

**BY ORDER OF THE
SECRETARY OF THE AIR FORCE**

**DEPARTMENT OF AIR FORCE
MANUAL 11-2 AE VOLUME 3**



28 SEPTEMBER 2023

Flying Operations

**AEROMEDICAL EVACUATION (AE)
OPERATIONS PROCEDURES**

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing web site at www.e-Publishing.af.mil for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AMC/A3VM

Certified by: AF/A3T
(Maj Gen Adrian L. Spain)

Supersedes: AFMAN11-2AEV3, 19 October 2020

Pages: 86

This manual implements Air Force Policy Directive (AFPD) 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, *Flight Operations*, 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, Air Force Reserve (AFR), and Air National Guard (ANG). This manual 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://dpcl.d.defense.gov/privacy/SORNS.aspx>. Ensure all records created as a result of processes prescribed in this publication adhere to AFI 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with Air Force Disposition Schedule which is located in the Air Force Records Information Management System. Refer recommended changes and questions about this publication to the office of primary responsibility (OPR) using the DAF Form 847, *Recommendation for Change of Publication*; route DAF 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 DAFMAN 90-161, *Publishing Processes and Procedures*, 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), Line of Safety Audit accepted recommendations. Several chapters have been reorganized for readability.

Chapter 1—GENERAL INFORMATION	7
1.1. General.....	7
1.2. The AE Mission.....	7
1.3. Aircraft.....	7
1.4. Command and Control (C2) and Patient Requirement.....	7
1.5. C2 Contact Information.....	7
Table 1.1. C2 Contact Information.....	7
1.6. Peacetime Preparation.....	8
1.7. Aircraft Availability for AE Missions Are Supported By:.....	8
1.8. Key Words Explained.....	8
1.9. Deviations and Waivers.....	8
1.10. Combined Command Operations.....	9
1.11. AE Readiness Programs.....	9
1.12. Improvement Recommendations.....	9
Chapter 2—ROLES AND RESPONSIBILITIES	10
2.1. Lead MAJCOM Delegation.....	10
2.2. AMC Directorate of Operations (AMC/A3).....	10
2.3. AMC Command Surgeon (AMC/SG).....	10
2.4. AMC Aeromedical Training Branch (AMC/A3TM).....	10
2.5. AMC Aeromedical Evacuation Contingency Plans Branch (AMC/A5XA).....	10
2.6. AMC Requirements Division (AMC/A5Q).....	10
2.7. Execution Authority.....	10

2.8.	Command and Control (C2) Centers.	11
2.9.	Unit Commanders.	11
2.10.	Pilot in Command (PIC).	11
2.11.	Medical Crew Director (MCD).	11
2.12.	Charge Medical Technician (CMT).	11
2.13.	ERCC Team.	12
Chapter 3—AIRCREW COMPLEMENT AND MANAGEMENT		13
3.1.	General.	13
3.2.	Aircrew Complement.	13
3.3.	Aircrew Member Qualification.	13
3.4.	Aircrew Management.	14
3.5.	Crew Duty Time (CDT).	14
3.6.	Crew Rest/En Route Ground Time.	14
3.7.	Alerting Procedures.	15
3.8.	Standby Force Duty.	15
3.9.	Interfly.	15
3.10.	Policies Governing Attendants.	16
Chapter 4—AIRCRAFT MEDICAL EQUIPMENT AND MEDICATION OPERATIONS		17
4.1.	Objective.	17
4.2.	Equipment Waiver Process.	17
4.3.	Controlled Medications.	17
Chapter 5—OPERATIONAL PROCEDURES		18
5.1.	Checklists.	18
5.2.	Duty Station.	18
5.3.	Seat Belts.	18
5.4.	Portable Electronic Devices.	18
5.5.	Electronic Flight Bag.	18
5.6.	Communications Guidance.	18
5.7.	Crew Resource Management (CRM)/Threat and Error Management (TEM).	19
5.8.	Aerial Refueling.	20
5.9.	Military Working Dogs.	20
5.10.	Operational Reports and Forms.	20

5.11.	AE Event/Near Miss Reporting Process.....	20
5.12.	Airman/Aviation Safety Action Program (ASAP).....	20
Chapter 6—AIRCREW PROCEDURES		22
Section 6A—Pre-Mission		22
6.1.	Aircrew Uniform.....	22
6.2.	Personal Requirements.	22
6.3.	Pre-mission Actions.....	23
6.4.	Aircrew Publications Requirements.	23
6.5.	Expected Cargo/Passenger Load and AE Configurations.....	23
Section 6B—Pre-departure		23
6.6.	Flight Crew Information File (FCIF) Procedures.	23
6.7.	Mission Kits.....	23
6.8.	Briefing Requirements.....	25
6.9.	Risk Management (RM).	26
Section 6C—Preflight		26
6.10.	AFTO Forms 781A.....	26
6.11.	Aircraft Servicing and Ground Operations.	26
6.12.	Aircraft Refueling and Concurrent Ground Operations.....	26
6.13.	Aircrew Emergency Equipment.....	26
6.14.	Mission Emergency Equipment.....	27
6.15.	Fleet Service.	28
6.16.	Airlifting Hazardous Cargo.....	28
6.17.	Patient/Cargo Mix.....	29
6.18.	Patient Preparation.....	29
Section 6D—Departure		29
6.19.	On Time Takeoffs.....	29
Section 6E—En route		29
6.20.	Communications and Documentation.....	29
6.21.	Transfer of Patient Care.....	30
Section 6F—Arrival		30
6.22.	Unscheduled Landings/RON.	30

Section 6G—Miscellaneous	31
6.23. Customs/Border Clearance.	31
6.24. Insect and Pest Control.	31
6.25. AFE and Dash 21 Equipment Documentation.	31
6.26. Overflying En Route Stops.	32
6.27. Medical Emergency/Change in Patient Status.	32
6.28. Apparent Patient Death in Flight.	32
6.29. Airlift of Human Remains.	33
6.30. Patients Requesting Release.	34
Chapter 7—AIRCRAFT SECURITY	35
7.1. General.	35
7.2. Arming of Crewmembers.	35
Chapter 8—AIRCREW OPERATIONS IN CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN) ENVIRONMENT	36
8.1. Overview.	36
Chapter 9—FLIGHT NURSE AND AEROMEDICAL EVACUATION TECHNICIAN PROCEDURES	37
9.1. General.	37
9.2. Mission Planning.	37
9.3. Preflight Duties.	38
9.4. Ground Operations.	40
9.5. Enplaning/Deplaning Procedures.	41
Table 9.1. Loading Equipment Capabilities.	43
9.6. Engines Running Onload/Offload.	47
9.7. Baggage Procedures.	48
9.8. En Route Duties.	49
9.9. Mission Delays.	49
9.10. Mission Termination.	49
9.11. Training Missions.	50
Chapter 10—AE MISSION SAFETY	51
10.1. Safety Responsibilities and Precautions.	51
10.2. Ground Safety.	51
10.3. Guidelines for Vehicle Drivers.	51

10.4. Emergency Exits and Safety Aisles.	52
10.5. Equipment Procedures.	52
10.6. In-Flight Safety Procedures.	54
Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION	56
Attachment 2—AEROMEDICAL EVACUATION CREW MEMBER EXPANDED CHECKLISTS	67

Chapter 1

GENERAL INFORMATION

1.1. General. 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 higher headquarters (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 1.9](#). 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*, AFMAN 11-2AEV3 Checklist (CL)-1, *Aeromedical Evacuation Checklist (AEC)*. 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 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, C-17, KC-135, C-21 and the KC-46. 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, C-17 and the KC-46.

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 or conduct quick response training in accordance with AFMAN 11-2AEV1, *Aeromedical Evacuation Aircrew Training*. **(T-1)**

1.5. C2 Contact Information. The tasking C2 agency [TRANSCOM Patient Movement Requirements Center (TPMRC), 618th Air Operations Center (AOC) and AE Control Team (AECT), 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 1.1. C2 Contact Information.

618 AOC	1-800-AIR-MOBL (1-800-247-6625)
618 AOC AE Cell	DSN 312-779-0330 (Commercial: 618-229-0330)
USEUCOM/USAFRICOM	DSN 314-478-9809/9810

603d Aeromedical Evacuation Control Team (AECT)	(Commercial: +49-6371-405-9809/9810)
USINDOPACOM 613 AECT	DSN 315-448-1607 (Commercial: 808-448-1607)
USCENTCOM 609 AECT	DSN 313-717-8426

1.6. Peacetime Preparation. AECMs prepare for the AE mission during peacetime by:

- 1.6.1. Organizing, training, and equipping assigned personnel.
- 1.6.2. Exercising and evaluating contingency AE capabilities.
- 1.6.3. Identifying medical and support equipment necessary to meet mission requirements.

1.7. Aircraft Availability for AE Missions Are Supported By:

- 1.7.1. Primary aircraft (scheduled or designated channel missions).
- 1.7.2. In system select (ISS - opportune aircraft).
- 1.7.3. Patient/cargo mix missions.
- 1.7.4. In all cases, use of specific aircraft is based on:
 - 1.7.4.1. Specific clinical requirements.
 - 1.7.4.2. Specific AE equipment needs.
 - 1.7.4.3. Timeliness of aeromedical evacuation.
 - 1.7.4.4. Airfield constraints.
 - 1.7.4.5. Aircraft availability.
 - 1.7.4.6. Financial considerations.

1.8. Key Words Explained.

- 1.8.1. “Will” indicates a mandatory requirement.
- 1.8.2. “Should” is used to indicate a preferred, but not mandatory, method of accomplishment.
- 1.8.3. “May” indicates an acceptable or suggested means of accomplishment.
- 1.8.4. “**Note**” indicates operating procedures, techniques, etc., that are considered essential to emphasize.
- 1.8.5. “**CAUTION**” indicates operating procedures, techniques, etc., which could result in damage to equipment if not carefully followed.
- 1.8.6. “**WARNING**” indicates operating procedures, techniques, etc., which could result in personal injury or loss of life if not carefully followed.

1.9. Deviations and Waivers. Do not deviate from the 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.

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

1.9.2. Long term waivers must be approved by each affected MAJCOM/Directorate of , Operations (A3) and a copy sent to Air Mobility Command (AMC) Aircrew Standards/Evaluation and Readiness Division (A3V) , utilizing an DAF Form 679, *Department of the Air Force Publication Compliance Item Waiver Request/Approval*. **(T-2)** Additional procedures are outlined in AFMAN 11-202V3_AMCSUP and DAFMAN 90-161.

1.10. 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 Special Instructions, (SPINS) and air operations directive review with supporting MAJCOM/A3.

1.11. AE Readiness Programs. AE Readiness Programs are outlined in AFI 10-2912, *Aeromedical Evacuation Readiness Programs* and provide guidance for unit readiness planning, training, exercising, and reporting in support of worldwide operations, and implements AFPD 10-29, *Worldwide Aeromedical Evacuation Operations*. AF Tactics, Techniques and Procedures (TTPs) and Mission Essential Task Lists can be accessed on via the AMC MEFPAK website.

1.12. Improvement Recommendations. Send comments and suggested improvements to this manual on an DAF Form 847, *Recommendation for Change of Publication*, through appropriate channels to AMC Aircrew Standards and Evaluation Aeromedical Evacuation Branch (AMC/A3VM) at amc.a3vm@us.af.mil in accordance with procedures in AFI 11-215, *Flight Manuals Program* and MAJCOM Supplement.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Lead MAJCOM Delegation. AMC is designated as the lead MAJCOM for AE. AMC will maintain Operational Control (OPCON) for all non-theater assigned AE forces. Total Force coordination ensures system-wide AE standardization for crew and AE mission support training requirements, for clinical in-flight care, and 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 Command Surgeon (AMC/SG), AFRC, NGB and other MAJCOMs, the standards for system-wide organization, equipping and training of the AE force.

2.3. AMC Command Surgeon (AMC/SG). The AMC SG dictates the 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. AMC Aeromedical Training Branch (AMC/A3TM). For all operational training related information, refer to AFMAN 11-2AEV1. For AE continuation training guidance, reference the current Ready Aircrew Program Tasking Memo available on the Aircrew Publications Library.

2.5. AMC Aeromedical Evacuation Contingency Plans Branch (AMC/A5XA).

2.5.1. Responsible for providing the AE force laydown for all Combatant Command Operational Plans (OPLANs) and Contingency Plans (CONPLANs) to United States Transportation Command (USTRANSCOM).

2.5.2. Provides advisement and subject matter expertise guidance for mitigation of any gaps and deficiencies to the global en route care structure.

2.5.3. Informs casualty estimates utilizing the Medical Planner Tool Kit and models patient evacuation networks utilizing the Joint Medical Planners Tool Kit.

2.6. AMC Requirements Division (AMC/A5Q). The executive agent to convert operational AE requirements into material solutions that interface with Mobility Air Forces (MAF) aircraft and fall outside the purview of SG.

2.7. Execution Authority. Headquarters commanders with command authority over 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. Operations Group Commanders (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. For contingency operations, patient movement must operate in a communication degraded or absent environment, with the ability to execute and function independently when command and control is degraded, or reach-back is not possible and still meet

casualty demands with limited resources. Commanders must utilize risk management to execute missions when available resources are decreased or non-existent.

2.8. Command and Control (C2) Centers. C2 centers are action agents for the AMC commander with execution authority (i.e., operational control) over mobility missions and forces. Reference AFMAN 11-202V3_AMCSUP regarding MAF C2 networks and execution authority.

2.9. Unit Commanders. Unit commanders [AE and Medical Treatment Facilities (MTF)] will make this AFMAN available to appropriate personnel electronically. **(T-3)**

2.10. Pilot in Command (PIC). PIC responsibilities are outlined in AFMAN 11-202V3 and applicable supplements.

2.11. Medical Crew Director (MCD). The MCD:

2.11.1. 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. **Exception:** A non-current or unqualified flight nurse regaining currency or qualification may serve as an MCD/FN on any mission when supervised by a qualified instructor or flight examiner nurse (direct supervision for critical phases of flight).

2.11.2. Will be designated on a flight authorization form, in accordance with AFI 11-401_AMCSUP, *Air Mobility Command Supplement Aviation Management*, Table 4.2.

2.11.3. Advises the PIC on patients' conditions and the use of medical equipment that may affect aircraft operations.

2.11.4. 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.

2.11.5. Facilitates communication throughout mission execution. During en route critical care (ERCC) missions, the 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)**

2.11.6. Ensures compliance with the following: All AFMAN and MAJCOM applicable guidance. Mission design series (MDS)-specific instructions and supplements. Flight Crew Information File (FCIF), Notices to Airmen (NOTAM), AMC/SG NOTAMs, Clinical Operations and Patient Safety Alerts and AMC SG Policy Letters, aircraft technical orders, Air Force directives, MAJCOM directives. **(See paragraph 6.7 for related publications).**

2.12. Charge Medical Technician (CMT). The CMT is a qualified Aeromedical Evacuation Technician (AET) and must supervise and manage the AETs assigned to perform duties on the mission. The CMT ensures that medical supplies and equipment are installed on the aircraft and it is operational. The CMT ensures the aircraft is configured in accordance with pre-mission brief or mission directives. The CMT coordinates 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. **Exception:** A non-current or unqualified AET regaining currency or qualification may serve as a CMT/2AET/3AET on any mission when supervised by a qualified instructor or flight examiner (direct supervision for critical phases of flight).

2.13. 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 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.

2.13.1. 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.

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

2.13.3. When in-flight, the ERCC works with and receives mission operational direction from the MCD. The mission operational management authority and responsibility remains with the 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. Aircrews are formed based on fragmentation order, mission directive, crew duty time (CDT) and flight duty period (FDP) requirements, Operational Risk Management (ORM) considerations, aircrew member qualifications, and other constraints to safely accomplish the mission tasking. **(T-3)** For operational missions the Chief Nurse Executive (CNE) will determine number of AECMs, and crew complement required to support the mission based on patient acuity, patient load, and en route care requirements. **(T-3) Note:** For deployment taskings aircrew must be current, qualified and mission ready in accordance with AFMAN 11-2AEV1. **(T-2)** For deployment unit type code taskings, a flight crew consists of two Flight Nurses (X46F) and three Aeromedical Evacuation Technicians (X4N0). **Note:** Reference AFMAN 11-2AEV1 for exception to Aeromedical Readiness Mission (ARM), Static Training Mission, Operational Training Mission, and Contingency Exercise Training Mission requirements.

3.2.1. Augmented Crew. (N/A for C-21) SQ/CC or designee will augment an aircrew in accordance with mission aircraft FDP requirements. **(T-2)** In situations requiring augmentation, the crew will be augmented from the start of the duty period. **(T-2)** If augmentees join the mission en route, the crew's FDP is computed based on the FDP of the most limited person. Augmented AE crews allow for each crew position to obtain 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. **Note:** AFTO Form 781, *ARMS Aircrew/Mission Flight Data Document* 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.

3.2.2. Supplemented Crew. 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)** 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 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 DAFMAN 11-401, *Aviation Management* for further guidance.

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

3.3.1. An aircrew member will be current and qualified or in qualification training to perform primary duties. **(T-2)** An aircrew member will remain qualified in accordance with AFMAN

11-2AEV1 and AFMAN 11-2AEV2 during and throughout the temporary duty (TDY) and deployment period.

3.3.2. Is a non-rated aircrew member as explained in AFD 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 duties in an authorized flying position and designated on the flight authorization. **(T-2)** Duties must be essential to performing patient care and operating associated equipment used for completing a mission.

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

3.3.4. Any non-current or unqualified AECM may serve as a primary aircrew member on any mission when supervised by a qualified instructor or flight examiner (direct supervision for critical phases of flight).

3.4. Aircrew Management.

3.4.1. SQ/CCs and en route C2 agents will 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_AMCSUP, for further guidance. Considerations for ERCC Work or Rest cycles are outlined in DAFI 48-107V2.

3.4.2. If an augmented crew enters crew rest scheduled for a basic FDP, the PIC may accept an augmented FDP as long as: 1) the C2 agent or PIC discovers the extenuating circumstances requiring the augmented FDP before the first takeoff and 2) the PIC verifies all augmenting aircrew members can get adequate rest en route. **(T-3)** ERCC team members log time as operational support flyers in accordance with DAFMAN 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 the period 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 remains overnight (RON), the PIC and MCD coordinate alert and take-off time based on the latest crewmember CDT end point. Reference AFMAN 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:** CDT/FDP includes both military and civilian work and begins when an individual reports for their first duty period (military or civilian).

3.6. Crew Rest/En Route Ground Time. Units and/or mission execution authorities must establish procedures to place aircrew members in crew rest. **(T-2)** For further guidance follow AFMAN 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 should send a copy of the AE crews AF Form 4327A, *Crew Flight Authorization (FA)* to C2 agency controlling the mission [as well as any C2 agencies geographically responsible for a mission RON location/618 AOC as applicable], no later than 24 hours prior to scheduled mission execution time. **(T-3)** The sending AE unit should upload the FA into Global Decision Support System (GDSS). This provides personnel oversight, for the C2 agency executing the mission and will assist C2 agencies with arranging billeting requirements (as needed). 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 and rank.

3.6.3. The MCD will interface with mission C2 agencies for all AE missions. **(T-3)** The MCD should contact the applicable AOC/AECT for the respective mission. The MCD ensures:

3.6.3.1. C2 agencies have MCD's contact information. **(T-3)**

3.6.3.2. Any mission irregularities are discussed (as needed).

3.6.3.3. In coordination with MCD, the PIC may modify normal ground time with concurrence of controlling agency in the interest of safety.

3.6.3.4. If post mission duties will extend into the scheduled crew rest timeline for a return flight or RON, the MCD with concurrence of the PIC, may contact C2 to request a ground time extension.

3.7. Alerting Procedures.

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

3.7.2. Reference AFMAN 11-202V3_AMCSUP for AE Alerting procedures regarding C2 agency responsibilities.

3.8. Standby Force Duty. Reference AFMAN 11-202V3_AMCSUP.

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

3.9.1. Aircrew will be current and qualified in the MDS, as well as unique systems or configuration required to fly the mission. **(T-3)** Conduct Quick Response Training in accordance with AFMAN 11-2AEV1 for non-unit assigned, non-universal aircraft.

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. For further guidance refer to AFMAN 11-2MDSV3, AFMAN11-202V3, and AFMAN 11-202V3_AMCSUP.

3.10. Policies Governing Attendants.

3.10.1. For medical attendants (MA), non-medical attendants (NMA), and ERCC see DAFI 48-107 series for guidance.

3.10.2. Guards of Prisoner Patients:

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

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

3.10.2.3. Are prohibited from handcuffing prisoner patients to any portion of the aircraft. **(T-1)**

3.10.2.4. Clinical considerations for Prisoner-Patients are outlined in DAFI 48-107V1.

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

Chapter 4

AIRCRAFT MEDICAL EQUIPMENT AND MEDICATION OPERATIONS

4.1. Objective.

4.1.1. Some medical equipment is non-compatible 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 are in the electronic flight bag (EFB) under AE folder. These references provide general guidance to safely secure and monitor frequently used patient movement inventory and non-patient movement inventory medical equipment. 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/Command Surgeon En Route Medical Care Division (AMC/SGK) establishes the authorized controlled medications list indicating types of controlled substances approved for AE missions. Guidance on controlled drug administration is described in DAFI 48-107V1.

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. Guidance on securing medications and controlled drug inventory processes are described in AFI 44-102, *Medical Care Management* and DAFI 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 point of contact. Operations Group Standards and Evaluation (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, 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 should coordinate with LM/BO for the most appropriate procedures for securing patients. Crewmembers should have seat belts fastened when occupying a seat.

5.3.2. Refer to AFMAN 11-202V3_AMCSUP for seatbelt requirements.

5.3.3. All patients, actual or simulated, will remain secured on a litter or seat for takeoff and landing and will be verified by AE crew. **(T-2)** Personal tethering devices are only used during contingency/emergency situations that requires AECMs to render care to patients during critical phase of flight. Proper coordination prior to use needs to be made with PIC and LM. AECMs will have a rigger's belt and the tethering device will have two points of contact. **(T-2)** One end of the tethering device will clip onto the rigger's belt and the other end to an aircraft floor tie-down ring. AECMs will utilize the patient litter as an additional safety point of contact in case of turbulence. **(T-2)**

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

5.5. Electronic Flight Bag. For guidance see AFMAN 11-202V3, applicable supplements and the Air Mobility Command Instruction (AMCI) 11-270, *Mobility Air Forces Electronic Flight Bag Program*.

5.6. 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 communication professionalism and crew coordination.

5.6.1. Aircraft Interphone. The MCD monitors interphone during critical phases of flight. Crewmembers advise the PIC 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) Note:** Every effort is to be made to accomplish briefings and appropriate checklist items prior to entering critical phases of flight.

5.6.2. 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 inter-phone cable is not available during take-off and landing, then the AECM will coordinate 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. Bose A-20 headsets are also authorized on the C-17 to facilitate communication with the front-end crew. The aircraft wireless intercommunication system (AWIS) and David Clark® headset is approved for use on the C-17, C-130, C-5, KC-10, C-12, KC-46 and KC-135.

5.7. Crew Resource Management (CRM)/Threat and Error Management (TEM). CRM emphasizes how flight and crewmembers communicate, manage resources, and make decisions. TEM emphasizes effective management and communications regarding operational threats and human error. Guidance on CRM and TEM programs is provided in AFMAN 11-290, *Cockpit/Crew Resource Management Program and Threat & Error Management Program*.

5.7.1. TEM provides strategies and tactics to help crews target threats for 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.

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

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

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

5.7.2.3. 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.

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

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

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

5.7.3.3. 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 patient related issues.

5.7.4. **Threat Identification and Mitigation.** Effective threat identification and mitigation strategies enhance situational awareness and reduce the potential for crewmember error. The appropriate response to a threat is: Identify and Prepare. The earlier threats are identified (both anticipated and unanticipated), the more quickly and effectively they can be managed. Threats not properly identified, or identified but not effectively mitigated, could result in degradation of safe operations or patient harm. Effective threat mitigation strategies include: persistently briefing known and anticipated threats along with actions, evaluating and confirming current and expected tasks and/or flight progress, effective wingman duties, and adhering to standard procedures.

5.7.5. **Error Recognition and Mitigation.** Effective error management addresses the negative consequences of human errors, either made by oneself or by another crewmember or ground personnel. Anticipate errors based on complexity and circumstance. The earlier an error is identified, the more quickly it can be repaired. Effective strategies for error management include: anticipation of errors (e.g., as discussed during mission planning), maintaining awareness of aircraft status and flight crew actions, ground personnel actions when enplaning or deplaning patients, and appropriate task prioritization. Effective error-countermeasures include continuous employment of CRM concepts, crewmember monitoring and communication/ coordination techniques such as verbalize, verify and monitor.

5.7.6. **Undesired State (US).** A US is a safety or mission compromised aircraft state (position, altitude, condition, configuration, or mission crew events/performance) resulting from ineffective CRM/TEM. The appropriate response to a US is: Identify and Recover. Once the US has been identified, aircrews must take immediate corrective action. This action will likely include a combination of CRM, TEM, and technical skills. A US from which a crew does not immediately recover may lead to an incident, accident, mishap, or mission failure.

5.8. Aerial Refueling. Aerial refueling is an option which may be considered when planning AE patient movement. Refer to DAFI 48-107V1 for nursing considerations related to air refueling. Refer to AFI 11-202V3_AMCSUP for further air refueling guidance. OG/CC may authorize air refueling on training missions. Efforts to maximize in-flight training opportunities for AECMs during air refueling missions should be taken into consideration by the PIC and MCD. Refer to AFI 11-202V3_AMCSUP, specific MDS V3, for air refueling considerations.

5.9. Military Working Dogs. Military working dogs (MWD) 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 must be muzzled and secured as directed by the handler or veterinarian. Ensure equipment and supplies accompany the animal for patient care needs.

5.10. Operational Reports and Forms. Refer to AFMAN 11-202V3_AMCSUP or MAJCOM specific guidance for operational reports and forms.

5.11. AE Event/Near Miss Reporting Process. Refer to DAFI 48-107V1, Chapter 9, Patient Movement Patient Safety Program.

5.12. Airman/Aviation Safety Action Program (ASAP). ASAP is an identity-protected, self-reporting system that is integral to reducing mishaps and improving operations and training. ASAP is designed for Airmen to report information and concepts critical to resolving mishap precursors

and to share this information across AF aviation communities. The information is used to reduce mishaps through operational, logistic, maintenance, training, and procedural enhancements. 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. Future development of SAFEREP program will replace the ASAP program.

Chapter 6

AIRCREW PROCEDURES

Section 6A—Pre-Mission

6.1. Aircrew Uniform.

6.1.1. Guidance on Aircrew uniform and authorized clothing is provided in DAFI 36-2903, *Dress and Personal Appearance of Air Force and United States Space Force Personnel*, and appropriate MAJCOM supplement on all missions, unless otherwise authorized. Additionally, guidance on aircrew authorized clothing and equipment is provided in AFI 11-301V1, *Aircrew Flight Equipment (AFE) Program*, MDSV3 guidance, aircraft flight manuals and theater SPINS. 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 on board all flights commensurate with mission, climate, and terrain involved.

6.2. Personal Requirements.

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

6.2.2. Aircrew Gloves. All crewmembers maintain Safe-to-Fly (STF) aircrew gloves in their possession (i.e., Nomex®, flame-resistant gloves as outlined in current Glove Certification STF memorandum).

6.2.3. Goggles. All crewmembers maintain impact resistant, wrap-around style glasses or goggles in their possession to protect from small projectiles, debris, and fragments. **(T-3)**

6.2.4. Passport. Guidance on passports is provided in AFMAN 11-202V3_AMCSUP, and DoD FCG.

6.2.5. Vaccination Record. Crewmembers maintain current certificates of immunization (shot record) in their possession. Each crewmember will carry a current paper or electronic copy of immunization (shot record). **(T-3)**

6.2.6. Driver's License. A valid state driver's license is required on each TDY where use of U.S. government general purpose vehicles may be required. Crewmembers will contact the local airfield manager before driving on the flight line. **(T-2)**

6.2.7. Identification Tags. Guidance on the wear or have identification tags in their possession while performing duty as an aircrew member is provided in DAFI 36-3802, *Force Support Readiness Programs*.

6.2.8. Foreign Object Damage Hazards. Crewmembers and Operational Support Fliers will not wear wigs, hairpieces, rings (regardless of material), 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 will be accounted for before and after flight. **(T-3)**

6.2.9. Flashlights. Each crewmember carries an operable flashlight.

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*. Each crewmember will carry their home station AF Form 1199 for proper unescorted entry procedures during missions. **(T-3)**

6.2.12. Individual Training Summary (ITS) and Individual Data Summary (IDS). Each crewmember will carry a current paper or electronic copy of ITS and IDS on EFB. **(T-3)**

6.2.13. Common Access Card (CAC). Each crewmember must carry a valid military CAC. **(T-3)**

6.3. Pre-mission Actions. Refer to AFMAN 11-202V3_AMCSUP for additional pre-mission actions. Aircrew Intelligence Briefings and additional guidance are outlined AFMAN 11-202V3_AMCSUP.

6.3.1. Ensure physiological training, annual physical, immunizations, Emergency Medical Technician certification, Basic Life Support (BLS) certification, Advanced Life Support (ALS) certification, and nursing license remain current for all crewmembers throughout the deployment or TDY period.

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

6.4. Aircrew Publications Requirements. Primary crewmembers will carry a current hard copy or digital version of AFMAN 11-2AEV3, AFMAN 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. Expected Cargo/Passenger Load and AE Configurations. At established locations with an AE Operations Teams (AEOT), the AEOT will provide the AE crew with the expected cargo/passenger upload, AE configuration and AE crew show time per expected alert sequences. **(T-3)**.

Section 6B—Pre-departure

6.6. Flight Crew Information File (FCIF) Procedures. For all FCIF procedures refer to AFMAN 11-202V2_AMCSUP, *Aircrew Standardization and Evaluation Program*.

6.7. 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 at a minimum:

6.7.1. 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:

6.7.1.1. AFMAN 10-2909, *Aeromedical Evacuation (AE) Equipment Standards*

6.7.1.2. AFMAN 11-2AEV1, *Aeromedical Evacuation Aircrew Training*

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

- 6.7.1.4. AFMAN 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*
- 6.7.1.5. AFMAN 11-2AEV3, Addenda A, *Aeromedical Evacuation Operations Configuration/Mission Planning*
- 6.7.1.6. AFMAN 11-202V3, *Flight Operations*
- 6.7.1.7. AFMAN 11-202V3_AMCSUP, *General Flight Rules*
- 6.7.1.8. AMCI 11-208, *Mobility Air Forces Management*
- 6.7.1.9. DAFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations*
- 6.7.1.10. DAFI 48-107V2, *En Route Critical Care*
- 6.7.1.11. DAFI 48-107V3, *En Route Care Documentation*
- 6.7.1.12. DAFMAN 11-401, *Aviation Management*
- 6.7.1.13. *Current Aeromedical Evacuation Medical Equipment Compendium*
- 6.7.1.14. *Current Aeromedical Evacuation In-flight Kit–Packaging Guide Allowance Standard*
- 6.7.1.15. *Lippincott Manual of Nursing Practice (current edition)*
- 6.7.1.16. *Current National ALS Guidelines, American Red Cross or equivalent guidelines.*
- 6.7.1.17. *Current Edition Nursing Drug Book*
- 6.7.1.18. *Current Ready Aircrew Program Tasking Memorandum (RTM)*
- 6.7.1.19. *Current Aeromedical Readiness Mission (ARM) Training Guide*
- 6.7.2. 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:
 - 6.7.2.1. DD Form 600, *Patient Baggage Tag*
 - 6.7.2.2. DD Form 1380, *Tactical Combat Casualty Care (TCCC) Card*
 - 6.7.2.3. DD Form 2852, *Patient Movement Event/Near Miss Reporting*
 - 6.7.2.4. AF Form 3829, *Summary of Patients Evacuated by Air*
 - 6.7.2.5. AF Form 3830, *Patient Manifest*
 - 6.7.2.6. AF Form 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*
 - 6.7.2.7. AF Form 3841, *Certificate of Release*
 - 6.7.2.8. AF Form 3851, *Patient Baggage Data*
 - 6.7.2.9. AF Form 4449, *En Route Care Equipment Malfunction Report Tag*
 - 6.7.2.10. AF Form 3854, *Receipt for Patient’s Valuables*
 - 6.7.2.11. AFTO Form 350, *Reparable Item Processing Tag*
 - 6.7.2.12. AF Form 3858, *Aeromedical Evacuation Mission Offload Message*

- 6.7.2.13. AF Form 3859, *Turn-In of Unaccompanied Narcotics*
- 6.7.2.14. AF Form 3899, *Aeromedical Evacuation Patient Record*
- 6.7.2.15. AF Form 3899A, *Patient Movement Record Progress Note*
- 6.7.2.16. AF Form 3899B, *Patient Movement Physician Orders*
- 6.7.2.17. AF Form 3899C, *Patient Movement Physical Assessment*
- 6.7.2.18. AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*
- 6.7.2.19. AF Form 3899E, *Patient Movement Intake/Output*
- 6.7.2.20. AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*
- 6.7.2.21. AF Form 3899G, *Patient Movement Restraint Observation Flowsheet*
- 6.7.2.22. AF Form 3899H, *Patient Movement Neurological Assessment*
- 6.7.2.23. AF Form 3899I, *Patient Movement Medication Record*
- 6.7.2.24. AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*
- 6.7.2.25. AF Form 3899K, *Patient Movement/In-Flight Resuscitation Flow Sheet*
- 6.7.2.26. AF Form 3899L, *En Route Critical Care*
- 6.7.2.27. AF Form 3899M, *Patient Movement Record PCA/PNB/Epidural Hand-Off*
- 6.7.2.28. AF Form 3899N, *Patient Movement Pain Adjunction Flowsheet*
- 6.7.2.29. I-SBAR, *Patient Movement Inpatient Handoff Report Worksheet*
- 6.7.2.30. Patient Positioning Plans for All AE Aircraft
- 6.7.2.31. CBP 6059B, *Customs Declaration*

6.8. Briefing Requirements.

- 6.8.1. AE Pre-Departure Briefing. The MCD will brief the PIC in regard to the AE mission utilizing appropriate checklist. **(T-3)**
- 6.8.2. PIC Pre-Departure Briefing. PIC briefs all crewmembers on the details of the mission. Cover all applicable items of the operations briefing, including HHQ or unit special interest items (SIIs), and ORM levels and mitigating factors. Use a MAJCOM approved briefing guide.
- 6.8.3. Cover applicable medical inflight emergency divert locations, off-load support requirements, and contact information for phone patch to controlling C2 agency.
- 6.8.4. Training/Evaluation Briefing. Before all training/evaluation missions, instructors and flight examiners brief the crew on requirements and objectives for each student or examinee.
- 6.8.5. Intelligence Briefings. Before operating in a combat environment, the crew obtains a current intelligence briefing.
- 6.8.6. Post-Mission Debrief. PICs debrief all sorties. Use the MAJCOM approved MAF AE Debrief Guide. MCDs debrief AE specific outcomes.

6.9. Risk Management (RM).

6.9.1. 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*.

6.9.2. MCDs will accomplish RM worksheets in accordance with AMCI 90-903, *Aviation Operational Risk Management (AVORM) Program* and additional MAJCOM or local guidance as part of preflight activities. (T-1)

6.9.3. 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

6.10. AFTO Forms 781A. AFTO Form 781A, *Maintenance Discrepancy and Work Document* is used to report unserviceable or discrepancies discovered by aircrew or maintenance personnel. 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)

6.11. Aircraft Servicing and Ground Operations. Refer to AFMAN 11-202V3_AMCSUP for additional guidance.

6.12. Aircraft Refueling and Concurrent Ground Operations. Refer to AFMAN 11-202V3_AMCSUP for additional guidance. See AFMAN 11-2MDSV3 for specific procedures.

6.13. Aircrew Emergency Equipment.

6.13.1. 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 will note unserviceable or missing AFE equipment on the AFTO Form 46, *Prepositioned Aircrew Flight Equipment*. (T-3) For C-21, the PIC must check out AFE. (T-3)

6.13.2. On missions carrying patients, distribute Emergency Passenger Oxygen System (EPOS) to each patient regardless of planned flight altitude. Ensure EPOS are readily available and serviceable for litter patients. Distribute and demonstrate use of EPOS prior to departure. **Note:** If a patient moves for comfort to a litter or a seat, ensure emergency equipment accompanies the patient to the litter or seat [i.e., EPOS or life preserver unit (LPU)].

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

6.13.4. 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.

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

6.13.6. AE crews ensure a 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 do not need to be worn for takeoffs, landings, or approaches. Ensure the appropriate number and type of life preservers are onboard for overwater missions carrying children and infants. Use the Adult/Child life preserver for patients. The use of the LPU-6/P Infant Cot is limited to infants 18 months of age or up to 30 lbs.

6.14. Mission Emergency Equipment.

6.14.1. AFMAN 11-2AEV3, Addenda A, provides guidance for MDS oxygen capabilities.

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

6.14.3. Crewmembers occupying a crew station will have an oxygen mask connected and readily available for use from before engine start until engine shutdown unless duties dictate otherwise per AFMAN 11-2AEV3 Attachment 2 and CL-1. **(T-3)**

6.14.4. 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.

6.14.5. 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.

6.14.5.1. 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 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.

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

6.14.5.3. 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 (if available). Refilling the MA-1 bottle to continue crew duties during emergency procedures is authorized, if it is safe to move about the cabin. If a PBE is not available and the 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)** 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)**

6.14.5.4. AE units will not service MA-1 portable oxygen bottles. **(T-3)** Dash 21/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:

6.14.5.4.1. Fill the bottle using oxygen recharger hose until full (300 psi [\pm 25 psi]).

6.14.5.4.2. Turn MA-1 bottle upside down and turn to EMERGENCY setting until empty.

6.14.5.4.3. Repeat for a total of three times.

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

6.14.6.1. P- Pressure: Ensure portable walk-around bottle indicates 300 \pm 25 psi.

6.14.6.2. 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.

6.14.6.3. 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.

6.14.6.4. C- Connections: Ensure Quick-don Mask is connected to O2 bottle. Adjust O2 bottle harness to expedite donning in emergency. MCD will verify communication capability with aircraft communication system. **(T-2) Note:** All AECMs attach AWIS to mask and verify operability. **(T-2) Note:** AECMs will adjust and fit shoulder harness and leg straps to prevent inadvertent swinging of the bottle when used in an emergency. **(T-2)**

6.14.6.5. 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. **Exception:** Where smoke or fumes are not present and goggles are not used, push the pin in the CLOSED position if available. **Note:** Refill MA-1 walk-around bottle and verify connection compatibility with the re-charger hose.

6.14.7. There may be instances where an AECM needs to disconnect their MA-1 bottle. **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.

6.14.8. 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)**

6.15. Fleet Service. Ensure the required fleet service items are onboard the aircraft early enough to permit inventory prior to engine start.

6.16. Airlifting Hazardous Cargo. Refer to AFMAN 11-202V3_AMCSUP for further discussion on MCD and PIC responsibilities related to hazardous cargo. Refer to AFMAN 24-604, *Preparing Hazardous Materials For Military Air Shipments* for hazardous product special provisions rating. Conflicts will be referred to the respective tasking AOC for further decision and discussion.

6.17. Patient/Cargo Mix.

6.17.1. Cargo and passengers may 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 and appropriate C2 agencies.

6.17.2. 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)**

6.17.3. 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. **(T-2).**

6.18. Patient Preparation.

Patients are prepared for AE in accordance with DAFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations*.

6.18.1. In the event the 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 controlling C2 agency to coordinate with the TPMRC before refusing the patient. **(T-3). Note:** In determining whether to refuse flight, the MCD will weigh the risks of transporting the patient against the risks of refusing flight. **(T-3)**

6.18.2. Coordination with the TPMRC 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)**

Section 6D—Departure

6.19. 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 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

6.20. Communications and Documentation.

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

6.20.2. The MCD will transmit an AF Form 3858, *Aeromedical Evacuation Mission Offload Message* to Command Post no later than one 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 MCD or designated

representative will relay the message. **Note:** MCDs update C2 agency with any variations to the mission as required.

6.20.3. During 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 DAFI 48-107V3. **(T-3)**.

6.20.4. Clinical documentation will be accomplished in accordance with DAFI 48-107V1 and V3. Aeromedical Evacuation (AE) Electronic Health Record (EHR) will be utilized as a closed network in-flight, until end of mission when EHR records are ready for transmission. **(T-2)** Ensure all records generated are maintained and disposed in accordance with with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System.

6.21. Transfer of Patient Care. In the AE system, transfer of patient care occurs between AE representatives of the MTF or external agencies to and from the AE crew. 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.

6.21.1. Clinical considerations for transfer of care are outlined in DAFI 48-107V1.

6.21.2. Clinical documentation considerations for transfer of care are outlined in DAFI 48-107V1 and 48-107V3 utilizing the I-SBAR sheet.

Section 6F—Arrival

6.22. 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:

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

6.22.2. On military installations, if appropriate medical personnel are not available for transfer of care, the MCD or FN must accompany all patients to the medical facility and provide report to the staff that assume patient care responsibilities. **(T-3)**

6.22.3. At scheduled RON stations, when a licensed provider is not available to receive report on the flight line, an AECM must accompany patients to the facility if the patient's medical condition warrants clinical observation during transport.

6.22.4. 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. A PSR will be completed and the C2 agency will be notified when the accompanying AECM completes their duties. **(T-3) Note:** This may affect CDT and execution of follow-on missions.

6.22.5. 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:

6.22.5.1. 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)

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

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

6.22.6. 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)

6.22.7. 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.

6.22.8. AETs must obtain 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.

6.22.9. The MCD coordinates all aspects of mission departure for the following day.

6.22.10. 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) FNs may have to report to the medical facility to receive patient report and to obtain controlled medications that were placed under security.

Section 6G—Miscellaneous

6.23. Customs/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 in accordance with the Foreign Clearance Guide website. (<https://www.fcg.pentagon.mil/fcg.cfm>) (T-3) The 3AET also distributes the forms to the AE crew, patients, and attendants, ensure completions and delivery to LM or BO prior to landing. **Note:** Ensure sufficient customs, CDP 6059B, *Customs Declaration*, forms are available for all personnel. Passenger service personnel should provide forms prior to departure.

6.24. 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 AFMAN 11-202V3_AMCSUP. (T-0). **WARNING:** Aircraft must never be sprayed with patients/passengers onboard. (T-2)

6.25. AFE and Dash 21 Equipment Documentation. The PIC or designated representative will:

6.25.1. 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 onboard the aircraft. (T-2)

6.25.2. 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, the initial check has been signed by maintenance, and configuration documents match mission requirements. (T-2)

6.25.3. 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-3) Ensure appropriate number and type of life preservers are onboard for over-water missions carrying children and infants. (T-2) Also ensure overwater flights do not carry more passengers and crew members than life rafts will accommodate. (T-2)

6.25.4. Missing Equipment. AECMs discovering equipment missing will notify LM/BO. (T-3)

6.26. Overflying En Route Stops. MCD will contact C2 immediately to determine disposition of patients if an en route stop is overflowed. (T-2)

6.27. Medical Emergency/Change in Patient Status. The MCD ensures immediate notification reaches the PIC if ALS/BLS algorithms are used in flight, and the patient meets USTRANSCOM “Call Criteria” or the AECMs deem necessary regarding the gravity and nature of the situation. The MCD coordinates with the PIC to establish immediate radio communication with the AOC/TPMRC for a physician and guidance for landing at an airfield capable of handling the situation regarding mission irregularities, coordination of mission needs and equipment requirements. **Note:** The patient’s personal identifiable information (PII) will not be used in radio or cell phone communications; use the patient’s cite number only. (T-1) **Note:** Refer to DAFI 48-107V1 for clinical management.

6.27.1. 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, to activate the appropriate local response. This will initiate the ground response to have available support personnel on site.

6.27.2. 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 applicable and the outcome. Be prepared to request orders, mission deviation to expedite meeting patient and mission requirements.

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

6.28. Apparent Patient Death in Flight. When a suspected death occurs in-flight, the MCD will contact C2 immediately. (T-2) **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)

6.28.1. 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).”

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

6.28.3. 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.

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

6.28.5. 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.

6.28.6. Home Station. In the event of patient death in flight or patient death within 24 hours of flight, upon mission completion, the SQ/CC will coordinate with C2 and conduct an investigation to determine if the AE crew 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-3)** SQ/CC will notify OG/CC who will notify the MAJCOM/A3 of incident and actions taken. **(T-1)**

6.28.7. Deployed AECMs. In the event of patient death in flight or patient death within 24 hours of flight, upon mission completion, the Unit/Detachment Commander, OG/CC with operation control of the mission will be notified of the incident by the C2 agency. **(T-1)** If the AE crew is in the mobility system, the AE detachment commander where the crew disembarks the aircraft will conduct the investigation to determine if the AE crew followed all aircrew procedures. In the event AECMs are in mission essential personnel status, AECMs will return to deployed/staged unit. **(T-3)**

6.28.8. The MCD, Unit/Detachment Commander, or OG/CC may consider notifying a Religious Support Team 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, unregulated patient flow, triage situations, etc. Focus would be on fortifying caregiver coping skills and personal resiliency in the face of high operational stressors.

6.29. Airlift of Human Remains. Refer to AMCI 11-208 and DAFI 24-602V2, *Cargo Movement*. Human remains should not be carried on AE missions except under extraordinary circumstances and after coordination with AE C2 agency.

6.30. Patients Requesting Release.

6.30.1. 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.

6.30.2. 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.

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

6.30.2.2. 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.

6.30.3. 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 Patient Safety 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 3841. 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.

6.30.4. Refusal to sign the AF Form 3841 is annotated in the patient's medical record.

6.30.5. 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). AFI 13-207-O, *Preventing and Resisting Aircraft Piracy (Hijacking)*, DAFI 31-101, and specific MAJCOM security publications contain additional guidance.

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 determines what items can be carried by/for AE patients. If a safety concern exists, the PIC is the final decision authority and ultimately responsible for the well-being of all persons onboard 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 and attendants will not carry weapons or ammunition on their person or in hand-carried baggage onboard 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 in the performance of official duties.

7.2. Arming of Crewmembers. Guidance on arming crews is in accordance with AFI 31-117, *Arming and Use of Force by Air Force Personnel*, AFMAN 11-202V3, MAJCOM publications and mission directives [Mission Detail, Special Instructions (SPINS), Operations Order (OPORD), etc.].

Chapter 8

AIRCREW OPERATIONS IN CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN) ENVIRONMENT

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

8.1.1. 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, U.S. Embassies, and foreign ambassadors in consultation with Department of Defense medical authorities.

8.1.2. AMC will train and equip AE Crews and stage required equipment at key hubs to carry out these limited missions for movement of respiratory or droplet contaminated patients. **(T-1)**

8.1.3. For aircrew and other specific CBRN Operations, refer to AFMAN 11-301V3, *Aircrew Flight Equipment (AFE) Contingency Operations and Planning* and Mobility Air Forces Counter-Weapons of Mass Destruction Concept of Operations.

Chapter 9

FLIGHT NURSE AND AEROMEDICAL EVACUATION TECHNICIAN PROCEDURES

9.1. 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:

9.1.1. Specialize in nursing care of patients in a hypobaric environment.

9.1.2. Have advanced training in the operation of specialized medical equipment designed and approved for use at altitude.

9.1.3. Are trained and current in the aircraft systems and configurations required for safe AE operations.

9.1.4. Provide in-flight assistance to medical attendants as situations dictate.

9.2. Mission Planning.

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

9.2.2. 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 AE crew will set up an emergency litter on all AE missions. **(T-1) Exception:** An emergency litter is not required for ambulatory patient movement on C-21/C-12 missions. When mission load permits, a minimum of one seat should be reserved for every three litter patients.

9.2.3. AE crew 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)**

9.2.4. 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.

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

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

9.2.7. TCTO 1C-130-2255, Inspection and Disposition of Litter Support Strap Brackets on Select C-130 Aircraft is the most accurate source for determining the serviceability of C-130 brackets. Determination is made by reading both the text and verifying the pictures in the TCTO to determine serviceability.

9.2.8. 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.

9.2.9. Available litter spaces and ambulatory seating depends on the aircraft cabin's mission configuration (i.e., aircrew flight equipment storage containers and toolbox stowage).

9.3. Preflight Duties.

9.3.1. 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.

9.3.2. Roller conveyors will be removed from all aisle ways, walkways, and AE litter patient positions. **(T-3)**

9.3.3. {KC-46} Omni rollers on the KC-46 cannot be removed. 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 enplaning and deplaning. **(T-2)** These pallets will be secured together with a cargo strap to prevent excessive movement. **(T-2)** Crew members should exercise heightened awareness as people transit around the omni-roller mats and will brief passengers/patients/personnel on the potential hazards that exist. **(T-3)** Crews should be available to assist where necessary to prevent any potential injuries from occurring.

9.3.4. {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)**

9.3.5. {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)**

9.3.6. 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.

9.3.7. Oxygen and Electrical. Lines may be ran 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.

9.3.8. 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 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 may jeopardize the safety of the aircraft, medical equipment and all persons on board and should be avoided.

9.3.9. AECMs will wear gloves when making electrical connections, during configuration and enplaning/deplaning procedures to prevent personal injury. **(T-2)**

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

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

9.3.12. Aircrew 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) CAUTION:** Do not drag the Schrader end of the oxygen line across the aircraft floor. **Exception:** During emergencies, AECMs may have to touch oxygen lines with gloves to refill oxygen source.

9.3.13. 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)**

9.3.14. "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 enplaning patients and remain connected until all patients have deplaned. **(T-2)**

9.3.15. AECMs will calculate pre-mission oxygen requirements in accordance with AFMAN 11-2AEV3 CL-1 and *Medical Equipment Compendium* for AE and Critical Care Air Transport Team (CCATT) patients. Prior to enplaning CCATT patients requiring mechanical ventilation, AE crew and CCATT personnel will verify patient oxygen requirements.

9.3.15.1. Calculated oxygen requirements may require the use of additional PTLOX/NPTLOX to meet the requirement for ventilated patients. Refer to AE *Medical Equipment Compendium* for PTLOX/NPTLOX restrictions. A Bag-Valve-Mask can be connected to the dedicated PTLOX/NPTLOX to support the ventilated patient.

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

9.3.16. 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.

9.4. Ground Operations. The CMT is responsible for all AE ground operations. AECMs will not direct the movement of vehicles within the 10-foot circle of safety from the nose, tail and wingtips of the aircraft. **(T-1)** Any movement within the 10-foot circle will be directed by the LM/BO/Properly Trained Maintenance Personnel. AECMs or ERC personnel will not direct the movement of fixed wing or rotary wing aircraft at any time. **(T-1)**

9.4.1. 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.

9.4.2. 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.

9.4.2.1. 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.

9.4.2.2. AE crew 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.

9.4.2.3. AE crew distributes hearing protection to all enplaning patients and attendants.

9.4.2.4. The CMT 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.

9.4.2.5. Ensure that all ambulatory patient personal belongings, to include medications if self-medicating, are in their possession.

9.4.2.6. Identify patients with non-certified medical equipment.

9.4.3. Patient Preparation for Deplane:

9.4.3.1. 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)**

9.4.3.2. 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)**.

9.4.3.3. AECMs will ensure soiled linen, sharps containers and contaminated items are collected for removal from the aircraft as specified in DAFI 48-107V1. **(T-3)**

9.5. 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.

9.5.1. 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.

9.5.1.1. 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 9.6](#). 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.

9.5.1.2. Keep ambulatory patients grouped together.

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

9.5.1.4. Monitor patient use of aircraft stairs/Patient Loading System (PLS). 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.

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

9.5.2. Enplaning/Deplaning Communication. When multiple litter patients are being loaded, hand signals will be used. **(T-3)** AECMs are responsible for control and verbal commands of litter loading.

9.5.2.1. 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)**

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

9.5.2.3. 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.

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

9.5.2.5. AECMs physically reach out and identify the litter arm or litter bracket on the stanchion where the litter will be placed. This allows litter bearers to visualize the position before they reach the litter tier.

9.5.2.6. 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.

9.5.3. General Litter Loading Considerations. Safety is the primary concern during litter transfers. Proper lifting techniques should always be used. 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.

9.5.3.1. 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/KC-46, litter patients will be enplaned head-first to eliminate the need to turn litter patients around once on the aircraft. **(T-3)**

9.5.3.2. 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.

9.5.3.3. When enplaning or deplaning litters through the paratroop doors and crew entrance door on the C-130, at least four people will be employed on the ground with an additional two to three people inside the aircraft. **(T-2)**

9.5.3.4. 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.

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

9.5.3.6. 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.

9.5.3.7. The preferred method to enplane or deplane ambulatory patients on the KC-135, KC-46, KC-10 and C-5 is the air stairs. The air stairs will not be used to enplane or deplane litter patients. **(T-2)** If there is no other option available, contact the appropriate C2 agency for further discussion and consultation with AMC/A3VM.

9.5.3.8. The primary means to enplane or deplane litters weighted with equipment, supplies or manikins on the KC-135, KC-46, KC-10 and C-5 is a high-lift capable vehicle, such as an High Deck Patient Loading Platform (HDPLP). If the HDPLP is not available, request a high-lift truck, K-Loader (Halverson Lift, Tunner). Ensure one AECM accompanies the patient(s) on the high-lift capable vehicle. **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/plates to cover gap between aircraft and K-Loader to prevent personnel from injury. See **Table 9.1** for further guidance on restrictions. The new PLS (manufactured by Wartech) is an approved piece of War Reserve Material (WRM) which can be used to enplane or deplane patients if available.

9.5.3.9. If no high-lift capable vehicle is available, enplane or deplane litters weighted with equipment, supplies or manikins 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 behind the litter bearers. The safety spotter's hands will be free to assist the litter bearers as necessary. **(T-3)**

Table 9.1. Loading Equipment Capabilities.

Capability	Weight Capacity	Wind Speed Limits
PLS (Manufactured by Wartech)	1,740 lbs	50 knots
HDPLP (Manufactured by Stinar)	2K lbs platform/6K van	40 knots
HDPLP (Manufactured by Clegg)	2.5K lbs platform/8K van	40 knots

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

9.5.3.11. Litter stanchion arms from the integral stanchions of the C-17, KC-46, LSAS and SLS will be loaded from top to bottom. **Exception:** For contingency operational missions, loading can be conducted non-sequentially.

9.5.3.12. 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)**

9.5.3.13. 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.

9.5.3.14. 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) WARNING:** 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.

9.5.4. C-130 aircraft litter loading procedures.

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

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

9.5.4.3. The two AECMs loading will always protect the patient from litter support brackets. **(T-3)**

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

- 9.5.4.4.1. AECMs hold the litter support straps to the outside of the litter area.
- 9.5.4.4.2. Litter bearers bring the litter into the litter tier area.
- 9.5.4.4.3. Without setting the litter down, the AECMs take the outside litter handle and then direct the litter bearer to take the inside handle.
- 9.5.4.4.4. The AECMs secure the outside bracket.
- 9.5.4.4.5. 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.
- 9.5.4.5. Loading into the centerline #2 and #1 position:
 - 9.5.4.5.1. The AECMs place the litter support strap on the litter above the position to be loaded.
 - 9.5.4.5.2. The litter bearers come on board and set the litter down in the aisle next to litter tier.
 - 9.5.4.5.3. 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.
 - 9.5.4.5.4. 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.
- 9.5.4.6. Loading into the sidewall track extenders #4 and #3 litter position:
 - 9.5.4.6.1. The AECMs hold the litter support strap to the outside of the litter tier.
 - 9.5.4.6.2. The litter bearers bring the litter on board and into the litter tier area.
 - 9.5.4.6.3. Without setting the litter down, the AECM takes the outside litter pole and then directs the litter bearer to take the inside handle.
 - 9.5.4.6.4. Once the AECMs secure the outside brackets, direct the litter bearers to exit the aircraft.
- 9.5.4.7. Loading into the sidewall track extenders #2 and #1 litter position:
 - 9.5.4.7.1. The AECMs place the litter support strap in the litter above the position to be loaded.
 - 9.5.4.7.2. The litter bearers come on board and stop in the aisle by the litter tier.
 - 9.5.4.7.3. Without setting the litter down, the AECMs take the outside litter handle and direct the litter bearers to take the inside litter handle.
 - 9.5.4.7.4. The AECM at the forward end of the litter give the command to lift the litter into the brackets.
 - 9.5.4.7.5. 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.

9.5.4.7.6. 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)**

9.5.5. C-17 Aircraft Litter Loading Procedures:

9.5.5.1. 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.

9.5.5.2. The LSAS should remain onboard the aircraft during enplaning and deplaning. **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.

9.5.5.3. 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 aerial delivery system 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.

9.5.5.4. 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)**

9.5.5.5. When loading CCATT or oversized litters, more than a four-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.

9.5.5.6. Litter position at or above waist level:

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

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

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

9.5.5.7. Loading into litter positions below waist level:

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

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

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

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

9.5.5.8. 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.

9.5.6. SLS Loading Procedures.

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

9.5.6.2. 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)**

9.5.6.3. Litter position at or above waist level:

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

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

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

9.5.6.4. Loading into litter positions below waist level:

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

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

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

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

9.5.6.5. 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.

9.5.7. KC-46 Aircraft Litter Loading Procedures:

9.5.7.1. Crewmembers should exercise heightened awareness as people transit around the omni-roller mats and will brief passengers/patients and personnel on the potential hazards that exist. Litter bearers will be made aware of this hazard prior to loading patients. **(T-2)**

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

9.5.7.3. 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.

9.5.7.4. Litter position at or above waist level:

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

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

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

9.5.7.4.4. Direct litter bearers to exit the aircraft.

9.5.7.4.5. Loading into litter positions below waist level:

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

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

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

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

9.5.7.5. 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.

9.6. Engines Running Onload/Offload.

9.6.1. 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:** Impact resistant, wrap-around style glasses or goggles 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. AECMs may exit the aircraft to conduct ground duties if not contraindicated by Intel/SPINS. At an airfield where a civilian entity or ambulance services has been coordinated, the AE crew will need to coordinate onload/offload and explain safety procedures during an ERO.

9.6.2. EROs are not conducted on the C-5, C-12, C-21, KC-10, KC-135 and KC-46.

9.6.3. 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)**

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

9.6.4.1. The spotter's primary responsibility is to indicate to the ground element when the AEC are ready for enplaning/deplaning, and to start/slow/stop the flow of patients as needed. Refer to paragraphs [9.5.2.1-9.5.2.6](#) for appropriate hand signals.

9.6.4.2. 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.)

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

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

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

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

9.7. Baggage Procedures. The 3AET (or designated representative) will complete patient baggage procedures. **(T-3)** Task may be delegated based on crew complement and responsibilities assigned.

9.7.1. 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.

9.7.2. 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.

9.7.3. 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)**

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

9.7.5. 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 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-12/C-21, PICs are responsible for required passenger handling duties. Passengers are limited to 30 pounds of baggage unless specific allowance for excess baggage is authorized and planned by the controlling C2 agency. Passengers with excess baggage may be transported after the PIC and AECMs determines the aircraft weight limitations and mission requirements are satisfied. **(T-3) 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 traffic management office (TMO) to home unit of record.

9.7.6. Patient/Attendant Unaccompanied Baggage. Unaccompanied baggage is not to be transported onboard AE aircraft.

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

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

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

9.8.1. Emergency signals and passenger evacuation.

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

9.8.3. 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.

9.9. Mission Delays. To preclude unnecessary patient holding on the flight line, aircraft departure times are not established based on an estimated time in commission (ETIC). Departure times will be scheduled only based on fully mission capable aircraft. **(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. The following guidance is offered:

9.9.1. 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. Keep patients informed of the current situation.

9.9.2. 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 (AOC/AECT/TPMRC) 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.

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

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

9.10.2. Accomplish applicable inventories.

9.10.3. The MCD/CMT ensures:

9.10.3.1. 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 AFMAN 11-202V3_AMCSUP.

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

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

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

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

9.10.3.6. 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 for AMC missions and appropriate AOC/AMD for theater missions. **Note:** If mission is continuing the next day or an unscheduled RON has occurred, MCD will give an update to appropriate C2 agencies that duties have terminated for the day. **(T-3)**

9.11. 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 10

AE MISSION SAFETY

10.1. Safety Responsibilities and Precautions. All AECMs will enforce and observe safety measures while performing the patient airlift mission. **(T-3)**

10.1.1. 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)**

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

10.1.3. Adherence to CRM, TEM principles and constant situational awareness are keys to safe mission accomplishment.

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

10.2. 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.

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

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

10.3. Guidelines for Vehicle Drivers. Vehicle operators will follow the guidelines prescribed in AFMAN 24-306, *Operation of Air Force Government Motor Vehicles*. **(T-3)** AECMs will not direct the movement of vehicles within the 10-foot circle of safety from the nose, tail, and wingtips of the aircraft. **(T-1)** Any movement within the 10-foot circle will be directed by the LM/BO. AECMs or ERC personnel will not direct the movement of fixed wing or rotary wing aircraft at any time. **(T-1)**

10.3.1. 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)**

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

10.3.3. 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)**

10.3.4. 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 always remains behind the wheel.

10.3.5. 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.

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

10.3.7. 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.

10.4. Emergency Exits and Safety Aisles.

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

10.4.2. 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.

10.4.3. {C-130} 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.

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

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

10.5. Equipment Procedures. WARNING: 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.

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

10.5.1.1. 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)**

10.5.1.2. Unoccupied ambulance-type stretchers/gurneys.

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

10.5.1.4. 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.

10.5.1.5. 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 24-604. **(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)**

10.5.1.6. H-Tank securing procedure. See H-Tank Shoring and Restraint located in Electronic Flight Bag. The Air Transportability Test Loading Activity letter specifies that these procedures are applicable to the C-17, KC-135, C-5 and C-130 variants.

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

10.5.2.1. Lifting a litter patient above waist level.

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

10.5.2.3. 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)**

10.5.2.4. 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)**

10.5.2.5. Patients on Stryker Frames or similar devices.

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

10.5.2.7. 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)**

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

10.5.3.1. 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.

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

10.5.3.2.1. 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.

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

10.5.3.2.3. 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.

10.5.3.3. Wheelchair patients/transporting battery powered wheelchairs.

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

10.5.3.3.2. 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)**

10.5.3.3.3. 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. The patient should be moved to a litter during flight.

10.5.3.3.4. 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)**

10.5.4. 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)**

10.6. In-Flight Safety Procedures.

10.6.1. 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.

10.6.1.1. When a parent or attendant holds a child/infant, the seat belt is never placed around both the parent/attendant and the child/infant.

10.6.1.2. 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.

10.6.1.3. 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.

10.6.1.4. Refer to AFMAN 11-202V3_AMCSUP for additional procedures on Infant Car Seat.

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

10.6.1.6. 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)**

10.6.1.7. 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.

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

10.6.3. 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 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.

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

10.6.5. 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:

10.6.5.1. 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)**

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

JAMES C. SLIFE, Lt Gen, USAF
Deputy Chief of Staff, Operations

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

- AFPD 10-29, *Worldwide Aeromedical Evacuation Operations*, 13 February 2019
- AFPD 11-2, *Aircrew Operations*, 31 January 2019
- AFPD 11-4, *Aviation Service*, 12 April 2019
- AFPD 90-8, *Environmental, Safety, and Occupational Health Management and Risk Management*, 23 December 2019
- AFPMG TG4 (Armed Forces Pest Management Board Technical Guide 4) – *Disinsection of Military Aircraft*, July 2018
- AMCI 11-208, *Mobility Air Forces Management*, 8 February 2017
- AFI 10-2912, *Aeromedical Evacuation Readiness Programs*, 20 June 2018
- AFI 11-200, *Aircrew Training, Standardization/Evaluation, and General Operations Structure*, 3 May 2022
- AFI 11-215, *Flight Manuals Program*, 25 March 2019
- AFI 13-207-O, *Preventing and Resisting Aircraft Piracy (Hijacking)(FOUO)*, 5 February 2019
- AFI 31-117, *Arming and Use of Force by Air Force Personnel*, 6 August 2020
- AFI 33-322, *Records Management and Information Governance Program*, 23 March 2020
- AFI 44-102, *Medical Care Management*, 17 March 2015
- AFI 65-503, *US Air Force Cost and Planning Factors*, 13 July 2018
- AFMAN 10-2909, *Aeromedical Evacuation (AE) Equipment Standards*, 13 March 2019
- AFMAN 11-2AEV1, *Aeromedical Evacuation Aircrew Training*, 7 December 2020
- AFMAN 11-2AEV2, *Aeromedical Evacuation Aircrew Evaluation Criteria*, 7 Feb 2023
- AFMAN 11-2AEV3, Addenda-A, *Aeromedical Evacuation Operations Configurations/Mission Planning*, 16 June 2020
- AFMAN 11-2AEV3, CL-1, *Aeromedical Evacuation Crew (AEC) Checklist*, 31 August 2021
- AFMAN 11-202V2_AMCSUP, *Aircrew Standardization and Evaluation Program*, 30 August 2021
- AFMAN 11-202V3, *Flight Operations*, 10 January 2022
- AFMAN 11-202V3_AMCSUP, *Flight Operations*, 14 June 2021
- AFMAN 11-218, *Aircraft Operations and Movement on the Ground*, 5 April 2019
- AFMAN 11-290, *Cockpit/Crew Resource Management Program and Threat & Error Management Program*, 25 October 2021
- AFMAN 11-402, *Aviation and Parachutist Service*, 24 January 2019

AFMAN 24-604, *Preparing Hazardous Materials for Military Air Shipments*, 9 October 2020
AFMAN 24-306, *Operation of Air Force Government Motor Vehicles*, 30 July 2020
AFPAM 10-1403, *Air Mobility Planning Factors*, 24 October 2018
AMCI 11-270, *Mobility Air Forces Electronic Flight Bag Program*, 6 February 2023
DAFI 24-602V2, *Cargo Movement*, 12 June 2019
DAFI 31-101, *Integrated Defense (ID)*, 25 March 2020
DAFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*, 7 February 2020
DAFI 36-3802, *Force Support Readiness Programs*, 9 January 2019
DAFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations*, 15 December 2020
DAFI 48-107V2, *En Route Critical Care*, 24 November 2020
DAFI 48-107V3, *En Route Care Documentation*, 17 December 2020
DAFMAN 11-401, *Aviation Management*, 27 October 2020
DAFMAN 11-401_AMCSUP, *Aviation Management*, 22 June 2023
DAFMAN 90-161, *Publishing Processes and Procedures*, 15 April 2022
DoD Foreign Clearance Guide, Current Edition
Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons*, 30 Nov 1943
Mobility Air Forces Counter-Weapons of Mass Destruction Concept of Operations
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 1199, *Air Force Entry Control Card*
AF Form 3829, *Summary of Patients Evacuated by Air*
AF Form 3830, *Patient Manifest*
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 Rhythm/Hemodynamic Strip*
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 Authorization (FA)*
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*
CB 6059B, *Customs Declaration*
DAF Form 679, *Department of the Air Force Publication Compliance Item Waiver Request/Approval*
DAF Form 847, *Recommendation for Change of Publication*
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

AE—Aeromedical Evacuation

AEC—Aeromedical Evacuation Crew

AECM—Aeromedical Evacuation Crewmember

AECT—Aeromedical Evacuation Control Team

AEOT—Aeromedical Evacuation Operations Team

AET—Aeromedical Evacuation Technician

AETC—Air Education and Training Command

AFE—Aircrew Flight Equipment

AFI—Air Force Instruction

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

ALS—Advanced Life Support

AFMAN—Air Force Manual

AFTO—Air Force Technical Order

AMBUS—Ambulance Bus

AMC—Air Mobility Command

AMCI—Air Mobility Command Instruction

AMCSUP—Air Mobility Command Supplement

ANG—Air National Guard

AOC—Airlift Operations Center

AR—Air Refueling

ARM/ARMs—Aeromedical Readiness Mission (s)

ARMs—Aviation Resource Management System

ASAP—Aviation Safety Action Program

AWIS—Aircraft Wireless Intercom System

BO—Boom Operator

BL—Basic Life Support

BVM—Bag-Valve-Mask

C2—Command and Control

CAC—Common Access Card
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—Continental United States
CRM—Crew Resource Management
DAFI—Department of the Air Force Instruction
DAFMAN—Department of the Air Force Manual
DO—Director of Operations
DOD—Department of Defense
ECAS—Electrical Cable Assembly System
EFB—Electronic Flight Bag
EHR—Electronic Health Record
EPOS—Emergency Passenger Oxygen System
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
FCG—Foreign Clearance Guide
FCIF—Flight Crew Information File
FDP—Flight Duty Period
FN—Flight Nurse
FLIP—Flight Information Publications
HDPLP—High Deck Patient Loading Platform
IDS—Individual Data Summary
IPE—Individual Protective Equipment
ISS—In System Select

ITS—Individual Training Summary
LM—Loadmaster
LOX—Liquid Oxygen
LPM—Liters per Minute
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
MRE—Meal, Ready-to-Eat
MTF—Medical Treatment Facility
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
OPLAN—Operations Plan
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
PSR—Patient Safety Report
PTLOX—Portable Therapeutic Liquid Oxygen
RM—Risk Management
RON—Remain over Night

SII—Special Interest Items
SLS—Stanchion Litter System
SPINS—Special Instructions
STT—Special Tactics Teams
TEM—Threat and Error Management
T.O.—Technical Order
TDY—Temporary Duty
TMO—Traffic Management Office
TPMRC—TRANSCOM Patient Movement Requirements Center
TTP—Tactics, Techniques and Procedures
US—Undesired State
U.S.—United States
USAFE—United States Air Forces in Europe
USTRANSCOM—United States Transportation Command

Office Symbols

AF/A3T—Director of Training and Readiness
AMC/A3—Director of Operations, Strategic Deterrence and Nuclear Integration
AMC/A3TM—Aeromedical Training Branch
AMC/A3V—Aircrew Standards/Evaluations and Readiness Division
AMC/A3VM—Aeromedical Evacuation Standards and Evaluation
AMC/A5Q—Requirements Division
AMC/A5X—Aeromedical Evacuation Contingency Plans Branch
AMC/SG—Office of the Command Surgeon
AMC/SGK—AMC/Command Surgeon En Route Medical Care Division
OG/CC—Operations Group Commander
SQ/CC—Squadron Commander

Terms

Aeromedical Evacuation (AE)—AE provides time-sensitive en route care of 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. AECT reports 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 performing airlift when manifested passengers or cargo is carried.

Aeromedical Readiness Missions (ARMs)—ARMS are designed to provide training in aircraft operations, in-flight medical care and application of medical equipment to simulated patients to prepare AECMS for patient movement operations.

Augmented Crew—Adding additional qualified aircrew by SQ/CC or designee based on scheduled FDP exceeding 16 hours available 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, 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 and has potential for transport by guards or security personnel. Detainees include, but are not limited to: Persons Under Control, Enemy Prisoners of War or others defined in Geneva Conventions.

Deviation—A deviation occurs when takeoff time is not within -20/+14 minutes of scheduled takeoff time. Scheduled takeoff time may be adjusted to make good an Air Refueling Control Time. Notify controlling agency prior to takeoff to adjust the scheduled takeoff time.

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/Operationally Necessary Missions—All missions that are not designated as training specific mission are considered “operational” and “operationally necessary.” All 618 AOC are considered operational/operationally 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 Safety Report—A document that reports patient movement patient safety events.

Pilot in Command—A qualified pilot responsible for command and control of all persons onboard 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 reports 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 U.S. 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. **(T-2)** The MCD supervises the nursing care and management of patients and will manage the AE crew and medical support personnel assigned to the mission. **(T-3)** 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. **(T-2)** If the checklist is accomplished by one or more flight nurses, accomplish all MCD and FN duties. **Exception:** A non-current or unqualified flight nurse regaining currency or qualification may serve as an MCD on any mission when supervised by a qualified instructor or flight examiner flight nurse (direct supervision for critical phases of flight).

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 a qualified Aeromedical Evacuation Technician (AET) and must supervise and manage the AETs assigned to perform duties on the mission. The CMT ensures that medical supplies and equipment are installed on the aircraft and it is operational. The CMT ensures the aircraft is configured in accordance with pre-mission brief or mission directives. The CMT coordinates 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. **Exception:** A non-current or unqualified AET regaining currency or qualification may serve as a CMT on any mission when supervised by a qualified instructor or flight examiner (direct supervision for critical phases of flight).

A2.2.4. Aeromedical Evacuation Technician (AET). The Second AET (2AET) and Third AET (3AET) will assist the CMT as required. **(T-1)** AETs provide in-flight patient care under supervision of a qualified FN, complete the appropriate forms, and perform duties as assigned by the CMT. The 3AET will complete patient baggage procedures. **(T-3)** Task may be delegated based on crew complement and responsibilities assigned.

A2.2.5. Crew positions appear after each step to show which crewmember is responsible, for example (MCD). When more than one crewmember appears after the step separated by a comma, those crewmembers share responsibility (CMT, 3AET). If the crew positions are separated by a slash (MCD/FN) that step may be performed by either crewmember.

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

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

MISSION PREPARATION.

1. Complete Administrative Duties prior to start of AEC Crew Brief (AEC)
 - a. Read and annotate FCIF/SII/SPINS/NOTAMs/Ensure EFB is current.
 - b. Obtain mission paperwork and documentation.
 - (1) Verify flight authorization information.
 - (2) Calculate ORM Factors.
 - (3) Obtain aircraft tail number and parking spot.
 - (4) Verify passport requirements (as required).
 - (5) Complete personal customs declaration forms (as required).
 - (6) Review patient manifest to include ERCC patient requirements (oxygen and electrical).
 - (7) Obtain expected cargo/passenger upload and AE configuration per AEOT, C2 or local agency.
 - 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)
 - e. Prepare load plan based on patient manifest and requirements.
2. AEC Crew Briefing (AEC)
 - a. Discuss/Review ORM/CRM/TEM. (MCD) **Note:** Review assertive statement procedures (“Time Out” & “Knock it Off”). **Note:** Identify threats and errors that could affect a successful mission and potential mitigation.
 - 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. Review ERCC/MA/NMA requirements/special patient requirements/equipment, and crew responsibilities and infection control procedures. Assign/discuss crew responsibilities for any additional crew members. (MCD)
 - e. Discuss medical emergency procedures. (MCD)
 - (1) Identify ALS/PALS, 7-level, etc. trained crewmembers.
 - (2) Identify credentialing body, American Heart Association versus American Red Cross, and review accordingly. AECM directing ALS event follows the protocols in which they are certified.
 - (3) Make cardiac arrest assignments.
 - (4) 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), including patient positioning plan, patient records, and patient medications. (MCD/FN)
 - (1) Verify patient passports and appropriate papers for non-U.S. 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. (MCD/FN)
 - (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) Stanchions/straps/stanchion arms/brackets/seat set-up.
 - (2) Therapeutic/emergency oxygen/O2 calculation.
 - (a) Total the oxygen flow in LPM for each patient. Calculate ventilator use at 15 LPM per unit. 20 LPM for LTV series ventilators. Add 7.5 LPM for emergency use to the patient total for the overall mission requirement (LPM). Consider additional ERCC patient emergency oxygen needs in calculation.
 - (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. (**Note:** When utilizing NPTLOX/PTLOX, if the minimum oxygen calculations is less than 5L, add 1L to total).
 - (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. (MCD)
- p. Identify primary AWIS channel used during mission. (MCD)
- q. Configure EFB. (AEC)

3. In-Flight Kit Preflighted/Loaded. (AEC)

- a. Obtain controlled medications, medication kits, and supplies.
- b. Perform operational preflight on medical equipment. (accomplished within 24 hours prior to mission launch or assuming standby force by qualified Aeromedical Evacuation personnel).
- c. Load medical supplies and equipment and transport to the aircraft.

4. 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-U.S. 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 briefing (as required). Identify armed crewmembers (as required).
- d. Obtain briefing on weather, en route times, flight/cabin altitudes, refueling stops and possible delays.
- e. Identify total number of crew, number of AE crew and expected number of patients and passengers.
- f. Coordinate egress plan and identify emergency and communication signals/methods with pilot and LM/BO. Discuss emergency requirements (radio transmissions/use of headsets).
- g. Discuss enplaning/ERO requirements (time constraints, loading requirements, i.e., ramps, AMBUS, safety observer, etc.).
- h. Identify Aeromedical Readiness Mission requirements (as required).
- i. Coordinate mission unique items with LM/BO. (as required)

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. If the checklist is accomplished by one or more flight nurses, accomplish all MCD and FN duties. If the checklist is accomplished by one or two AETs, accomplish all CMT/2AET/3AET duties. Duties may be delegated by the CMT. 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/verified for aircraft interphone system. (MCD)
- *! 5. Cabin preparation – Checked/Completed. (AEC)
 - a. Configure aircraft for patient requirements per configuration plan, T.O. 1C-MDS-9, and AFMAN 11-2AEV3, Addenda A.
 - b. Litter stanchions/straps/brackets installed per mission requirements.
 - c. Seats properly secured to the aircraft and seat belts are attached.
 - d. Check and adjust litter brackets according to patient positioning plan.
 - e. Inspect LSAS/SLS/PSP.
 - (1) Annotate discrepancies on AFTO Form 350/AFTO Form 244, *Industrial/Support Equipment*.
 - f. Secure Medications. (patient, emergency, and controlled medications).
 - g. Infection control/isolation area setup per established procedures.
- *! 6. Therapeutic Oxygen System - Checked/Secured. (AEC) **WARNING:** Do not position PTLOX/NPTLOX near hydraulic reservoirs.
 - a. Check aircraft oxygen quantity and ensure system is – ON and PRESSURIZED. (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/NPTLOX 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. 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.
- b. Ensure BVM is available and connected to an emergency oxygen source.
- *! 9. Medical Supplies/Equipment – Checked/Secured. (AEC)
 - a. Ensure medical and computer equipment is accessible and complete functional check.
 - b. Ensure supplies are accessible and secured, including special supplies/equipment/computers.
- * 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.
- 11. Aircraft Acceptability/Discrepancies - Reported. (AEC)
 - a. Report duties accomplished/discrepancy to CMT. (2AET/3AET)
 - b. Report discrepancies to MCD. (CMT)
- 12. Emergency Egress Passageways - Clear. (AEC)

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 placement of Ground Loading Ramps/Ramp Toes (as required) - Installed. (CMT)
- 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. (MCD/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. 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)
11. Aircraft Ready for Enplaning – Safety Huddle/Report (AEC)
- a. Review checklist items prior to enplaning patients and ensure all items have been completed.
 - b. Confirm AEC/aircraft ready for patient enplaning.
 - c. Assume enplaning positions.
12. Patients/Enplaned/ERC Specialty Team (as required). (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 cancellations/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)
13. Baggage Procedures/Anti-hijacking - 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/ERCC/MA/NMA 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-2)**
- ! 3. Souls on Board Received and Reported to MCD/AEC. (FN)
 - a. FN will physically obtain Souls on Board.

! 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. Reported to CMT that checklist is complete. (AEC)

4. Before Takeoff Report (PIC) – Ready for take-off (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-2)** **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) **Note:** If a patient moves for comfort to a litter or a seat, ensure emergency equipment accompanies the patient to the litter or seat. (i.e., EPOS or LPU)
 - 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. (AEC)
 - f. Direct and supervise AEC in their duties. (MCD)

Note: MCD will notify the PIC and supporting C2 agencies (AOC/PMRC) of all in-flight emergencies or changes in patient status.

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:** 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 patient encounter notes. (as required) (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 1 hour prior to time of arrival. (MCD)
 6. Cabin Clean and Secure - Maintained. (AEC)
 - a. Collect garbage after meals and prior to descent. (AEC)
 - b. Verify patient and equipment secure, as required. (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. (AEC)
 - 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. (AEC)
6. Descent Checklist Complete. (AEC)
 - 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. **Note:** MCD will notify LM/BO if AECMs or medical attendants must stand during landing.

OFFLOADING.

1. ERO Preparations (as required) - Completed. (AEC)
 - a. Coordinate ERO activities with LM. (C-17 and C-130)
 - b. At en route stops, prepare cabin for ERO operations after departing the active runway. (as required)
2. Coordinate with LM for placement of Ground Loading Ramps/Ramp Toes (as required)- Installed. (CMT)
 - a. Ensure ground loading ramps/ramp toes 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 PCA/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. Contact tasking C2 agency and report mission status. (MCD)
16. Offload Checklist Complete. (AEC) **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.

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*, or if unavailable complete the AFTO Form 350/AFTO Form 244.

5. Cargo Compartment in order. (CMT)

POST MISSION.

1. Post Flight Debriefings - Attended. Use CL-1 Insert: MAF AE Debrief Guide to facilitate discussion. (AEC)
2. Properly store all medical /computer equipment/supply kits per local policy. (AEC)

- a. Turn in medical supply inventory. (as required)
3. Contact tasking C2 agency (AOC) to provide End of Mission Report. (MCD)
4. Complete any Patient Safety Reports or Aviation Safety Action Reports (as required). (AEC)
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 AECM plans. (MCD)
11. Configure EFB. (AEC)

Note: If mission is continuing the next day or an unscheduled RON has occurred, MCD will give an update to appropriate C2 agencies that duties have terminated for the day.

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 directs crewmembers to fight the fire as required. Crewmembers not directly involved with combating the fire will proceed with their emergency procedures checklist.

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 (Read as applicable to the mission)

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.
 - 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.
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. (AOC/TPMRC) (MCD)

Table A2.2. Aeromedical Evacuation Crew Combined Ditching Chart.

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
<ol style="list-style-type: none"> 1. Acknowledge pilot's order to prepare for ditching. Reconfirm egress with PIC/LM/BO and brief AEC. (MCD) <ol style="list-style-type: none"> a. Brief any special instructions from PIC. (i.e., Type of emergency, type of landing, time remaining, etc.) 2. Don life preserver. (AEC) 3. Brief assigned assistants to remain in aircraft to assist in evacuation of patients (as required). (AEC) <ol style="list-style-type: none"> a. Select able-bodied ambulatory patients to assist (as required). 4. Inflate LPU 6/P (Infant Cot). (As required). (AEC) 5. Brief patients on assigned side of aircraft on evacuation procedures. (AEC) 	<ol style="list-style-type: none"> 1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. (AEC) 2. Take assigned seat. (AEC) 3. Fasten seat belt. (AEC) 4. Assume appropriate position at "Brace for Impact" signal. (AEC) 	<ol style="list-style-type: none"> 1. Medical supplies, medications, equipment. (AEC) 2. Flashlight (AEC) 3. First aid kit. (AEC) 4. Patient manifest. (MCD) 	<ol style="list-style-type: none"> 1. Assigned seat. (AEC) 	<ol style="list-style-type: none"> 1. Remain seated until aircraft has come to a complete stop. (AEC) 2. Open exits. (AEC) <ol style="list-style-type: none"> a. Open available exits and deploy life rafts per egress plan or as directed by PIC/LM/BO. 3. Direct and assist patient egress per egress plan or as directed by PIC/ LM/BO; ambulatory followed by litters. (AEC) <p>WARNING: Ensure patients inflate life preservers <u>after</u> leaving the aircraft.</p> 4. Evacuate aircraft. (AEC) 5. Board assigned life raft. (AEC) <ol style="list-style-type: none"> a. The first crewmember into the life raft secures the clamp on the equalizer tube (as required). b. Assist patients into the life rafts.

<p>a. Identify emergency exits to be utilized and order in which to evacuate.</p> <p>b. Position to assume at the “Brace for Impact” signal.</p> <p>(1) Side/Forward facing seats-lean forward, place hands behind neck and pull head to knees; elbows are outside of knees.</p> <p>(2) Aft facing seats-sit erect with head firmly against headrest, arms grasping armrests.</p> <p>(3) Litters-lie flat, grasp sides of litter tightly.</p> <p>6. Prepare and secure litter and ambulatory patients on assigned side of aircraft. (AEC)</p> <p>a. Assist AEC with positioning patients, checking litter straps and litter support systems.</p> <p>(1) Remove sharp objects, ties; loosen collars/tight fitting clothing.</p> <p>(2) Place sharp objects and loose items in a plastic bag and secure. Remove eyeglasses and dentures; pad and secure on the patient.</p> <p>(3) Position litter patients in seats (if condition permits).</p>				<p>c. Group life rafts together (if possible).</p>
--	--	--	--	--

<p>a. Apply extra padding and litter straps to litter patients.</p> <p>b. Move litters to the lowest litter spaces.</p> <p>(4) Remove IV lines, catheters, etc. that may impede egress.</p> <p>(5) Assist patients in donning life preservers.</p> <p>WARNING: Brief patients not to inflate the life preservers until after leaving the aircraft.</p> <p>Note: The LPU 6/P (infant cot) can be inflated inside the aircraft.</p> <p>(6) Secure small children with extra litter straps and pads with pillows and blankets (as required).</p> <p>7. 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)</p> <p>8. Remove restraints from psychiatric patients. (AEC)</p> <p>9. Secure cabin. (AEC)</p> <p>a. Check seat belts and litter straps. Ensure patients are secure.</p>				
--	--	--	--	--

<p>b. Secure all loose items/equipment.</p> <p>10. Report cabin secure to CMT (FN, 2AET, 3AET).</p> <p>a. Report Cabin secured to MCD. (CMT)</p> <p>11. Receive cabin secured report from CMT. (MCD)</p> <p>12. Report cabin secured to PIC/LM/BO. (MCD)</p>				
--	--	--	--	--

Table A2.3. Aeromedical Evacuation Combined Emergency Landing Chart.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
<p>1. Acknowledge pilot's order to prepare for emergency landing. Reconfirm egress with PIC/LM/BO and brief AEC. (MCD)</p> <p>a. Brief any special instructions from PIC (i.e., Type of emergency, type of landing, time remaining, etc.)</p> <p>2. Brief assigned assistants to remain in aircraft to assist in evacuation of patients (as required). (AEC)</p> <p>a. Select able-bodied ambulatory patients to assist (as required).</p> <p>3. Brief patients on assigned side of aircraft</p>	<p>1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. (AEC)</p> <p>2. Take assigned seat. (AEC)</p> <p>3. Fasten seat belt. (AEC)</p> <p>4. Assume appropriate position at "Brace for Impact" signal. (AEC)</p>	<p>1. Medical supplies, medications, equipment. (AEC)</p> <p>2. Flashlight (AEC)</p> <p>3. First aid kit. (AEC)</p> <p>4. Patient manifest. (MCD)</p>	<p>1. Assigned seat. (AEC)</p>	<p>1. Remain seated until aircraft has come to a complete stop. (AEC)</p> <p>2. Open exits. (AEC)</p> <p>a. Open available exits per egress plan or as directed by PIC/LM/BO.</p> <p>3. Direct and assist patient egress per egress plan or as directed by PIC/ LM/BO; ambulatory followed by litters. (AEC)</p> <p>4. Evacuate aircraft. (AEC)</p> <p>5. Direct patients away from the aircraft. (AEC)</p> <p>a. Direct patients to meet upwind of the aircraft or as directed by the PIC/LM/BO.</p> <p>b. Accomplish a head count and provide numbers to the</p>

<p>on evacuation procedures. (AEC)</p> <p>a. Identify emergency exits to be utilized and order in which to evacuate.</p> <p>b. Position to assume at the “Brace for Impact” signal.</p> <p>(1) Side/Forward facing seats-lean forward, place hands behind neck and pull head to knees; elbows are outside of knees.</p> <p>(2) Aft facing seats-sit erect with head firmly against headrest, arms grasping armrests.</p> <p>(3) Litters-lie flat, grasp sides of litter tightly.</p> <p>4. Prepare and secure litter and ambulatory patients on assigned side of aircraft. (AEC)</p> <p>a. Assist AEC with positioning patients, checking litter straps and litter support systems.</p> <p>(1) Remove sharp objects, ties; loosen collars/tight fitting clothing.</p> <p>(2) Place sharp objects and loose items in a plastic bag and secure. Remove eyeglasses, dentures. Pad and secure on the patient.</p>				<p>PIC or senior ranking survivor.</p>
---	--	--	--	--

<p>(3) Position litter patients in seats (if condition permits)</p> <ol style="list-style-type: none"> a. Apply extra padding and litter straps to litter patients. b. Move litter patients to the lowest litter spaces. <p>(4) Remove IV lines, catheters, etc. that may impede egress.</p> <p>(5) Secure small children with extra litter straps and pads with pillows and blankets (as required).</p> <p>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)</p> <p>6. Remove restraints from psychiatric patients. (AEC)</p> <p>7. Secure cabin. (AEC)</p> <ol style="list-style-type: none"> a. Check seat belts and litter straps. Ensure patients are secure. b. Secure all loose items/equipment. <p>8. Report cabin secure to CMT (FN, 2AET, 3AET).</p>				
---	--	--	--	--

a. Report Cabin secured to MCD. (CMT) 9. Receive cabin secured report from CMT. (MCD) 10. Report cabin secured to PIC/LM/BO. (MCD)				
--	--	--	--	--