mechanism.

6.1.4.2. Medical Logistics Planning. When deployed in conjunction with AFSOC equipment UTCs, AFSOC medical assets are normally capable of providing medical support to a deployed AFSOC unit for up to 30 days without resupply. Consequently, such operations may require particularly careful coordination to ensure resupply when and if necessary. SOF medical logistics are normally coordinated through the SOF medical plans officer and the TSOC. This can be provided by the nearest Theater Lead Agent for Medical Materiel (TLAMM).

6.1.5. Reconstitution. All AFSOC medical WRM packages are maintained in a "ready to deploy" configuration. Medical supply and equipment packages returned to the unit following deployment will be reconstituted to meet required response times in Designed Operational Capability statements. UTCs must be maintained to 90% readiness posture for critical items.

6.1.6. Rebuilding. Documentation of medical supplies and equipment used/expended during any training or operational deployment will be maintained by AFSOC medical personnel to assist in the recovery of after-the-fact funding as required. Details and specifics of logistical support will be provided and will be identified in applicable base support plans. Established AFSOC medical assemblage AS will be modified through recommendations of the pilot units, as appropriate. AFSOC medical assemblages are specifically designed for rapid load planning, deployment, employment, and reconstitution.

6.2. Medical Supplies and Equipment Operations.

6.2.1. Initial Deployment. Theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies. The initial deployment load for AFSOC units will vary based on mission requirements and operational constraints. To remain agile, AFSOC medical forces only possess short-term logistical support capabilities. AFSOC medical units have medical stock record accounts at home station but may depend on local base/host medical treatment facilities for various types of medical logistics support, linen control (as applicable), and biomedical equipment repair support.

6.2.2. Re-supply. In many SOF operations, the nature of the operation (clandestine, short-term, etc.), will not allow or require a resupply mechanism to be established. Theater familiarization and robust mission analysis can potentially help mitigate some of the risk to mission that is presented by difficult re-supply. Pre-planning with the TSOC medical logistics team, which can coordinate with the TLAMM, may help establish a defined re-supply while in theater.

6.2.3. Sustainment Operations. When deployed in support of a major regional conflict, AFSOC medical logistics support is provided by the conventional HSS system (reference AFTTP 3-42.711, *Blood Support Operations* and AFMAN 41-209*, Medical Logistics Support*). Prior coordination with the TSOC/SG or JTF /SG will help ensure adequate medical logistics support is available.

6.2.4. SOF Medical Logistics Supply Chain Essentials. Medical logistics personnel must be familiar with the following supply chain methods and programs to ensure SOF forces maintain adequate supplies for long periods of time: Government Purchase Cards programs, TLAMM, Department of Defense (DoD)Acquisition Code, and AOR funding programs.

6.2.5. TLAMM. In overseas theaters, these organizations have historically included Army medical materiel centers (MMC) that provide comprehensive medical logistics support to both institutional

MTFs and contingency operations. Defense Logistics Agency (DLA) recognized the value of these theater medical logistics organizations leading to their designations as TLAMM. Currently, the Chairman of the Joint Chiefs of Staff, on recommendation of the DLA Director, has approved TLAMM designations for each CCMD as follows:

Table 6.1. TLAMM Designations

Combatant Command	Designated Theater Lead Agent for Medical Materiel (TLAMM)
USEUCOM	US Army Medical Materiel Center – Europe (USAMMC-E)
USAFRICOM	
USCENTCOM	US Army Medical Materiel Center – Southwest Asia (USAMMC-SWA)
USINDOPACOM	18th Medical Group, Kadena AB – (TLAMM-Pacific)
USFK	US Army Medical Materiel Center – Korea (USAMMC-K)
USNORTHCOM	US Army Medical Command
USSOUTHCOM	Air Force Medical Readiness Agency, Medical Logistics Division

Theater Lead Agents support the CCMD and its Service components, as well as DLA, in planning and execution of medical supply chain support and provide a single point of contact for medical logistics support to theater medical forces.

6.2.6. Blood and Blood Products. The Armed Services Blood Program is a DoD level function governed by Department of Defense Instruction (DoDI) 6480.04, *Armed Services Blood Program (ASBP)*. Other key references include AFTTP 3-42.711, *Blood Support Operations*, AFI 44-105, *The Air Force Blood Program*, AFH 44-152, *Armed Services Blood Program – Joint Blood Program Handbook*, and the theater specific blood program guidance are key references for SOF medics in managing and administering blood and blood products in a deployed environment. AFSOC operational medical units will establish local policies and procedures for use, storage, and re-supply of blood and blood products. AFSOC operational medical units will incorporate the use of blood and blood products in their training.

6.3. Integration. Integration of the deployed AFSOC medical assets with other SOF component medical teams, as well with the line special operations units, is necessary to facilitate required ECS and AE support.

6.3.1. ECS Support. ECS requirements may include, but are not limited to, power, messing, water, fuel, billeting, transportation, communication, logistics, security, medical oxygen, and operational funds.

6.3.2. AE Support. Rapid patient evacuation is essential to mission success. The teams are not capable of furnishing medical supplies and equipment to patients during the conventional AE process when not accompanying the patient. Medical involvement in all phases of patient movement mission planning is essential for mission success. Early CASEVAC to definitive care will enhance patient survivability and mission success. Integration with the conventional AE will improve patient survivability.

6.3.2.1. PMI. These items are the jointly designated supplies and equipment necessary to support patient movement within AE. The system exchanges like-kind equipment without degrading

capabilities and provides prompt recycling of PMI. The equipment management process system provides seamless, in-transit visibility of PMI from its initial entry into the AE system to the patient's final destination. While the PMI program is mandated by the Assistant SecDef (Health Affairs), the HAF/SG has oversight responsibility, and Air Mobility Command (AMC)/SG has program management responsibility. MAJCOM and CCDR/SG are executive managers of PMI within their AOR (i.e. AMC/SG, Pacific Air Forces/SG, United States Air Forces in Europe/SG).

6.4. Ground Transportation Consideration. AFSOC medics may require dedicated vehicles. These can function as patient transport vehicles/ambulances, medical response vehicles, and to move medical equipment as needed. The request should be coordinated with the respective logistician.

6.5. Additional support. The medical operations planner/medical logistics NCO interfaces with TSOC and AFSOC staff to plan for and coordinate medical readiness, medical logistics, and mission planning needs of the AFSOC medical assets.

Chapter 7

TRAINING

7.1. Objective. The overall objective of SOF medical training programs is to develop and maintain a high state of mission readiness of AFSOC medical personnel for rapid employment across the spectrum of SOF operational requirements. AFSOC medical personnel interface with conventional, nonconventional, joint, coalition medical forces and conventional patient movement systems as dictated by circumstances and requirement. AFSOC medical personnel must be interoperable with all other SOF medical personnel. AFSOC medics must be trained to perform their roles at night, during low-light or blackout conditions, in environmental extremes, and in combat environments. The overarching goal is for AFSOC mission commanders to have the operational control of the medical assets required to support short notice and/or highly specialized missions and to ensure these personnel have the required training prior to being tasked to support such operations.

7.2. Responsibilities. AFSOC/SG is lead command designee for training course requirements, training tasks, and coordinating the development and publication of SOF medical training standards. AFSOC/Chief Medical Operations is the OPR for clinical and operational medicine issues that impact non-aerospace medicine deployed medical forces while AFSOC/Chief Aerospace Medicine (SGP) is the OPR for all aerospace medicine issues. The SGP represents AFSOC at the Pararescue Medical Oversight Advisory Board to address clinical and operational medicine issues that impact pararescue forces.

7.3. Medical Training Requirements.

7.3.1. Joint Medical Training. Successful joint interoperability is achieved through joint medical training standards. SOF Medic is the current standard and AFSOCI 48-1010, *Aeromedical Special Operations* outlines AFSOC medics compliance with this standard.

7.3.2. Air Force Medical Service Medical Training. AFSOC medical personnel will train and maintain medical readiness skills, clinical currency, medical licensure, and specialty credentials IAW AFSOCI 48-1010, *Aeromedical Special Operations*.

7.3.3. AFSOC Medical Training. All AFSOC medical personnel will meet all training requirements outlined in AFSOCI 48-1010, *Aeromedical Special Operations*. Medical units will track and report training status in accordance with AFI 41-106, *Air Force Medical Readiness Program*, AFI 10-201, *Force Readiness Reporting*, and other AFSOC guidance.

7.3.4. UTC-specific Training. AFSOC medical personnel assigned to deployable UTCs may have additional training requirements in order to provide all capabilities as per MISCAPs as well as to ensure complete familiarity with UTC equipment and supplies. These additional training requirements are outlined in AFSOCI 48-1010, *Aeromedical Special Operations*. Medical units will track and report training status in accordance with AFI 41-106, *Air Force Medical Readiness Program*, AFI 10-201, *Force Readiness Reporting*, and other AFSOC guidance. Metric requirements for tracking specific training line items will be provided by AFSOC/SG.

7.3.5. Operational Training. AFSOC medical personnel are expected to operate effectively across a variety of austere, far-forward scenarios as well as in the airborne environment on AFSOC and other opportune aircraft in garrison, while airborne, and in areas of elevated threat, regularly without

the benefit of mature echelons of care. Operational training requirements include advanced tactical practitioner skills, unregulated casualty evacuation, operational medical planning, and prolonged casualty care. The requirements for training include advanced survival training, advanced weapons training, night operations training, small unit tactics, aircraft emergency procedures, egress training, and use of aircraft emergency equipment. Additionally, AFSOC medical personnel must be trained to meet USSOCOM interoperability requirements standards when required for AFSOC missions. Finally, AFSOC medical personnel are expected to sustain comprehensive medical readiness for rapid deployment with assigned AFSOC task groups and task units.

7.4. Credentials. AFSOC medical personnel must fulfill all medical credentialing requirements IAW USAF and home station medical group credentialing requirements.

7.5. Recruitment. Recruitment of AFSOC medical personnel must take into consideration the nature of the SOF mission. Candidates must be highly motivated; have a proclivity for the mental and physical challenges associated with AFSOC operational medic duties; willingly accept a high operations tempo that has the potential to interfere with personal interests (e.g., family life); be prepared to tolerate environmental extremes and substandard living conditions; accept a level of physical risk greater than that faced by conventional medical forces; function effectively despite circadian disruption; possess the interpersonal skills needed to integrate with SOF. Candidates must also be able to meet rigorous training requirements as delineated in this chapter and AFSOCI 48-1010, *Aeromedical Special Operations*.

Chapter 8

COMMUNICATIONS

8.1. Medical Communications. AFSOC medical personnel must be able to communicate with other medics via secure intra-team radios, with other tactical SOF elements via secure line-of-sight communications, and with the SOTG, TSOC, and AFSOC headquarters via secure beyond-line-of-sight communication as well as via secure and non-secure internet access. AFSOC medical personnel should coordinate deployed communications requirements with SOG communications planners. AFSOC medics cannot rely on conventional FOB support for its communications needs and must be prepared to deploy with communications capability.

8.2. Line-of-sight communications. In general, AFSOC medics use the aircraft radios and/or the supported team's radios. However, they may require line-of-sight radios if working independently or with a small team. During CASEVAC missions AFSOC medical personnel must have the capability to communicate with the CASEVAC aircrew from aid stations or medical facilities that are not necessarily adjacent to the runway during CASEVAC missions.

8.3. Over-the-horizon communications. Normally, the SOFME uses aircraft or the supported team's satellite communications (SATCOM). However, the SOFME may require organic SATCOM radios, secure satellite phones, or secure capable cellular phones in special situations, such as when working independently or with a small team. Standard operating procedure is to maintain connectivity with higher headquarters.

8.4. Internet access. To maintain planning capacity, the AFSOC medics must have ready access to Secret Internet Protocol Router Network and Non-secure Internet Protocol Router Network as available for email and portal access. Medical operations planners should be able to access Top-Secret platforms to accomplish mission analysis and planning.

Chapter 9

OPERATIONAL RISK MANAGEMENT

9.1. ORM Utilization. AFSOC medical personnel will utilize operational risk management when planning and executing training. They will also use ORM for real world operations wherever they may be in the world to ensure the safety of AFSOC personnel and equipment. AFSOC medics will provide clinical operations, quick medical focused reaction forces, advanced trauma life support, damage-control surgery, peri-operative resuscitation and CASEVAC aboard SOF aircraft or other opportune air, land, or sea platforms. AFSOC medical personnel will be able to plan actions using risk mitigation to operate in semi and non-permissive threat environments, forward of established healthcare systems, to include outside the wire with BOS and security provided by the supported force. All AFSOC operational medics will complete ORM training. Every medical event or exercise planner will complete an ORM brief and include risks specific to medical training and operations. This will include submission of AF Form 4437 "Deliberate Risk Assessment Worksheet" or DD Form 2977 "Deliberate Risk Assessment Worksheet" for Joint operations. The ORM will be assumed by the senior G-Series Commander. The commander can seek advice from the senior medical officer at the unit, Group, Wing, or AFSOC/SG Risk Management Advisor if any concerns arise.

9.2. Risk Mitigation. No pharmacologically active (expired or unexpired) medications are authorized to be present in training equipment kits when live human role players are serving as simulated patients as part of a training event. Prior to the beginning of the training event all assemblages, bags and kits will be inspected by a minimum of two individuals to ensure no pharmacologically active medications can accidentally be introduced. Training vials that are free of any active medication and safe for injection can be used. These vials must consist of normal saline only and be clearly labeled to identify them for "training use only."

9.2.1. Medication Management. No pharmacologically active (expired or unexpired) or simulated medications will be injected through intravenous catheters or otherwise administered to live human role players serving as simulated patients as part of a training event. Injection of saline is only allowed when all other means of simulation have been exhausted or directly stated in specific Terminal and/or Enabling Learning Objectives (e.g. IV administration, flow/drip rate calculations). In this instance an intravenous line can be established and flushed with saline on a human role player. The role player must consent utilizing the AFSOC approved Volunteer Patient Consent Form for Medical Exercises to the procedure and consent must documented appropriately. Once the intravenous line has been successfully established, it will be discontinued or saline locked appropriately.

9.2.2. Real World Medical Care Distinction. Primary medical support will be clearly identified for real world medical assistance and will not participate in the training event. Primary medical support members are allowed to integrate with their respective teams operationally and tactically. Their medical equipment will be clearly marked and not utilized for training. The medical response plan will be briefed and rehearsed before training events.

9.3. Operational Risk Mitigation Training. Every AFSOC operational medic will complete ORM computer-based training within 60 days after reporting to first permanent duty station or assignment (120 days of initial duty station or assignment for AFR and ANG personnel).

9.3.1. Risk Mitigation Training. Risk mitigation training will be completed through approved Air Force computer-based training courses, standalone computer-based training courseware media, or equivalent courseware. For mass briefings, presentations will be coordinated through MAJCOM RM process managers and the AF RM process manager.

9.3.2. Risk Mitigation Process Updates. Individuals will periodically receive RM refresher briefings and presentations as directed by MAJCOM, wing or unit-level commanders.

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Command Surgeon

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AE – Aeromedical Evacuation
AFFORGEN – Air Force Force Generation
AFRC – Air Force Reserve Command
AFSOC – Air Force Special Operations Command
AFSOF – Air Force Special Operations Forces
AFTTP – Air Force Tactics, Techniques, and Procedures
AMC – Air Mobility Command
ANG – Air National Guard
AOR – Area of Responsibility
ARC – Air Reserve Components
AS – Allowance Standard
ATLS – Advanced Trauma Life Support
ATTU – Air Transportable Treatment Unit
BOS – Base Operating Support
C2 – Command and Control

CASEVAC – Casualty Evacuation
CCDR – Combatant Commander
CCMD – Combatant Commander
CL – Contingency Location
CSAR – Combat Search and Rescue
DA – Direct Action
DCR – Damage Control Resuscitation
DCS – Damage Control Surgery
DLA – Defense Logistics Agency
DNBI – Disease Non-Battlefield Injury
DOD – Department of Defense
DODI – Department of Defense Instruction
ECS – Expeditionary Combat Support
EMEDS – Expeditionary Medical Support
FOB – Forward Operating Base
FOS – Forward Operating Site
HN – Host Nation
HSS – Health Service Support
IAW – In Accordance With
SOIDMT – Special Operations Independent Duty Medical Technician
JSOC – Joint Special Operations Command
JSOTF – Joint Special Operations Task Force
JTF – Joint Task Force
MAJCOM – Major Command
MISCAP – Mission Capability Statement
MMC – Medical Material Centers
MTF – Medical Treatment Facility
NCO – Noncommissioned Officer
OPCON – Operational Control
OPR – Office of Primary Responsibility
OSM – Operations Support Medical
PA – Physician Assistant
PAR – Population at Risk
PJ – Pararescue Specialist
PMI – Patient Movement Items
PMRC – Patient Movement Requirement Center
PN – Partner Nations
PR – Personnel Recovery
RRDK – Rapid Response Deployment Kit
SATCOM – Satellite Communications
SEAL – Sea-Air-Land
SecDef – Secretary of Defense
SG – Surgeon General
SGP – Chief Aerospace Medicine
SOF – Special Operations Forces
SOFME – Special Operations Forces Medical Element
SOG – Special Operations Group
SOJTF – Special Operations Joint Task Force

SOMDG – Special Operations Medical Group
SOSS – Special Operations Support Squadron
SOST – Special Operations Surgical Team
SOW– Special Operations Wing
SR – Special Reconnaissance
TCCC – Tactical Combat Casualty Care
TLAMM – Theater Lead Agent for Medical Material
TSOC/SG – Theater Special Operations/Command Surgeon
TSOC – Theater Special Operations Command
TTP – Tactics, Techniques, and Procedures
USAMMC – United States Army Medical Materiel Center
USAF – United States Air Force
USEUCOM – United States European Command
USNORTHCOM – United States Northern Command
USFK – United States Forces Korea
USSOCOM – United States Special Operations Command
USSOUTHCOM – Untied States Southern Command
UTC – Unit Type Code
WRM – War Reserve Materiel

Terms

Aeromedical Evacuation (AE) – The movement of patients under medical supervision to and between medical treatment facilities by air transportation. (Source: JP 4-02)

Casualty Evacuation (CASEVAC) – The unregulated movement of casualties that can include movement both to and between medical treatment facilities (Source: JP 4-02). Movement of patients using any vehicle of opportunity (to include fixed wing assets) from either the point of injury and/or a transload site to a higher level of medical care or a regulated patient movement system.

Damage Control Surgery (DCS) – Surgery that is required to save life or limb and to stabilize a patient for transport.

Medical Evacuation– The timely, efficient movement and en route care by medical personnel of the wounded, injured, or ill persons from the battlefield and/or other locations to and between MTFs. MEDEVAC is conducted with dedicated ground and air ambulances, properly marked and employed in accordance with the Geneva Conventions and the law of war. MEDEVAC involves the movement of both unregulated and regulated patients. (Source: JP 4-02)

Patient Movement Items (PMI) – The medical equipment and supplies required to support patients during aeromedical evacuation, which is part of a standardized list of approved safe-to-fly equipment. (Source: JP 4-02)

Pararescue Team – Specially trained personnel qualified to penetrate to the site of an incident by air, land or sea, render medical aid, accomplish survival methods and rescue survivors.

Special Operations Forces (SOF) – Those Active and Reserve Component forces of the Services designated by the SecDef and specifically organized, trained, and equipped to conduct and support special operations. (Source: JP 3-05)

Stabilized Patient – A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (Source: JP 4-02)

Transload – Transfer of casualties from one form of conveyance to another. Examples would be using an MC-130 or SF ground vehicle to CV-22, to facilitate casualty evacuation from forward areas. A transload also implies that casualty care is transferred from one team to another. This function can be performed across the spectrum of permissive, denied or hostile environments.