This manual implements Department of the Air Force Policy Directive (DAFPD) 11-2, *Aircrew Operations*, and supports Air Force Instruction (AFI) 11-200, *Aircrew Training, Standardization/Evaluation*, and *General Operations Structure*, and Air Force Manual (AFMAN) 11-202V3, *General Flight Rules*, by establishing specific guidance for Aeromedical Evacuation. This is a specialized publication intended for use by Airmen who have graduated from technical training related to this publication. This manual applies to all commanders, operations supervisors, and aircrew assigned or attached to all flying activities of commands of Aeromedical Evacuation. This manual applies to all civilian and uniformed members in the Regular Air Force (RegAF), Air Force Reserve (AFR), and Air National Guard (ANG). It does not apply to the United States Space Force. This manual requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Title 5 United States Code Section 552a and Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons*. The applicable System of Records Notice F011 AF XO, Aviation Resource Management System (ARMS), is available at https://dpcld.defense.gov/privacy/SORNS.aspx. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Instruction (AFI) 33-322, Records Management and Information Governance Program, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). Refer recommended changes and questions about this publication to the office of primary responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. This publication may be supplemented at any level, but all supplements
must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance statement. See DAFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestor’s commander for non-tiered compliance items. 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. Compliance with attachment 2 in this publication is mandatory.

SUMMARY OF CHANGES

This document has been substantially revised and needs to be completely reviewed. Major changes include incorporation of multiple Flight Crew Information Files (FCIFs). Several chapters have been removed and placed in the AFMAN 11-202V3 and applicable supplements. Air refueling guidance is located in AFI 11-202V3_AMCSUP, General Flight Rules.

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Chapter 1

GENERAL INFORMATION

1.1. Overview. This AFMAN provides guidance for aeromedical evacuation operations. It is an original source document for many areas but, for efficacy, restates information found in aircraft flight manuals, flight information publications (FLIP), and other Air Force directives. When guidance in this AFMAN conflicts with another Departmental Level or HHQ publication, guidance in the Departmental Level or HHQ publication takes precedence. For matters where this AFMAN is the source document, waiver authority is paragraph 1.10 This AFMAN provides guidance for aeromedical evacuation operations. This AFMAN complements but does not supersede or take precedence over other documents such as AFMAN 11-2AEV3, Addenda A, Aeromedical Evacuation Configuration and Mission Planning, AFI 11-2AEV3 Checklist List (CL)-1, Aeromedical Evacuation (AEC) Checklist. It is recommended that a review of external references be conducted prior to its use to ensure the specific reference is current and unchanged.

1.2. The AE Mission. To provide time-sensitive en route care of casualties to medical treatment facilities, using organic or contracted aircraft with medical aircrew trained explicitly for this mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full range of military operations, and in all operating environments.

1.3. Aircraft. The primary USAF aircraft supporting intratheater AE are the C-130 Hercules, C-17 Globemaster, KC-135 Stratotanker, C-21 and the KC-46 Pegasus. Theater commanders have operational control of theater-assigned or attached aircraft through the Airlift Operations Center (AOC), who allocates those airframes as required to meet operational mission requirements. Primary intertheater aircraft are KC-135 Stratotanker, C-17 Globemaster and the KC-46 Pegasus.

1.4. Command and Control (C2) and Patient Requirement. Opportune airlift is preferred to launching a special airlift aircraft. Theater specific aircraft can be used when available and if suitable to meet patient requirements. The C2 agency should direct the move. Use of opportune airlift is considered an unscheduled AE mission and managed in the same manner as any other AE mission, to include the change of the mission number when patient(s) are onboard. Aeromedical evacuation crewmembers (AECMs) on these missions must be universally qualified and conduct quick response training in accordance with AFMAN 11-2AEV1, Aeromedical Evacuation Aircrew Training. (T-1).

1.5. Patient Preparation. Patients are prepared for AE in accordance with AFI 48-307V1, En Route Care and Aeromedical Evacuation Medical Operations.

1.5.1. In the event the Medical Crew Director (MCD) has determined a patient is not stable, is at significant risk of medically deteriorating during flight, or requires care beyond the scope of the AE crew, the MCD will contact the Major Command (MAJCOM) sponsored AOC to coordinate with the Patient Movement Requirement Center (PMRC) before refusing the patient. (T-3). Note: In determining whether to refuse flight, the MCD shall weigh the risks of transporting the patient against the risks of refusing flight. (T-3).
1.5.2. Coordination with the PMRC should occur when determining the risk for the patient in flight versus remaining in place; consideration must be given to the medical capability of the sending facility, the receiving AE crew, and the current operational situation. (T-3).

1.6. **C2 Contact Information.** The tasking C2 agency [PMRC, 618 Air Operations Center (AOC) Tanker Airlift Control Center (TACC), etc.] should determine the size and composition of the patient load on AE missions in accordance with this manual, AFMAN 11-2AEV3 Addenda A, and AFPAM 10-1403, *Air Mobility Planning Factors*. **Note:** See Table 1.1 for C2 contact information.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>618 TACC</td>
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<td>618 TACC AE Cell</td>
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<tr>
<td>603d Aeromedical Evacuation Control Team (AECT)</td>
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<td>USPACOM 613 AECT</td>
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<td>USCENTCOM 609 AECT</td>
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1.7. **Peacetime Preparation.** AECMs prepare for the AE mission during peacetime by:

1.7.1. Organizing, training, and equipping assigned personnel.
1.7.2. Exercising and evaluating contingency AE capabilities.
1.7.3. Identifying medical and support equipment necessary to meet mission requirements.

1.8. **Aircraft Availability for AE missions Are Supported By.**

1.8.1. Primary aircraft (scheduled or designated channel missions).
1.8.2. In system select (ISS - opportune aircraft).
1.8.3. Patient/cargo mix missions.
1.8.4. In all cases, use of specific aircraft are based on:

1.8.4.1. Specific clinical requirements.
1.8.4.2. Specific AE equipment needs.
1.8.4.3. Timeliness of patient movement.
1.8.4.4. Airfield constraints.
1.8.4.5. Aircraft availability.
1.8.4.6. Financial constraints.
1.9. **Key Words Explained.**

1.9.1. “Will” and “Shall” indicate a mandatory requirement.

1.9.2. “Should” is used to indicate a preferred, but not mandatory, method of accomplishment.

1.9.3. “May” indicates an acceptable or suggested means of accomplishment.

1.9.4. “Note” indicates operating procedures, techniques, etc., that are considered essential to emphasize.

1.9.5. “CAUTION” indicates operating procedures, techniques, etc., which could result in damage to equipment if not carefully followed.

1.9.6. “WARNING” indicates operating procedures, techniques, etc., which could result in personal injury or loss of life if not carefully followed.

1.10. **Deviations and Waivers.** Do not deviate from the policies and guidance in this AFMAN under normal circumstances, except for safety and emergency situations, or when a waiver has been granted from the appropriate authority. The Pilot in Command (PIC) is vested with ultimate mission authority and responsible for each course-of-action they choose to take.

1.10.1. Equipment waivers are in accordance with AFMAN 10-2909, *Aeromedical Evacuation Equipment Standards.*

1.10.2. Long-term waivers that affect theater unique circumstances and need to be enduring in nature do not require an expiration date, so long as some other type of feature bounds the waiver, such as the end of a particular operation or every time the theater commander changes. These must be by approved each affected MAJCOM/Air, Space and Information Operations (A3) and a copy sent to AMC Stan/Eval. (T-2).

1.11. **Combined Command Operations.** Plan and conduct all operations that include forces from multiple MAJCOMs using provisions in this manual. MAJCOM A3s planning multiple command operations are responsible for coordinating MAJCOM/theater unique procedures to include SPINS and air operations directive review with supporting MAJCOM A3.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Lead MAJCOM Delegation. AMC is designated as the lead MAJCOM for AE. Operational Control (OPCON) for all non-theater assigned AE forces will be AMC when performing AE missions. (T-1). Total Force coordination ensures standards for system-wide AE crew and AE mission support training requirements, for clinical in-flight care, and for AE crew performance. AE crewmembers serve in the following commands: AMC, United States Air Force Europe (USAFE), Pacific Air Forces (PACAF), Air Force Reserve Command (AFRC) and National Guard Bureau (NGB).

2.2. AMC Directorate of Operations (AMC/A3).

2.2.1. The executive agent for operational AE missions.

2.2.2. Establishes, in coordination with the AMC Surgeon General (AMC/SG), AFRC, NGB and other MAJCOMs, the standards for system-wide organization, equipage and training of the AE force.

2.3. AMC Surgeon General (SG). The AMC SG is responsible for standardization of medical and nursing policies and procedures, clinical training, equipment, patient safety, and quality programs for the evaluation of care provided in the en route care system.

2.4. Execution Authority. Headquarters commanders with command authority over Mobility Air Force (MAF) resources hold execution authority for directed missions. Commanders with execution authority formulate plans, allocate assets, and approve missions through a local command post or C2 element. OG/CCs serve as execution authority for local training missions. The PIC will execute missions operating outside normal communication channels (i.e., use last known mission orders or best course of action). (T-1). C2 of AE missions is the same as for any other airlift missions.

2.5. Command and Control (C2) Centers. C2 centers are action agents for the MAF commander with execution authority (i.e., operational control) over mobility missions and forces. C2 centers shall make this AFMAN available to appropriate personnel. (T-3). The following are C2 centers:

2.5.1. Tanker Airlift Control Center (TACC).

2.5.2. Pacific Air Forces AOC.

2.5.3. United States Air Forces Europe AOC.

2.5.4. Air National Guard (ANG) Readiness Center.

2.5.5. Air Force Reserve Command Command Center.

2.5.6. Air Mobility Division (AMD).

2.5.7. Joint Operational Support Airlift Center (JOSAC).

2.5.8. Office of Assistant Vice Chief of Staff, USAF (CVAM).

2.5.9. Air Mobility Control Centers (AMCC).
2.5.10. Contingency Response Groups (CRG).
2.5.11. USAF Expeditionary Center.
2.5.12. Air Mobility Operations Wing (AMOW).
2.5.13. Air Mobility Operations Group (AMOG).
2.5.14. Contingency Response Elements (CRE), and Special Tactics Teams (STT). C2 centers are action agents for the MAF commander with execution authority (operational control) over mobility forces.


2.7. Unit Commanders. Unit commanders [AE and Military Treatment Facilities (MTF)] shall make this AFMAN available to appropriate personnel. (T-3).

2.8. Pilot in Command (PIC). PICs are:
   2.8.1. In command of all persons aboard the aircraft.
   2.8.2. Vested with authority to accomplish the assigned mission. The PIC shall only fly events authorized in the mission tasking unless, in the PIC’s judgment, an emergency condition demands otherwise. (T-3). PIC may fly unscheduled training events (Example, air-to-air refueling (AAR) or transition training) after obtaining approval of the execution authority.
   2.8.3. The final mission authority and make decisions not assigned to higher authority.
   2.8.4. The final authority for requesting or accepting aircrew or mission waivers.
   2.8.5. Are responsible for passing mission progress reports (at least daily) to C2 agents.
   2.8.6. Are responsible for interaction between aircrew and mission support personnel and establish a point-of-contact (POC) with the appropriate C2 agent prior to entering crew rest. Local C2 agents are responsible for coordinating mission support requirements on the PIC’s behalf.
   2.8.7. Are responsible for the welfare of aircrew, mission essential personnel (MEP), passengers, and the safe accomplishment of the mission.

2.9. Medical Crew Director (MCD). The MCD:
   2.9.1. Is a qualified flight nurse responsible for the overall supervision of patient care and management of aeromedical evacuation crew (AEC) assigned to AE missions. The MCD is expected to use their best judgment to ensure the safe conduct of the flight.
   2.9.2. Advises the PIC on patients’ conditions and the use of medical equipment that may affect aircraft operations.
   2.9.3. Is directly responsible for the safety and medical well-being of patients on the aircraft and coordinates enplaning and deplaning procedures with supporting agencies. In matters of patient management, the decisions of the MCD are final.
2.9.4. Facilitates communication throughout mission execution. During en route critical care (ERCC) missions MCD coordinates Operational Risk Management (ORM)/Crew Resource Management (CRM) process with the ERCC team and incorporates the ERCC team into emergency response procedures. (T-2).

2.9.5. Ensures compliance with the following: All AFMAN and MAJCOM applicable guidance. Mission designed series (MDS)-specific instructions and supplements. Flight Crew Information File (FCIF), Notices to Airmen (NOTAM), AMC/SG NOTAMs and AMC SG Policy Letters, aircraft technical orders, Air Force directives, MAJCOM directives. (See paragraph 6.8.1 for related publications).

2.9.6. Ensures all records created as a result of processes prescribed in this publication are maintained in accordance with AFI 33-322 and disposed of in accordance with the Air Force Records Disposition Schedule located in the Air Force Records Information Management System.

2.10. Charge Medical Technician (CMT). The CMT is a qualified Aeromedical Evacuation Technician (AET) responsible for the supervision and management of AETs assigned to perform duties on the mission. The CMT ensures that medical supplies and equipment are on the aircraft and installed equipment is operational.

2.11. En Route Critical Care (ERCC) Team. The ERCC team (i.e., Critical Care Air Transport Team; Burn Team; Neonatal Intensive Care Team) represent a specialty or critical care team that can supplement an AE crew in order to offer a higher level of care to stabilized patients during AE staging and flight. The ERCC team utilizes basic AE equipment and enhances treatment capability with expanded drugs and ventilation equipment. ERCC teams have no stand-alone electrical, mechanical or oxygen equipment.

2.11.1. During mission execution, ERCC teams are organizationally aligned under the AE command structure, and are a supporting element of the staging facility or any AE element. The ERCC physician is the clinical authority during missions.

2.11.2. The ERCC is responsible for documenting and providing care; they may be called upon to consult and assist in the care of other patients.

2.11.3. When in-flight, the ERCC works with and receives mission operational direction from the MCD. The mission operational management authority and responsibility remains with MCD.
Chapter 3

AIRCREW COMPLEMENT AND MANAGEMENT

3.1. General. This chapter provides guiding principles to manage AE aircrews. Commanders at all levels will follow this guidance to form aircrews and to develop aircrew related work/rest schedules that optimize efficiency of AE forces engaged in worldwide operations. (T-3).

3.2. Aircrew Complement. SQ/CCs shall form aircrews based on fragmentation order and mission directive, crew duty time (CDT) and flight duty period (FDP) requirements, aircrew qualifications, and other constraints to safely accomplish the mission tasking. (T-3). Note: For deployment tasking’s augmented aircrew must be current, qualified and mission ready in accordance with AFMAN 11-2AEV1. (T-2). In those situations requiring augmentation, the crew will be augmented from the start of the duty period. (T-3). If augmentees join the mission en route, the crew’s FDP is computed based on the FDP of the most limited person. For deployment unit type code taskings and Aeromedical Readiness Missions (ARMs) a flight crew consists of two Flights Nurses (X46F) and three Aeromedical Evacuation Technicians (X4N0). Note: Reference AFMAN 11-2AEV1 for exception to ARM policy. For operational missions the Chief Nurse Executive (CNE) will determine number of AECMs and crew compliment required to support the mission based on patient acuity, patient load, and en route care requirements. (T-3).

3.2.1. Augmented Crew. SQ/CC or designee will augment an aircrew in accordance with mission aircraft FDP requirements. (T-3). The mission profile allows augmenting aircrew adequate time to rest en route. Additional litter spaces should be reserved for augmented crewmembers rest purposes unless mission load does not allow litter space for crew rest and would result in removal of patients from mission. Maximum FDP for an augmented aircrew is based on the mission aircraft FDP requirements.

3.2.2. Supplemented Crew (N/A for C-21). CNE or designee may reduce or increase the crew complement based on the AECM Risk Management (RM) Worksheet and will notify controlling C2 agency if changes to crew complement are required. (T-3). Basic or augmented crews may be supplemented. Number of AECMs and AFSC may vary, for example, an additional Flight Nurse (FN) and AET may be added for large patient loads or 2 additional AECMs may be added to assist with increased medication administration requirements. Note: AFTO Form 781, ARMS Aircrew/Mission Flight Data Document Documentation Procedures. When AE crews are supplemented for patient acuity; primary crew and those added to supplement for patient acuity will log primary time. (T-2). Reference AFI 11-401 for further guidance.

3.3. Aircrew Member Qualification. Aeromedical Evacuation Crewmember. An individual who meets all of the following:

3.3.1. An aircrew member will be current and qualified aircrew member or in qualification training to perform duties as a primary aircrew member. (T-2).

3.3.2. Is a non-rated aircrew member as explained in AFPD 11-4, Aviation Service, and AFI 65-503, US Air Force Cost and Planning Factors, specifically trained to operate safely during ground and flight operations of the aircraft and is proficient with onboard emergency procedures and operation of emergency equipment. Individuals must be on aeronautical
orders and perform their principal duties in-flight. (T-2). Duties must be essential to performing patient care and operating associated equipment used for completing a mission. (T-2).

3.3.3. Required for the mission as described in AFI 11-401.

3.3.4. Designated on the flight authorization to fulfill specific aeronautical tasks.

3.4. Aircrew Management.

3.4.1. SQ/CCs and en route C2 agents shall ensure work/rest cycles are adequate to permit an aircrew time to safely accomplish mission duties and personal time for rest. (T-3). Reference AFMAN 11-202V3, for further guidance.

3.4.2. When extended en route ground times, non-optimum routing and winds, weather delays or other extenuating circumstances will increase a basic to an augmented FDP, the MCD with an augmented crew may accept an augmented FDP as long as the C2 agent or PIC discovers the extenuating circumstances before the first takeoff of the day. (T-2). The MCD and PIC verify all augmenting aircrew can get adequate rest en route. Note: AFTO Form 781 Documentation Procedures. When AE crews are augmented for time, only log primary time when accomplishing flight duties. When crewmembers are in rest cycles, log other time. ERCC team members log time as operational support flyers in accordance with AFI 11-401, Aviation Management. Reference AFMAN 11-402, Aviation and Parachutist Service for further guidance on operational support flyers and their respective duties.

3.5. Crew Duty Time (CDT).

3.5.1. CDT is that period of time an aircrew may perform combined ground and flight duties. For AECMs, CDT ends when the patients have been delivered to the receiving medical representative or when aircraft medical equipment has been secured, whichever is later. If the mission RON, the PIC and MCD coordinate alert and take-off time based on the latest crewmember CDT end point. Reference, AFI 11-202V3_AMCSUP, for specific maximum CDT for a basic aircrew.

3.5.2. ANG and AFRC crews may perform mission-related events on local training missions provided their time from start of CDT/FDP does not exceed 16 hours. Note: AFRC and ANG CDT/FDP includes both military and civilian work. It begins when the individual reports for his or her first duty period (military or civilian).

3.6. Crew Rest/En Route Ground Time. OG/CCs shall establish procedures to place aircrew in crew rest. (T-3). For further guidance follow AFI 11-202V3_AMCSUP.

3.6.1. The local C2 agency provides PIC and MCD AE mission information when they check on mission status. The local C2 agency is the link between the AE crews and the PIC, thus permitting mission status updates to both parties without interruption of crew rest.

3.6.2. AE units fax a copy of the AEC’s AF Form 4327A, Crew Flight (FA) Authorization to local C2 agency where the AE mission is staging from, or will RON, and 618 AOC (TACC) (as applicable) NLT 24 hours prior to scheduled mission date. (T-3). This fax copy notifies C2 agencies of mission dates which assists the AE POC (MCD) with billeting arrangements. At a minimum, include the following:

3.6.2.1. Where the AE mission is staging from or RON locations.
3.6.2.2. Identify the MCD.
3.6.2.3. Mission number.
3.6.2.4. Mission date(s).
3.6.2.5. AE Crew and ERCC names/ranks/gender.

3.6.3. The MCD will interface with local C2 agencies for all AE missions. (T-3). The MCD ensures:

3.6.3.1. Orders have been received. (T-3).
3.6.3.2. C2 agencies have MCD’s contact information. (T-3).
3.6.3.3. Any mission irregularities are discussed. This will occur prior to crew rest, at en route mission stops, and at AE mission termination. (T-3).
3.6.3.4. In coordination with MCD, the PIC may modify normal ground time (with concurrence of controlling agency in the interest of safety). (T-3).

3.7. Alerting Procedures.

3.7.1. MAJCOM C2 agents shall establish a legal for alert time with the PIC and when appropriate, the MCD. (T-1). C2 agents will inform PICs and MCD of aircraft status, expected patient up load time, and other pertinent mission details that will streamline mission launch. (T-3).

3.7.2. Crew alerts are per applicable MDS V3. Alert times usually allow 1 hour for reporting and an adequate number of hours for mission preparation. Refer to AFI 11-2MDSV3. Exception: Crew alerts for local training sorties per applicable AFI 11-2MDSV3 and local operating procedures. OG/CCs may establish self-alert procedures for local training missions.


3.9. Interfly. AE crewmembers are exempt from interfly requirements. Conduct AE interoperability operations as follows:

3.9.1. Aircrew shall be current and qualified in the MDS, as well as unique systems or configuration required to fly the mission. (T-3).
3.9.2. Aircrew follow operational procedures established by the lead command. The Mission Commander or PIC will brief MAJCOM-specific items. (T-3).
3.9.3. Each affected group commander who commits resources (personnel or aircraft) must concur with interfly proposal. (T-3).
3.9.4. For further guidance refer to AFI11-2MDSV3, AFMAN11-202V3, and AFI 11-202V3_AMCSUP.


3.10.1. For medical attendants (MA), non-medical attendants (NMA), and ERCC see AFI 48-307 series for guidance.

3.10.2. Guards of Prisoner Patients:
3.10.2.1. Accompany assigned prisoner-patients to their destination facility.

3.10.2.2. Turn in weapons and ammunition to the PIC/Loadmaster (LM)/Boom Operator (BO), as required by appropriate AFI 11-2MDSV3 instructions.

3.10.2.3. Coordinate with the MCD when handcuffs (if applicable) may be removed from the prisoner-patient while the aircraft is airborne.

3.10.2.4. Are prohibited from handcuffing prisoner patients to any portion of the aircraft.

3.10.3. Enemy Prisoners of War (EPW). When EPWs are moved through the AE system, originating medical facilities will arrange for appropriate host support agencies to provide guards for prisoners on AE missions. (T-2). The AE system does not have the capability to provide guards, and prisoners will not be accepted into the AE system without guards. (T-2). Guards assigned to medical prisoners must accompany them to the destination facility. (T-3). AECMs will not accept custody of prisoners. (T-3). The AE system is not responsible for returning guards to the originating location.

3.10.4. Detainee Transport. Providing AE medical support for detainee missions will not normally be practiced unless detainees require in-flight medical care. Refer to 48-307V3 for prisoner-patients care.
Chapter 4

AIRCRAFT MEDICAL EQUIPMENT OPERATIONS

4.1. Objective.

4.1.1. Some medical equipment is incompatible with the airborne environment. See AFMAN 10-2909 and Aeromedical Evacuation Medical Equipment Compendium located on the Aircrew Publications library for further guidance.

4.1.2. The Aeromedical Evacuation Medical Equipment Compendium and respective equipment user’s manual provides general guidance to safely secure and monitor frequently used patient movement inventory and non-patient movement inventory medical equipment and can be located in the electronic flight bag (EFB) under AE folder. Refer to AFMAN 10-2909 for all equipment program requirements and operations.

4.2. Equipment Waiver Process. For all procedures see AFMAN 10-2909.

4.3. Controlled Medications. AMC/Surgeon Generals En Route Medical Care Division (SGK) establishes the authorized controlled medications list indicating types of controlled substances approved for AE missions. Any additions or deletions to this list must be forwarded to the AES pilot unit, and then approved by AMC/SGK. (T-3). Exception: Guidance for C-21 missions and controlled medications can be located in the AE In-Flight Kit, Packaging Guide Allowance standard for small aircraft.

4.3.1. Procedures to requisition, manage, re-supply, and turn in controlled medications will be established at the unit level. (T-3). Guidance from operating instructions for these procedures should align with existing USAF and AMC directives.

4.3.2. A disinterested officer or senior noncommissioned officer appointed by the unit commander will inventory medications monthly in presence of the unit pharmaceutical nurse (T-1).

4.3.3. The administration of any controlled drug to any patient will be annotated on the AF Form 579, Controlled Substances Register by a qualified nurse or medical technician. (T-1).

4.3.4. Guidance on securing medications and the inventory procedures are described in AFI 44-102, Medical Care Management and AFI 31-101, Integrated Defense.
Chapter 5

OPERATIONAL PROCEDURES

5.1. Checklists. A checklist is not complete until all items have been accomplished. Notes amplifying checklist procedures or limitations may be added to the checklists (in pencil or digital marking). Currency of notes is a crewmember’s responsibility.

5.1.1. Checklist Insert Placement. MAJCOM Stan/Evals approve the use of checklist inserts in accordance with AFI 11-215, Flight Manuals Program. For AMC and AMC-gained units, AMC/A3V is the checklist insert approval authority. The inserts should be placed at the end of the appropriate checklist or in an in-flight guide. All checklist inserts must have a POC. OGVs approve local in-flight guides and inserts not affecting technical order (T.O.) guidance and procedures.

5.1.2. Checklist Insert Approval Authority. Only MAJCOM/A3 approved inserts and briefings pertaining to crew positions are kept in the abbreviated flight crew checklist binders. Information in the AECM checklists are typically changed by published revisions or changes.

5.2. Duty Station. AECMs occupying a primary crew position should be at their duty stations during all critical phases of flight (takeoff, air refueling [AR], approach, and landing) unless crew duties dictate otherwise. During other phases of flight, crewmembers may leave their duty station to meet physiological needs and to perform normal crew duties.

5.3. Seat Belts.

5.3.1. All patients and attendants should have a designated seat with a seat belt. When seats are not available the crew will coordinate with the Load Master or Boom Operator for the most appropriate procedures for securing patients. (T-3). Crewmembers should have seat belts fastened when occupying a duty position, unless crew duties dictate otherwise.

5.3.2. All crewmembers will have seat belts fastened during takeoff and landing. (T-3). For tactical and AAR operations, all crewmembers and passengers will have seat belts fastened (unless authorized by the PIC, or crew duties dictate otherwise). (T-3). Crewmembers performing instructor or flight examiner duties are exempt from seat belt requirements if not occupying a primary crew position; however, they will have a seat available with an operable seat belt. (T-3).

5.3.3. All patients, actual or simulated, will remain secured on a litter or seat for takeoff and landing and will be validated by AEC. (T-3). Note: Tethering is an approved securing device.

5.4. Portable Electronic Devices. For guidance see AFMAN 11-202V3.

5.5. Communications Guidance. The Air Force does not give a promise of confidentiality to aircrews regarding their recorded aircraft crew communications. Crewmembers are expected to maintain a high degree of cockpit professionalism and crew coordination at all times.

5.5.1. During critical phases of flight or periods of increased workloads, cockpit conversation will be limited to communications that enhance flight safety or furthers the mission. (T-3). All crewmembers are responsible for enforcing sterile cockpit procedures,
but the PIC remains ultimately responsible for determining and communicating to the crew when sterile cockpit is in effect.  **Note:** Every effort is to be made to accomplish briefings and appropriate checklist items prior to entering critical phases of flight.

5.5.2. Aircraft Interphone. The MCD monitors interphone during critical phases of flight. Crewmembers advise the pilot flying before checking off interphone. Crewmembers ensure personnel on headset, or within listening distance, are cleared prior to discussing classified information over the interphone. (**T-3**).

5.5.3. The MCD or designated AECM should monitor interphone (headset) during flight. The MCD should be on headset with the PIC during in-flight emergencies.  **Exception:** Headset is not required for the C-21.  **Note:** If the PA is inoperative on the KC-10 or the interphone cable is not available during take-off and landing, then the AECM will coordinates with crew to facilitate clear communication. (**T-3**).  **Note:** Units may purchase David Clark® high impedance headset (NSN 5495-01-424-3297) to facilitate communication with the flight crew on the C-17. The aircraft wireless intercommunication system (AWIS) is approved for use on the C-17, C-130, C-5, KC-10, KC-46 and KC-135. See Aeromedical Evacuation Equipment Compendium for further information on AWIS.

5.6. **Crew Resource Management** (CRM)/**Threat and Error Management** (TEM). CRM and TEM will be conducted in accordance with AFI 11-290_AMCSUP, Cockpit/Crew Resource Management Program. (**T-3**).

5.6.1. Threat and Error Management provides strategies and tactics to help crews target threats to safe flight operations and decrease the potential for crew error. External threats are events that occur outside the influence of the flight crew and require crew attention and management to maintain adequate safety margins. Internal threats are crew related and are factors that could lead to an error if not recognized and controlled.

5.6.2. "Time Out" is the common assertive statement for use by all crewmembers. The use of "Time Out" is intended to:

5.6.2.1. Provide a clear warning sign of a deviation or loss of situational awareness.

5.6.2.2. Provide an opportunity to break the error chain before a mishap occurs.

5.6.2.3. Notify all crewmembers that someone sees the aircraft or crew departing from established guidelines, the briefed scenario, or that someone is simply uncomfortable with the developing conditions.

5.6.3. As soon as possible after a "Time Out" has been called, the aircrew should take the following actions:

5.6.3.1. Safety permitting, the flight crew stabilize the aircraft and ensure terrain clearance.

5.6.3.2. The initiating crewmember voice their concerns to the crew.

5.6.3.3. The PIC and MCD will provide all other crewmembers with the opportunity to voice inputs relative to the stated concerns. (**T-3**).

5.6.3.4. After considering all inputs, the PIC and MCD will direct the aircrew to continue the current course of action or direct a new course of action. (**T-3**).  **Note:** The PIC is
the final decision authority. The MCD is final decision authority regarding AE related issues.

5.6.4. CRM Enhancement. PICs will conduct a CRM exercise on the first suitable segment of each mission. (T-3). This will be done at level off on a non-interference basis with other mission requirements. (T-3). Take the exercise to a logical conclusion and ensure crew communications and duties are appropriate. Suggested topics are rapid decompression, oceanic contingency operation, emergency divert or other MAJCOM or locally generated special interest item (SII).

5.7. Patient Path Management (PPM). The term “patient path” denotes any time the patient is in the care of AECMs which includes enplaning and acceptance of patient to deplaning/hand-off of patient. PPM is the planning, execution, and assurance of the patient’s care, in flight or on the ground. All AECMs must ensure that effective PPM is a primary and shared responsibility during all phases of flight. (T-3).

5.7.1. Planning. All AECMs will participate in mission preparation. (T-3). Crew brief is critical. All safety aspects of crew brief as described in the checklist are covered. Patient considerations are discussed as appropriate and when information is available. At a minimum, the CMT briefs emergency procedures, areas asterisked, and emergency oxygen requirements and patient placement and crew responsibilities.

5.7.2. Executing. Mission execution includes AEP responsibilities, automated and manual patient care, critical actions, emergency procedures and AECM monitoring (as described below). All aspects of patient care, beginning with enplaning and ending with deplaning and patient handoff, are evaluated.

5.7.3. Monitoring. The process through which aircrew monitor compliance with the desired (planned) patient path. Effectively monitoring the patient path is a critical Threat and Error Management (TEM) task that discovers and corrects PPM errors that might lead to flight path deviations or undesired aircraft states (UAS). As a primary and shared responsibility, monitoring is equally as important as controlling the aircraft. Monitoring requirements vary depending on phase of flight and on situations encountered within each phase of flight. Aircrews should anticipate flight situations or phases where they will be most vulnerable to patient path deviations (areas of vulnerability) and strategically manage workload and distractions. AECM Monitoring may be the AECM who is not providing direct patient care, yet is primarily responsible to actively monitor the patient’s current/projected patient path. The AECM Monitoring supports the AEP and is additionally responsible for accomplishing non-patient path actions (e.g., radio communications, aircraft systems, off load message, baggage, meal prep) but must never allow this to interfere with his/her primary responsibility. (T-3). Reference AFI 11-202V3_AMCSUP for further CRM/TEM guidance.

5.8. Transportation of Pets. Military working dogs (MWD) and therapy pets may be manifested on AE missions as patients. The animal should be transported in a kennel and accompanied by a trained handler manifested as a medical attendant responsible for providing in-flight care. Note: The animal may be transported and secured on a litter if medically necessary. Ambulatory MWD and therapy pets must be muzzled and secured as directed by the handler or veterinarian. All equipment and supplies will accompany the animal. (T-3).
Chapter 6

AIRCREW PROCEDURES

Section 6A—Pre-Mission

6.1. Aircrew Uniform.

6.1.1. Aircrew will wear and use authorized clothing and equipment as outlined in AFI 36-2903, Dress and Personal Appearance of Air Force Personnel, and appropriate MAJCOM supplement on all missions, unless otherwise authorized. (T-1). When the DoD Foreign Clearance Guide (FCG) requires civilian attire, dress conservatively.

6.1.2. OG/CCs determine clothing and equipment to be worn or carried aboard all flights commensurate with mission, climate, and terrain involved.


6.1.4. Crewmembers will remove rings, earrings, and scarves before performing aircrew duties. (T-3).

6.1.5. Personnel will have the appropriate items of clothing in their possession when flying in Arctic and Antarctic regions. (T-3). Exception: Not applicable to transoceanic flights or when staging or transiting Elmendorf AFB AK.

6.2. Personal Requirements.

6.2.1. Refer to current Unit Deployment Manager guidance for applicable deployment requirements.

6.2.2. Nomex® Gloves. All crewmembers maintain Nomex® gloves in their possession.

6.2.3. Goggles. All crewmembers maintain goggles in their possession. Eye protection will be squadron approved eye protection. (T-3).

6.2.4. Passport. Crewmembers will follow the guidance in AFI 11-202V3_AMCSUP, and DoD FCG. (T-3).

6.2.5. Vaccination Record. Crewmembers have current certificates of immunization (shot record) when required.

6.2.6. Driver’s License. A valid state driver’s license is required on each temporary duty (TDY) where use of US government general purpose vehicles may be required. Crewmembers will contact the local airfield manager before driving on the flight line. (T-3).

6.2.7. Identification Tags. Crewmembers are required to carry two identification tags on all in accordance with AFI 36-3802, Force Support Readiness Programs. (T-2).

6.2.8. Foreign Object Damage Hazards. Crewmembers and Operational Support Fliers must not wear wigs, hairpieces, rings, ornaments, or earrings in the aircraft or on the flight line. (T-3). Exception: Crewmembers may wear plain elastic hair fasteners or pins, clips, or
barrettes providing they do not interfere with the wearing of headsets, or the donning of oxygen equipment. They must be accounted for before and after flight. (T-3).

6.2.9. Flashlights. Each crewmember must carry an operable flashlight. (T-3).

6.2.10. Reflective Belt. Each crewmember must wear a reflective belt on flight lines during hours of darkness or periods of reduced visibility. (T-3).

6.2.11. AF Form 1199, Air Force Entry Control Card. Crewmembers will follow the guidance in AFI 11-202V3_AMC SUP. (T-3).

6.2.12. Individual Training Summary (ITS) and Individual Data Summary (IDS). Each crewmember must carry a current hard or electronic copy of ITS and IDS. (T-3).


6.3. Pre-mission Actions. Refer to AFI 11-202V3_AMCSUP for additional pre-mission actions.

6.3.1. Ensure physiological training, annual physical, immunizations, Emergency Medical Technician certification, Cardio Pulmonary Resuscitation (CPR) certification, Advanced Cardiac Life Support (ACLS) certification, nursing licensure, and flight evaluations remain current for all crewmembers throughout the TDY period.

6.3.2. Passenger Restrictions. Refer to AFI 11-202V3_AMCSUP for additional guidance.

6.4. Aircrew Publications Requirements. Primary crewmembers will carry a current hard copy or digital version of AFI 11-2AEV3, CL-1, Emergency Procedures Checklist, and AMC Approved Checklist Inserts. (T-3). Units may specify additional publications in their local unit supplement. Additional publications may be either hard copy or electronic. (For electronic publications a software reading device must be available on the mission). (T-3).

6.5. Aircrew Intelligence Briefing. Refer to AFI 11-202V3_AMCSUP for additional guidance.

Section 6B—Pre-departure


6.7. Flight Crew Bulletins (FCB). Items in the FCB may include local procedures and policies concerning equipment and personnel generally not found in any other publications.

6.8. Mission Kits. Carry mission kits on all operational and training AE missions. Publications may be maintained and carried electronically provided operable in-flight capability exists. Forms may be maintained and carried electronically provided operable in-flight printing capability exists. AE Mission Kit(s) include as a minimum:

6.8.1. Publications. If the following publications are available via EFB, it is not required to maintain them in the Mission Kit. These publications may be maintained electronically or by hard copy:

6.8.1.1. AFMAN 10-2909, Aeromedical Evacuation (AE) Equipment Standards
6.8.1.2. AFMAN 11-2AEV1, *Aeromedical Evacuation Aircrew Training*

6.8.1.3. AFMAN 11-2AEV2, *Aeromedical Evacuation Aircrew Evaluation Criteria*


6.8.1.6. AFI 11-401, *Aviation Management*

6.8.1.7. AFI 48-307V1, *En Route Care and Aeromedical Evacuation Medical Operations*

6.8.1.8. AFI 48-307V2, *En Route Critical Care*

6.8.1.9. AFI 48-307V3, *En Route Care Documentation*


6.8.1.11. AFI 11-202V3_AMCSUP, *General Flight Rules (as applicable)*

6.8.1.12. Current *Aeromedical Evacuation Medical Equipment Compendium*

6.8.1.13. AMCI 11-208, *Mobility Air Forces Management*


6.8.1.15. Lippincott Manual of Nursing Practice (current edition)

6.8.1.16. Current National ACLS Guidelines, American Red Cross or equivalent guidelines and Military Training Network


6.8.2. Forms. If the following forms are available via EFB, it is not required to maintain them in the mission kit if crews have the ability to print forms:

6.8.2.1. DD Form 600, *Patient Baggage Tag*

6.8.2.2. DD Form 1380, *Tactical Combat Causality Care (TCCC) Card*

6.8.2.3. DD Form 2852, *Patient Movement Event/Near Miss Reporting*

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

6.8.2.5. AF Form 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*

6.8.2.6. AF Form 3841, *Certificate of Release*

6.8.2.7. AF Form 3851, *Patient Baggage Data*

6.8.2.8. AF Form 4449, *En Route Care Equipment Malfunction Report Tag*

6.8.2.9. AF Form 3854, *Receipt for Patient’s Valuables*

6.8.2.10. AFTO Form 350, *Reparable Item Processing Tag*

6.8.2.11. AF Form 3858, *Aeromedical Evacuation Mission Offload Message*
6.8.2.12. AF Form 3859, *Turn-In of Unaccompanied Narcotics*
6.8.2.13. AF Form 3899, *Aeromedical Evacuation Patient Record*
6.8.2.14. AF Form 3899A, *Patient Movement Record Progress Note*
6.8.2.15. AF Form 3899B, *Patient Movement Physician Orders*
6.8.2.16. AF Form 3899C, *Patient Movement Physical Assessment*
6.8.2.17. AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*
6.8.2.18. AF Form 3899E, *Patient Movement Intake/Output*
6.8.2.19. AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*
6.8.2.20. AF Form 3899G, *Patient Movement Restraint Observation Flowsheet*
6.8.2.21. AF Form 3899H, *Patient Movement Neurological Assessment*
6.8.2.22. AF Form 3899I, *Patient Movement Medication Record*
6.8.2.23. AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*
6.8.2.24. AF Form 3899K, *Patient Movement/In-Flight Resuscitation Flowsheet*
6.8.2.25. AF Form 3899L, *En Route Critical Care*
6.8.2.26. AF Form 3899M, *Patient Movement Record PCA/PNB/Epidural Hand-Off*
6.8.2.27. AF Form 3899N, *Patient Movement Pain Adjunction Flowsheet*
6.8.2.28. 1-SBAR, *Patient Movement Inpatient Handoff Report Worksheet*
6.8.2.29. Patient Positioning Plans for All AE Aircraft

6.9. Briefing Requirements.

6.9.1. AE Pre-Departure Briefing. The MCD shall brief the PIC in regards to the AE mission utilizing appropriate checklist. (T-3).

6.9.2. Pilot in Command Pre-Departure Briefing. PIC briefs all crewmembers on the details of the mission. Cover all applicable items of the operations briefing, including MAJCOM, Numbered Air Force (NAF), unit special interest items (SIIs), CRM, and ORM levels and mitigating factors. Use a MAJCOM approved briefing guide.

6.9.3. Cover applicable medical inflight emergency divert locations, off-load support requirements and contact information for phone patch to controlling command and control agent.

6.9.4. Training/Evaluation Briefing. Before all training/evaluation missions, instructors and flight examiners brief the crew on requirements and objectives for each student or examinee.

6.9.5. Intelligence Briefings. Before operating in a combat environment, the crew obtain a current intelligence briefing.

6.10. Risk Management (RM).

6.10.1. RM is a logic based, common sense approach to making calculated decisions on human, material, and environmental factors before, during, and after all operations. USAF policy on RM is contained in AFPD 90-8, *Environment, Safety, and Occupational Health Management and Risk Management*. MCDs will accomplish RM worksheets in accordance with MAJCOM and local guidance as part of preflight activities. (T-1).

6.10.2. Flying units will develop a local RM program to include personal RM assessment for all missions and accomplished by all crewmembers prior to each flight. (T-2).

Section 6C—Preflight

6.11. AFTO Forms 781A. AFTO Form 781A, *Maintenance Discrepancy and Work Document* is used to report unserviceable or missing aircraft emergency equipment items. This form is usually maintained by the LM/BO/Flight Engineer (FE). All aircraft discrepancies observed by AECMs are to be reported for inclusion on the AFTO Form 781A. (T-1).


6.14.1. The CMT coordinates with the LM/BO to determine that sufficient AFE is onboard prior to departure. The CMT ensures all AFE equipment is distributed and immediately available to all patients before mission departure. The LM/BO is responsible for noting unserviceable or missing AFE equipment on the AFTO Form 46, *Prepositioned Aircrew Flight Equipment*. For C-21, the PIC is responsible for checking AFE.

6.14.2. On missions carrying patients, distribute Emergency Passenger Oxygen System (EPOS) to each patient regardless of planned flight altitude. Ensure EPOS are readily available for litter patients. Distribute and demonstrate use of EPOS prior to departure.

6.14.3. Demonstration of onboard aircrew flight equipment is required for all missions carrying patients. May completed by AE crew/LM/BO. Ensure a demonstration kit is onboard prior to departure. (T-3).

6.14.3.1. Demonstration of the EPOS includes emphasizing proper hand placement during activation.

6.14.3.2. During activation, grasp the body (large rounded end) of the cylinder. Failure to do so restricts the metal tab from opening and activating the oxygen system. The EPOS does not function without the removal of the metal tab.

6.14.3.3. If the red knob separates, grasp the lanyard to pull the metal tab off the cylinder and then proceed to use the EPOS as directed. **WARNING:** Failure to activate the flow of oxygen reduces the level of oxygen inside the hood and results in suffocation and death.
6.14.4. Protective Breathing Equipment (PBE), if available, may be used in smoke, fume, or fire environments. These devices can be used as an oxygen source in a rapid or slow decompression.

6.14.5. On overwater flights do not carry more passengers and crewmembers than life rafts accommodate.

6.14.6. AE crews ensure a life preserver unit (LPU) are within easy reach of each passenger/patient and aircrew before takeoff on overwater flights (outside gliding distance to land). AECMs assist with distribution of LPUs to patients. Crewmembers fit and adjust LPUs (if applicable) for overwater flights and wear them on overwater missions below 2,000 feet. Exception: LPUs need not be worn for takeoffs, landings, or approaches. Ensure the appropriate number and type of life preservers are aboard for overwater missions carrying children and infants. Use the Adult/Child life preserver for litter patients. The use of the LPU-6/P Infant Cot is limited to infants 18 months of age or less and up to 30 lbs.


6.15.1. AFMAN 11-2AEV3, Addenda A, provides guidance for MDS oxygen requirements.

6.15.2. Aircrew comply with the oxygen requirements in AFMAN 11-202V3.

6.15.3. Crewmembers occupying a crew station will have an oxygen mask connected and readily available for use from before engine start until engine shutdown. (T-3).

6.15.4. The A-21 regulators of some MA-1 bottles are modified to restrict flow of oxygen during servicing. The modification is designed to reduce risk of fire when servicing bottles off aircraft. Restricted flow increases on-aircraft fill time from 30-45 seconds (unmodified regulator) to as much as 3.5 minutes (modified regulator). Under certain conditions, bottles are depleted faster than they can be refilled.

6.15.5. Regulator type is determined by viewing the inside of the fill nozzle. Unmodified regulators have a push valve inside the nozzle resembling a standard tire valve stem. Modified regulators have a brass plate/filter covering inside of nozzle. Modified 2 regulators have a brass plate/filter covering inside of the nozzle and no valve stem is visible. Crewmembers occupying a crew station will have an oxygen mask connected and readily available for use from before engine start until engine shutdown. (T-3).

6.15.5.1. The MA-1 portable walk-around bottle is the primary emergency oxygen source for AECMs. Exception: If the MA-1 portable walk-around bottle is not available due to inventory shortage, the Protective Breathing Equipment (PBE), may be used as a primary oxygen source while performing crew duties. AECMs will coordinate with LM (C-17) for use of on-board MA-1 portable walk-around bottles. (T-3). Note: The MCD may use a C-17A sidewall quick don mask to communicate with the primary aircraft crew due to C-17A masks being high impedance.

6.15.5.2. Basic Operation. Except for fill times, operation of bottles is identical.

6.15.5.3. AECMs will check regulator type during pre-flight. (T-3). Modified, modified 2, or unmodified MA-1 bottles may be used. AECMs will ensure MA-1 bottle is full at mission preflight. (T-3). If emergency oxygen is required during flight and the walk-around bottle is depleted, the AECM will don PBE as the second source of emergency oxygen. (T-3). Once the PIC has determined it is safe to move about the cabin and
AECMs may remove emergency oxygen, AECMs will check the patients. (T-3). After all patients’ needs are met, AECMs will refill their MA-1 bottle. (T-3). Should emergency oxygen be required before the walk-around bottle is refilled, a PBE will be used. If a PBE is not available and the Emergency Passenger Oxygen System (EPOS) is the only available source, the AECM will cease crew duties and be seated until the PIC has directed crewmembers to remove emergency oxygen. (T-3).

6.15.5.4. AE units will not service MA-1 portable oxygen bottles. (T-3). Dash 2/alternate mission equipment shops ensure MA-1 portable oxygen bottles are serviceable and properly maintained. Note: If a MA-1 bottle is accidentally left open or the system is depleted and not recharged within two hours, bottles will be purged as follows:

6.15.5.4.1. Fill the bottle using oxygen recharger hose until full (300 psi +/- 25 psi).
6.15.5.4.2. Turn MA-1 bottle upside down and turn to EMERGENCY setting until empty.
6.15.5.4.3. Repeat for a total of three times. Crewmembers will check their emergency oxygen equipment during the preflight inspection. (T-2). Oxygen equipment will be immediately available at each crew position, individual masks will not be disconnected until all patients and attendants have deplaned. (T-3).

6.15.6. MA-1 portable walk-around bottle preflight (PRICE Check).

6.15.6.1. P- Pressure: Ensure portable walk-around bottle indicates 300 +/- 25 psi.
6.15.6.2. R- Regulator: Ensure there are no signs of visible damage to the regulator gauge, and view inside of the fill nozzle to identify if bottle is modified or unmodified.
6.15.6.3. I- Inspection: Ensure Quick-don Mask and goggles are properly secured and clean. Check for holes, tears, cuts or abrasions. Inspect bottle for signs of damage.
6.15.6.4. C- Connections: Ensure Quick-don Mask is connected to O2 bottle. Adjust O2 bottle harness to expedite donning in emergency. If connected to aircraft communication system, confirm communication capability.
6.15.6.5. E- Emergency: Don mask with goggles, pull purge valve (as applicable), rotate through all settings (Normal – Emergency). Oxygen should be felt inside goggles. Leave purge valve in the OPEN (pulled out) position for flight. Note: The one piece Quick-don Masks do not have a purge valve. Refill MA-1 walk-around bottle and verify connection compatibility with the re-charger hose. Exception: Where smoke or fumes are not present and goggles are not used, push the pin in the CLOSED (pushed in) position if available. Note: AECMs will adjust and fit shoulder harness and leg straps to prevent inadvertent swinging of the bottle when used in an emergency situation. (T-3). Exception: The 3AET may disconnect and off load their mask if duties require them to depart the flight line. Exception: If all patients and attendants have been deplaned and the AECMs are deplaning at that station; AECMs may remove oxygen masks if the passengers are supervised by the flight crew.

6.15.7. AECMs will have emergency oxygen source available (i.e., MA-1, PBE, EPOS) for flights above 10,000 feet in accordance with AFMAN 11-202V3 Table 3.2. (T-1).
6.16. Fleet Service. Ensure the required fleet service items are aboard the aircraft early enough to permit inventory prior to engine start.

6.17. Airlifting Hazardous Cargo. Cargo should be carried with patients unless a clear detriment to the health and well-being of the patient or passengers can be demonstrated. **Exception:** Hazardous cargo will not be carried on the KC-135 with patients onboard. (T-3). The decision is to be made by the MCD and PIC, considering the need for maximum utilization of the aircraft. Refer to AFMAN 24-204/IP, *Preparing Hazardous Materials For Military Air Shipments* for hazardous product special provisions rating. For further guidance see AFI 11-202V3_AMCSUP for passengers and cargo on AE missions. Conflicts will be referred to the respective tasking AE command element for decision. (T-3).

Section 6D—Departure

6.18. On Time Takeoffs. Mission departures are on time if the aircraft is airborne within -20/+14 minutes of scheduled takeoff time or as specified in a MAJCOM supplement. **Note:** Early departures are authorized to prevent a delay due to weather, Air Traffic Control (ATC) restrictions, airfield or aircraft operational limitations, to adjust mission flow during a large-scale operation, or if approved through C2 channels provided the impact on local and downrange facilities and crew duty is evaluated.

Section 6E—En route


6.19.1. At military bases, the flight crew pass inbound off-load messages to Command Post. At civilian airfields, notify ground control.

6.19.2. The MCD will submit an Aeromedical Evacuation Mission Offload Message to Command Post no later than 1 hour prior to arrival. (T-3). If it is a standard mission and patients do not require any special medical equipment or attention, the PIC can disseminate the offload message however, if there is a medical need, the AEC should relay the message. **Note:** MCDs update C2 agency with any variations to the mission as required.

Section 6F—Arrival

6.20. Unscheduled Landings/RON. Normally, AE missions, if able, remain overnight at bases where Patient Staging is located. Exceptions may occur due to weather, equipment failure, or patient needs. In these instances, the following procedures apply:

6.20.1. Coordinate with the appropriate C2 agency TACC or AECT to ensure that the medical facility selected for patient care has the capability to meet patient needs.

6.20.2. On military installations, if appropriate medical personnel are not available for transfer of care, the MCD or FN is responsible for accompanying all patients to the medical facility and provide report to the staff that assume patient care responsibilities.

6.20.3. Remain with patients until assured of their acceptance into the appropriate medical service and that adequate arrangements for care have been made. Include patient disposition in end of mission report to appropriate C2 agency.
6.20.4. If care is transferred to a civilian medical facility, the MCD or FN may accompany all patients to the civilian medical facility and assume responsibility for the following items:

6.20.4.1. Coordinate with the Director of Patient Administration, or equivalent, indicating the number of patients involved and their nursing care requirements. Problems encountered during the admission process should be managed tactfully, emphasizing patient necessity. If personnel at the facility resist the recommendation, the MCD will refer the matter to the appropriate C2 agency. (T-2).

6.20.4.2. Furnish a complete clinical report to the receiving facility licensed medical staff.

6.20.4.3. Remain with patients until assured of their acceptance and that adequate arrangement for care have been made with the appropriate medical service.

6.20.5. Whether military or civilian facility, AECMs will be responsible for care of their patients whenever hospital staffing is unable to provide adequate support. (T-2). The appropriate C2 agency will be notified immediately when this occurs and will provide further guidance. (T-2).

6.20.6. The MCD ensures all medications and medical supplies are adequately secured. Controlled medications should be placed in the custody of the MTF pharmacy section. When the RON occurs off a military installation, the MCD determines the best method to adequately secure all drugs and medication supplies.

6.20.7. AETs are responsible for obtaining adequate patient baggage storage. Based on local situations or patient status, bags may be stored centrally or may be given to the RON patient. Regardless of process used, patients should be allowed access to their baggage while staying in RON facilities at a military installation.

6.20.8. The MCD coordinate all aspects of mission departure for the following day.

6.20.9. The MCD will ensure adequate preparation of patients and sufficient transportation, the hospital Patient Administration office will be notified of the estimated departure time. (T-3). FN may have to report the medical facility in sufficient time to receive patient report and to obtain controlled medications that were placed under security.

6.21. Border Clearance. Customs, Immigration, and Agriculture require certain forms for border clearance. The 3AET is the custodian for border clearance and will ensure all required forms are onboard the aircraft before takeoff. (T-3). The 3AET also distributes the forms to the AEC, patients and attendants, ensure completion prior to landing and deliver completed forms to LM or BO. Note: Ensure sufficient customs, DD Form 1854, US Customs Accompanied Baggage Declaration, forms are available for all personnel. Passenger service personnel should provide forms for prior to departure.

6.22. Insect and Pest Control. PICs will ensure required spraying is accomplished according to AFPMG TG4 (Armed Forces Pest Management Board Technical Guide 4) – Disinsection of Military Aircraft, Department of Defense FCG, or as directed by higher headquarters and the steps outlined in AFI 11-202V3_AMCSUP. (T-0). CAUTION: Aircraft should not be sprayed with patients onboard.
Section 6G—Miscellaneous

6.23. Aircrew Flight Equipment and Dash 21 Equipment Documentation. The PIC or designated representative will:

6.23.1. Before departing home station or en route stations, ensure appropriate serviceable protective clothing, aircrew flight equipment, and Dash 21 equipment for the entire or remainder of the mission are aboard the aircraft. (T-1).

6.23.2. Before departing home station and following en route crew changes, review AF Form 4076, Aircraft Dash 21 Equipment Inventory, to ensure all required Dash 21 equipment has been certified as installed by maintenance. (T-1). Ensure the initial check has been signed by maintenance, and configuration documents match mission requirements. (T-1).

6.23.3. Before departing home station and following en route crew changes, review, sign, and date the AFTO Form 46, Prepositioned Aircrew Flight Equipment, to ensure all required protective clothing and aircrew flight equipment have been certified as installed by AFE personnel and that configuration documents match mission requirements. (T-1). Ensure appropriate number and type of life preservers are aboard for over-water missions carrying children and infants. (T-1).

6.23.4. Missing Equipment. AECMs discovering equipment missing, notify LM/BO. (T-1).

6.24. Passenger Restrictions. No-show passengers, including patients, baggage will be off-loaded prior to departure. (T-3).

6.25. Overflying En Route Stops. MCD will contact C2 immediately to determine disposition of patients if an en route stop is overflown. (T-1).

6.26. Medical Emergency/Change in Patient Status. If ACLS/Basic Life Support (BLS) algorithms are used in flight, and the patient meets USTRANSCOM “Call Criteria” or the AECMs deem necessary, MCD will immediately notify the PIC regarding the gravity and nature of the situation. (T-2). The MCD coordinates with the PIC to establish immediate radio communication with the TACC/Air Mobility Operations Control Center (AMOC)/AOC/PMRC for a physician and guidance for landing at an airfield capable of handling the situation, when indicated. (T-3). Note: Refer to AFI 48-307 series for clinical management.

6.26.1. Per TACC/AOC guidance, land at the nearest airfield capable of handling the situation. In grave circumstances, the MCD may request the PIC declare an in-flight medical emergency to expedite landing. PIC should consider calling in an In-Flight Emergency, medical in nature, in order to activate the appropriate local response. This will initiate the ground response to have available support personnel on site.

6.26.2. Notify the supporting TACC/AOC and PMRC regarding changes in patient status, mission irregularities, coordination of mission needs, and equipment requirements as soon as possible. (T-2). Note: The patient’s personally identifiable information (PII) will not be used in radio or cell phone communications; use the patient’s cite number only. (T-1).

6.26.3. Be ready to communicate age, gender, diagnosis, subjective and objective data, including vital signs and pulse oximetry, known allergies, and for women of childbearing years, date of last menstrual cycle, if indicated. Also report interventions, date and time (if
indicated) and the outcome. Be prepared to request orders, mission deviation, etc. to expedite meeting patient and mission requirements.

6.26.4. Anytime a patient is removed from a flight for clinical evaluation, treatment or there is a change in status, notify TACC/AOC and PMRC as soon as possible.

6.27. **Apparent Patient Death in Flight.** When a suspected death occurs in-flight, the MCD will contact C2 immediately. (T-3). **Exception:** If a suspected death occurs during a critical phase of flight, the MCD will contact C2 as soon as possible. If the next stop is the patient’s destination, the itinerary will not be interrupted, otherwise C2 directs the PIC/MCD where to take the patient. (T-1).

6.27.1. When notified by the MCD that a suspected death has occurred, the PIC should immediately provide C2 agencies with the following information: “A suspected death has occurred on (mission number) ETA to (next stop) is (time) Z, (patient cite number).” The PIC relays this information to the controlling agency for relay to the appropriate C2 agencies.

6.27.2. If a physician is not onboard during the flight the C2 agencies will make arrangements to have a physician meet the aircraft and pronounce the patient dead. (T-1).

6.27.3. If a physician is onboard during the flight, they may pronounce death in-flight. The MCD documents time of pronouncement in Zulu time and the physician co-signs the AF Form 3899.

6.27.4. AECMs inventory records, medication, baggage and physical effects prior to offloading and document on AF IMT 3854, Receipts for Patient’s Valuables. Document the event on the AF Form 3829 and submit an Aeromedical Evacuation Event/Near Miss report.

6.27.5. The MCD will contact the deplaning airfield’s Air Transportation Operations Center (ATOC) and request mortuary affairs at military installations or, civilian coroner at civilian airfields. (T-1). Once the aircraft has landed, follow that airfield’s guidelines for death certificate and body removal. (T-1). Once the patient has been pronounced deceased, airlift ceases, unless the MCD/PIC contact C2 authorities for unique situations. Do not continue airlift without a death certificate.

6.27.6. **Home Station.** In the event of patient death in flight or patient death within 24 hours of flight, upon mission completion, the AES/CC will coordinate with C2 and conduct an investigation to determine if the AEC followed all aircrew procedures. If necessary, appropriate actions will be taken to resolve any digressions (AF Form 8, Certificate of Aircrew Qualification, retraining, credentialing) prior to returning individual(s) involved to flying status. (T-2). AE unit commander shall notify Operations Group Commander who will notify the MAJCOM A3 of incident and actions taken. (T-1).

6.27.7. Deployed AECMs. In the event of patient death in flight or patient death within 24 hours of flight, upon mission completion, the Detachment Commander or Detachment Operations Group Commander with operation control of the mission will be notified of the incident by the C2 agency. (T-1). If the AEC is in the mobility system, the AE detachment commander where the crew disembarks the aircraft will conduct the investigation to determine if the AEC followed all aircrew procedures. In the event AECMs are in MEP status, AECMs will return to deployed/staged unit. (T-3).
6.27.8. The MCD, Detachment Commander, or Detachment Operations Group Commander may consider notifying a Religious Support Team (RST, one chaplain and one Religious Affairs Airman) to help debrief the AECMs after a highly distressing AE mission. These events would include a patient death in flight or patient death within 24 hours of flight, high numbers of urgent patients, deregulated patient flow, reverse triage situations, etc. Focus would be on fortifying caregiver coping skills and personal resiliency in the face of high operational stressors.

6.28. Airlift of Human Remains. Remains of deceased personnel are not normally carried on AE missions. However, in the interest of timely movement or other factors, which cannot otherwise be satisfied by subsequent airlift, transportation of remains may be authorized.

6.28.1. For 618 AOC (TACC) controlled missions, submit requests for movement of remains on aeromedical aircraft to the 618 TACC/APCC. The 618 TACC/XOZ, will provide approval. Approval authority will not be delegated below the 618 TACC/XOZ level. (T-2).

6.28.2. For Non-USTRANSCOM controlled mission’s contact appropriate C2 agency. If approval is granted to move remains on aeromedical mission, the ATOC chief will ensure loading or offloading is accomplished discreetly; not concurrently with passenger and patient loading or offloading. (T-2).

6.28.3. In each case, the PIC will ensure the on-load, position, and off-load are conducted in a discrete manner. (T-3). In most situations, a ceremony will be conducted to pay respect and honor to the deceased member. (T-3).

6.29. Patients Requesting Release from AE System.

6.29.1. The MCD may release active duty patients or attendants only upon a competent medical authority's recommendation and with the concurrence of the active duty member's commander.

6.29.2. The MCD ensures AF Form 3841, Certificate of Release, is completed when a non-active duty patient or attendant requests release from the AE system during a mission. (T-3). If the patient is under the age of 18 years, the patient’s legal guardian must sign the form prior to the patient’s release.

6.29.2.1. Whenever completing this form, ensure proper AE C2 agency is informed immediately. (T-3).

6.29.2.2. Prior to obtaining the signature of the requesting individual, the MCD determines if the individual is sufficiently competent to understand the purpose of the AF Form 3841. If not, the MCD requests advice from a medical authority or the staff judge advocate at the place of requested debarkation, if such personnel are available. In all instances, guidance from the C2 agency should be requested.

6.29.3. Prepare the AF Form 3841 in triplicate. The original will be placed in the patient’s medical record; one copy will be attached to the AF Form 3829, (or TRAC2ES equivalent) to be filed upon termination of the mission; one copy will be given to the individual requesting release from the AE system. (T-1). Also, submit a DD Form 2852, Patient Movement Event/Near Miss Report. (T-1). Note: When a patient, or his or her authorized representative requests release from further airlift, the MCD advises the individual requesting release the purpose of the AF Form 3481. The AF Form 3841 releases the U.S.
Government, its’ agents, and employees from all responsibility for further aeromedical airlift services arising pursuant to the patient’s movement. The MCD also advises the patient, or his or her authorized representative, of any medical risks which may arise from the patient’s request for release from the AE system. These risks are annotated on the AF Form 3841. Patients requesting release from the AE system should be advised that signing the AF Form 3841 does not prohibit the individual from receiving future AE services. **Note:** The individual’s signature on the AF Form 3841 indicates release of the AE system from responsibility for the patient requesting release from the AE system.

6.29.4. Refusal to sign the AF Form 3841 is annotated in the patient’s medical record.

6.29.5. Ensure the patient is aware they may not be reimbursed for travel expenses if their orders require AE transportation.
Chapter 7

AIRCRAFT SECURITY

7.1. General.

7.1.1. This chapter provides guidance on aircraft security and preventing and resisting aircraft piracy (hijacking) or aircraft. AFI 13-207-O, Preventing and Resisting Aircraft Piracy (Hijacking), AFI 31-101, and specific MAJCOM security publications contain additional guidance. Guidance on the release of information concerning hijacking attempts or identify armed crewmembers to the public is provided in AFI 13-207-O and AFI 31-101 and AFI 11-202V3_AMCSUP.

7.1.2. Medical facility commanders are responsible for anti-hijacking inspection of patients. When patients are delivered to the aircraft by civilian sources, the aircrew will perform required inspections prior to loading. (T-3). MCD will be provided a written statement that all patients and baggage were anti-hijacked in accordance with AFI 13-207-O. (T-3). Note: For AE missions, the MCD is the final authority for determining what items can be carried by/for AE patients. If a safety concern exists, the PIC is the final mission authority and is responsible for the wellbeing of all persons aboard the aircraft.

7.1.3. During exercises or contingencies in support of combat operations involving the movement of large groups of personnel, the unit being supported should manifest passengers and perform anti-hijacking inspections.

7.1.4. Passengers will not carry weapons or ammunition on their person or in hand-carried baggage aboard an aircraft. (T-2). Exception: Special agents, guards of the Secret Service or State Department, RAVEN Team Members, and other individuals specifically authorized to carry weapons.

Chapter 8

OPERATIONAL REPORTS AND FORMS

8.1. General. This chapter provides guidelines for worksheets, reports, and forms associated with AMC operational activities. Consult governing instruction or contact wing, unit, or local flight safety officers for assistance with safety forms.

8.2. AMC Form 97, AMC In-Flight Emergency and Unusual Occurrence Worksheet. The AMC Form 97 is a tool to notify appropriate authorities of any mishap involving crewmembers or aircraft. Unless other MAJCOM guidance directs, PICs shall complete all appropriate areas of the form in as much detail as possible. (T-3). When notified, MAJCOM C2 agents will inform their supervisor/commander to start investigation and reporting activities in accordance with AFI 91-204, Safety Investigation and Hazard Reporting, and Operation Report 3 procedures. (T-2). See AFI 11-2MDSV3 for further details.

8.3. AE Event/Near Miss Reporting Process. Refer to AFI 48-307V1, Chapter 9, Patient Movement Patient Safety Program (PMPS).

8.4. Aviation Safety Action Program (ASAP). The Military Aviation Safety Action Program is an anonymous, self-reporting system modeled after successful Federal Aviation Administration (FAA)/Airline programs to encourage the voluntary reporting operational issues and events. It is designed to provide a non-punitive environment for the open reporting of safety concerns and information that might be critical to identifying hazardous situations and precursors to accidents. These safety concerns may be either observed or experienced by the submitter. The goal is to prevent mishaps by addressing those unintentional errors, hazardous situations and events, or high-risk activities not identified or correctable by other methods or through traditional safety reporting sources. The ASAP Report Submission, Fatigue Submission, and ASAP Scoreboard websites are accessible at https://asap.safety.af.mil or https://afsas.safety.af.mil as well as the Airman Safety Application on the EFB. Crewmembers can contact the AMC ASAP Program Manager via e-mail at amc.asap@us.af.mil.
Chapter 9

TRAINING GUIDANCE

9.1. General. For all training related information, refer to AFMAN 11-2AEV1.

9.2. For AE continuation training guidance reference the current Ready Aircrew Program Task Memo available on the Aircrew Publications Library.
Chapter 10
AIRCREW OPERATIONS IN CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN), AND HIGH-YIELD EXPLOSIVE THREAT ENVIRONMENT

10.1. Overview. This chapter provides guidance on patient movement in a chemical, biological, radiological, nuclear environment.

10.1.1. The USTRANSCOM policy is patients, personnel, or casualties with known or suspected contamination from chemical, biological, or nuclear warfare agents will not be transported within the aeromedical patient movement system prior to decontamination. (T-0). Decontamination must be performed prior to transport to prevent the potential spread of contamination. (T-1). In rare cases, transport may be essential to preserve life or continue critical missions. If such transport is deemed essential, all efforts must be made to prevent the spread of contamination. (T-3). In these cases, prior approval must be given by the involved geographic combatant commanders, Commander USTRANSCOM, the Secretary of Defense, US Embassies and foreign ambassadors in consultation with Department of Defense medical authorities.

10.1.2. AMC will train and equip Aeromedical evacuation crews and stage required equipment at key hubs to carry out these limited missions for movement of decontaminated and contagious patients. (T-1).

Chapter 11

FLIGHT NURSE AND AEROMEDICAL EVACUATION TECHNICIAN PROCEDURES

11.1. General. The primary duty of the FN and AET is to conduct AE operations. Primary duties include mission planning, coordinating and supervising enplaning and deplaning of patients and special medical equipment, and providing in-flight patient care and assistance to patients. The FN and AET:

11.1.1. Specialize in nursing care of patients in a hypobaric environment.
11.1.2. Have advanced training in the operation of specialized medical equipment designed and approved for use at altitude.
11.1.3. Are trained and current in the aircraft systems and configurations required for safe AE operations.
11.1.4. Provide in-flight assistance to medical attendants as situations dictate.


11.2.1. Aircraft seats identified in applicable T.O.s or AFMAN 11-2AEV3 Addenda A and AFI 11-2MDSV3 Addenda A as aircrew seats will not be used for patient passenger seating. (T-3).

11.2.2. The MCD may reserve get-down litters as mission needs dictate. For mission legs exceeding four hours in length; a minimum of two litters should be set up for ambulatory patient use. The AEC will set up an emergency litter on all AE missions. (T-1). When mission load permits, a minimum of one seat should be reserved for every three litter patients. Exception: An emergency litter is not required for ambulatory patient movement on C-21 missions.

11.2.3. AEC will ensure that patients and attendants will not be relocated to litters, in order to make seats available for passengers. (T-3). Regardless of age, all ambulating patients and attendants will have their own assigned seat and will not be required to give up their seat for passengers. (T-3). In-lap seating of patients and attendants to accommodate passengers is prohibited on AE missions. (T-3).

11.2.4. For planning purposes, critical care patients should have an entire litter tier to accommodate patient care and additional medical equipment. Exception: During contingency and humanitarian missions, maximize the aircraft capability for all litter patients.

11.2.5. A five high configuration using the litter stanchions is approved for all C-130 AE missions.

11.2.6. When cargo requirements permit, the seat and litter stanchion ladder will be installed for all C-130 AE missions. (T-2).

11.2.7. TCTO 1C-130-2255 is the most accurate source for determining the serviceability of C-130 brackets.

11.2.8. Ensure adequate space for in-flight treatment of litter patients. The vertical distance between each loaded patient litter will not be less than 21 inches (18 inches on C-130 when
loading 5-high).  (T-2).  **Note:** When litter patients are wearing personal gear (i.e., web belts, canteen, helmets, flak vests, etc.), consider loading four high versus five high in the center seat and litter stanchions, to increase space between litters to accommodate gear. If situation requires, remove personal gear from patients and secure on ramp or in a designated area.

11.2.9. Available litter spaces and ambulatory seating depends on the aircraft cabin’s mission configuration (i.e., aircrew flight equipment storage containers and tool box stowage).

11.2.10. Patient/Cargo Mix.

11.2.10.1. Cargo and passengers should be carried with patients unless a clear detriment to the health and well-being of the patient or passengers can be demonstrated. The decision will be made by the MCD, considering the need for maximum utilization of the aircraft. Conflicts will be referred to the respective tasking AE command element for a final decision.  (T-1).  **Note:** Cargo should not be bumped except in very unusual cases, and only after the PIC/MCD contacts 618 AOC (TACC) and appropriate C2 agencies.

11.2.10.2. When transporting both cargo and litter patients, litters will be transported forward of the cargo pallets, if possible.  (T-2).  **Note:** Patients may be placed forward of cargo on the KC-135. Discretion will be used in considering patient and cargo mix when using the stanchion litter system (SLS) configurations.  (T-2).

11.2.10.3. If not possible, and the PIC and MCD agree, patients may be transported aft of the cargo. The LM or BO must make every effort to stay in the vicinity of the aircrew and patients in-flight, and during critical phases of flight.  (T-2).

11.3. Preflight Duties.

11.3.1. Ground support members, consisting of at least one qualified AECM, may preflight the aircraft for an AE mission. It is the responsibility of the CMT to ensure the aircraft has been correctly configured and preflighted before accepting the aircraft for patient transport. A qualified AECM from the ground support team briefs and conducts aircraft walk through with the CMT on completed abbreviated checklist items prior to the aircrew assuming responsibility.

11.3.2. Roller conveyors will be removed from all aisle way, walkway, and AE litter patient positions.  (T-3).  **Exception:** Omni rollers on the KC-46 cannot be removed.  (KC-46) Until a removable barrier has been made to cover the omni rollers, AECMs will ensure two empty pallets are installed over the omni rollers for patient enplane and deplaning.  (T-2).  These pallets will be secured together with a cargo strap to prevent excessive movement.  (T-2).

11.3.3. [C-17] On the ramp, roller conveyors will be stowed unless the baggage pallet or Litter Station Augmentation Set (LSAS) are in position.  (T-3).  Before enplaning/deplaning procedures, the LSAS will be secured in the aerial delivery system rails in position 10. All rollers in position 11 will be stowed.  (T-3).

11.3.4. [C-130] Patient and aircrew safety will be evaluated prior to enplaning/deplaning of patients. If safety concerns exist and time permits, roller conveyors will be removed from the ramp.  (T-3).  As mission dictates, rollers required to remain on the ramp during enplaning and deplaning will be positioned as close to the ramp edge as possible.  (T-3).
11.3.5. If the aircraft is configured with airline seats, the CMT will check the security of all patient and attendants seats by lifting upward on the front of the seat frame and gently pushing and pulling on the seat backs. (T-3). Minimal movement is acceptable.

11.3.6. Oxygen and Electrical. Lines may be run together (parallel) throughout the aircraft cabin. Electrical outlets with electrical equipment plugged into them will not have an oxygen flow meter within 12 inches of that outlet. (T-2). Do not secure any oxygen and/or electrical lines on the floor, across aisles or areas where they will be walked on. (T-3). Exception: When patients are floor-loaded, oxygen and or electrical lines may be secured on the floor.

11.3.7. Secure oxygen and electrical lines to litter clamps, or secure with hook and loop fasteners or procured equipment securing devices located in the in-flight kit. When securing oxygen or electrical lines in litter brackets, inspect the bracket for visible wear on the rubber pad of the bracket. If the bracket’s rubber pad is worn, pad the bracket with available material. Do not use tape. All brackets without rubber pads will be annotated on applicable AFTO Form 781A, for turn- in to maintenance for repair or replacement. (T-2). WARNING: The only acceptable options to run oxygen and electrical lines without the concurrence of the LM/BO is to utilize the stanchion poles, stanchion straps, C-17 fuselage or SLS securing devices. Coordinate with the LM or BO prior to securing oxygen and electrical lines outside of these parameters. Lines looped over moving parts jeopardize the safety of the aircraft, medical equipment and aircrew.

11.3.8. AECMs will wear gloves when making electrical connections, during configuration and patient loading to prevent personal injury. (T-2).

11.3.9. AECMs will not be plug in equipment until after the aircraft electrical system has been turned on. (T-2).

11.3.10. AECMs will secure electrical lines and complete a functional check of medical equipment performed on the aircraft prior to enplaning patients. (T-2). Exception: May be modified as situation dictates for operational contingency and combat missions.

11.3.11. Flight gloves will not be worn by the crew when handling or connecting oxygen equipment devices to an oxygen delivery source. (T-2). Hands will be clean and free from oils, lotions, paints, grease, or similar materials. (T-3). Note: Do not drag the Schrader end on the oxygen line across the aircraft floor. Exception: During emergency AECMs may have to touch oxygen lines with gloves to refill oxygen source.

11.3.12. Oxygen lines will be secured by the crew prior to enplaning patients. (T-2). Exception: For operational contingency and combat missions, oxygen lines will be secured prior to take-off. (T-2).

11.3.13. “Oxygen available” means oxygen can be made quickly available to the patients. Positioning of a flow meter, O2 adapter, and unopened mask or nasal cannula somewhere in the vicinity of the patient, meets this requirement. Note: The AE crew is not required to have therapeutic oxygen immediately available for space available passengers. A dedicated patient emergency oxygen line connected to a Bag-Valve-Mask (BVM) will be set up by the AE crew prior to patient on-load and remain connected until all patients have deplaned. (T-2).
11.3.14. During all operational and ARM AE missions, an AECM will document on the AF Form 3829, Summary of Patients Evacuated By Air or on computer generated TRAC2ES cover sheet in accordance with AFI 48-307V3. *(T-3).*

11.3.15. On missions with patients requiring mechanical ventilation, AECMs will calculate pre-mission oxygen requirements in accordance with AFMAN 10-2909. *(T-3).*

11.3.16. Prior to enplaning Critical Care Air Transport Team (CCATT) patients requiring mechanical ventilation, AEC and CCATT personnel will verify patient oxygen requirements. *(T-3).*

   11.3.16.1. For C-17 missions, use aircraft therapeutic oxygen as the primary source for ventilated patients.

   11.3.16.2. Calculated oxygen requirements may require the use of additional PTLOX/NPTLOX to meet the requirement for a dedicated source. AECMs will not use the dedicated PTLOX/NPTLOX for any other patient or emergency equipment. *(T-2).* A Bag-Valve-Mask can be connected to the dedicated PTLOX/NPTLOX to support the ventilated patient. At locations where there is AE ground support, the CMT coordinates enplaning and deplaning procedures with the en route casualty care facility and LM or BO prior to enplaning and deplaning patients.

11.4. **Ground Operations.** The CMT is responsible for all AE ground operations. The CMT, in coordination with the LM or BO, is responsible for vehicle movement and positioning around the aircraft.

   11.4.1. At locations without AE ground support, the CMT coordinates enplaning and deplaning procedures with the sending or receiving facility and LM or BO. **Note:** Medical facility support personnel on the aircraft should be kept at a minimum during ground operations prior to enplaning and deplaning.

   11.4.2. Patient Preparation for Enplane. **Note:** MCD and CMT ensures that all preparation and enplaning tasks are completed prior to patient onload and may delegate these tasks as necessary.

      11.4.2.1. The AECM will verify with the FN receiving report that anti-hijacking procedures were accomplished prior to enplaning. *(T-2).* Perform anti-hijacking procedures if not accomplished.

      11.4.2.2. AEC identifies patients requiring assistance. Litter patients may be enplaned or deplaned as ambulatory if in the professional judgment of the FN no contraindications exist (e.g., doctor’s order for bed rest, inability to climb stairs or walk long distances, etc.). **Note:** Patients and passengers may be allowed to use canes, crutches, or walkers for enplaning at the discretion of the AECM.

      11.4.2.3. AEC distributes hearing protection to all enplaning patients and attendants.

      11.4.2.4. The AECM ensures litter patients are checked for security to include approved litter, litter strap placement, and proper backrest placement prior to enplaning. However, all AECMs monitor for safe litter strap placement. Ensure all patient personal items located on litter are secured prior to patient movement.
11.4.2.5. Ensure that all ambulatory patient personal belongings, to include medications if self-medicating, are in their possession.

11.4.2.6. Identify patients with non-certified medical equipment.

11.4.3. Patient Preparation for Deplane:

11.4.3.1. AECMs will check litter patients for security to include litter strap and backrest placement prior to deplaning. (T-2). AECMs will ensure all equipment used on the patient is disconnected from aircraft systems. (T-2). All patient medical devices and personal items located on the litter will be secured prior to patient movement. (T-2).

11.4.3.2. AECMs will ensure that all ambulatory patient personal belongings, to include medications if self-medicating, hand carried bags, and medical supplies are in their possession. (T-3).

11.4.3.3. AECMs will ensure soiled linen, sharps containers and contaminated items are collected for removal from the aircraft as specified in AFI 48-307V1. (T-3).

11.5. Transfer of Patient Care. In the AE system, transfer of patient care occurs between AE representatives of the MTF, en route casualty care system, or external agencies to and from the AEC. Transfer of physical care is complete once the patient enters or exits the ground vehicle of transportation. Note: Enplaning or deplaning during patient report is highly encouraged. Final approval is at the discretion of the MCD.

11.5.1. Transfer care to a comparable or higher level of care capability. Time should be allotted for the ground healthcare provider and AECM to have an opportunity to ask and respond to questions as needed. A verbal report includes, but is not limited to:

11.5.1.1. Patient Identification.

11.5.1.2. Patient’s present clinical situation such as, diagnosis, date of injury, date of surgery, responsiveness, ambulatory status, code status, number of attendants.

11.5.1.3. Patient’s recent and significant clinical background such as allergies, if the patient self-administers medications, when the last dose of prescribed medications were given or taken, and any other pertinent information or history.

11.5.1.4. Patient’s pertinent assessment information such as vital signs, pain level, airway status, breathing, oxygenation, circulatory status, any intravenous solutions or blood products, accompanying or attached medical equipment or devices, abnormal labs, and any other pertinent information.

11.5.1.5. Any new or specific clinical orders and instructions or important information specific for the patient transport. Note: AE Patient Safety recommends using a standard format for patient handoff in the AE system.

11.5.1.6. AECMs ensure the AF Form 3899 series is complete and supports transfer of care communications between the AEC and the AE representative. Note: Enlisted personnel may only take control of controlled medications if they have been trained and appointed by the MTF or AE Squadron commander. Note: If any patient condition is questionable or exceeds the capabilities of the AEC, notify the MCD. The MCD may refuse a patient for AE transport if the patient’s behavior is determined to be detrimental to self and others, the patient has not been adequately prepared for AE movement, or
therapeutic interventions are ineffective. Document on AF Forms 3829/3899, AF IMT 3830 and Patient Manifest, the information related to refusal of patient. Notify controlling MAJCOM C2 agent and PMRC at time of refusal.

11.5.2. Medical attendants accompany patients to the destination medical facility. FNs must exercise good judgment in determining the need for an AECM to accompany patients to the destination medical facility. (T-3).

11.5.3. At scheduled RON stations, when a licensed provider is not available to receive report on the flight line, an AECM is responsible for accompanying patients to the facility if the patient’s medical condition warrants clinical observation during transport.

11.5.4. If medical personnel do not meet the aircraft, the MCD ensures a member of the crew accompanies patients to the destination facility to provide transfer of care to an appropriate medical representative. A transfer of care handoff must occur between the medical crew and a medical representative taking responsibility for the patient. (T-3). An Aeromedical Evacuation Event/Near Miss report will be completed and the C2 agency will be notified when the accompanying AECM completes their duties. (T-3). Note: This will extend CDT.

11.6. Enplaning/Deplaning Procedures. The MCD and CMT have direct and final authority over all patient enplaning and deplaning activities. AECMs are responsible to oversee all activities involved with patients in and around the aircraft.

11.6.1. During enplaning or deplaning of patients, the MCD or designated AECM controls operations from the aircraft ramp. Position on the ramp is at the discretion of the AECM. Note: On the ramp, only wireless headsets are approved during enplaning/deplaning operations.

11.6.1.1. All aircraft should have engines shut down during enplaning and deplaning of patients unless conducting engines running onload/offload (ERO) procedures in accordance with paragraph 11.6.7 Safe, smooth enplaning activities depend on the coordinated efforts of the AECMs and the MTF. Consideration of climate conditions, ground support capability to include manpower and vehicular support, all play a role in safe operations.

11.6.1.2. Keep ambulatory patients grouped together.

11.6.1.3. Patients will not walk under aircraft wings. (T-1).


11.6.1.5. Ensure all patients keep one hand free for grasping the handrail. Note: Attendants may carry infants on and off the aircraft. Infants may be carried in a chest or back carrier.

11.6.1.6. Patients will not be seated in seats that do not lock in the full upright position or secure into applicable aircraft track. (T-1).

11.6.2. Enplaning/Deplaning Communication. When multiple litter patients are being loaded, hand signals will be used. (T-3).
11.6.2.1. The THUMBS UP signal indicates to the litter bearers the aircrew is prepared for litter enplaning or deplaning. An exaggerated motion, raising the whole arm above the head, must be used during ERO procedures. (T-3).

11.6.2.2. Extending crossed arms above the head indicates a STOP signal to the litter bearers to stop all movement.

11.6.2.3. The SLOW DOWN signal indicates to the litter bearers to gradually slow the pace until the signal is ceased. The signal is given by extending arms outward and raising and lowering the arms from shoulder to waist with palms facing the ground.

11.6.2.4. AECMs direct and signal litter bearers to the proper litter tier as they enter the aircraft. This is done using exaggerated hand motions.

11.6.2.5. AECMs physically reach out and identify the litter arm or litter bracket on the stanchion where the litter will be placed. (T-3). This allows litter bearers to visualize the position before they reach the litter tier.

11.6.2.6. Litter Commands. The AECM at the forward end of the litter will give the command to lift the litter into the litter brackets. (T-3). The AECM at the forward end of the litter will ensure everyone is prepared to lift using the preparatory command “PREPARE TO LIFT.” (T-3). If no indication of a negative response, give the execution command “LIFT”. Clear communication is the key. If a clear preparatory command and a clear execution command is given and the movement is executed smoothly and safely then this is acceptable.

11.6.3. General Litter Loading Considerations. Safety is the primary concern during litter transfers. Proper lifting techniques should be used at all times. At no time should patient safety be compromised. In the event of large litter loads, ensure workload is distributed among numerous litter bearers, when available. **WARNING:** Litters lifted above waist level will first be brought to the shortest litter barriers chest level and then lifted into place by no less than four-persons. (T-2). **Note:** Patients should have minimal exposure to the elements during enplaning or deplaning. Patients will not be positioned on the aircraft ramp or flight line during inclement weather. (T-3). Setting patients on either platform should be avoided. **Note:** Patients may be positioned with their head towards the flight deck if the physician determines patient condition warrants head first placement.

11.6.3.1. On the C-17 and C-130, litter patients should be enplaned feet first and deplaned head first due to minimal degree of ramp incline. This eliminates the need to turn litter patients around on the cargo ramp prior to placing them in the litter tier. On the KC-135, litter patients will be enplaned head first to eliminate the need to turn litter patients around once on the aircraft. (T-3).

11.6.3.2. When the cargo ramp is unavailable or if cargo is already on the aircraft prior to enplaning or deplaning litter patients, litters may be loaded through the paratroop doors and crew entrance door.

11.6.3.3. When enplaning or deplaning litters through the paratroop doors and crew entrance door on the C-130, at least four people should be employed on the ground with an additional two to three people inside the aircraft.
11.6.3.4. On the C-17, to load through the paratroop doors or the forward emergency escape door, a minimum of six people on the ground to lift over the head and four on the aircraft is required.

11.6.3.5. Position personnel in a way that they can safely hand the litter off to others as needed.

11.6.3.6. When a comfort pallet is in place (C-17) first determine if there is adequate clearance to safely enplane or deplane the litter and any medical support equipment through the crew entrance door.

11.6.3.7. The preferred method to enplane or deplane ambulatory patients on the KC-135/KC-10/KC-46/C-5 is the air stairs. The air stairs should not be used to enplane or deplane litter patients. If there is no other option available, the MCD will contact the appropriate C2 agency for waiver. *(T-2)*

11.6.3.8. The primary means to enplane or deplane litters weighted with equipment, supplies or manikins is a high-lift capable vehicle. If no high-lift capable vehicle is available, enplane or deplane weighted litters using a 4-person carry on the air stairs. If the air stairs are deemed too narrow by the MCD and CMT to safely perform a 4-person carry, a 2-person carry may be used. When a 2-person carry is employed, 2 additional AECMs will act as safety spotters and be positioned in the front and in back of the litter bearers. The safety spotter’s hands will be free to assist the litter bearers as necessary. *(T-3)* Litter patients will not be enplaned or deplaned on the air stairs without a waiver coordinated through the appropriate C2 agency. *(T-3)*

11.6.3.9. Both litter and ambulatory patients should enplane and deplane, using the Patient Loading System (PLS) or High Deck Patient Loading Platform (HDPLP). Maximum PLS weight capacity is 1500 lbs. distributed and is rated to withstand 50 knot winds. Maximum HDPLP weight capacity is 8000 lbs. distributed, the lift gate capacity is 2600 lbs. distributed and is rated to withstand 40 knot winds.

11.6.3.10. If the HDPLP is not available, request a hi-lift truck, Halverson Lift, Tunner (K-Loader), for patient enplaning and deplaning. Ensure one AECM accompanies the patient(s). **WARNING:** Ensure all safety precautions are utilized when enplaning and deplaning patients on a K-Loader. One AECM should be directing patients during enplaning and deplaning. AECMs should coordinate with BO to utilize ramps to cover gap between aircraft and K-Loader to prevent personnel from injury.

11.6.3.11. Rollers on alternate platforms such as the Tunner will be turned over before beginning enplaning and deplaning operations. *(T-3)*

11.6.3.12. Litter stanchion arms from the integral stanchions of the C-17, KC-46, LSAS and SLS are designed for non-sequential loading.

11.6.3.13. AECMs always secure the outside litter bracket immediately after loading a litter into a litter position. *(T-2)* The inside bracket can be secured if time permits but will be secured prior to take-off. *(T-2)*

11.6.3.14. When only one patient occupies a litter tier, the patient should be placed at a level that optimizes medical care, and allows the patient to easily get on and off the litter.
11.6.3.15. When a litter, occupied or unoccupied, is placed in the lowest litter tier, a litter must be secured at waist level above it to prevent a tripping hazard. *(T-3)*. **CAUTION:** Be mindful of the potential strike hazard unoccupied litter stanchion arms present. To help eliminate the hazard: remove litter stanchion arms and store in a secure location on the aircraft. If a secure location is not available, place an empty litter in a vacant position or cover empty litter stanchion arms with blankets and secure with litter straps.

11.6.4. C-130 aircraft litter loading procedures.

11.6.4.1. It is the MCD and CMT discretion either to use a four or two person carry for C-130 enplaning and deplaning.

11.6.4.2. The four to two person switch may be performed on or off the aircraft.

11.6.4.3. The two AECMs actually loading will protect the patient from litter support brackets at all times. *(T-3)*.

11.6.4.4. Loading into the centerline #3, #4 and #5 litter positions:

11.6.4.4.1. AECMs hold the litter support straps to the outside of the litter area.

11.6.4.4.2. Litter bearers bring the litter into the litter tier area.

11.6.4.4.3. Without setting the litter down, the AECMs take the outside litter handle and then direct the litter bearer to take the inside pole.

11.6.4.4.4. The AECMs secure the outside bracket.

11.6.4.4.5. Once the litter is in place, the litter bearers should be directed to exit the aircraft. If only one side of the aircraft is being used, litter bearers should be directed around the other side of the aircraft to avoid congestion. If loading both sides simultaneously (cross-loading), litter bearers should be sent back down the same side aisle but kept to the outside.

11.6.4.5. Loading into the centerline #2 and #1 position:

11.6.4.5.1. The AECMs place the litter support strap on the litter above the position to be loaded.

11.6.4.5.2. The litter bearers come on board and set the litter down in the aisle next to litter tier.

11.6.4.5.3. The AECMs take the inside litter pole and direct the litter bearers to take the outside litter pole. **Note:** When loading litter position #1, it is the AECMs discretion either to use a four or two person lift into the litter brackets. If AECMs decide to use a two person lift, release the litter bearers immediately.

11.6.4.5.4. After the litter is placed in the inside litter bracket, the AECM moves the outside litter bracket into place and secure. Direct litter bearers to exit the aircraft.

11.6.4.6. Loading into the sidewall track extenders #4 and #3 litter position:

11.6.4.6.1. The AECMs hold the litter support strap to the outside of the litter tier.

11.6.4.6.2. The litter bearers bring the litter on board and into the litter tier area.
11.6.4.6.3. Without setting the litter down, the crewmember takes the outside litter pole and then directs the litter bearer to take the inside pole.

11.6.4.6.4. Once the AECMs secure the outside brackets, direct the litter bearers to exit the aircraft.

11.6.4.7. Loading into the sidewall track extenders #2 and #1 litter position:

11.6.4.7.1. The AECMs place the litter support strap in the litter above the position to be loaded.

11.6.4.7.2. The litter bearers come on board and stop in the aisle by the litter tier.

11.6.4.7.3. Without setting the litter down, the AECMs take the outside litter handle and direct the litter bearers to take the inside litter handle.

11.6.4.7.4. The AECM at the forward end of the litter give the command to lift the litter into the brackets.

11.6.4.7.5. AECMs position the outside bracket under the litter handle and secure the outside litter bracket. Direct litter bearers to exit the aircraft. **Note:** Litter support straps (C-130) will be secured to the aircraft floor prior to take-off. *(T-2).* If litters are not in the tier, loose litter support straps will be secured in a top and bottom litter support bracket on the litter stanchion. *(T-2).* This prevents a free-swinging strap from becoming a hazard.

11.6.4.7.6. Procedures for C-130 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning will remain the same. *(T-3).*

11.6.5. C-17 Aircraft Litter Loading Procedures:

11.6.5.1. When on/offloading patients, pay attention to the elevated area around the edge of the LSAS (this area could be a potential tripping hazard). Spotter(s) should be used to ensure litter bearers are aware of the hazard. When on/offloading patients of excessive weight or with excessive equipment requiring more than a four-person carry, extra caution should also be used.

11.6.5.2. The LSAS should remain onboard the aircraft during patient loading and offloading. **Exception:** in the rare event that a specific patient's condition, equipment needs or size raises serious safety concerns, the LSAS box may be removed from the aircraft for increased clearance. The PIC, with coordination between the MCD and LM, is the final authority in determining if the LSAS should be removed to facilitate patient on and offloading. MCD should request ground handling equipment, as required, on the offload message.

11.6.5.3. Litter arms should be positioned and secured with brackets open on all identified litter tiers. When configured to an AE-2 with the LSAS positioned on the ramp in the ADS rails, the most aft litter arms can be removed before loading if they present a safety hazard. Reposition the removed litter arms prior to loading that specific litter tier.

11.6.5.4. A four person carry can be utilized throughout the C-17 cargo compartment. **WARNING:** To ensure patient safety when loading and unloading litter stations, two
AECMs will maintain control of the litter until it is safely locked into the stanchion or cleared the stanchion for deplaning. (T-2).

11.6.5.5. When loading CCATT or oversized litters, more than a 4 person carry can be utilized. It is at the AECMs discretion not to release any of the litter bearers to assist with loading. AECMs are responsible for control and verbal commands of litter loading.

11.6.5.6. Litter position at or above waist level:

11.6.5.6.1. AECMs direct the litter bearers to the litter station.

11.6.5.6.2. Without setting the litter down, the AECMs take the inside litter handle and then direct the litter bearers to take the outside handle.

11.6.5.6.3. After the litter is placed in the litter arms, the AECMs secure the outside bracket. Direct litter bearers to exit the aircraft.

11.6.5.7. Loading into litter positions below waist level:

11.6.5.7.1. AECMs direct the litter bearers to the litter station.

11.6.5.7.2. Direct litter bearers to lower litter to the floor next to the litter station.

11.6.5.7.3. AECMs take the inside litter handle and then direct the litter bearer to maintain outside litter handles.

11.6.5.7.4. After the litter is placed in the litter arms, the AECMs secure the outside litter bracket. Direct litter bearers to exit the aircraft.

11.6.5.8. Procedures for C-17 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning remains the same.

11.6.6. SLS Loading Procedures.

11.6.6.1. Litter stanchion arms should be positioned and secured with brackets open on all identified litter tiers.

11.6.6.2. KC-135 operations, a four to a two person switch is performed once all litter bearers are on board. The released litter bearers will exit the aircraft or return to the loading platform to allow for unobstructed movement of the two litter bearers. (T-3).

11.6.6.3. Litter position at or above waist level:

11.6.6.3.1. AECMs direct the litter bearers to the litter station.

11.6.6.3.2. Without setting the litter down, the AECMs take the inside litter handle and then direct the litter bearers to take the outside litter handle.

11.6.6.3.3. After the litter is placed in the litter arms, the AECMs secure the outside bracket. Direct litter bearers to exit the aircraft.

11.6.6.4. Loading into litter positions below waist level:

11.6.6.4.1. AECMs direct the litter bearers to the litter station.

11.6.6.4.2. Direct litter bearers to lower litter to the floor next to the litter station.
11.6.6.4.3. AECMs take the inside litter handle and then direct the litter bearer to maintain outside litter handles.

11.6.6.4.4. After the litter is placed in the litter arms, the AECMs secure the outside litter bracket. Direct litter bearers to exit the aircraft.

11.6.6.5. Procedures for KC-135 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning will remain the same.

11.6.7. KC-46 Aircraft Litter Loading Procedures:

11.6.7.1. When pallets are in position during on/offloading patients, pay attention to the few rows of exposed omni roller at the edge of the pallet. Litter barriers will be made of aware of this hazard prior to loading patients. *(T-2).*

11.6.7.2. Litter arms should be positioned and secured with brackets open on all identified litter tiers.

11.6.7.3. A four to a two or three person switch is performed once all litter bearers are on board. The released litter bearers will exit the aircraft or return to the loading platform to allow for unobstructed movement of the remaining litter bearers.

11.6.7.4. AECMs are responsible for control and verbal commands of litter loading.

11.6.7.5. Litter position at or above waist level:

11.6.7.5.1. AECMs direct the litter bearers to the litter station.

11.6.7.5.2. Without setting the litter down, the AECMs take the inside litter handle and then direct the litter bearers to take the outside handle.

11.6.7.5.3. After the litter is placed in the litter arms, the AECMs secure the outside bracket.

11.6.7.5.4. Direct litter bearers to exit the aircraft.

11.6.7.5.5. Loading into litter positions below waist level:

11.6.7.5.6. AECMs direct the litter bearers to the litter station.

11.6.7.5.7. Direct litter bearers to lower litter to the floor next to the litter station. **Note:** Due to the sensitivity of the floor, litter should be placed down gently.

11.6.7.5.8. AECMs take the inside litter handle and then direct the litter bearer to maintain outside litter handles.

11.6.7.5.9. After the litter is placed in the litter arms, the AECMs secure the outside litter bracket. Direct litter bearers to exit the aircraft.

11.6.7.6. Procedures for KC-46 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning remains the same.


11.6.8.1. For AE missions, an ERO is authorized for contingency operations or during non-contingency AE missions when requirements dictate minimum ground time. EROs
should not be used in a non-contingency environment unless mission essential. ERO procedures may be trained during ARMs, joint training operations, exercises, etc. **WARNING:** Eye protection will be worn outside the aircraft during all ERO procedures. (T-2). **Exception:** For the C-17, eye protection is not necessary, except when operating in parking areas where flying debris could be picked up from engine exhaust.

11.6.8.2. C-5, C-21, KC-10, KC-135 and KC-46 Aircraft. AE EROs are not conducted on these aircraft for AE missions. AECMs may exit the aircraft to conduct ground duties if not contraindicated by Intel/SPINS.

11.6.8.3. The loadmaster should be positioned in a location to observe safety and on headset during actual on-load procedures. The LM observes for aircraft threats, and will enforce compliance with safety requirements. (T-3).

11.6.8.4. A spotter may be provided by the ground AE element and is positioned 50 feet aft of the aircraft ramp.

11.6.8.4.1. The spotter’s primary responsibility is to indicate to the ground element when the AEC are ready for patient loading, and to start/slow/stop the flow of patients as needed. Refer to paras 11.6.2.1-11.6.2.5 for appropriate hand signals.

11.6.8.4.2. The spotter monitors the litter-bearers to determine if assistance is needed and to ensure safe practices are maintained around the aircraft (i.e., prevent litter bearers from entering the prop wash/jet blast etc.)

11.6.8.5. Cross-loading. Patients can normally be cross loaded during EROs depending on the aircraft configuration and cargo requirements.

11.6.8.6. For the C-130, litters are brought onboard as safety considerations allow and loaded forward to aft/top to bottom.

11.6.8.7. Baggage loaded on the aircraft ramp as to not impede emergency egress.

11.6.8.8. If duties permit, loadmasters can assist AECMs with securing baggage.

11.6.9. Baggage Procedures: The 3AET is responsible for patient baggage procedures.

11.6.9.1. Accompanied patient baggage receives expeditious handling and is processed separately from passenger baggage. Anti-hijack inspection of all persons and hand-carried articles transported in the AE system is required. While this is normally accomplished by the originating MTF, the MCD ensures anti-hijacking statement is documented on the AF Form 3851 and or appropriate documentation. All baggage requires inspection.

11.6.9.2. The 3AET ensures all baggage is tagged with a DD Form 600 or equivalent and reflected on the original baggage manifest. The original baggage manifest is given to the MCD at the end of the mission and filed with mission paperwork.

11.6.9.3. Due to space limitations onboard the aircraft, all patients and attendants are limited to one hand-carried item (e.g., backpack, small luggage) and one personal item (e.g., purse, cosmetic bag). Carry-on baggage must fit under the seat and may not exceed 45 linear inches. (T-3). If hand-carried baggage does not fit under the patient’s seat and
is stored in the cargo compartment, a DD Form 1839, *Baggage Identification* or equivalent will be accomplished. (T-3).

11.6.9.4. Patients will not be permitted access to checked baggage. (T-2).

11.6.10. Baggage Restrictions. Special care should be exercised by all AE agencies to ensure that stowed and hand-carried baggage does not contain unauthorized weapons, explosive devices, or unauthorized drugs. Patients are authorized two pieces of checked baggage. Checked baggage may not exceed 62 linear inches (length plus width plus height) or 70 pounds for each piece (140 pounds total for two pieces of checked baggage). Any duffel bag, sea bag, B-4 bag, flyers kit bag, or diver’s traveling bag that exceeds 62 linear inches but does not exceed 100 pounds may be substituted for one of the checked baggage items. *Note:* On the C-21, patients and attendants will be limited to one stowed bag not exceeding 30lbs. (T-3). In addition one hand carried article (brief case, laptop case, or purse) may be carried. If extra baggage is carried, it will be processed by the sending facility into the Traffic Management System. *Note:* This does not include A/B/C bags or Individual Battle Attire Equipment. Every effort should be made to keep this equipment with the patient. If necessary, the A/B/C bags and excess gear may be moved as unaccompanied baggage through travel management office (TMO) to home unit of record.

11.6.11. Patient/Attendant Unaccompanied Baggage. Unaccompanied baggage are not to be transported onboard AE aircraft.

11.6.11.1. No-show patient/attendant baggage or baggage of patients/attendants removed from flight will be off-loaded prior to departure. (T-2).

11.6.11.2. Baggage that becomes separated from the owner becomes freight. Direct personnel to turn unaccompanied baggage over to TMO for proper manifesting.

11.7. **En Route Duties.** LM/BO/AECM, or other members of the aircrew, are responsible for ensuring information briefings highlight the following areas:

11.7.1. Emergency signals and passenger evacuation.

11.7.2. Use of emergency oxygen equipment and LPU (if applicable).

11.7.3. Location of restroom. *Note:* The AEC are not passenger monitors. When aircrew duties permit, AECMs may make every effort to assist the LM/ BO in accomplishing their passenger-related duties.

11.8. **Mission Delays.** To preclude unnecessary patient holding on the flight line, aircraft departure times are not established on the basis of an estimated time in commission (ETIC). Departure times will be scheduled only on the basis of fully mission capable. (T-3). *Note:* The MCD should immediately notify the applicable C2 agency of any mission delays. The MCD must be cognizant that guidelines are not a substitute for sound judgment. (T-3). Decisions should be put into action only after making a thorough assessment of the patient’s medical needs and considering surrounding circumstances. With this in mind, the following guidance is offered:

11.8.1. If the delay exceeds 1 hour, ambulatory patients should be deplaned to a rest area such as a lounge or terminal facility. These patients remain the responsibility of the AECMs. If feasible, litter patients should be evaluated and appropriate action taken for their care.
Further guidance on obtaining meals for patients can be located in AFI 48-307V1. Keep patients informed of the current situation.

11.8.2. Once the mission is in delay and the aircraft ETIC is more than 3 hours after scheduled departure, consider moving all patients to the nearest medical facility capable of supporting patient requirements. Before the actual movement of patients takes place, contact the appropriate C2 agency (TACC/AECT) for consultation and assistance. The MCD will ensure the C2 agency is promptly notified of the problem as the facts are known. (T-2).

Note: Ground transportation time to the MTF should be considered.

11.9. **Mission Termination.** The following tasks must be completed by AECMs before an AE mission may be terminated:

11.9.1. Disconnect all medical equipment and personal flying gear after patients have been deplaned.

11.9.2. Accomplish applicable inventories.

11.9.3. The MCD/CMT will ensure:

11.9.3.1. AECM aircraft interior cleaning tasks are completed, which includes the cleaning and proper disposal of blood and/or body fluids from the aircraft. For further guidance refer to AFI 11-202V3_AMCSUP.

11.9.3.2. Trash and all used disposable medical supplies are collected for removal by aircraft services.

11.9.3.3. The aircraft is properly secured at RON points as specified in local directives.

11.9.3.4. All aircraft systems discrepancies and malfunctions have been reported to the LM or BO for repair by maintenance personnel.

11.9.3.5. All inoperative medical equipment is properly identified and tagged.

11.9.3.6. A post mission debrief will be conducted after all AE missions. (T-3). MCD completes End of Mission Report with AE Cell in the 618 AOC (TACC) for AMC missions and appropriate AOC/AMD for theater missions.
Chapter 12

AERIAL REFUELING

12.1. **General.** AR is an option which may be considered when planning AE patient movement. Refer to AFI 48-307V1, for nursing considerations related to air refueling.

12.2. **Refer to AFI 11-202V2_AMCSUP for further air refueling guidance.** Refer to AFI 11-202V3_AMCSUP, specific MDS V3, for air refueling considerations.

12.3. **Training Missions.** OG/CC may authorize air refueling on training missions. PIC and MCD will maximize in-flight training opportunities for AECMs during air refueling missions.
Chapter 13

AE MISSION SAFETY

13.1. Safety Responsibilities and Precautions. All AECMs are responsible for enforcing and observing safety measures while performing the patient airlift mission.

13.1.1. Emergency procedures outlined in aircraft T.O.s, required directives, and abbreviated checklists must be reviewed frequently to ensure fully coordinated action of all AECMs. (T-2).

13.1.2. AECMs must remain alert for unusual occurrences and immediately report any safety hazards to the MCD or PIC. (T-2).

13.1.3. Adherence to crew resource management (CRM), threat error management (TEM) and patient path management (PPM) procedures/practices and constant situational awareness are keys to safe mission accomplishment.

13.1.4. Open abbreviated checklist to the appropriate phase of flight from preflight briefing through mission termination.

13.2. Ground Safety. As prescribed by AFMAN 11-218, Aircraft Operations and Movement on the Ground, personnel in the immediate area of an operating aircraft will wear hearing protection. (T-2). AECMs will exercise extreme caution during all ground procedures. (T-1).

13.2.1. A high accident potential exists due to noise level, vehicle activity around the aircraft, blackout/low-light conditions and inclement weather.

13.2.2. No smoking is allowed within 50-feet of the aircraft.

13.3. Guidelines for Vehicle Drivers. Vehicle operators will follow the guidelines prescribed in AFMAN 24-306, Operation of Air Force Government Motor Vehicles. (T-3). Note: Vehicle supervision, movement, and placement in and around the aircraft are the responsibility of the CMT with concurrence of the LM/BO, or PIC (as applicable).

13.3.1. All vehicular movement around the aircraft must maintain the 10-foot circle of safety from the nose, tail and wingtips of the aircraft. (T-2). Any movement required within this circle will be directed by the CMT with concurrence of the LM/BO. (T-2).

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

13.3.3. The spotter pre-positions wheel chocks between the aircraft and vehicle within the 10 foot circle of safety, to prevent vehicles from damaging the aircraft. Additional vehicles can be parked without chocks (no closer than 10 feet to the aircraft) providing a chocked vehicle is between the un-chocked vehicle and the aircraft. Chocks will remain in position until the vehicle(s) are ready for movement. (T-2).

13.3.4. Vehicles parked on the flight-line will remain unlocked with the key in the ignition. (T-3). If the vehicle driver does not remain in the driver’s seat after parking, the ignition must be turned off and the parking brake applied. (T-3). In addition, the gear lever will be placed in a gear on vehicles with standard transmission, park for vehicles with automatic
transmission. These requirements are not necessary if a driver remains behind the wheel at all times.

13.3.5. Only vehicles required to enplane/deplane patients or passengers or service the aircraft are permitted to approach the aircraft after it has blocked in. (T-2). All vehicles remain clear until directed to proceed towards aircraft. More than one vehicle may be positioned in the vicinity of the aircraft; however, only one vehicle may be in motion toward the aircraft at any one time.

13.3.6. AE ground support vehicles should be positioned near the ramp entrance for aircraft set up, enplaning/deplaning of AE medical equipment/supplies.

13.3.7. The ambulance bus (AMBUS) or ambulances should be positioned near the ramp entrance. Additional AMBUSs or ambulances may be parked next to the first AMBUS and/or ambulance, to expedite enplaning/deplaning patients.

13.4. Emergency Exits and Safety Aisles.

13.4.1. When patients are seated in side facing seats, the LM/BO AECMs ensure there is sufficient space between the cargo and the seats to permit patient’s leg room.

13.4.2. When the load consists of palletized netted cargo or is secured with straps or chains, maintain a 30-inch space between the cargo and the nearest forward litter or occupied seat.

13.4.3. Ensure at least one unobstructed emergency exit is available for each 20 passengers. This does not restrict over water flights if the three overhead escape hatches are available for egress. Litters and seats erected across an emergency exit are not considered an obstruction. WARNING: For KC-135, SLSs, and litters cannot be placed in front of hatches.

13.4.4. Do not secure aircraft or medical equipment adjacent to an emergency exit in a manner that impedes egress.

13.4.5. During egress, ramps on all aircraft may be used if already deployed and unobstructed.

13.5. Equipment Procedures. CAUTION: When heavy or bulky equipment is rolled up/down the aircraft ramp, ensure an adequate number of personnel are available to prevent injury to personnel, or damage to equipment.

13.5.1. Equipment that may be rolled up/down the ramp of C-130 and C-17:

13.5.1.1. Unoccupied transport incubators, securely attached to a wheeled frame or containing integral wheels. Exception: An occupied neonatal transport system (NTS) may be rolled up or down ramps due to the weight of the NTS. Ensure the infant is properly secured inside the incubator. Enplane/deplane the NTS with 4 or more people. The MCD and CMT should use good judgment and common sense to carry out this operation in a safe manner. Occupied or unoccupied NTS will not be rolled up or down PLS, jarring may damage components. (T-3).

13.5.1.2. Unoccupied ambulance-type stretchers/gurneys.

13.5.1.3. Any other item that has integral wheels and is required to support a mission.

13.5.1.4. Pressurized gas cylinders secured to wheeled dollies. Note: Regulators must be removed and cylinders capped prior to enplaning/deplaning. (T-2). Only cylinders
with caps are accepted. **Exception:** Cylinders carried as part of a system (transport incubator, etc.) with cylinders in their applicable transport compartment do not need to be capped.

13.5.1.5. Compressed gas cylinders may be utilized as a source to provide oxygen or other compressed gas on any AE mission. These cylinders provide the drive pressure and gas mixes for ventilator patients and supplemental oxygen as required. When a patient is delivered to their final destination and the cylinders are deplaned, they will be prepared for return shipment as hazardous cargo per AFMAN 24-204_IP. *(T-2).* When the same aircraft returns to home station where the cylinders originated, they may remain onboard as aeromedical equipment. Always have the regulators removed and the cylinder capped when returning cylinders. *(T-2).*

13.5.1.6. H-Tank securing procedure. See H-Tank Shoring and Restraint (all aircraft) located in Electronic Flight Bag for the procedures.

13.5.2. Minimum of a four person carry is required for enplaning/deplaning the following:

13.5.2.1. Lifting a litter patient above waist level.

13.5.2.2. Litter patients of excessive weight or those required to be carried for long distances.

13.5.2.3. Occupied civilian ambulance type stretchers/gurneys. **Note:** Prior to placing a patient on or removing a patient from an ambulance gurney/stretcher, ensure the gurney/stretcher is in the lowest position, side rails are down, and wheels are locked or a member from the ambulance team has control of the gurney/stretcher. *(T-3).*

13.5.2.4. Transport incubators with infants. **Note:** Infant transport incubators are placed in any litter tier in the middle position. The infant’s head is positioned forward or aft within the incubator according to the manufacturer’s instruction. At least two securing straps will be connected around the infant for takeoff, landing and in flight. *(T-2).*

13.5.2.5. Patients on Stryker Frames or similar devices.

13.5.2.6. When inclement weather creates a hazardous condition (e.g., icy or wet ramp).

13.5.2.7. Whenever determined by the aircrew to be the safest method for enplaning/deplaning based on conditions. **Note:** Due to the limited aisle width onboard most aircraft, a switch to a two person carry may be conducted in the interest of safety. Use good judgment prior to the switch, to prevent undue injury or strain to the two person carry team. AECMs switch back to four-persons if lifting above waist level into litter stanchions. Ensure ramp extenders are placed/spaced to facilitate the safe loading/unloading of patients in the given operating environment (i.e., contingency, low-light, inclement weather etc.). Position spotters as required to ensure safe operations. *(T-3).*

13.5.3. A minimum three person carry is required for the following:

13.5.3.1. Enplaning/deplaning a litter patient with a backrest. Two individuals are at the head of the litter and the third at the foot of the litter. **Note:** AECMs may revert to a two person carry once inside the aircraft. Backrests will not be in the 90-degree position
during enplaning/deplaning or during take-off and landing. (T-2). The backrest may be changed to the 90-degree angle in-flight for patient comfort and care.

13.5.3.2. Lifting litter patients into or out of an ambulance, AMBUS or a vehicle that does not have a ramp.

13.5.3.2.1. Position one person at the foot of the litter and two persons on either side of the litter at the door of the vehicle to lift and assist in moving the litter.

13.5.3.2.2. Physically secure or manually hold vehicle doors in the open position when litter patients are being loaded/unloaded.

13.5.3.2.3. As the litter is pulled out of the vehicle, the two individuals positioned at the sides of the litter will grasp the litter with one hand at or above the patient’s waist and one hand at the patient’s head. (T-2). Position personnel in a way that they can safely hand the litter off to others as needed.

13.5.3.3. Wheelchair patients/transporting battery powered wheelchairs.

13.5.3.3.1. Position one individual behind and two forward of the patient in the wheelchair.

13.5.3.3.2. Locate space in the aircraft cabin to secure the wheelchair. Note: When a wheelchair patient is scheduled for transport, the tasking C2 agency will ensure adequate space is available for wheelchair storage. (T-2).

13.5.3.3.3. Secure the wheelchair upright in the aircraft cabin. Ensure the wheelchair does not interfere with emergency egress or pose a safety hazard. (T-2). To prevent wheelchair damage, do not over tighten cargo tie-down straps.

13.5.3.3.4. Deactivate the battery. Remove the connection at the battery terminals or otherwise disconnect power source per manufactures guidance. WARNING: Do not charge the battery or electric wheelchairs via the aircraft electrical system. Ensure the battery is securely attached to the wheelchair. Do not remove the battery from the wheelchair. (T-3).

13.5.4. Defibrillation Procedures. To safely defibrillate a patient positioned on the aircraft floor, place a dry, woolen/cotton blanket under the patient. If any part of the patient contacts the floor, the distribution of current may be affected, resulting in the patient receiving less than the programmed amount of defibrillating current and/or possible skin burns. When monitoring electrodes are attached to the patient, the ground electrode possesses a ground potential. Patients may be defibrillated on litters with aluminum handles. Normal safety precautions must be followed (i.e., avoid direct contact with the patient or any portion of the litter during the procedure). (T-3).


13.6.1. All patients, regardless of age, are assigned a seat. The parent or guardian has the option to hold the infant or place them in an FAA approved infant car seat in the assigned seat.

13.6.1.1. The FAA has banned the use of booster seats, harness and vest child restraints.
13.6.1.2. When a parent or attendant holds a child/infant, the seat belt is never placed around both the parent/attendant and the child/infant.

13.6.1.3. In the event of turbulence, the weight of the adult against the child/infant could result in injury to the child/infant. The attendant secures the seat belt around their waist, with the seat belt securing mechanism secured to the aisle side of the attendant (if possible) to prevent the child/infant from sitting on the securing mechanism. A litter strap is placed through the seat belt, around the child/infant, and then secured. Additional padding should be placed between the child and the litter strap buckle.

13.6.1.4. When a small child occupies a seat, a pillow (if available) or some type of padding (i.e., blanket) should be placed between the child and the seat belt securing mechanism. Acceptable child/infant safety seats/restraints may be used during all phases of flight in forward or aft facing seats. Note: These types of seats/restraints may will not normally be used in side facing (web type) seats, to transport patients or attendants. (T-2). Passenger Services has approved the transport of passengers requiring child/infant safety seats/restraints in side facing (web type) seats.

13.6.1.5. If the aircraft is equipped with airline type seats, seat children/infants in child/infant seats/restraints by the fuselage with an adult in the aisle or middle seat.

13.6.1.6. An adult must be able to reach emergency oxygen/life vest under all circumstances. (T-2).

13.6.1.7. Never seat young children where they are required to distribute oxygen masks. Ensure parents with young children can reach the oxygen mask container. (T-2).

13.6.1.8. Secure pregnant patients with a small pillow (if available) or some type of padding (i.e., blanket, etc.) between their lower abdomen and the seat belt. (T-1). The seat belt is secured under the abdomen, across the hips.

13.6.2. Crewmembers should keep one hand free in-flight, if possible, to allow for stabilization in the event of turbulence.

13.6.3. Smoking in aircraft lavatories is a federal offense. Patients or passengers smoking in lavatories or tampering with detectors (if applicable) should be deplaned, medical condition permitting, at the next en route stop. Alert local authorities of the offense. Notify tasking AE C2 agency for patient offenses, 618 AOC (TACC) for passenger offenses and document actions/details on AF Form 3829, (or TRAC2ES equivalent). WARNING: Under no circumstances will the flameless ration heaters, included in Meal, Ready-to-Eat (MREs), be handled inside the aircraft. (T-2). Tests conducted by FAA state that the release of hydrogen gas from MREs is of a sufficient quality to pose a significant hazard onboard aircraft. Do not activate flameless MRE ration heaters during flight.

13.6.4. AECMs should escort patients to the latrine. Same sex AECM should accompany mental health patients to the latrine to provide supervision.

13.6.5. When required to perform aircrew duties for a litter patient during takeoff and/or landing, FNs, AETs, or MAs will be properly secured to the litter. (T-2). Three litter straps are required for the following procedure:
13.6.5.1. One litter strap must be placed through the stirrups on each end of the litter and attached securely through a litter strap placed around the waist of the person standing. (T-2).

13.6.5.2. The person standing should be positioned on the aisle of the litter.

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
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AMCI 11-208, Mobility Air Forces Management, 8 February 2017
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AFI 48-307V1, En Route Care and Aeromedical Evacuation Medical Operations, 9 January 2017
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AFI 48-307V3, En Route Care Documentation, 12 April 2016
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AFPAM 10-1403, *Air Mobility Planning Factors*, 24 October 2018
AFTTP 3-4, *Airman’s Manual*, 11 January 2018
DoD Foreign Clearance Guide, Current Edition
DoDI 4515.13, *Air Transportation Eligibility*, 22 January 2016
Privacy Act (5 U.S.C. § 552a)
Current *Aeromedical Evacuation Medical Equipment Compendium*, Aircrew Publications Library

**Prescribed Forms**
AF Form 3858, *Aeromedical Evacuation Mission Offload Message*

**Adopted Forms**
AF Form 8, *Certificate of Aircrew Qualification*
AF Form 579, *Controlled Substances Register*
AF Form 673, *Air Force Publication/Form Action Request*
AF Form 847, *Recommendation for Change of Publication*
AF Form 1199, *Air Force Entry Control Card*
AF Form 3829, *Summary of Patients Evacuated by Air*
AF Form 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*
AF Form 3841, *Certificate of Release*
AF Form 3851, *Patient Baggage Data*
AF Form 3854, Receipt for Patient’s Valuables
AF Form 3859, Turn-In of Unaccompanied Narcotics
AF Form 3899, Aeromedical Evacuation Patient 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 Flowsheet
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 Flowsheet
AF Form 3899H, Patient Movement Neurological Assessment
AF Form 3899I, Patient Movement Medication Record
AF Form 3899J, Patient Movement/Pain Adjunction Flowsheet
AF Form 3899K, Patient Movement/In-flight Resuscitation Flow Sheet
AF Form 3899L, En Route Critical Care
AF Form 3899M, Patient Movement Record PCA/PNB/Epidural Hand-Off
AF Form 3899N, Patient Movement Pain Adjunction Flowsheet
AF Form 4076, Aircraft Dash 21 Equipment Inventory
AF Form 4327A, Crew Flight (FA) Authorization
AF Form 4449, En Route Care Equipment Malfunction Report Tag
AFTO Form 46, Prepositioned Aircrew Flight Equipment
AFTO Form 244, Industrial/Support Equipment Record
AFTO 350, Reparable Item Processing Tag
AFTO Form 781, ARMS Aircrew/Mission Flight Data Document
AFTO Form 781A, Maintenance Discrepancy and Work Document
AMC Form 97, AMC In-Flight Emergency and Unusual Occurrence Worksheet
DD Form 600, Patient’s Baggage Tag
DD Form 1380, Tactical Combat Causality Care (TCCC) Card
DD Form 1839, Baggage Identification
DD Form 1854, US Customs Accompanied Baggage Declaration
DD Form 2852, Patient Movement Event/Near Miss Report
Abbreviations and Acronyms

AAR—Air to Air Refueling
ACLS—Advanced Cardiac Life Support
ACM—additional crew member
ADS—Aerial Delivery System
AE—Aeromedical Evacuation
AEC—Aeromedical Evacuation Crew
AECM—Aeromedical Evacuation Crewmember
AECT—Aeromedical Evacuation Control Team
AEM—Aeromedical Evacuation Crew Monitoring
AEP—Aeromedical Evacuation Primary
AET—Aeromedical Evacuation Technician
AETC—Air Education and Training Command
AFE—Aircrew Flight Equipment
AFI—Air Force Instruction
AFRC—Air Force Reserve Command
AFMAN—Air Force Manual
AGE—Aerospace Ground Equipment
AMBUS—Ambulance Bus
AMC—Air Mobility Command
AMCC—Air Mobility Control Center
AMD—Air Mobility Division
AMOG—Air Mobility Operations Group
AMOW—Air Mobility Operations Wing
ANG—Air National Guard
AOC—Airlift Operations Center
AR—Air Refueling
ARM—Aeromedical Readiness Mission
ATC—Air Traffic Control
AWIS—Aircraft Wireless Intercom System
BO—Boom Operator
BVM—Bag-Valve-Mask
BWA—Biological Warfare Agent
C2—Command and Control
CAC—Common Access Card
CB—chemical and biological
CBRN—Chemical, Biological, Radiological, Nuclear
CC—Commander
CCATT—Critical Care Air Transport Team
CDT—Crew Duty Time
CMT—Charge Medical Technician
CNE—Chief Nurse Executive
CONOPS—Concept of Operations
CONUS—Contiguous United States
CRE—Contingency Response Element
CRG—Contingency Response Group
CRM—Crew Resource Management
CWA—Chemical Warfare Agent
DO—Director of Operations
DOD—Department of Defense
ECAS—Electrical Cable Assembly Set
EFB—Electronic Flight Bag
EHR—Electronic Health Record
EPOS—Emergency Passenger Oxygen System
EPW—Enemy Prisoner of War
ERCC—En Route Critical Care Team
ERO—Engines Running Onload or Offload
ERPSS—En Route Patient Staging System
ETIC—Estimated Time in Commission
FAA—Federal Aviation Administration
FCB—Flight Crew Bulletin
FCIF—Flight Crew Information File
FCG—Flight Clearance Guide
FDP—Flight Duty Period
FN—Flight Nurse
FLIP—Flight Information Publications
GCE—Ground Crew Ensemble
HDPLP—High Deck Patient Loading Platform
JOSAC—Joint Operational Support Airlift Center
IDS—Individual Data Summary
IPE—Individual Protective Equipment
ISS—In System Select
ITS—Individual Training Summary
ITLS—International Trauma Life Support
LM—Loadmaster
LPU—Life Preserver Unit
LSAS—Litter Station Augmentation Set
MAF—Mobility Air Force
MAJCOM—Major Command
MA—Medical Attendants
MCD—Medical Crew Director
MDS—Mission Design Series
MEP—Mission Essential Personnel
MHE—material handling equipment
MOPP—mission oriented protective posture
MRE—Meal, Ready-to-Eat
MTF—Medical Treatment Facility
NAF—Numbered Air Force
NGB—National Guard Bureau
NMA—Non-Medical Attendant
NOTAM—Notice to Airman
NPTLOX—Next Generation Portable Liquid Oxygen
NTS—Neonatal Transport System
OG—Operations Group
OPORD—Operations Order
OPR—Office of Primary Responsibility
ORM—Operational Risk Management
PACAF—Pacific Air Forces
PBE—Protective Breathing Equipment
PIC—Pilot in Command
PII—Personally Identifiable Information
PLS—Patient Loading System
PMRC—Patient Movement Requirements Center
POC—Point of Contact
PPM—Patient Path Management
PTLOX—Portable Therapeutic Liquid Oxygen
RM—Risk Management
RON—Remain over Night
SII—Special Interest Items
SLS—Stanchion Litter System
STT—Special Tactics Teams
TACC—Tanker/Airlift Control Center
TALCE—Tanker Airlift Control Element
TDY—Temporary Duty
TMO—Traffic Management Office
T.O.—Technical Order
TPMRC-A—Theater Patient Movement Requirements Center-Americas
USAFE—United States Air Forces in Europe
USTRANSCOM—United States Transportation Command

Terms
Aeromedical Evacuation (AE)—AE provides time-sensitive en route care of regulated casualties to and between medical treatment facilities, using organic and/or contracted aircraft with medical aircrew trained explicitly for this mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full range of military operations, and in all operating environments.

Aeromedical Evacuation Crew (AEC)—Applies to entire crew: Medical Crew Director (MCD), Flight Nurse (FN), Charge Medical Technician (CMT), Second Aeromedical Evacuation Technician (2AET), Third Aeromedical Evacuation Technician (3AET).

Aeromedical Evacuation Control Team (AECT)—A cell within the air operations center and one of the core teams in the air mobility division. Provides command and control for theater aeromedical evacuation elements. It is responsible to the director of mobility forces for current
aeromedical evacuation operational planning and mission execution. The aeromedical evacuation control team analyzes patient movement requirements; coordinates airlift to meet aeromedical evacuation requirements; tasks the appropriate aeromedical evacuation elements including special medical requirements, when necessary; and passes mission information to the patient movement requirement center.

**Aeromedical Evacuation Crewmember (AECM)**—Qualified Flight Nurses (FN), Aeromedical Evacuation Technicians (AET), performing AE crew duties.

**Aeromedical Evacuation Technician**—Certified Nationally Registered Emergency Medical Technician. Trained to provide in-flight inpatient medical-surgical level care. Knowledgeable about the stresses of flight, aerospace physiology, basic trauma skills and patient safety. Experts on the interface between aircraft systems and medical equipment to meet clinical care requirements.

**Airlift**—Aircraft is considered to be performing airlift when manifested passengers or cargo is carried.

**Air Traffic Control (ATC)**—A service provided by an appropriate authority to promote the safe, orderly and expeditious use of the air transportation system and to maximize airspace utility.

**Aeromedical Readiness Missions (ARMs)**—Simulated Aeromedical Evacuation missions that are the primary means of preparing for AE airlift. These missions can be diverted to fulfill real versus simulated patient airlift requirements.

**Augmented Crew**—Adding additional qualified aircrew by SQ/CC or designee based on scheduled FDP exceeding 16 hours. Responsible for mission accomplishment for the aircraft to arrive at (block in) or depart from (block out) the parking spot.

**Border Clearance**—Clearances and inspections required to comply with federal, state, and local agricultural, customs, immigration, and immunization requirements.

**Charge Medical Technician (CMT)**—A qualified Aeromedical Evacuation Technician (AET) who supervises other AETs in the other aircrew positions on AE missions and ensures completion of enlisted AE crew duties.

**Command and Control (C2)**—Exercise of direction and authority over assigned forces by a properly designated command echelon in the accomplishment of the mission.

**Command and Control (C2) Center**—Each C2 Center provides supervision, guidance, and control within its assigned area of responsibility. For the purpose of this AFMAN, C2 Centers include operations centers, command posts, air mobility elements, tanker airlift control elements (TALCE), air mobility control centers, and tanker task forces.

**Concurrent servicing**—Simultaneous refueling or de-fueling while cargo or maintenance operations are being performed.

**Critical Phase of Flight**—Takeoff, AR, approach, and landing.

**Detainee**—A term used to refer to any person captured or otherwise detained by an armed force. Detainees include, but are not limited to, those persons held during operations other than war.
Deviation—A deviation occurs when takeoff time is not within \(-20/\pm 14\) minutes of scheduled takeoff time. Scheduled takeoff time may be adjusted to make good an ARCT. Notify controlling agency prior to takeoff to adjust the scheduled takeoff time.

Enemy Prisoner of War (EPW)—A detained person as defined in Articles 4 and 5 of the Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949. In particular, one who, while engaged in combat under orders of his or her government, is captured by the armed forces of the enemy.

En Route Critical Care (ERCC)—specialized teams for patient movement. (i.e., Critical Care Air Transport Team; Burn Team; Neonatal Intensive Care Team).

Estimated Time in Commission (ETIC)—Estimated time required to complete required maintenance.

Execution—Command-level approval for initiation of a mission or portion thereof after due consideration of all pertinent factors. Execution authority is restricted to designated command authority.

Flight Nurse—Registered Nurse. Trained to provide in-flight inpatient medical-surgical level care. Knowledgeable about the stresses of flight, aerospace physiology, basic trauma skills and patient safety. Experts on the interface between aircraft systems and medical equipment to meet clinical care requirements.

Ground Time—Interval between engine shut down (or arrival in the blocks if engine shutdown is not scheduled) and next takeoff time.

Hazardous Cargo or Materials (HAZMAT)—Articles or substances that are capable of posing significant risk to health, safety, or property when transported by air and classified as explosive (class 1), compressed gas (class 2), flammable liquid (class 3), flammable solid (class 4), oxidizer and organic peroxide (class 5), poison and infectious substances (class 6), radioactive material (class 7), corrosive material (class 8), or miscellaneous dangerous goods (class 9). Classes may be subdivided into divisions to further identify hazard. (i.e., 1.1, 2.3, 6.1, etc)

Home Station—Location where individual finance and personnel records are maintained.

Interfly—The exchange and/or substitution of aircrews and aircraft between MAF including crewmembers and/or aircraft from AETC, ACC, PACAF, and AMC-gained ANG and AFRC forces.

Local Training Mission—A mission scheduled to originate and terminate at home station (or an off-station training mission), generated for training or evaluation, and executed at the local level.

Medical Crew Director (MCD)—A qualified FN responsible for supervising patient care and AECMs assigned to AE missions.

Mission Essential (ME)—An item, system, or subsystem component essential for safe aircraft operation or mission completion.

Mission—Movement of aircraft from a designated point of origin to a designated destination as defined by assigned mission identifier, mission nickname, or both in the schedule, mission directive, OPORD, OPLAN, or Frag order.
Mobility Air Force (MAF)—Forces assigned to mobility aircraft or MAJCOMs with operational or tactical control of mobility aircraft.

Operational Missions—Missions executed at or above 618 AOC (TACC) level. Operational missions termed "CLOSE WATCH" include CORONET missions and AFI 11-221, Air Refueling Management (KC-10 and KC-135), priority 1, 2, and 3 missions tasked by the 618 AOC (TACC). Other operational missions such as deployment, re-deployment, reconnaissance operations, operational readiness inspections (ORI), AMC channel or SAAM, and JA/ATT missions may be designated "CLOSE WATCH" as necessary.

Operational Risk Management (ORM)—A logic based common sense approach to making calculated decisions on human, materiel, and environmental factors before, during, and after Air Force operations. It enables commanders, functional managers, and supervisors to maximize operational capabilities while minimizing risks by applying a simple, systematic process appropriate for all personnel and Air Force functions.

Opportune Airlift—Transportation of personnel, cargo, or both onboard aircraft with no expenditure of additional flying hours to support the airlift.

Over water Flight—Any flight that exceeds power off gliding distance from land.

Patient Movement Categories:—See below

Urgent—Patients who must be moved immediately to save life, limb, or eyesight, or to prevent complication of a serious illness.

Priority—Patients requiring prompt medical care that must be moved within 24 hours.

Routine—Patients who should be picked up within 72 hours and moved on routine/scheduled flights.

Pilot in Command—A qualified pilot responsible for command and control of all persons aboard the aircraft.

Positioning and De-positioning Missions—Positioning missions are performed to relocate aircraft for the purpose of conducting a mission. De-positioning missions are made to return aircraft from bases at which missions have terminated.

Remain Over Night (RON)—A scheduled or unscheduled mission stop that requires the aircrew to spend the night at a given location due to maintenance, crew duty or patient emergency concerns.

Scheduled Takeoff Time—Takeoff time is established in the schedule or OPORD. For air aborts and diversions, this will be engine shut down time (or arrival in the blocks if engine shutdown is not scheduled) plus authorized ground time. Early deviation does not apply to aborts or diversions unless the mission is formally rescheduled by current operations.

Supplemented crew—Adding additional qualified aircrew by CNE to aid in patient care based on increased patient load/acuity.

Theater Patient Movement Requirements Center (TPMRC)—The TPMRC is responsible for theater wide patient movement (e.g., medical regulating and AE scheduling), and coordinates with theater MTFs to allocate the proper treatment assets required to support its role. The primary role of the TPMRC is to devise theater plans and schedules and then monitor their
execution in concert with the GPMRC. The TPMRC is responsible to the Combatant Commander through the Combatant Command Surgeon. The TPMRC is also responsible for all aspect of intratheater patient movement management. A TPMRC provides command and control for patient movement management operations in its theater of operations, as directed by its Combatant Commander’s operational policy, and in coordination with USTRANSCOM, acting as a supporting combatant command, responsible for intertheater and CONUS patient movement.

**Theater Patient Movement Requirements Center-Americas (TPMRC-A)**—Provides global oversight and synchronization of patient movement during wartime, peacetime and contingency operations; facilitate safe, effective and expeditious patient movement for US Northern and Southern Commands by providing medical regulating services, clinical and administrative validation, in transit visibility, and deployable patient movement enablers.

**Time Out**—Common assertive statement used to voice crewmember concern when safety may be jeopardized.

**Training Mission**—Mission executed at the unit level for the sole purpose of aircrew training for upgrade or proficiency. Does not include operational missions as defined in this AFMAN.
Attachment 2

**AEROMEDICAL EVACUATION CREW MEMBER EXPANDED CHECKLISTS**

A2.1. Section I. This checklist establishes procedures for Aeromedical Evacuation Crews (AEC) on aircraft employed by Mobility Air Forces (MAF) to accomplish their worldwide missions. This checklist is intended to provide quick and reliable references to aid the AEC for mission planning and use inflight. It can be utilized as a digital or printed reference and available to AECs on all missions.

A2.2. Section II.

A2.2.1. Medical Crew Director (MCD). The MCD ensures the aircraft is acceptable and configured for the assigned mission. The MCD supervises the nursing care and management of patients and is responsible for managing the AE crew and medical support personnel assigned to the mission. The MCD advises and/or coordinates all pertinent aspects of the mission with the PIC. The MCD will immediately notify C2 agency of patient or mission status changes as required. If the checklist is accomplished by one FN, accomplish all MCD and FN duties.

A2.2.2. Flight Nurse (FN). The FN assists the MCD as required. The FN provides professional nursing care during all aspects of AE missions, reviews and coordinates in-flight patient care requirements as required with origination and destination MTF personnel, completes appropriate forms, and performs additional duties as assigned by the MCD. The FN is accountable for collection and storage of medications (including controlled medications).

A2.2.3. Charge Medical Technician (CMT). The CMT is responsible for the supervision and management of AETs assigned to perform duties on the mission. It is the responsibility of the CMT to ensure that medical supplies and equipment are on the aircraft and installed equipment is operable. The CMT is responsible for all AE ground operations around the aircraft. CMT will receive directions from and be responsible to the MCD (or assistant) and will also assist the flight crew if required.

A2.2.4. Aeromedical Evacuation Technician (AET). The Second AET (2AET) and Third AET (3AET) will assist the CMT as required. AETs provide in-flight patient care under supervision of a qualified FN, complete the appropriate forms, and perform duties as assigned by the CMT. 3AET is responsible for all patient baggage procedures.

A2.3. Aeromedical Evacuation Crew Member Expanded Checklists. See Table A2.1 - Table A2.3.

Table A2.1. Aeromedical Evacuation Crew Member Expanded Checklists.

<table>
<thead>
<tr>
<th>MISSION PREPARATION.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Administrative Duties prior to start of AEC Crew Brief (AEC)</td>
</tr>
<tr>
<td>a. Read and annotate FCIF/SII/SPINS/NOTAMs/Ensure EFB is current.</td>
</tr>
<tr>
<td>b. Obtain mission paperwork and documentation</td>
</tr>
<tr>
<td>(1) Verify flight authorization information.</td>
</tr>
</tbody>
</table>
(2) Calculate ORM Factors.
(3) Obtain aircraft tail number and parking spot.
(4) Obtain passport (as required).
(5) Complete personal customs declaration forms (as required).
(6) Review patient manifest.
c. Identify patient requirements and prepare nursing care plan.
   (1) Verify receipt of approved A3VM waiver instructions (if required).
d. Collect all AEC customs forms. (3AET)
AEC Crew Briefing (AEC)
a. Discuss/Review ORM/CRM/TEM. (MCD) **Note:** Review assertive statement procedures (“Time Out” & “Knock it Off”). (MCD)
b. Address Go/No-Go process, personal requirements and special interest items. (MCD)
c. Brief known mission information (i.e., U, P, 1A, 1B, prisoners, security police and armed attendants, etc.) unregulated patients and airlift/sortie considerations. (MCD)
d. Coordinate with ERCC/MA/NMA requirement/special patient requirements/ equipment, and crew responsibilities and infection control procedures. (MCD)
e. Discuss medical emergency procedures. (MCD)
   (1) Identify ACLS/PALS, International Trauma Life Support (ITLS), 7-level, etc. trained crewmembers.
   (2) Make cardiac arrest assignments.
   (3) Discuss emergency patient placement.
f. Review/discuss aircraft emergencies and egress plan. **Note:** May use patient positioning plans as applicable. (MCD)
g. Release 3AET for baggage procedures (as required).
h. Receive patient report from Nurse of the Day (if available) or MCD/FN, including patient positioning plan, patient records, and patient medications.
   (1) Verify patient passports and appropriate papers for non-US citizens are available (as required).
   (2) Received hard copy of approved A3VM equipment waiver instructions (if required).
i. Create/discuss patient positioning plan and assign patient care responsibilities.
   (1) Identify patient or equipment requirements that may require extended ground time/use of aircraft systems.
j. Assign specific equipment, supplies, and configuration duties. (CMT)
   (1) Stanchion/straps/stanchion arms/brackets/seat set-up.
   (2) Therapeutic/emergency oxygen/02 calculation.
   (a) Total the oxygen flow in LPM for each patient. Calculate ventilator use at 15 LPM per unit.
LPM for LTV series ventilators. Add 7.5 LPM for emergency use to the patient total for the overall mission requirement (LPM).

(b) Add the estimated flight time to the estimated ground time to get total mission hours. **Note:** When calculating estimated ground time, calculate the estimated ground time with patients anticipated on board. Configuration and cargo off load will not be considered.

(c) Multiply total mission hours by 60 to get total mission minutes.

(d) Multiply the total mission minutes by the total oxygen flow (LPM) to get the mission’s total gaseous oxygen requirement (liters-gaseous).

(e) Since 1 liter of LOX equals 860 gaseous liters of oxygen, divide the total gaseous oxygen requirement (liter-gaseous) by 860 to get the mission’s total patient LOX requirement (liters-LOX).

**Note:** Utilized NPTLOX/PTLOX. Determine amount. (Minimum oxygen calculations, add 1 L for anything under 5Ls).

(3) Electrical set up/accomplish amperage calculation/function checks (All medical equip).

(4) In-flight kit set up/placement.

k. Discuss enplaning/deplaning, safety procedures, cabin coverage, and assign crew position areas of security. (MCD/CMT)

l. Review/discuss updates to aircraft emergencies and egress plan. (MCD)

m. Coordinate tentative meal plan/fluid distribution for patients and crew. (MCD)

n. Coordinate refueling stop requirements. (MCD)

o. Review aircraft security, theater terrorist threat, and anti-hijacking procedures.

p. If medical attendant is present, brief on duties and responsibilities. Collect copy of orders. (MCD)

q. Identify primary AWIS channel used during mission. (MCD)

r. Configure EFB. (AEC)

In-Flight Kit Preflighted/Loaded. (AEC)

a. Obtain medication kits/supplies.

b. Perform operational preflight on medical equipment. (accomplished within 24 hours prior to mission launch or assuming alert posture by qualified Aeromedical Evacuation personnel).

c. Load medical supplies and equipment and transport to the aircraft.

Pilot/LM/BO Briefing (AEC) **Note:** This step may be accomplished on the aircraft and will include ORM/CRM scores.

a. Verify mission itinerary, threats, flight profile, station time, etc.

b. Brief pilot on non-US citizens, altitude restrictions, unique patient requirements, and electrical and oxygen requirements inflight or on the ground, only if it limits aircraft operation. Notify pilot of medical equipment requiring waivers.

c. Obtain escape and evasion (E & E) briefing (as required). Identify armed crewmembers (as required).

d. Obtain briefing on weather, en route times, total number of crew, flight/cabin altitudes, refueling
stops and possible delays.

e. Identify emergency and communication signals/methods with pilot and LM/BO.

f. Discuss enplaning/ERO requirements (time constraints, loading requirements, i.e., ramps, AMBUS, safety observer, etc.).

g. Identify Aeromedical Readiness Mission (ARM) requirements (as required).

h. Discuss emergency requirements (radio transmissions/use of headsets).

i. Brief PIC/LM/BO on anticipated patient load, number of AEC, souls on board verification, and cabin secure prior to take-off.

j. Coordinates egress plan, meal times, special diets, and mission unique items with LM/BO.

Crew Duties AECM. AECMs are required to use and refer directly to this publication when accomplishing their abbreviated flight crew checklist duties. The abbreviated flight crew checklist will be used during all phases of the mission. (T-3). If the checklist is accomplished by one or more AECMs, accomplish all AEC duties. When aircraft preparation and loading are accomplished by a ground support crew, checklist items denoted by “*” WILL be briefed by ground support personnel (qualified AECM) prior to the flight crew assuming responsibility. Interior inspection/enplaning duties and procedures may have to be modified as the situation dictates. Items with an “!” WILL be accomplished prior to take-off for contingency & combat missions. Resume the applicable section of the checklist, once in flight.

**PREFLIGHT INSPECTION.** The interior inspection will be accomplished by using the abbreviated flight crew checklist.

! 1. Loadmaster/BO Coordination. (CMT)

a. AFTO Form 781A – Checked.

b. Verify numbers and types of survival equipment (LPUs, EPOS) available for patients.

c. Notify LM/BO of total equipment weight and when applicable total estimated SLS weight including patient weights.

d. Coordinate vehicle movement positioning.

2. Rollers stowed (as required).

! 3. Oxygen Mask/MA-1 Bottle/Goggles/PBE/LPU/EPOS - Checked. (AEC)

a. Attach mask to MA-1 bottle and check operation via PRICE check.

b. Attach AWIS to mask and verify operability.

c. Ensure unit is properly secured at duty station.

d. Check for currency of PBE/LPU/EPOS.

e. Secure all personal equipment and set up work area.

! 4. Headset and extension connected. (MCD)

*! 5. Cabin preparation – Checked/Completed. (AEC)

a. Configure aircraft for patient requirements per configuration plan, T.O. 1C-MDS-9, and AFMAN
1. Litter stanchions/straps/brackets installed per mission requirements.
2. Seats properly secured to the aircraft and seat belts are attached.
3. Check and adjust litter brackets according to patient positioning plan.
4. Inspect LSAS/SLS.
   (1) Annotate discrepancies on AFTO Form 350/AFTO Form 244, Industrial/Support Equipment.
5. Secure Medications. (patient, emergency, and controlled medications).
6. Infection control/isolation area setup per established procedures.
   * 6. Therapeutic Oxygen System - Checked/Secured. (AEC) **WARNING:** Do not position PTLOX/NPTOLX near hydraulic reservoirs.
   a. Check aircraft oxygen quantity and ensure system is – On. (C-17) **Note:** Place the On/OFF levers to ON one at a time and lift the levers slowly from OFF to ON to ensure stable output pressure. Coordinate with LM for use of HALO. (as required)
   b. Set-up/secure (as required) PTLOX/NPTOLX and verify quantity/pressure.
   c. Attach oxygen hose(s) flow control device(s), and flow meter(s) and check for proper operation.
   ! 7. Electrical System(s) – Connected/Secured. (AEC) **WARNING:** Estimate total equipment draw from electrical system prior to connecting any electrical equipment to prevent overload of the aircraft electrical system and the frequency converter(s). **CAUTION:** Assess aircraft amperage capacity. Ensure electrical equipment is not plugged in until aircraft electrical power is on. (T-2). Coordinate with LM/BO. (as required)
   a. Connect electrical frequency converter(s) to aircraft.
   b. Connect Electrical Cable Assembly Set (ECAS) to aircraft following established procedures, ensuring cord(s) are attached to appropriate outlet(s).
   c. Medical Equipment and computers plugged in.
   *! 8. Suction/Bag-Valve-Mask (BVM) - Operable/Secured. (AEC)
   a. Ensure suction equipment is set up and available. (T-3).
   b. Ensure BVM is available and connected to an emergency oxygen source. (T-3).
   *! 9. Medical Supplies/Equipment – Checked/Secured. (AEC)
   a. Ensure medical and computer equipment is accessible and complete functional check. (T-3).
   b. Ensure supplies are accessible and secured, including special supplies/equipment/computers. (T-3).
* 10. Meals/Service Items – Available/Received. (CMT/3AET)
   a. Verify number of regular/special diets required for the mission.
   b. Ensure aircraft lavatory is stocked with service items. (T-3).
11. Aircraft Acceptability/Discrepancies - Reported. (AEC)
   a. Report duties accomplished/discrepancy to CMT. (2AET/3AET)
b. Report discrepancies to MCD. (CMT)


LOADING.

! 1. ERO Preparations (as required) - Completed. (AEC)
   a. Coordinate ERO activities with LM.
   b. At en route stops, prepare cabin for ERO operations after departing the active runway. (as required)

2. Coordinate with LM for Auxiliary Ground Loading Ramps (as required) - Installed. (CMT) N/A for KC-135, KC-46, KC-10 and C-21.
   a. Ensure auxiliary ground loading ramps are installed when enplaning patients via the cargo ramp. (as required)

3. Vehicle positioning coordinated with LM/BO. - Completed. (as required) (CMT)

4. Coordinate enplaning procedures with ground support - Accomplished. (CMT)

! 5. Confirm anti-hijacking procedures have been completed. - Accomplished. (CMT)
   a. Perform anti-hijacking procedures if not already accomplished by MTF or ERPSS personnel.

6. Identify patients requiring assistance - Accomplished. (CMT)

7. Distribute hearing protection - Completed. (CMT)

! 8. Check psychiatric litter patients for sharp objects - Completed. (CMT)

! 9. Check litter patients for security, approved litters, strap placement, and backrest placement - Completed. (CMT) **Note:** If any patient condition is questionable or exceeds the capabilities of the AEC, notify the MCD. **Note:** Enplaning during patient report is highly encouraged but final approval is at the discretion of the MCD.

**Note:** CMT may check prior to onload or after enplaning during contingency operations.

10. Aircraft Ready for Enplaning - Coordinated.
   a. Confirm AEC/aircraft ready for patient enplaning.
   b. Assume enplaning positions.

! 11. Patient Report/Records-Paper or Electronic/Medications/Supplies/Anti-hijacking Statement/Equipment waivers (hard copy preferred) – Received. (MCD/FN)
   a. Receive patient clinical update, medical records (paper/electronic), X-rays, medications, passports, anti-hijacking statement, etc. from en route casualty care facility. (MCD/FN)
   b. Boot up EHR computers and import EHR data from received media if available. (MCD/FN)
   c. AMC/A3VM may issue verbal approvals for equipment waivers under certain circumstances. (AEC)

12. Anti-hijacking procedures. (as required) (AEC)
   a. Verify anti-hijacking procedures were accomplished by MTF or ERPSS personnel. (MCD/FN)

13. Patients/Enplaned/Health Care Specialty team. (AEC)
a. Coordinate/direct patient enplaning procedures with CMT and MTF/ERPSS personnel per patient positioning plan. (MCD/FN)

b. Assume enplaning positions. (AEC)

c. Assist with enplaning litter patients. (AEC)

d. Supervise/assist with enplaning of ambulatory patients/attendants. (AEC)

e. Notify MCD of any changes in patient status. (AEC)

f. Correct manifest(s) and revise patient positioning plan to reflect cancelations/add-on patients and number of correct souls on board. (AEC)

g. Coordinate cardiac arrest plan/medical emergencies with ERCC/medical attendants, as applicable. (MCD)

14. Baggage Procedures - Completed/Secured. (3AET)

  a. Validate patient baggage manifest.

  b. Sign for baggage on appropriate forms.

  c. Assist LM/BO with loading/securing of patients/crew baggage.

BEFORE TAXI.

1. Patient Briefing - Completed. (AEC)

  a. Brief emergency signals, patient evacuation, use of emergency oxygen, and restrooms.

  b. Assist LM/BO with demonstration of LPUs, EPOS, and emergency exits to patients.

  c. Provide individual briefings to litter patients and other individual patients. (as required)

  d. Ensure litter/ambulatory patients have emergency oxygen/LPU.

  ! 2. Patients/Equipment/Computers/Cabin- Secured. (AEC)

  a. Ensure all litter/ambulatory patients in assigned area are secured.

  b. Ensure all medical equipment, computers, and supplies are secured. WARNING: As a minimum, outside litter brackets will be secured before taxi. (T-2). WARNING: If the AEC is not ready for taxi, the MCD will immediately notify the PIC. (T-3).

  ! 3. Souls on Board Received and Reported to MCD/AEC. (FN)

  a. FN will physically obtain Souls On Board. (T-3).

  ! 4. Souls On Board - Reported to PIC/LM/BO. (MCD)

BEFORE TAKE-OFF.

  ! 1. Patient Care - Completed. (AEC)

  a. Direct patient care. (MCD/FN)

  b. Perform pre-departure patient care as directed by MCD/FN. (AET)

  c. Check condition/comfort/pain of patients. (AEC)

  d. Notify MCD if a potential delay will occur due to patient needs. (T-3). (AEC)
2. Cabin Secure - Completed. (AEC)
a. Ensure all patients/equipment/baggage are secured.
b. Take assigned seat and report cabin secure to MCD/CMT. (AEC)

3. Before Take-Off Checklist Complete. (AEC)
a. Report take-off checklist complete to CMT. (FN/2AET/3AET)
b. Acknowledge before take-off checklist complete from CMT. (AEC)
c. Report before take-off checklist complete to PIC. (MCD) **WARNING:** Ensure all litter stanchion brackets/patients are secure prior to take-off. MCD will immediately notify PIC if the cabin is not secure for take-off. (T-3). **Note:** MCD will notify PIC/LM/BO if AECMs or medical attendants must stand during take-off. (T-2).

**ASCENT.**
1. Observe for unusual occurrences/emergency situations. (AEC)
2. Observe patients during ascent. (AEC)
3. Review patient records and develop patient care plan. (AEC)
4. Communicate patient assignments and start EHR encounters. (AEC) **Note:** MCD will notify LM/BO if AECMs must attend to patient during ascent. (T-2).

**CRUISE.** (When safe to move about the cabin)
1. Patient Check - Completed. (AEC)
a. Check patient’s pain level/condition.
2. Patient Care - Administered. (AEC)
a. Assess patient; perform patient care.
b. Document patient medications and treatments. (as applicable)
c. Distribute comfort items and provide fluids every two hours if not contraindicated.
d. Direct AEC in management/performance of patient care requirements. (MCD)
e. Administer/document patient medications and treatments. (FN)
f. Direct and supervise AEC in their duties. (MCD)
3. Verify therapeutic oxygen quantities. (CMT)
4. In-Flight Meal Service - Completed. (AEC)
a. Coordinate meal service with MCD. (CMT)
b. Assist LM/BO with meal briefing (crew duties permitting). (3AET)
c. Assist in distribution of meals.
d. Assist patients who cannot feed themselves and/or require help to eat. **Note:** MCD will notify the PIC and supporting C2 agencies (TACC/AOC/PMRC) of all in-flight emergencies or changes in patient status. (T-2). **Note:** Recommend meal service in the following order: special diets, litter
patients, ambulatory patients.
5. Administrative Duties - Completed. (AEC)
a. Complete all patient records. Ensure all vital signs and intake/output results are documented. (AEC)
b. Obtain FN signature on patient records after last entry. (AET)
c. Co-sign EHR patient documentation records. (MCD/FN)
d. Print EC patient notes. (AEC)
e. Export EHRs to external media. (as required) (AEC)
f. Complete baggage manifest for offload station. (3AET)
g. Coordinate agriculture, border clearance, customs, and immigration requirements with LM/BO. (as required) (3AET)
h. Separate patient paperwork and medications according to destination medical facility. (as required) (MCD/FN)
i. Ensure AFTO Form 781 information is correct, and provide to Flight Engineer/LM/BO. (MCD/FN)
j. Communicate offload message indicating any special ground support requirements a minimum of 45 minutes prior to time of arrival. (MCD)
6. Cabin Cleanliness - Maintained. (AEC)
a. Collect garbage after meals and prior to descent. (AEC)
7. Medical/Supply Inventory - Tracked. (AEC)
a. Document supplies used during the mission.

DESCENT.
1. Enplaning/Deplaning - Coordinated/Briefed to AEC. (CMT)
a. Discuss tentative enplaning/deplaning procedures and any special procedures at en route stop and/or final destination. (CMT)
b. Provide individual briefings to litter patients and other individual patients.
c. Consolidate patient report information. (MCD/FN)
2. Prepare Patients for Landing. (AEC)
a. Wake patients and provide individual briefings to litter patients and other individual patients.
b. Ensure all litter/ambulatory patients in an assigned area are secured. (MCD/FN)
c. Ensure all medical equipment and supplies are secured. (AEC)
3. Patients and Equipment - Secured. (AEC)
a. Ensure all litter/ambulatory patients in assigned area are secured. (AET)
b. Ensure all medical equipment and supplies are secured. (AEC)
4. Take assigned seat and report cabin secure to MCD/CMT. (AEC)
5. Observe patients during descent.
6. Descent Checklist Complete. (MCD/FN/CMT/2AET/3AET)
   a. Report descent checklist complete to CMT. (FN/2AET/3AET)
   b. Acknowledge descent checklist complete from CMT. (MCD)
   c. Report descent checklist complete to PIC. (MCD) **WARNING**: MCD will immediately notify LM/BO if the cabin is not secure for landing. **(T-2).**  **Note:** MCD will notify LM/BO if AECMs or medical attendants must stand during landing. **(T-2).**

**OFFLOADING.**

1. ERO Preparations (as required) - Completed. (AEC)
   a. Coordinate ERO activities with LM. (N/A for KC-135m KC-10 and C-21)
   b. At en route stops, prepare cabin for ERO operations after departing the active runway. (as required)
2. Auxiliary Ground Loading Ramps (as required) - Installed. (CMT)
   a. Ensure auxiliary ground loading ramps are installed when enplaning patients via the cargo ramp. (as required)
3. Vehicle positioning – Completed. (CMT)
4. Coordinate deplaning procedures with ground support. (CMT)
5. Check litter patients for security, strap placement, backrest placement, and secure IV/Oxygen lines prior to removal from litter tier. (AEC)
6. Provide ground support personnel with paperwork and conduct PCS/Epidural hand off with MTF or ERPSS personnel. (as required) (MCD/FN)
7. Ensure patients have supplies/equipment/personal belongings. (AEC)
8. Remove EPOS/LPUs from patient litters. (AEC)
9. Identify patients requiring assistance – Accomplished. (AEC)
10. Patients - Deplaned. (AEC)
   a. Confirm AEC/aircraft ready for deplaning and ground medical facility ready to receive patients.
   b. Deplane patients.
11. Contaminated Waste/Lines - Offloaded. (AEC)
12. Provide clinical update to ERCC personnel. (MCD/FN)
13. Obtain signature for patient records- (paper/electronic), X-rays, medications, supplies, and equipment being offloaded. (MCD/FN)
14. Baggage Procedures - Completed. (3AET)
   a. Validate patient baggage manifest.
   b. Obtain signature on appropriate forms.
   c. Assist with offloading patient/attendant baggage.
15. Update C2 agency on mission status. (MCD)
16. Offload Checklist Complete. (MCD/FN/CMT/2AET/3AET) **Note:** Deplaning during patient report if highly encouraged but final approval is at the discretion of the MCD. **Note:** Medical equipment remains on board and operationally ready for use until all patients have deplaned. Individual oxygen masks will not be disconnected until all patients and attendants have been deplaned. (T-3).

**BEFORE LEAVING AIRCRAFT.**

1. Discrepancies - Reported. (AEC)
   a. Receive mission/aircraft discrepancy report from FN/CMT. (MCD)
   b. Report patient care related discrepancies to MCD. (FN)
   c. Report aircraft discrepancies to LM/BO for documentation on aircraft forms. (MCD)
2. Aircraft Flying Time Forms - Obtained. (MCD)
   a. Obtain certified, extract copy of AFTO Form 781. (as required)
3. Equipment/Computers/Supplies - Removed/Stowed. (AEC)
   a. Identify and tag all inoperable AE equipment/computers.
   b. Properly repack all medical equipment/supplies/computer equipment.
   c. Remove all medical and computer equipment/supply kits.
   d. Remove all professional gear and personal bags per local policy.
4. Deconfigure aircraft. (as required) (AEC)
   a. Inspect/package LSAS, (as applicable)
   (1) Annotate discrepancies on AF Form 4449, *En-Route Care Equipment Malfunction Report tag*, of if unavailable complete the AFTO Form 350/AFTO Form 244.
5. Cargo Compartment in order. (CMT)

**POST MISSION.**

1. Post Flight Debriefings - Attended. (AEC)
   a. Attend applicable debrief(s) (pilot, intelligence, crew, etc.)
2. Discuss mission discrepancies, positive mission outcomes, configure EFB, etc. (AEC)
3. Properly store all medical /computer equipment/supply kits per local policy. (AEC)
   a. Turn in medical supply inventory. (as required)
4. Brief/Update C2 agency of patient status changes. (MCD)
5. Calculate crew rest. (MCD/CMT)
6. Coordination with Command Post, Squadron, etc. (AEC)
7. Complete mission paperwork. (AEC)
8. Arrange for flight home. (as required) (MCD/CMT)
9. Coordinate billeting arrangements with pilot. (as required) (MCD)
10. Notify tasking AE command element of crew’s status, billeting arrangements and AE CM plans. (MCD)

Emergency Procedures

**FUSELAGE FIRE/SMOKE AND FUMES ELIMINATION**

1. **OXYGEN - ON, 100% (ALL)**
   
   **Note:** Protective Breathing Equipment (PBE) or Emergency Passenger Oxygen System (EPOS) may be used if oxygen mask/eye protection is not available.
   
   **Note:** The MA-1 portable oxygen bottle delivers 100% oxygen at all settings. The regulator does not have to be turned to emergency to provide 100% oxygen.
   
   **WARNING:** Removal of oxygen masks when smoke or fumes are present can result in personal injury or death.

2. Crew Alerted (AEC)
   a. Notify pilot/LM/BO (if origin of fire is in the cabin) and aeromedical evacuation crew of nature of emergency.

3. Combat Fire As Directed (AEC)

   **Note:** The pilot/LM/BO will direct crewmembers to fight the fire as required. (T-2). Crewmembers not directly involved with combating the fire will proceed with their emergency procedures checklist. (T-3).
   
   **WARNING:** Although Halon 1211 vapor has a low toxicity, its decomposition products can be hazardous. On decomposition, Halon 1211 has a characteristic sharp acrid odor, even in concentrations of only a few parts per million. The odor provides a built-in warning system for the agent and at the same time creates a noxious, irritating atmosphere for those who are in the hazard area during and following a fire. Leave and/or ventilate area after fighting a fire.

   **Note:** To use the Halon 1211 fire extinguisher, hold in a vertical position, about eight feet from the fire. Remove the pull ring and aim nozzle at base of the fire. Squeeze lever and sweep agent across base of fire.

4. Patients and Passengers Assist. (As Required) (AEC)
   a. Assist patients in donning emergency oxygen equipment.
   b. Relocate patients out of the vicinity of the fire.
   c. Secure patients in preparation for Smoke and Fumes Removal procedures.

   **Note:** Placing a wet towel or handkerchief over the nose and mouth or over the mask, when utilized, affords better protection from smoke and fumes. Relocate the patients as necessary.

**EMERGENCY SIGNALS**

1. Ground Evacuation
   a. Prepare to abandon airplane - three short rings. (KC-135 only)
b. Abandon airplane - one long sustained ring/horn blast.
c. Emergencies will be announced via intercom (KC-46 only)

2. Ditching or Crash Landing (Reference Table A2.2. and Table A2.3.)
   a. Prepare for ditching or crash landing - six short rings/horn blasts.
   b. Brace for impact - one long sustained ring/horn blast.
   c. Emergencies will be announced via intercom. (KC-46 only)

**INFLIGHT DOOR WARNING**

1. Oxygen. (As Required) (AEC)
   a. The pilot will direct all crewmembers to don oxygen. (as appropriate)

2. Crew Notified. (AEC)

3. Patients/Passengers Secured. (AEC)

4. Crewmember Secured. (As Required) (AEC)

**RAPID DECOMPRESSION**

1. **OXYGEN - ON, 100% (ALL)**

   **Note:** The MA-1 portable oxygen bottle delivers 100% oxygen at all settings. The regulator does not have to be turned to Emergency to provide 100% oxygen.

   2. Crewmember Secured (As Required) (AEC)
      a. If structural damage or aircraft flight maneuvers preclude personal safety without a seat belt, aeromedical evacuation crewmembers will make every effort to secure themselves in any available seat until it is safe to move about the cabin. (T-2).
      b. If rapid decompression is not accompanied by unusual aircraft movements, AE crewmembers will continue with the checklist. If in the litter section, hold on to the nearest litter stanchion or aircraft structure. (T-2).

   3. Patients and Passengers Assist (As Required) (AEC)
      a. When it is safe to move about, check patients and assist them with their oxygen source.
      b. Ensure all patients are secured.

**MEDICAL EMERGENCY/CHANGE IN PATIENT STATUS**

1. First responder notify crew. (AEC)

2. Render patient care in accordance with current guidelines. (AEC)

3. Notify PIC (MCD)

4. Notify applicable C2 agencies (TACC/AOC/PMRC) (MCD)
Table A2.2. Aeromedical Evacuation Crew Combined Ditching Chart.

<table>
<thead>
<tr>
<th>FIRST ACTION</th>
<th>DITCHING IMMINENT (10 Minutes Left)</th>
<th>PROVIDE</th>
<th>POSITION</th>
<th>AFTER DITCHING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acknowledge pilot’s order to prepare for ditching. Reconfirm egress with PIC/LM/BO and brief AEC. (MCD)</td>
<td>1. Check patients on assigned side of aircraft are properly secured and assuming “Brace for Impact” position. (AEC)</td>
<td>1. Medical supplies, medications, equipment. (AEC)</td>
<td>1. Assigned seat. (AEC)</td>
<td>1. Remain seated until aircraft has come to a complete stop. (AEC)</td>
</tr>
<tr>
<td>a. Brief any special instructions from PIC. (i.e., Type of emergency, type of landing, time remaining, etc.)</td>
<td>2. Take assigned seat. (AEC)</td>
<td>2. Flashlight (AEC)</td>
<td></td>
<td>2. Open exits. (AEC)</td>
</tr>
<tr>
<td>2. Don life preserver. (AEC)</td>
<td>3. Fasten seat belt. (AEC)</td>
<td>3. First aid kit. (AEC)</td>
<td></td>
<td>a. Open available exits and deploy life rafts per egress plan or as directed by PIC/LM/BO.</td>
</tr>
<tr>
<td>3. Brief assigned assistants to remain in aircraft to assist in evacuation of patients (as required). (AEC)</td>
<td>4. Assume appropriate position at “Brace for Impact” signal. (AEC)</td>
<td>4. Patient manifest. (MCD)</td>
<td></td>
<td>3. Direct and assist patient egress per egress plan or as directed by PIC/LM/BO; ambulatory followed by litters. (AEC)</td>
</tr>
<tr>
<td>a. Select able-bodied ambulatory patients to assist (as required).</td>
<td></td>
<td></td>
<td></td>
<td><strong>WARNING:</strong> Ensure patients inflate life preservers after leaving the aircraft.</td>
</tr>
<tr>
<td>4. Inflatable LPU 6/P (Infant Cot).- As required. (AEC)</td>
<td></td>
<td></td>
<td></td>
<td>4. Evacuate aircraft. (AEC)</td>
</tr>
<tr>
<td>5. Brief patients on assigned side of aircraft on evacuation procedures. (AEC)</td>
<td></td>
<td></td>
<td></td>
<td>5. Board assigned life raft. (AEC)</td>
</tr>
<tr>
<td>a. Identify emergency exits to be utilized and</td>
<td></td>
<td></td>
<td></td>
<td>a. The first crewmember into the life raft secures the clamp on the equalizer tube (as required).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>b. Assist patients into the life rafts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>c. Group life rafts</td>
</tr>
<tr>
<td>order in which to evacuate.</td>
<td>b. Position to assume at the “Brace for Impact” signal.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>(1) Side/Forward facing seats-lean forward, place hands behind neck and pull head to knees; elbows are outside of knees.</td>
<td>(2) Aft facing seats-sit erect with head firmly against headrest, arms grasping armrests.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(3) Litters-lie flat, grasp sides of litter tightly.</td>
<td>6. Prepare and secure litter and ambulatory patients on assigned side of aircraft. (AEC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Assist AEC with positioning patients, checking litter straps and litter support systems.</td>
<td>(1) Remove sharp objects, ties; loosen collars/tight fitting clothing.</td>
<td></td>
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<tr>
<td>(2) Place sharp objects and loose items in a plastic bag and secure. Remove eyeglasses, dentures; pad and secure on the</td>
<td>together (if possible).</td>
<td></td>
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</tbody>
</table>
patient.
(3) Position litter patients in seats (if condition permits).
   a. Apply extra padding and litter straps to litter patients.
   b. Move litters to the lowest litter spaces.
(4) Remove IV lines, catheters, etc. that may impede egress.
(5) Assist patients in donning life preservers.
**WARNING:** Brief patients not to inflate the life preservers until after leaving the aircraft. **Note:** The LPU 6/P (infant cot) can be inflated inside the aircraft.
(6) Secure small children with extra litter straps and pads with pillows and blankets (as required).
7. Distribute medical supplies, medications, and equipment to crewmembers. As a minimum collect controlled medications, oral airways, Bag-Valve-Mask
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<tbody>
<tr>
<td>7.</td>
<td>resuscitator, flashlight, first aid kit (AEC) and patient manifest. (MCD)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Remove restraints from psychiatric patients. (AEC)</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Secure cabin. (AEC)</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Check seat belts and litter straps. Ensure patients are secure.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Secure all lose items/equipment.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Report cabin secure to CMT (FN, 2AET, 3AET).</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Report Cabin secured to MCD. (CMT)</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Receive cabin secured report from CMT. (MCD)</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Report cabin secured to PIC/LM/BO. (MCD)</td>
<td></td>
</tr>
</tbody>
</table>
Table A2.3. Aeromedical Evacuation Combined Emergency Landing Chart.

<table>
<thead>
<tr>
<th>FIRST ACTION</th>
<th>EMERGENCY LANDING (10 Minutes Left)</th>
<th>PROVIDE</th>
<th>POSITION</th>
<th>AFTER DITCHING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acknowledge pilot’s order to prepare for emergency landing. Reconfirm egress with PIC/LM/BO and brief AEC. (MCD)</td>
<td>1. Check patients on assigned side of aircraft are properly secured and assuming “Brace for Impact” position. (AEC)</td>
<td>1. Medical supplies, medications, equipment. (AEC)</td>
<td>1. Assigned seat. (AEC)</td>
<td>1. Remain seated until aircraft has come to a complete stop. (AEC)</td>
</tr>
<tr>
<td>a. Brief any special instructions from PIC (i.e., Type of emergency, type of landing, time remaining, etc.)</td>
<td>2. Take assigned seat. (AEC)</td>
<td>2. Flashlight (AEC)</td>
<td>2. Open exits. (AEC)</td>
<td>2. Open exits per egress plan or as directed by PIC/LM/BO.</td>
</tr>
<tr>
<td>2. Brief assigned assistants to remain in aircraft to assist in evacuation of patients (as required). (AEC)</td>
<td>3. Fasten seat belt. (AEC)</td>
<td>3. First aid kit. (AEC)</td>
<td>3. Direct and assist patient egress per egress plan or as directed by PIC/LM/BO; ambulatory followed by litters. (AEC)</td>
<td>3. Direct and assist patient egress per egress plan or as directed by PIC/LM/BO.</td>
</tr>
<tr>
<td>3. Brief patients on assigned side of aircraft on evacuation procedures. (AEC)</td>
<td>a. Identify emergency exits to be utilized and order in which to evacuate. (AEC)</td>
<td>a. Direct patients to meet upwind of the aircraft or as directed by the PIC/LM/BO.</td>
<td>5. Direct patients away from the aircraft. (AEC)</td>
<td>5. Direct patients away from the aircraft. (AEC)</td>
</tr>
<tr>
<td>a. Position to assume at the “Brace for Impact”</td>
<td>b. Position to assume at the “Brace for Impact”</td>
<td>b. Accomplish a head count and provide numbers to the PIC or senior ranking survivor.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
signal.
(1) Side/Forward facing seats-lean forward, place hands behind neck and pull head to knees; elbows are outside of knees.
(2) Aft facing seats- sit erect with head firmly against headrest, arms grasping armrests.
(3) Litters- lie flat, grasp sides of litter tightly.

4. Prepare and secure litter and ambulatory patients on assigned side of aircraft. (AEC)
   a. Assist AEC with positioning patients, checking litter straps and litter support systems.

(1) Remove sharp objects, ties; loosen collars/tight fitting clothing.
(2) Place sharp objects and loose items in a plastic bag and secure. Remove eyeglasses, dentures; pad and secure on the patient.
(3) Position litter patients in seats (if condition permits)
a. Apply extra padding and litter straps to litter patients.
b. Move litters to the lowest litter spaces.

(4) Remove IV lines, catheters, etc. that may impede egress.

(5) Secure small children with extra litter straps and pads with pillows and blankets (as required).

5. Distribute medical supplies, medications, and equipment to crewmembers. As a minimum collect controlled medications, oral airways, Bag-Valve-Mask resuscitator, flashlight, first aid kit (AEC) and patient manifest. (MCD)

6. Remove restraints from psychiatric patients. (AEC)

7. Secure cabin. (AEC)

a. Check seat belts and litter straps. Ensure patients are secure.
b. Secure all lose
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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>items/equipment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Report cabin secure to CMT (FN, 2AET, 3AET).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Report Cabin secured to MCD. (CMT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Receive cabin secured report from CMT. (MCD)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Report cabin secured to PIC/LM/BO. (MCD)</td>
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</tbody>
</table>