

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

**AIR FORCE INSTRUCTION 10-2519**

**10 DECEMBER 2019**



**Operations**

**PUBLIC HEALTH EMERGENCIES AND  
INCIDENTS OF PUBLIC HEALTH  
CONCERN**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

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This publication implements Air Force Policy Directive (AFPD) 10-25, *Air Force Emergency Management*, and Global Campaign Plan (GCP) for Pandemic Influenza and Infectious Disease (PI&ID) 3551-13, *Department of Defense Global Campaign Plan for Pandemic Influenza and Infectious Disease*. It also supports the World Health Organization, *International Health Regulations*, Department of Defense Instruction (DoDI) 6440.03, *DoD Laboratory Network (DLN)*, DoDD 6400.04E, *DoD Veterinary Public and Animal Health Services*, DoDM 6025.18, *Implementation of The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule In DoD Health Care Programs*, AFPD 10-2, *Readiness*, AFPD 10-26, *Countering Weapons of Mass Destruction*, AFPD 48-1, *Aerospace and Operational Medicine Enterprise*, Air Force Instruction (AFI) 10-208, *Continuity of Operations (COOP) Program*, and Air Force Manual (AFMAN) 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures*. This document provides guidance to protect Air Force-led installations, assets, personnel, and base population in the event of a public health emergency or incident of public health concern. This publication applies to military and civilian members of the Regular Air Force, Air Force Reserve and Air National Guard, except when noted otherwise, and those with contractual obligation to comply with Air Force publications, per Section 2672 of Title 10, U.S.C. and sections 243, 248, 249, and 264-272 of Title 42 U.S.C. Air Force units in joint basing situations in the supporting role and supported role are to follow guidelines outlined in [paragraph 1.8](#). Failure to observe the prohibitions and mandatory provisions in [paragraph 3.2.8.1](#), [paragraph 3.2.10.2](#), [paragraph 3.2.10.3](#), and [paragraph 3.2.10.5](#) of this publication by military members is a violation of Article

92 of the Uniform Code of Military Justice (UCMJ). This publication may not be supplemented or further implemented/extended.

This publication applies to civilian personnel, dependents of military or civilian personnel, and contractors present on an Air Force installation (collectively referred to as “non-military personnel”); Air Force facilities; Air Force-owned, leased, or managed infrastructure and assets critical to mission accomplishment; and other Air Force-owned, leased, or managed mission essential assets overseas and in the United States, its territories, and possessions. In areas outside of U.S. control, this Instruction applies to the extent it is consistent with local conditions and treaty requirements, Status of Forces Agreements, and other applicable arrangements with foreign governments and allied forces. Ultimately, U.S. prerogatives and control at overseas locations may require adjustment to accommodate the sovereignty interests of the host nation (HN), except as otherwise defined in applicable international agreements (e.g., Status of Forces Agreements, defense cooperation agreements, and base rights agreements).

Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Disposition Schedule located in the Air Force Records Information Management System or any updated statement provided by the Air Force Records Management office (SAF/CIO A6P). Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the Air Force Form 847, *Recommendation for Change of Publication*; route Air Force Forms 847 from the field through the appropriate functional chain of command.

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 Air Force Instruction (AFI) 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestors commander for non-tiered compliance items.

## ***SUMMARY OF CHANGES***

This document has been substantially revised and must be completely reviewed. The changes in this document align it with DoDI 6200.03 and GCP PI&ID 3551-13. This Instruction provides guidance on emergency health powers, further delineates roles and responsibilities, summarizes disease containment planning and response for a public health emergency or incident of public health concern, outlines available medical countermeasures and the appropriate process for acquisition/use of the Strategic National Stockpile (SNS), and includes specific guidance for the Air National Guard (ANG) and Air Force Reserve.

<b>Chapter 1—PROGRAM OVERVIEW</b>	<b>5</b>
1.1. Overview. ....	5
1.2. Public Health Emergencies. ....	6

<b>AFI10-2519 10 DECEMBER 2019</b>	<b>3</b>
1.3. Incidents of Public Health Concern. ....	7
1.4. Situational Standards of Care. ....	8
1.5. Installation Response Plans. ....	8
1.6. Overseas Limitations. ....	8
1.7. Air Reserve Component (ARC) and Geographically Separated Units (GSU) Limitations. ....	9
1.8. Joint Base Requirements. ....	9
<b>Chapter 2—ROLES AND RESPONSIBILITIES</b>	<b>11</b>
2.1. Headquarters Air Force.....	11
2.2. Major Commands and Direct Reporting Units. ....	14
2.3. Installations. ....	16
<b>Chapter 3—EMERGENCY HEALTH POWERS FOR INSTALLATION COMMANDERS</b>	<b>26</b>
3.1. Public Health Emergency Declaration. ....	26
3.2. Legal Authorities. ....	26
3.3. Violation of Restriction of Movement. ....	29
3.4. Contesting Restriction of Movement. ....	29
<b>Chapter 4—PLANNING AND RESPONSE</b>	<b>30</b>
4.1. Purpose. ....	30
4.2. Assumptions of Biological Incidents. ....	30
4.3. Planning. ....	30
4.4. Response. ....	30
Table 4.1. Health Protection Measures.....	31
Table 4.2. Personal Protective Equipment Options. ....	32
<b>Chapter 5—STRATEGIC NATIONAL STOCKPILE AND MEDICAL COUNTERMEASURE PLANNING REQUIREMENTS</b>	<b>34</b>
5.1. Medical Countermeasure Sources. ....	34
5.2. Strategic National Stockpile Planning Guidance. ....	34
5.3. Mass Prophylaxis Point of Dispensing. ....	35
5.4. Receiving, Staging, and Storage (RSS) Sites. ....	35

5.5. Overseas Installations. ....	35
<b>Chapter 6—AIR NATIONAL GUARD</b>	<b>37</b>
6.1. Purpose. ....	37
6.2. Co-located Installations. ....	37
6.3. Stand-alone Air National Guard Medical Units. ....	37
6.4. Roles and Responsibilities. ....	39
<b>Chapter 7—AIR FORCE RESERVE</b>	<b>43</b>
7.1. Purpose. ....	43
7.2. Co-located Installations. ....	43
7.3. Stand-alone Air Force Reserve Installations. ....	43
7.4. Roles and Responsibilities. ....	45
<b>Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION</b>	<b>50</b>
<b>Attachment 2—TEMPLATE: DECLARATION OF A PUBLIC HEALTH EMERGENCY</b>	<b>57</b>
<b>Attachment 3—TEMPLATE: NOTICE OF QUARANTINE</b>	<b>59</b>
<b>Attachment 4—TEMPLATE: NOTICE OF ISOLATION</b>	<b>61</b>

## Chapter 1

### PROGRAM OVERVIEW

**1.1. Overview.** This AFI specifies the authority of installation commanders and assigns responsibilities for declaring, reporting, and managing a public health emergency or incident of public health concern. Although ultimate responsibility and authority for managing such incidents falls to the Installation Commander, the entire installation and all functional organizations will have a role to play. The Medical Treatment Facility (MTF) Commander is advised to coordinate with the Defense Health Agency as needed.

1.1.1. The Public Health Emergency Officer (PHEO) is one of the key subject matter experts who will serve as a resource to help guide the Installation Commander during these incidents.

1.1.2. The MTF Commander (for the Air Reserve Component (ARC), Guard Medical Unit (GMU) commander and Reserve Medical Unit (RMU) commander) has responsibility for helping the Installation Commander with medical resources and capabilities.

1.1.3. The AFI provides guidance on disease containment planning and response to a public health emergency or incident of public health concern. It identifies actions that installations/wings must take before, during, and after public health emergencies or incidents of public health concern to slow or stop the spread of the disease and ensure mission continuation. These actions are summarized in a set of standard Health Protection Conditions (HPCON) that define appropriate measures to take based on the disease's mode of transmission; as well as responses commanders may take based on the scope and severity of the situation. Measures include the commander's authority to enforce restriction of movement (ROM), social distancing, and administration of prophylaxis treatment. Reference the public health emergency management handbook which is available by contacting the Air Force Medical Support Agency, Medical Preparedness and Response Branch (AFMSA/SG3XC), via sending an email to the following mailbox: usaf. pentagon. af-sg. mbx. [afmsa-sgx-workflow@mail.mil](mailto:afmsa-sgx-workflow@mail.mil).

1.1.4. This AFI compliments AFI10-2501, *Air Force Emergency Management Program*, which establishes responsibilities, procedures, and standards for AF mitigation and emergency response to physical threats resulting from major accidents, natural disasters, conventional attacks, terrorist attacks, and chemical, biological, radiological, and nuclear (CBRN) attacks.

1.1.5. This Instruction applies to all installations, including those with Limited Readiness Capability, activities under Air Force command, and geographically-separated units (GSU) (hereafter referred to collectively as "installations"). ANG units will follow the guidelines outlined in **Chapter 6**. The term "commanders," as used in this Instruction, refers to commanders at the installation and wing (for AFR) level unless specifically stated otherwise. For stand-alone Air Force Reserve (AFR) installations, the Bioenvironmental Engineering (BE)/Public Health Office (PHO) is the local equivalent to a Regular Air Force MTF's Public Health Flight (see **Chapter 7**).

## 1.2. Public Health Emergencies.

1.2.1. Situations that may be Public Health Emergencies in accordance with DoDI 6200.03 include the occurrence or the imminent threat of an illness or health condition with a high probability of any of the following:

1.2.1.1. A significant number of deaths.

1.2.1.2. A significant number of serious or long-term disabilities.

1.2.1.3. Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm.

1.2.1.4. Health care needs that exceed available resources.

1.2.1.5. Severe degradation of mission capabilities or normal operations.

1.2.1.6. May result from any of the following: natural disasters, industrial accidents, or intentional CBRNE events, including the release of a novel or reintroduced infectious agent, biological toxin, zoonotic disease, or radiological agent. They may also result from a cyberattack on critical infrastructure with cascading consequences that endanger the public's health.

1.2.1.7. May require World Health Organization notification as a Public Health Emergency of International Concern IAW International Health Regulations (2005). See DoDI 6200.03 paragraph 3.4. for reporting potential Public Health Emergencies of International Concern.

1.2.2. Specifically, the following diseases and public health conditions when taken in context of morbidity, mortality, and geographic proximity to the installation may be grounds for the Installation Commander to declare a Public Health Emergency (**Attachment 2** provides a template for declaring a public health emergency):

1.2.2.1. One or more human cases of any of the following diseases that are unusual or unexpected and may have serious public health impact: smallpox, cholera, pneumonic plague, poliomyelitis due to wild-type poliovirus, human influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic, severe acute respiratory syndrome, and viral hemorrhagic fevers (e.g., Ebola, Lassa, Marburg).

1.2.2.2. Any other disease of special military, national, or regional concern (e.g., Dengue fever, Yellow fever, West Nile fever, Rift Valley fever, meningococcal disease) that is unusual and unexpected, may have a serious impact on public health or has a significant risk of spread and/or affecting the mission.

1.2.2.3. The occurrence of any item listed in **paragraph 1.2.1** that overwhelms the local capabilities to respond to the situation, to include requesting assets from the Strategic National Stockpile (SNS). See **Chapter 5** for SNS planning requirements. SNS assets will not be relied upon as part of an installation's initial response capability.

1.2.2.4. One or more cases of any disease that requires the use of quarantine to control. Orders for quarantine or for the apprehension, detention, or conditional release of personnel exposed to a contagious disease but without confirmed illness *may not be issued by the PHEO unless the Installation Commander has declared a public health emergency*. A Notice of Quarantine template is provided in [Attachment 3](#). Orders regarding isolation and ROM of individuals with a confirmed illness may be issued during a public health emergency or during incidents of public health concern. A Notice of Isolation template is provided in [Attachment 4](#).

1.2.3. Authority for Declaring a Public Health Emergency (Emergency Health Powers are covered in [Chapter 3](#)).

1.2.3.1. Installation Authority. The Installation Commander, in consultation with their PHEO, may declare a DoD public health emergency and implement relevant emergency health powers to achieve the greatest public health benefit while maintaining operational effectiveness. The Installation Commander is the only authority who can declare a public health emergency on an Air Force installation. Commanders on ANG installations will coordinate with their Joint Force Headquarters-State (JFHQ-State) and the ANG prior to declaring a public health emergency. **(T-0)**.

1.2.3.2. Local Authority. Where individual states (and in some instances local governments) have the authority to declare a public health emergency, DoD installations in that State or jurisdiction shall, to the extent practicable, act consistently with applicable provisions of those declarations. State, local, tribal, and territorial (SLTT) public health laws vary between jurisdictions, and the JA may be required to provide a legal opinion on the installation's legal obligations to comply with the SLTT requirement.

1.2.3.3. National Authority. The Secretary of Health and Human Services has the authority to declare a national public health emergency pursuant to Title 42 United States Code Section 247d. When the Secretary of Health and Human Services declares a national public health emergency, the DoD shall, to the extent practicable, act consistently with applicable provisions of that declaration. **(T-2)**.

### **1.3. Incidents of Public Health Concern.**

1.3.1. There may be situations when a contagious disease or other biological incident has the potential to impact installation operations; however, it does not meet the criteria for an Installation Commander to declare a public health emergency. These incidents of public health concern should be managed in a similar fashion to a declared public health emergency.

1.3.2. Incidents of public health concern are defined as occurrences of an illness or health condition caused by an epidemic, or a serious and potentially fatal infectious agent that poses a substantial risk of human infection, but that does not constitute a public health emergency.

1.3.2.1. Examples of incidents of public health concern: a single case of infectious tuberculosis, viral hemorrhagic fever that is contained prior to multiple deaths or disability and that can be addressed using available healthcare resources.

1.3.2.2. Many of the directives issued in this Instruction apply to responding to an incident of public health concern. The PHEO will provide recommendations to the Installation Commander and/or the MTF Commander (for the ARC, GMU Commander or RMU Commander) on the actions necessary to respond, mitigate, and control the public health incident. **(T-0)**.

**1.4. Situational Standards of Care.** Public health emergencies may result in surge requirements that overwhelm the response capacity, capability, and resources of medical facilities and health care providers, resulting in an inability to meet normal standards of care. Under these conditions, it may be necessary to provide situational standards of care. Such situational standards will be directed IAW Section 5 of DoDI 6200.03. **(T-0)**.

**1.5. Installation Response Plans.** Installations will develop disease containment and public health emergency response guidance as part of the Installation Emergency Management Plan (IEMP) 10-2. **(T-1)**. Reference the public health emergency management handbook which is available by contacting the Air Force Medical Support Agency, Medical Preparedness and Response Branch (AFMSA/SG3XC), via sending an email to the following mailbox: [usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil](mailto:usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil).

**1.6. Overseas Limitations.** Host Nation (HN) agreements, governmental oversight, and control of overseas installations may prevent commanders from unilaterally implementing many of the provisions of this Instruction. Ultimately, U.S. prerogatives and control at overseas locations are subject to the sovereignty of the HN, except as otherwise defined in applicable international agreements, (e.g., Status of Forces Agreements (SOFAs), defense cooperation agreements, and base-rights agreements).

1.6.1. A U.S. installation commander's authority overseas extends generally only to U.S. service members, civilian employees of U.S. forces, U.S. DoD contractor employees (when specified by agreements), and the dependents of these categories of personnel.

1.6.2. A commander's authority may be limited in scope as it pertains to HN personnel. Overseas installations will review their respective HN agreements and incorporate guidance into existing installation emergency management and response plans (i.e., Installation Emergency Management Plan (IEMP 10-2) and Medical Contingency Response Plan) and agreements. **(T-3)**.

1.6.3. Many of the authorities cited in this publication cannot be implemented in an overseas environment without the cooperation of HN authorities, except to the extent specified by governing international agreements.

1.6.4. Should it be necessary to enter into international agreements to adequately address the requirements of this Instruction, Major Commands (MAJCOM) and Commanders of Air Force forces outside the continental United States (OCONUS) will consult AFI 51-701, *Negotiating, Concluding, Reporting, and Maintaining International Agreements*, and applicable combatant command regulations, to determine whether authority exists, or must be requested, to negotiate and conclude such agreements. **(T-1)**.



**1.7. Air Reserve Component (ARC) and Geographically Separated Units (GSU) Limitations.** ARC units and GSUs may not have the resident capability or personnel to prepare for or respond to a public health emergency or incident of public health concern. This will ultimately limit a commander's ability to implement some of the provisions of this Instruction, to include designating a PHEO. **Chapter 6** and **Chapter 7** provide specific guidance for ANG and AFRC organizations, respectively.

1.7.1. Commanders of GSUs will review their respective emergency management and response plans and incorporate measures from this AFI that are reasonable and appropriate given their GSU's hazard assessment. **(T-2)**. At a minimum, such measures will include coordination of emergency management plans and response procedures with applicable local and/or state authorities. **(T-2)**.

1.7.2. The appointed State Air Surgeon (SAS) will advise ANG Installation Commanders on potential public health emergency situations. **(T-2)**.

1.7.3. For stand-alone Air Force Reserve Installations the Reserve PHEO shall be familiar with civilian agencies/local authorities for emergency response for that state. **(T-2)**.

1.7.4. ARC units and GSUs shall negotiate and conclude memorandums of understanding (MOU) or memorandums of agreement (MOA) with appropriate local organizations when necessary to adequately address the requirements of this Instruction. **(T-2)**.

## **1.8. Joint Base Requirements.**

1.8.1. Air Force units in Joint Basing situations, in the supporting role, must comply with Air Force guidance to ensure installation personnel are adequately protected and cared for during public health emergencies or incidents of public health concern, supported/supporting units should implement standards of support MOAs. **(T-1)**. Units that cannot meet Air Force requirements must coordinate with their MAJCOM to alleviate discrepancies. **(T-2)**. MAJCOMs that cannot resolve discrepancies will coordinate with the appropriate Headquarters Air Force (HAF) office to determine a solution. **(T-1)**.

1.8.2. Joint Base Air Force MTFs in a supported role will have the Installation Commander appoint the PHEO. **(T-1)**. In some joint base locations, it may be appropriate (through coordination with the tenant organization) to appoint an alternate PHEO from a Service different to that of the PHEO, especially where a highly specialized skill set exists in a tenant organization. Joint basing standard operating procedures and tenant organization agreements should reflect the requirement to provide a single coordinated response to any public health emergency or incident of public health concern.

1.8.3. Air Force units hosted by another component, North Atlantic Treaty Organization, or on a coalition base will follow host base protocols. **(T-2)**. Commanders should identify specific protection measures the host base cannot or is unable to provide. Units that cannot meet Air Force requirements must coordinate with their MAJCOM to alleviate discrepancies. **(T-2)**. MAJCOMs that cannot resolve discrepancies will coordinate with the appropriate HAF office to determine a solution.

1.8.4. In cases where no Air Force medical personnel who meet the PHEO qualifications are assigned to the Air Force unit(s), the installation must obtain an MOA ensuring “back-up” PHEO consultation, with another fully-qualified installation PHEO (within the MAJCOM, another MAJCOM, or a sister service), in the event of a public health incident/emergency. **(T-1)**. If unable to coordinate an MOA with another installation PHEO, the parent MAJCOM PHEO Consultant will provide installation back-up coverage and an MOU indicating such will be kept on file. **(T-1)**.

1.8.5. In joint basing and tenant organization situations, the Installation Commander will appoint the PHEO and alternate PHEO(s). **(T-1)**. On installations where the supported MTF is a tenant, a qualified individual will be nominated and made available to serve as the host installation PHEO. **(T-1)**. In some locations, it may be appropriate to appoint a PHEO from one of the other tenant organizations, especially where a highly-specialized skill set exists in another organization. Alternate PHEOs may be selected from Military Services different to that of the PHEO. Joint basing and tenant organization agreements should reflect the requirement to provide a single coordinated response to any public health emergency. When the appointment of an appropriate PHEO is not forthcoming or causes local difficulties, the Service Headquarters PHEO should be consulted for adjudication; however, the final appointment decision rests with the Installation Commander.

## Chapter 2

### ROLES AND RESPONSIBILITIES

#### 2.1. Headquarters Air Force.

2.1.1. Air Force Surgeon General (AF/SG) will establish policy and guidance and obtain and allocate medical resources to effectively prepare for, respond to, recover from, and mitigate a public health emergency or incident of public health concern. AF/SG will:

2.1.1.1. Be prepared to issue specific Air Force guidance to service members if a disease-specific vaccine is or becomes available. Air Force guidance will be based on published DoD and Assistant Secretary of Defense for Health Affairs (ASD(HA)) policies.

2.1.1.2. Provide medical guidance and oversight to MAJCOMs during public health emergencies or incidents of public health concern.

2.1.1.3. Appoint a HAF PHEO and alternate PHEO from AFMSA to act as the Air Force Medical Service (AFMS) focal point for public health emergency policy issues.

2.1.1.4. Appoint a HAF Medical Emergency Manager (MEM) and alternate MEM from AFMSA to act as the AFMS focal point for medical emergency management policy issues.

2.1.1.5. Coordinate on DoD stockpile procedures (i.e., access, release prioritization, and terms of use) and DoD guidance.

2.1.1.6. Serve as the Air Force lead directorate for the DLN. In that role, the AF/SG will appoint an Air Force Laboratory Response Network Gatekeeper who will also serve as a representative to the DLN.

2.1.1.7. Serve as the Air Force lead for Pandemic Influenza & Infectious Disease (PI&ID) and support United States Northern Command (USNORTHCOM) as the DoD Global Synchronizer for PI&ID.

2.1.1.7.1. Provide supporting information to Office of the Secretary of Defense (OSD) agencies as required and/or requested for *Department of Defense Implementation Plan for Pandemic Influenza* task completion.

2.1.1.7.2. Develop and maintain Air Force PI&ID planning guidance to support executive and DoD-level efforts to contain and mitigate the effects of PI&ID on military operations. Coordinate with United States Northern Command to ensure guidance aligns with DoD GCP PI&ID 3551-13.

2.1.1.7.3. In coordination with the Office of the Secretary of the Air Force, Public Affairs (SAF)/PA), develop and provide detailed information on the internal communication plan to be used during a public health emergency or public health incident of concern.

2.1.2. Deputy Chief of Staff for Manpower, Personnel, and Services (AF/A1) will:

2.1.2.1. Ensure guidance exists to address the following items in the event of a public health emergency or incidents of public health concern: (1) child care for well (i.e., screened and identified as not sick) children of key personnel, (2) temporary housing, (3) educational needs, (4) financial assistance, (5) locator assistance, (6) family employment, (7) casualty assistance, (8) civilian personnel, and (9) food and water.

2.1.2.2. In conjunction with Air Force Services Activity, establish special procedures to protect force support facilities. Special care must be taken to develop procedures that will minimize contagion risk while allowing installation population access to facilities and services.

2.1.2.3. Direct inventory of non-medical essential supplies to include food and water.

2.1.2.4. Initiate a census of available force support facilities (e.g., fitness centers) that can serve as alternate medical care facilities.

2.1.2.5. Establish guidelines and procedures for the recall of Air Force Reserve personnel with critical skill sets IAW policy guidance from the Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&R)).

2.1.3. Deputy Chief of Staff for Intelligence, Surveillance, and Reconnaissance (AF/A2) will coordinate on disease containment and public health emergency response activities dealing with intelligence, surveillance, and reconnaissance matters to ensure compatibility with Intelligence Community guidance. These activities include, but are not limited to:

2.1.3.1. Coordinate new intelligence requirements to United States Northern Command for advocacy to Joint Staff, OSD, and interagency partners, if applicable, for inclusion into revisions of DoD GCP PI&ID 3551-13.

2.1.3.2. Ensure Force Health Protection and disease-specific intelligence collection and analysis are fused with all aspects of Force Protection intelligence analysis.

2.1.4. Deputy Chief of Staff for Operations (AF/A3) will support Medical Operations and Research (AF/SG3/5) and the Civil Engineers (AF/A4C) to establish operational policy and guidance to effectively prepare for, respond to, mitigate, sustain, and recover operations from a public health emergency or incident of public health concern. In addition AF/A3 will provide operational guidance and oversight to MAJCOMs during public health emergencies or incidents of public health concern.

2.1.5. Deputy Chief of Staff for Logistics, Engineering, and Force Protection (AF/A4) will establish appropriate logistic and mission support policy and guidance to obtain and allocate non-medical resources to prepare for, respond to, and recover from a public health emergency or incident of public health concern IAW AFI 10-2501, *Air Force Emergency Management Program*, AF/A4 will:

2.1.5.1. Provide logistics and mission support guidance and oversight to MAJCOMs prior to and during public health emergencies or incidents of public health concern.

2.1.5.2. Release guidance to implement Force Protection actions protecting personnel and facilities from public health emergencies or incidents of public health concern while on installations or geographically-separated facilities, during deployed operations, and during civil support operations. Support Air Force components to geographic combatant commands in working with Interagency partners and HN agencies to ensure Force Protection of forces during a public health emergency or incident of public health concern.

2.1.5.3. Ensure integration of emergency management capabilities related to disease containment planning, and public health emergency response and recovery into Air Force policy and guidance for all hazards emergency management.

2.1.5.4. Direct inventory of non-medical essential supplies, including infection control material (e.g., hand sanitizer and antibacterial wipes), and ensure authorization for resupply.

2.1.5.5. Provide guidance for the use of military installations as Base Support Installations (BSI) or mobilization centers by federal response agencies, reception sites for international aid donations, and Intermediate Staging Bases for Noncombatant Evacuation Operations.

2.1.5.5.1. Establish civilian access control guidance to include a standard process of vetting of authorized civilian personnel in support of Base Support Installations operations during a public health emergency or incident of public health concern.

2.1.5.5.2. Per Section 797 of Title 50, U.S.C. and direction of the Installation Commander, limit access to specific/designated areas on DoD installations in support of Base Support Installations operations during a public health emergency or incident of public health concern.

2.1.5.6. Provide disease-specific guidance for air terminal (cargo and passenger) operations to help contain the spread of disease. Recommended guidance can be found at Federal Agency sites, such as The Centers for Disease Control and Prevention, <https://emergency.cdc.gov/agent/agentlist-category.asp>. The United States Environmental Protection Agency, <https://www.epa.gov/emergency-response/biological-agents> and the Department of Transportation, Pipeline and Hazardous Material Safety Administration, <https://www.phmsa.dot.gov>.

2.1.5.7. In coordination with AF/SG, provide guidance for the disposal of Category A contaminated waste.

2.1.5.8. Ensure a representative is available to serve as the HAF Emergency Manager during public health emergencies or incidents of public health concern.

2.1.6. Office of the Secretary of the Air Force, Director of Public Affairs (SAF/PA) will work with AF/SG and AF/A4 Emergency Management Program leadership to ensure clear, effective, and coordinated communication before, during, and following a public health emergency or incident of public health concern. Specifically, SAF/PA through the AF/SG PA will:

2.1.6.1. Establish measures to ensure effective communication in support of Air Force personnel and in conjunction with the other Services, DoD, combatant commands, and civil agencies in the event of a public health emergency or incident of public health concern.

2.1.6.2. Communicate/disseminate public health advisories, communication themes, and other messages consistent with Assistant Secretary of Defense for Public Affairs and Assistant Secretary of Defense for Homeland Defense and Global Security (ASD(HD&GS)) guidance, as well as National and DoD policy and guidance.

2.1.7. Director of Lessons Learned (LeMay Doctrine Center) will collect, analyze, and provide analysis, at a minimum annually, to AF/A4 and AF/SG on lessons learned from public health emergencies or incidents of public health concern.

2.1.8. The Judge Advocate General (AF/JA) will:

2.1.8.1. Provide legal analysis and review of Air Force use of emergency health powers.

2.1.8.2. Provide guidance regarding policy and legislative issues and/or changes that will enhance support to affected DoD personnel and family members.

2.1.9. Assistant Secretary, Financial Management and Comptroller (SAF/FM) will provide PI&ID programming support to AF/SG.

## 2.2. Major Commands and Direct Reporting Units.

2.2.1. MAJCOM (to include ANG) and Direct Reporting Unit (DRU) Commanders will ensure installations are organized, trained, and equipped to support disease containment planning and response. Preparation includes all aspects unique to a particular command's mission, and agreements with local communities, municipalities, and/or HN authorities. **(T-1)**.

2.2.1.1. Specifically, MAJCOM/DRU commanders will:

2.2.1.1.1. Oversee the creation of MAJCOM/DRU-level plans related to preparedness for and response to a public health emergency or incident of public health concern. **(T-1)**. **Note:** These plans are not required if MAJCOM/DRU personnel are accounted for in installation plans as directed by [paragraph 2.3.1.1](#).

2.2.1.1.2. Incorporate public health emergency requirements and data into relevant procedures, education, and training materials as appropriate. **(T-1)**.

2.2.1.2. In addition, MAJCOM Commanders will:

2.2.1.2.1. Assist installations with the preparation of disease containment and public health emergency response guidance within IEMP 10-2.

2.2.1.2.2. During a public health emergency or incident of public health concern, maintain command and control of assigned installations. For the ANG, the governor of each state in conjunction with the Adjutant General will maintain command and control. As required, convene an existing working group (e.g., Emergency Management Working Group (EMWG)) of appropriate subject matter experts to provide guidance to installations.

2.2.1.2.3. Ensure installations have required training materials, equipment, and resources to properly implement preventive health measures for personnel and their families. For Air Force Reserve stand-alone installations, resources are not directed towards beneficiaries and dependents of Air Force Reserve members.

2.2.2. Major Command and Detachment Emergency Managers (A4C), or equivalent will serve as the Emergency Management Consultant for their respective areas of responsibility. **(T-1)**.

2.2.3. Major Command Chief of Aerospace Medicine (SGP) or other appropriate Medical Officer will serve as the PHEO Consultant for their respective commands and have the following roles and responsibilities: **(T-1)**.

2.2.3.1. Complete all PHEO training requirements contained in [paragraph 2.3.6.1.8](#). **(T-1)**.

2.2.3.2. Provide expertise and guidance to installation PHEOs conducting emergency response actions as needed. **(T-1)**.

2.2.3.3. Maintain a list of installation PHEOs and alternate PHEOs to include, contact information, and training currency within their command. A consolidated MAJCOM PHEO list will be provided to HAF PHEO on a semi-annual basis (15 Jan and 15 Jul). **(T-1)**.

2.2.3.4. Provide MAJCOM-supplemental guidance on disease containment and public health emergency response activities as necessary. **(T-1)**.

2.2.3.5. During public health emergencies or incidents of public health concern, coordinate medical information and requirements to HHQs and between MAJCOMs, as appropriate.

2.2.4. Major Command Chief of Medical Readiness (SGX) or other appropriate individual in SGX will serve as the MEM consultant for their respective commands and have the following roles and responsibilities:

2.2.4.1. Complete all MEM training requirements in [paragraph 2.3.6.2.5](#). **(T-1)**.

2.2.4.2. Provide expertise and guidance to installation MEMs conducting public health emergency response actions, as needed. **(T-1)**.

2.2.4.3. Maintain a list of installation MEMs to include, contact information, and training currency within their command. **(T-1)**. A consolidated MAJCOM MEM point of contact (POC) list will be provided to HAF MEM on a semi-annual basis (15 Jan and 15 Jul). **(T-1)**.

2.2.4.4. In concert with the MAJCOM PHEO Consultant, provide MAJCOM-specific public health emergency preparedness and planning activity guidance to supplement guidance from HHQs, as necessary. **(T-1)**.

2.2.4.5. In concert with the MAJCOM PHEO Consultant and as appropriate, coordinate information and requirements to HHQs and between MAJCOMs during public health emergencies or incidents of public health concern. **(T-1)**.

2.2.5. Field Operating Agencies:

2.2.5.1. Oversee the creation of Field Operating Agencies plans related to preparedness for and response to a public health emergency or incident of public health concern. **Note:** these plans are not required if Field Operating Agencies personnel are accounted for in installation plans as directed by [paragraph 2.3.1.1](#).

2.2.5.2. Incorporate public health emergency requirements and data into relevant procedures, education, and training materials as appropriate. **(T-1)**.

2.2.5.3. HAF PHEO as appointed under AFMSA will:

2.2.5.3.1. Serve as the POC for execution of AFMS policy and provide reach back capability to MAJCOM PHEO Consultants.

2.2.5.3.2. Serve as the AFMS co-representative to ASD(HA), ASD(HD&GS), and MAJCOMs for developing disease containment and public health emergency response policy.

2.2.5.3.3. Act as the co-Air Force stakeholder to ensure joint PHEO training (i.e., DoD Public Health Emergency Management (PHEM) Basic and Sustainment Courses) is developed and maintained appropriately.

2.2.5.3.4. Lead efforts to integrate public health and medical preparedness and planning for public health emergencies or incidents of public health concern into guidance using an all-hazards approach.

2.2.5.4. HAF MEM as appointed under AFMSA will:

2.2.5.4.1. Serve as the AFMS co-representative to ASD(HA), ASD(HD&GS), and MAJCOMs for developing disease containment and public health emergency response policy to include Defense Support of Civil Authorities (DSCA).

2.2.5.4.2. Act as the co-Air Force stakeholder to ensure MEM joint training (i.e., DoD PHEM Basic and Sustainment Courses) is developed and maintained appropriately.

2.2.5.4.3. Provide MAJCOM MEM consultants reach back capability.

2.2.5.4.4. Assist the HAF PHEO with the integration of public health and medical preparedness and planning for public health emergencies or incidents of public health concern.

2.2.5.4.5. Serve as the SG representative to the HAF-level EMWG.

2.2.5.4.6. Maintain and provide a Mass Prophylaxis Plan template.

2.2.5.4.7. Provide HAF program oversight of the Home Station Medical Response.

### **2.3. Installations.**

2.3.1. Commander. The Installation Commander is responsible for protecting assigned Air Force units, tenant units, GSUs, joint or coalition forces, government organizations, civilians, civilian contractors, military dependents, HN or third country civilians, and guests (where applicable) present on their installation during a public health emergency or incident of public health concern. In addition, it is their responsibility to ensure mission essential operations on the installation continue with little to no interruption. To that end, the Installation Commander will:

2.3.1.1. Appoint EMWG as office of primary responsibility for and to monitor development of disease containment and public health emergency response guidance within IEMP 10-2 that allows the installation to effectively prepare for, respond to, and recover from public health emergencies or incidents of public health concern. **(T-1)**.



2.3.1.2. Exercise the disease containment and public health emergency response guidance within IEMP 10-2 IAW AFI 90-201, *The Air Force Inspection System*, Table A2.1. *Wing Commander's Inspection and Exercise Requirements (T-1)*.

2.3.1.2.1. Direct that a public health emergency exercise (e.g., disease containment or mass prophylaxis plan) and a mass casualty exercise are conducted annually in conjunction with installation or command chemical, biological, radiological, and nuclear (CBRN) exercises or as a stand-alone event, IAW DoDI 6200.03. **(T-0)**.

2.3.1.2.2. Direct the Wing Inspection Team to work with the PHEO and MEM to incorporate mass prophylaxis and/or immunization, medical surge capability, and disease containment strategies (e.g., stand up a quarantine facility, execute a mass prophylaxis point of dispensing (POD), and establish ROM) in public health emergency response exercises. **(T-1)**.

2.3.1.2.3. Accomplish collections and After-Action Reports (AAR) for major operations, contingencies, key exercises and experiments, and other significant incidents and topics identified by leadership in accordance with (IAW) AFI 90-1601, *Air Force Lessons Learned Program*. **(T-1)**. Post approved AARs to the Air Force Joint Lessons Learned Information System, either directly or by forwarding to LeMay Doctrine Center. **(T-1)**.

2.3.1.3. Determine prioritization of limited stocks of vaccine and other medical countermeasures, in coordination with the MTF Commander, PHEO, and MEM IAW applicable HHQ guidance. **(T-1)**.

2.3.1.4. Capture costs related to DSCA operations in support of public health emergencies or incidents of public health concern for ultimate reimbursement from the primary agency, obtain reimbursable authority from U.S. Army North (the Executive Agent for Domestic Emergencies) upon tasking, ensure SAF/FM has identified Emergency and Special program codes to track expenses, and submit reimbursement requests to Defense Finance and Accounting Service IAW AFI 65-601 Vol. 1, *Budget and Guidance Procedures*, the Stafford Act or Economy Act, and AFI 10-801, *Defense Support of Civil Authorities (DSCA)*. **(T-1)**.

2.3.1.5. Establish a passenger-screening capability and conduct planning for the reception, quarantine, and/or isolation of arriving passengers with disease symptoms or suspected of having been exposed to contagious disease. **(T-1)**. This task only applies at installations with air passenger terminals and will be done in conjunction with the MTF Commander or ARC equivalent. For stand-alone Air Force Reserve Installations, follow local protocols. **(T-1)**. For the ANG, follow local and state ANG protocols. **(T-1)**.

2.3.1.6. Designate, in writing, an installation PHEO and an alternate PHEO to provide recommendations in response to public health emergencies. **(T-0)**. If the installation has associated GSUs, DRUs, or Field Operating Agencies, designate liaisons as appropriate. **(T-0)**.

2.3.1.7. Consult with the installation PHEO prior to declaring a public health emergency. **(T-0)**.

2.3.1.8. Ensure the PHEO, alternate PHEO, MEM, and alternate MEM are provided the time and support required to accomplish their mission. **(T-0)**.

2.3.1.9. Invoke emergency health powers necessary to respond to a public health emergency or incident of public health concern, and coordinate all emergency health power actions, to include planning and response, with local and HN officials. **(T-0)**. **Chapter 3** provides a listing of emergency health powers available to an Installation Commander following the declaration of a public health emergency. **Note:** Public health emergency declarations will terminate automatically in 30 days, unless renewed and re-reported. Declarations may be terminated sooner by the commander who made the declaration, any senior commander in the chain of command, the Secretary of the Air Force, or the Secretary of Defense.

2.3.1.10. Ensure disaster mental health (DMH) services are available through a DMH team in response to a public health emergency or incident of public health concern (or delegate this responsibility to the MTF Commander). **(T-1)**. For the ANG, refer to **Chapter 6**.

2.3.1.10.1. Appoint a licensed mental health provider, trained in DMH services, as the DMH team lead. **(T-0)**. DMH Team lead has overall responsibility for DMH Team training and service implementation.

2.3.1.10.2. Integrate DMH response into related DMH teams for preparedness and response with other DoD installation and military command emergency response plans. **(T-1)**.

2.3.1.10.3. Enter into agreements, as needed, with other installations, AFR units, ANG units, and/or civilian providers to ensure access to a DMH team when the personnel and resources necessary for such a team are not present on the installation. **(T-0)**.

2.3.2. Mission Support Group Commander (MSG Commander) is responsible for ensuring the resources necessary to support installation response to a public health emergency or incident of public health concern. The MSG Commander will:

2.3.2.1. As the EMWG chair, task a sub-working group to incorporate installation disease containment and public health emergency response guidance into the IEMP 10-2 and ensure installation-wide functional organizations provide function-specific guidance. **(T-3)**.

2.3.2.1.1. Ensure guidance meets applicable federal, state, and local regulations and all applicable HN arrangements or agreements (e.g., Status of Forces Agreements). **(T-1)**.

2.3.2.1.2. Share guidance among and across Service Components, DoD agencies, and community organizations to ensure a coordinated and synchronized effort. **(T-3)**.

2.3.3. Staff Judge Advocate (SJA) is the legal POC for installation activities related to the preparation for and response to a public health emergency or incident of public health concern. The SJA will:

2.3.3.1. Provide legal advice (e.g., declaration of a public health emergency, vaccination and prophylaxis of military and non-military members, rules for the use of force for quarantine and isolation enforcement, or coordination with local authorities) to the commander and staff, including deployed elements, in response to a biological incident. **(T-0)**.

2.3.3.2. Provide legal services to eligible personnel and their dependent family members affected by a biological incident, in order to facilitate a more rapid return to legal stability and independence. **(T-0)**.

2.3.3.3. Participate in the development of disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.

2.3.4. Public Affairs Officer is responsible for internal and external public information communications on an installation during a public health emergency or response to an incident of public health concern. The Public Affairs Officer will:

2.3.4.1. Coordinate with local authorities to ensure clear, effective, and coordinated risk communication before, during, and after contagious disease outbreaks. **(T-1)**.

2.3.4.2. Participate in the development of disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.

2.3.5. Chaplain provides guidance on religious, ethical, moral, morale and quality of life matters as they pertain to a public health emergency or response to an incident of public health concern. The Chaplain will:

2.3.5.1. Participate in the development of disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.

2.3.5.2. Identify areas within IEMP 10-2 where Chaplain Corps support (e.g., Mortuary Affairs and Medical Services) is required or recommended. **(T-1)**.

2.3.6. Medical Treatment Facility Commander (or ARC equivalent) is responsible for airbase medical operations. Specifically, the MTF Commander or ARC equivalent (i.e., GMU Commander or RMU Commander) will:

2.3.6.1. Nominate a primary and alternate PHEO to the Installation Commander as specified in [paragraph 2.3.1.6](#) **(T-1)**. The PHEO (unless specified the term PHEO refers to both the primary and alternate PHEO) must possess the following qualifications and skills:

2.3.6.1.1. The primary PHEO must be a senior AFMS officer with a clinical degree (e.g., Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Veterinarian Medicine (DVM) and must have either a Master of Public Health (MPH) degree or related (e.g., Master of Science in Public Health, Master in Health Affairs), or at least four years of experience in public health or preventive medicine. **(T-1)**. See [Chapters 6](#) and [7](#) for ANG and AFR PHEO-POC requirements.

2.3.6.1.2. The alternate PHEO must be a senior Medical Corps or Public Health Officer and must have either a Master of Public Health degree or related (e.g., Master of Science in Public Health, Master in Health Affairs), or at least four years of experience in public health or preventive medicine. If the primary PHEO is a DVM, the alternate PHEO must be a senior Medical Corps officer. **(T-1)**.

2.3.6.1.3. The alternate PHEO will perform all primary PHEO roles, which may include advising incident commanders during a public health incident, when the primary PHEO is not available. **(T-1)**. As such, the alternate PHEO must complete all PHEO training requirements and be fully engaged in public health emergency planning, preparedness, and response activities. **(T-1)**.

2.3.6.1.4. If an MTF cannot provide a qualified PHEO, they must nominate the most qualified individual. In turn, the installation must obtain an MOA ensuring “back-up” PHEO consultation, with another fully-qualified installation PHEO (within the MAJCOM, another MAJCOM, or a sister service), in the event of a public health incident/emergency. **(T-1)**. If unable to coordinate an MOA with another installation PHEO, the parent MAJCOM PHEO Consultant will provide installation back-up coverage and a MOA indicating such will be kept on file. **(T-1)**.

2.3.6.1.5. The PHEO must obtain an active national security clearance at the SECRET level. **(T-2)**.

2.3.6.1.6. The PHEO must have experience and training in functions essential to effective PHEM (i.e., National Incident Management System, National Response Framework). **(T-1)**.

2.3.6.1.7. The PHEO must be the primary medical representative to the Threat Working Group and a member of the EMWG. **(T-2)**.

2.3.6.1.8. PHEO training requirements provide the minimum knowledge necessary for a PHEO to effectively support the Installation Commander during a public health emergency or incident of public health concern. PHEOs will complete the following training: **(T-1)**.

2.3.6.1.8.1. Upon appointment:

2.3.6.1.8.1.1. PHEM Basic Course – 40 hours, sponsored by the Defense Medical Readiness Training Institute, within one year of appointment. Training expires after five years.

2.3.6.1.8.1.2. IS 300 Intermediate Incident Command System (ICS) for Expanding Incidents (ICS 300) (Residence) – 24 hours.

2.3.6.1.8.1.3. DSCA Phase 1 – 6 hours Distance Learning Course – 6 hours, Joint Knowledge Online, sponsored by U.S. Army North.

2.3.6.1.8.2. Advanced Material, to be completed within 24 months of assignment:

2.3.6.1.8.2.1. Medical Management of Chemical and Biological Casualties Course (MMCBC) (Residence) – 48 hours.

2.3.6.1.8.2.2. Medical Effects of Ionizing Radiation Course (Residence) – 24 hours.

2.3.6.1.8.2.3. DSCA Phase II (Air Force MAJCOM PHEOs) (Residence) – 24 hours, sponsored by U.S. Army North.

2.3.6.1.8.3. Sustainment:

2.3.6.1.8.3.1. PHEM Sustainment Course – 24 hours, sponsored by the Defense Medical Readiness Training Institute, prior to completion of their fifth year of service in the role. Personnel returning to the PHEO role after three or more years in other duty assignments will complete a PHEM Course, either the Basic or Sustainment Course, within one year of resuming responsibilities. **(T-1)**. Returning PHEOs will consult with their MAJCOM to determine the appropriate level of the PHEM Course to complete. **(T-2)**.

2.3.6.1.8.3.2. IS 400 Advanced ICS, Command and General Staff/Complex Incident (ICS 400) (Residence) – 20 hours, can be taken in conjunction with PHEM Sustainment Course.

2.3.6.2. Designate, in writing, a MEM and an Alternate MEM (unless specified the term MEM refers to both the primary and alternate MEM). **(T-1)**. The MEM must possess the following qualifications and skills, and will be required to take training courses both prior to and upon assignment to the position. **(T-1)**.

2.3.6.2.1. The MEM will be a service member (e.g., Medical Readiness Officer), DoD civilian employee (i.e., Medical Readiness Manager), or other qualified individual who is a member of the MTF. **(T-1)**.

2.3.6.2.2. The MEM must have experience and training in functions essential to effective PHEM (i.e., National Incident Management System, National Response Framework, and Air Force Incident Management System). **(T-1)**.

2.3.6.2.3. The MEM must be the primary medical representative to the EMWG and a member of the Threat Working Group. **(T-2)**.

2.3.6.2.4. The MEM must obtain an active national security clearance at the SECRET level. **(T-2)**.

2.3.6.2.5. MEM training requirements provide the minimum knowledge necessary to effectively work with the PHEO and support the MTF Commander during a public health emergency. The MEM and alternate MEM will complete the following training: **(T-1)**.

2.3.6.2.5.1. Upon appointment:

2.3.6.2.5.1.1. PHEM course – 40 hours, sponsored by Defense Medical Readiness Training Institute, within one year of appointment. This training expires after five years.

2.3.6.2.5.1.2. IS 100 Introduction to ICS (ICS 100) – 3 hours.

2.3.6.2.5.1.3. IS 120 An Introduction to Exercises (ICS 120) – 5 hours.

2.3.6.2.5.1.4. IS 139 Exercise Design and Development (ICS 139) – 2 hours.

2.3.6.2.5.1.5. IS 200 Single Resources and Initial Action Incidents (ICS 200) – 3 hours.

2.3.6.2.5.1.6. IS 300 Intermediate ICS for Expanding Incidents (ICS 300) (Residence) – 24 hours.

2.3.6.2.5.1.7. IS 700 National Incident Management System, An Introduction (ICS 700) – 3 hours.

2.3.6.2.5.1.8. IS 775 Emergency Operations Center Management and Operations (ICS 775) – 4 hours.

2.3.6.2.5.1.9. IS 800 National Response Framework, An Introduction (ICS 800) – 3 hours.

2.3.6.2.5.1.10. DSCA Phase 1 – 6 hours Joint Knowledge Online, sponsored by U.S. Army North.

2.3.6.2.5.2. Advanced Material, to be completed within 24 months of assignment:

2.3.6.2.5.2.1. IS 235 Emergency Planning (ICS 235) – 5 hours.

2.3.6.2.5.2.2. K0146 – Homeland Security Exercise and Evaluation Program Basic Course (Residence) Federal Emergency Management Agency – 16 hours.

2.3.6.2.5.2.3. DSCA Phase II (Air Force MAJCOM MEMs) (Residence) – 24 hours, sponsored by U.S. Army North.

2.3.6.2.5.3. Sustainment:

2.3.6.2.5.3.1. PHEM Sustainment Course – 24 hours, sponsored by the Defense Medical Readiness Training Institute, prior to completion of their fifth year of service in the role. Personnel returning to the MEM role after three or more years in other duty assignments will complete a PHEM Course, either the Basic or Sustainment Course, within one year of resuming responsibilities. **(T-1)**. Returning MEMs will consult with their MAJCOM to determine the appropriate level of the PHEM Course to complete. **(T-2)**.

2.3.6.2.5.3.2. IS 400 Advanced ICS, Command and General Staff/Complex Incident (ICS 400) (Residence) – 20 hours, can be taken in conjunction with PHEM Sustainment Course.

2.3.6.3. Nominate a licensed mental health provider as the DMH Team Lead to the Installation Commander as specified in [paragraph 2.3.1.10.1](#). **(T-1)**. For the ANG, refer to [Chapter 6](#).

2.3.6.4. As needed award temporary or disaster privileges when the emergency management plan has been activated and the MTF is unable to handle the immediate patient care needs. There must be policy and procedure in place that addresses current accreditation requirements and temporary privileges. **(T-0)**.

2.3.6.5. Upon direction from the Installation Commander, direct the pharmacy to employ mass prophylaxis POD. **(T-0)**.

2.3.6.6. In conjunction with functional subject matter experts, provide the Installation Commander medical response recommendations and mitigation procedures to include health risks, benefits, and operational implications. **(T-0)**.

2.3.6.7. Advise commanders/installation leadership, as necessary, of health risks associated with enforcing ROM and procedures for safe personnel handling. **(T-0)**.

2.3.6.8. Coordinate with the Mission Support Group on reasonable and necessary measures for testing and safely transferring or temporarily disposing of human and animal remains in order to prevent the spread of disease. **(T-1)**. Ensure proper labeling, identification, and records regarding the circumstances of death and disposition. **(T-1)**. Ensure contaminated remains are handled IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*, and AFI 34-501, *Mortuary Affairs Program*. **(T-1)**.

2.3.6.9. Responsibilities outlined in [paragraph 2.3.6.4](#) to [paragraph 2.3.6.8](#) apply to ANG GMUs, as applicable. **(T-2)**.

2.3.7. The Public Health Emergency Officer (PHEO) is the central POC and clearinghouse for health-related information during a declared public health emergency. The PHEO will:

2.3.7.1. Upon initial declaration of a public health emergency, ensure notification of the MTF Commander, MAJCOM/SGP, and installation Public Health. **(T-1)**.

2.3.7.2. In collaboration with the PHO, maintain public health and medical threat situational awareness to ascertain the existence of cases suggesting a public health emergency and support epidemiological investigations. **(T-1)**.

2.3.7.3. Provide proper control measure recommendations to installation and MTF commanders. **(T-1)**.

2.3.7.4. In coordination with PA, share epidemiologic information with SLTT or HN officials responsible for public health and public safety. Such information may include personally identifiable health information only to the extent necessary to protect the public health and safety and as otherwise permitted by law, IAW DoDI 6025.18, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*, DoDM 6025.18, *Privacy of Individually Identifiable Health Information in DoD Health Care Programs* and AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*. **(T-0)**.

2.3.7.5. Notify, through applicable military channels, the installation Antiterrorism Officer and Threat Working Group of any information indicating a possible terrorist incident or other crime. Cooperate with authorized law enforcement agencies investigating any such incidents. **(T-1)**.

2.3.7.6. Recommend to installation commanders when access to the SNS is warranted to sustain the response to a public health emergency or incident of public health concern. **(T-1)**.

2.3.7.7. Establish procedures for all non-military personnel subject to quarantine or isolation who contest their detention to present information requesting an exemption or release. The Installation Commander will be the final authority for resolution. **(T-1)**.

2.3.7.8. Ensure every individual subject to quarantine or isolation is provided written notice of the reason and the plan of examination, testing, and/or treatment designed to resolve the reason for the quarantine or isolation. **(T-0)**.

2.3.7.9. Delegate, as necessary or desired, oversight of select actions in this instruction to the alternate PHEO, Public Health personnel, or qualified individuals during a declared public health emergency to better manage the evolving situation. Those to whom this authority is delegated will keep the PHEO informed of the progress and outcomes of those actions. **(T-1)**.

2.3.7.10. Determine what local authority (i.e., local, county, state) has the ability to declare a public health emergency. Assess the need to coordinate with this external authority and the impacts an external declaration would have on the mission and the installation. **(T-1)**.

2.3.7.11. Provide the Installation Commander with information on significant PI&ID threats via the Threat Working Group, and recommend phase-appropriate countermeasures and training IAW HAF guidance. **(T-1)**.

2.3.8. The Medical Emergency Manager (MEM) coordinates public health emergencies or incidents of public health concern medical planning and preparedness using an all-hazards approach, and assists in the execution of emergency response management activities on behalf of the MTF Commander. During public health emergencies, the MEM will be an alternate central POC and, in support of the PHEO, a clearinghouse for health-related information. IAW DoDI 6200.03 and this Instruction, the MEM will:

2.3.8.1. Act as primary POC with the Installation Emergency Manager and serve as the MTF lead for military/civilian coordination as it relates to medical emergency management. **(T-0)**.

2.3.8.1.1. Establish working relationships with public health officials, emergency medical services, and medical/health/behavioral care providers, to increase medical response and recovery coordination for a public health emergency or incident of public health concern. **(T-0)**.

2.3.8.1.2. Determine need for, as well as coordination and maintenance of MOUs/MOAs/ Mutual Aid Agreements with civilian agencies so necessary resources can be obtained and effectively utilized during a public health emergency or incident of public health concern. **(T-0)**.

2.3.8.1.3. Represent the medical unit at the installation EMWG.

2.3.8.1.4. Serve as the MTF wing inspection team lead. **(T-1)**.

2.3.8.2. Ensure the integrated risk management process described in AFI 10-2501 and all mitigating actions are considered in executing MTF emergency management activities. **(T-1)**.

2.3.8.2.1. Collaborate with the Antiterrorism Officer to exchange public health emergency or incident of public health concern information with installation groups (e.g., Antiterrorism Working Group, Threat Working Group, and Vulnerability Assessment Team). Review material with PHEO, PHO, and BE and address any issues at the EMWG. **(T-1)**.

2.3.8.2.2. Work with wing PA to develop and deliver public health emergency or incident of public health concern incident-specific, science-based risk-communication activities and messages. **(T-1)**.



2.3.8.3. Ensure MTF emergency management plans are comprehensive, integrated, and compliant with DoDI 6200.03, AFPD 10-25, *Emergency Management*, and AFI 10-2501. **(T-1)**.

2.3.8.3.1. Incorporate Joint Commission management standards into the medical contingency response plan. **(T-1)**. The standards can be obtained from AFMSA/SG3XC if unavailable at local MTF, via sending an email to the following mailbox: [usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil](mailto:usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil).

2.3.8.3.2. Collaborate with PHEO, PHO, Wing Plans (XP), and EMWG members to create, update, and revise the installation's disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.

2.3.8.4. Coordinate integration of public health emergency response in emergency management-related training and exercises. Ensure exercises are planned and conducted IAW AFI 90-201. **(T-1)**.

2.3.8.4.1. In collaboration with the unit Medical Contingency Response Plan Team Chiefs and PHEO, determine exercise goals and objectives to fully test medical response capabilities within IEMP 10-2. **(T-1)**.

2.3.8.4.2. Lead exercise scenario design and development to ensure medical strengths are recognized and areas for improvement are identified and corrected. **(T-1)**.

2.3.8.5. Serve as the primary advocate to ensure appropriate medical resource needs are identified to execute mission requirements. **(T-1)**.

2.3.8.5.1. Integrate the acquisition, delivery, and distribution procedures of all available public health and medical material caches, to include home station medical response, DoD stockpiles, and SNS, into installation response plans (i.e., IEMP 10-2 and medical contingency response plan). **(T-1)**.

2.3.8.5.2. Identify training and exercise funding requirements through the unit Medical Readiness Committee to include Medical Counter-CBRN program requirements. **(T-1)**.

## Chapter 3

### EMERGENCY HEALTH POWERS FOR INSTALLATION COMMANDERS

**3.1. Public Health Emergency Declaration.** In response to a suspected or confirmed public health emergency, the Installation Commander in consultation with the PHEO, may declare a public health emergency and implement relevant emergency health powers as described in this chapter. To the extent necessary for protecting or securing military property or places and associated military personnel, such powers may also extend to non-military personnel who are present on Air Force installations. See DoDI 6200.03 paragraph 3.3. for reporting and notification of Public Health Emergencies.

3.1.1. Emergency health powers prescribed in this Instruction are not intended to provide for the apprehension, detention, or conditional release of individuals except for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified in Executive Orders of the President upon the recommendation of the National Advisory Health Council and Surgeon General of the United States (i.e., Executive Order 13295, *Revised List of Quarantinable Communicable Diseases*, amended by Executive Order 13375, *Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases*).

3.1.2. Overseas Installation Commanders will exercise emergency health powers in agreement with HN authorities under applicable international agreements. **(T-0)**. The PHEO will function as the Installation Commander's primary public health advisor during an emergency regardless of HN actions. **(T-1)**.

**3.2. Legal Authorities.** IAW DoDI 6200.03, during a declared public health emergency, the Installation Commander, as reasonable and necessary for the emergency response, has the legal authority to:

3.2.1. Collect specimens and perform tests on installation property or on any animal or disease vector, living or deceased, as reasonable and necessary for emergency response.

3.2.2. Close, direct the evacuation of, or decontaminate, any affected asset, or facility that endangers public health; decontaminating or destroying any material that endangers public health.

3.2.2.1. However, to the fullest extent possible under the circumstances, evidence should be preserved so appropriate investigations and/or remedial actions can be taken.

3.2.2.2. Commanders can close installation facilities or the entire base prior to confirmatory identification, which may take several days.

3.2.3. Assert control over any animal or disease vector that endangers public health, including quarantine and isolation of animals on the installation.

3.2.4. Use facilities, materials, and services for purposes of communications, transportation, occupancy (e.g., emergency shelters or quarantine/isolation), fuel, food, clothing, health care, and other purposes, and controlling or restricting the distribution of commodities as reasonable and necessary for emergency response.

3.2.5. Control evacuation routes on, and ingress and egress to and from, the affected installation.

3.2.6. Take measures to safely contain and dispose of infectious or contaminated waste as may be reasonable and necessary for emergency response.

3.2.7. Take measures as reasonable and necessary, pursuant to applicable law, and AFI 41-209, *Medical Logistics Support*, to obtain and control use and distribution of needed health care supplies.

3.2.7.1. Installation commanders have local purchase approval authority for medical and non-medical materiel, as well as services.

3.2.7.2. Installation commanders may delegate this approval authority to an authorized representative (usually the MTF Commander).

3.2.8. Direct military personnel to submit to medical examinations and/or testing as necessary to diagnose or treat the condition causing the public health emergency or incident of public health concern. Non-military members may be required as a condition of exemption or release from restrictions of movement to submit to a physical examination or testing, as necessary, to diagnose and prevent the transmission of a communicable disease and enhance public health and safety.

3.2.8.1. Privileged providers will be responsible for all examinations and testing. Failure by military members to submit to medical examinations and/or testing as necessary to diagnose or treat the condition causing the public health emergency or incident of public health concern is a violation of Article 92 of the UCMJ.

3.2.8.2. The PHEO will coordinate such actions with local health authorities as necessary.

3.2.9. Authorize conditional release, a less restrictive alternative to quarantine, for persons who may have been exposed to a communicable disease or hazardous substance and require continued health monitoring and supervision but have been assessed and determined to be asymptomatic and present a low risk to public health.

3.2.10. Restrict movement of military and non-military persons to prevent the introduction, transmission, and spread of communicable diseases or any other hazardous substances that pose a threat to public health and safety.

3.2.10.1. The needs of persons or groups of persons quarantined or isolated shall be addressed in a systematic and competent fashion. **(T-0)**. Places of quarantine shall be maintained in a safe and hygienic manner, designed to minimize transmission of infection/contamination or other harm to persons subject to quarantine. **(T-0)**. Adequate food, clothing, medical care, and other necessities will be provided as expeditiously as possible under the circumstances. **(T-0)**.

3.2.10.2. Persons subject to quarantine or isolation shall obey the rules and orders established by the Installation Commander in consultation with the PHEO, shall not go beyond the quarantine premises, and shall not put himself/herself in contact with any person not subject to quarantine, except as the Installation Commander authorizes. Public Health will assist the PHEO with tracking of persons subject to quarantine or isolation. Failure by military members, who are subject to quarantine or isolation, to obey the rules and orders established by the Installation Commander; to remain within the quarantine premises; or to refrain from putting himself/herself in contact with any person not subject to quarantine (except as the Installation Commander authorizes) is a violation of Article 92 of the UCMJ.

3.2.10.3. No person may, without authorization, enter quarantine or isolation premises. **(T-0)**. A person who by reason of unauthorized entry poses a danger to public health becomes subject to quarantine. Unless authorized, failure by military members to refrain from entering quarantine or isolation premises is a violation of Article 92 of the UCMJ.

3.2.10.4. Quarantine or isolation will be accomplished through the least restrictive means available, consistent with protection of public health. **(T-0)**. Quarantine or isolation of any person shall be terminated when no longer necessary to protect public health. **(T-0)**.

3.2.10.5. Military personnel may be ordered to submit to diagnostic or medical treatment for the condition causing the public health emergency or incident of public health concern IAW Centers for Disease Control and Prevention (CDC) and Food and Drug Administration guidelines. Military members shall submit to diagnostic or medical treatment for the condition causing the public health emergency or incident of public health concern. **(T-0)**. Failure by military members to submit, when ordered, to diagnostic or medical treatment (IAW CDC and Food and Drug Administration guidelines) for the condition causing the public health emergency or incident of public health concern is a violation of Article 92 of the UCMJ.

3.2.10.6. In the case of persons other than military personnel, ROM may include isolation or limiting ingress and egress to, from, or on an Air Force installation. Persons other than military personnel may be required, as a condition of exemption or release from ROM, to submit to vaccination or treatment diagnostics as necessary. Submitting to vaccination, treatment, or diagnostic testing for the condition causing the public health emergency or incident of public health concern may be a requirement for returning to work or gaining access to an Air Force installation. In the United States, coordinate all ROM actions involving non-military personnel through the nearest CDC Quarantine Officer and/or SLTT health department officials. **(T-0)**.

3.2.10.7. Quarantine or isolation measures may be implemented in healthcare facilities, living quarters, or other appropriate buildings on an Air Force installation. These measures do not lessen the responsibilities of the medical unit to provide medical care to infected persons to the standard of care feasible given resources available.

3.2.10.8. In the case of ROM of persons other than military personnel on U.S. installations, the PHEO will coordinate through his/her respective medical chain of command in relation to CDC actions under quarantine authorities provided in this Instruction; DoDI 6200.03; Title 42, Code of Federal Regulations (CFR), Parts 70 and 71, and Executive Orders 13295 and 13375.

3.2.10.9. With regard to emergency health powers, an Installation Commander's authority may be limited in scope as it pertains to HN personnel. OCONUS installations will review their respective HN agreements and incorporate into their IEMP 10-2 the authority local commanders possess as it pertains to HN personnel. **(T-0)**. Coordination of ROM actions will be sought with the Department of State and appropriate HN public health officials. **(T-0)**.

**3.3. Violation of Restriction of Movement.** Individuals and groups subject to quarantine shall be advised that violators may be charged with a crime pursuant to law (Title 50 United States Code (USC) Section 797, 18 USC Section 1382, Title 42 Code of Federal Regulations (CFR) Parts 70-71) and subject to punishment of a fine or imprisonment for not more than one year, or both.

3.3.1. In the case of U.S. military personnel, these potential sanctions are in addition to applicable provisions of the UCMJ, to the extent allowed by law.

3.3.2. Those individuals or groups not subject to military law and who refuse to obey or otherwise violate an order under this Instruction may be detained by the Installation Commander until appropriate civil authorities can respond.

**3.4. Contesting Restriction of Movement.** Any persons subject to quarantine or isolation who contest the reason for quarantine/isolation will be provided an opportunity to present information supporting an exemption or release. **(T-0)**. The Installation Commander or a designated representative (who has not been previously involved in any medical determination concerning the person) will make the final determination on all requests for exemption or release. **(T-0)**.

3.4.1. Upon receiving a request for exemption or release, the PHEO will immediately provide the information to the Installation Commander. **(T-0)**.

3.4.2. The PHEO will consult with appropriate medical and legal personnel regarding the request for exemption or release to ensure he/she is informed of all pertinent facts prior to providing a recommendation to the Installation Commander or designated representative. **(T-0)**.

3.4.3. The PHEO will provide the requesting member with the commander's or designated representative's written decision on the quarantine or isolation exemption as soon as possible, but no more than 24 hours after receipt of the member's initial request. **(T-0)**.

## Chapter 4

### PLANNING AND RESPONSE

**4.1. Purpose.** Effective base-wide disease containment planning coordinates unit capabilities and integrates medical and non-medical measures implemented by all personnel before, during, and after a public health emergency or incident of public health concern.

**4.2. Assumptions of Biological Incidents.** A biological incident may not result in noticeable effects for hours or days. Responses to a biological incident are further complicated by the variety of potential pathogens, limitations in accurate detection and identification, and disease-specific treatment requirements.

**4.3. Planning.** The more prepared an installation is prior to a biological incident, the greater the potential number of options available for the Installation Commander to mitigate the effects of the incident. Sound preparation through disease containment planning will ensure commanders have the greatest range of options available to respond to a given trigger event while appropriately balancing mission requirements with the risk to personnel. The EMWG will support the planning process by providing a forum for public health emergency preparedness and response activities for the installation. **(T-1).**

4.3.1. The PHEO and MEM will actively participate and contribute to the ongoing EMWG All-Hazards Response Planning Team IAW AFI 10-2501 in order to:

4.3.1.1. Ensure disease containment and public health emergency response guidance is discussed and appropriately included in the IEMP 10-2. Reference the public health emergency management handbook which is available by contacting the Air Force Medical Support Agency, Medical Preparedness and Response Branch (AFMSA/SG3XC).

4.3.1.2. Review and discuss health threat situations (e.g., identified spread of human-to-human transmission of highly-pathogenic avian influenza in another country or region) and potential local actions (e.g., distribution of prophylaxis or PA guidance) that may be required.

4.3.2. The All-Hazards Planning Response Team, via the EMWG, will coordinate non-medical procedures that support the health risk and medical needs of public health emergencies and incidents of public health concern.

**4.4. Response.** Installation commanders will use the following HPCON framework to select an appropriate response to a public health emergency or incident of public health concern. **(T-1).** The framework, see [Table 4.1](#), clarifies much of the uncertainty associated with these situations and provides options based on the scope and severity of the situation. The framework stratifies health-protection measures into categories beginning with simple standard precautions and gradually increasing the level of effort and expense. Standardizing responses within categories ensures a measured local response, understood by all, up, down, and across command chains—just like Force Protection Condition levels. HPCON visual aids (AFVA 10-2591, *HPCON Normal*, AFVA 10-2592, *HPCON Alpha*, AFVA 10-2593, *HPCON Bravo*, AFVA 10-2594, *HPCON Charlie*, and AFVA 10-2595, *HPCON Delta*) are available on the Air Force e-Publishing website. In addition, recommended personal protective equipment (PPE) Levels, see [Table 4.2](#), will be used to determine appropriate equipment required for protection based on the mode of transmission of the disease in question. **(T-1).** (Reference public health emergency management

handbook for more specific language. Contact the Air Force Medical Support Agency, Medical Preparedness and Response Branch (AFMSA/SG3XC), via sending an email to the following mailbox: [usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil](mailto:usaf.pentagon.af-sg.mbx.afmsa-sgx-workflow@mail.mil).

#### 4.4.1. Health Protection Conditions (HPCON).

4.4.1.1. HPCON 0 – Normal Operations. No known health risks, other than diseases endemic to the area surrounding the installation.

4.4.1.2. HPCON A – Limited Disease Threat. There is a limited threat to personnel based on the existence of a disease or unusual human health threat that has the potential to rapidly move into the local area (i.e., an area defined by each installation as consisting of a pre-determined distance or a list/map depicting by-name counties surrounding the installation).

4.4.1.3. HPCON B – Moderate Disease Threat. There is a moderate disease threat and/or a real risk of exposure to personnel due to a significant outbreak of disease in the local area or imminent spread of disease to the local area. HPCON B would be employed by the commander if notified by the PHEO that there has been an initial case identification of a contagious disease, such as a novel influenza, or a dramatic increase in the risk of acquiring a new significant disease from the environment within the local area.

4.4.1.4. HPCON C – Substantial Disease Threat. There is a substantial threat of disease for personnel due to a local epidemic outbreak of a disease with a high morbidity rate, imminent spread of such a disease to the local area, and/or a wide area of contamination that requires special or costly avoidance procedures.

4.4.1.5. HPCON D – Severe Disease Threat. A local epidemic with a high mortality rate or imminent spread of such a disease to the local area will drive enactment of HPCON D.

**Table 4.1. Health Protection Measures.**

Situation	HPCON	Example Health Protection Measures
Normal Baseline	0	Routine: Standard precautions such as routine hand washing, cough on sleeve, diet, exercise, vaccinations, education, stockpiling, planning, routine health alerts, etc.
Report of unusual health risk or disease	A	Limited: Health Alert, communicate risk and symptoms, review plans, verify preparation: training, stocks, posture, prepare to diagnose, isolate, and report new cases
Outbreak or heightened exposure risk	B	Moderate: Strict hygiene (no handshaking, wipe common-use items); if exposed, self-isolate (wear mask or remain home); avoid contaminated water/food or risk area; vector control
High morbidity epidemic or contamination	C	Substantial: Social distance (limit: meetings, socials, TDYs); shelter in-place indoors; or, if directed, don respirators; mass distribution of medical countermeasures, if applicable
High mortality epidemic or containment	D	Severe: Restrict movement (quarantine), mass evacuation, mass decontamination, subsist on secure food/water sources

#### 4.4.2. Personal Protective Equipment (PPE).

4.4.2.1. The use of PPE established in [Table 4.2](#), will be instituted based upon the mode of transmission of the disease organism. **(T-1)**. The appropriate Level instituted (i.e., I-IV) will be based upon consultation of the PHEO, MEM, BE Flight, and the Infection Control Professional from the MTF. **(T-1)**.

4.4.2.2. PPE selection may exceed, but cannot be less than, appropriate Level recommendations. **(T-1)**.

**Table 4.2. Personal Protective Equipment Options.**

PPE Levels		Applicability or Mode of Transmission		Example Infections and Conditions		
Level I (Standard Precautions)		Universal Precautions and Body Substance Isolation Applicable for all patient encounters.		Anthrax, tularemia, ricin and some contagious disease (e.g., common cold and seasonal influenza)		
Level II (Contact Precautions)		Contact		Generalized and progressive vaccinia		
Level III (Droplet Precautions)		Droplet		Viral hemorrhagic fevers and pneumonic plague		
Level IV (Airborne Precautions)		Airborne		Novel influenza, severe acute respiratory syndrome, pulmonary or laryngeal tuberculosis, smallpox, EVD due to suspected deliberate release with undetermined modes of transmission, EVD undergoing aerosolizing activities (e.g., childbirth, dialysis)		
PPE	Protected Body Parts	Types Of Hazards Protected Against	Level IV	Level III	Level II	Level I
Coverall Suits	Body	Contact (Blood/Body Fluids)	X			
Gowns	Body	Contact (Blood/Body Fluids)	X	X	X	X
Aprons	Body	Contact (Blood/Body Fluids)	X			



Scrubs, Top	Body	Contact (Blood/Body Fluids)	X	X	X	X
Scrubs, Bottom	Body	Contact (Blood/Body Fluids)	X	X	X	X
Respirators	Face/Respiratory Tract	Inhalation (Aerosolized Droplets)	X			
Surgical Masks	Face/Respiratory Tract	Contact (Blood/Body Fluids)		X	X	X
Face Shields	Face/Respiratory Tract	Contact (Blood/Body Fluids)	X	X	X	X
Goggles	Face	Contact (Blood/Body Fluids)	X	X	X	
Surgical Hoods or Head/Neck Covers (including those parts of any loose-fitting or helmet/hood PAPRs that protect the head and neck)	Head/Neck	Contact (Blood/Body Fluids)	X	X	X	
Shoes	Foot	Contact (Blood/Body Fluids)	X	X	X	X
Boot Covers	Foot	Contact (Blood/Body Fluids)	X	X		
PVC Boots	Foot	Contact (Blood/Body Fluids)	X	X		
Hand Sanitizer	Hand	Contact (Blood/Body Fluids)	X	X	X	X
Duct Tape	Hand	Contact (Blood/Body Fluids)	X			
Gloves	Hand	Contact (Blood/Body Fluids)	X	X	X	X

## Chapter 5

### STRATEGIC NATIONAL STOCKPILE AND MEDICAL COUNTERMEASURE PLANNING REQUIREMENTS

**5.1. Medical Countermeasure Sources.** Public health emergency medical countermeasures are used to prevent or mitigate the health effects of CBRN threats and naturally-occurring epidemics. Medical countermeasures include both pharmaceuticals (e.g., vaccines, antibiotics, antivirals, antitoxins) and non-pharmaceuticals for MTF personnel (e.g., diagnostics, ventilators, PPE such as face masks and gloves, and other devices).

5.1.1. The SNS is a national repository of prophylaxis and treatment medications, as well as medical supplies and equipment established by the CDC. The SNS is designed to supplement and re-supply SLTT public health agencies in the event of a national emergency. It is capable of delivering vast amounts of medical countermeasures (e.g., sufficient antibiotics for ten-day regimens for over 400,000 people) within 12 hours to anywhere in the United States or its territories. The SNS is the primary domestic source for medical countermeasures in a large-scale public health emergency.

5.1.2. Air Force installations will maintain a medical initial response capability for responding to public health emergencies through the home station medical response program. **(T-1)**. Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, and Nuclear (CBRN) Events*, provides additional information on the home station medical response program.

5.1.3. In the event of a larger-scale public health emergency or incident of public health concern, Air Force installations may have access to additional medical countermeasures and material. If Air Force installation countermeasure requirements exceed local capabilities installation MEMs will contact their MAJCOM MEM. **(T-1)**. MAJCOM MEMs will contact the HAF MEM to coordinate access to enterprise-wide countermeasure materiel if available. Installation MEMs will ensure MAJCOM appropriate medical countermeasures coordination requirements are included in IEMP 10-2 under the disease containment and public health emergency response section.

**5.2. Strategic National Stockpile Planning Guidance.** All Air Force installations in the United States and its territories must develop MOUs/MOAs with their SLTT health agencies to receive SNS assets during a public health emergency or incident of public health concern. **(T-0)**. Request for SNS will be made by the Installation Commander to the governor of the applicable state or through the military chain of command to the Secretary of Defense. This section does not apply to an ANG GMU. For the ANG guidance, refer to **Chapter 6** of this instruction.

5.2.1. MOUs/MOAs will be signed by the Installation Commander and the senior representative from the coordinating agency (e.g., director of the county/state health department) and will be reviewed by the installation base legal office prior to the Installation Commander's signature. **(T-1)**.

5.2.2. All MOUs/MOAs will follow guidance as outlined in DoDI 4000.19, *Support Agreements*. **(T-0)**. Agreements will clarify responsibilities and must address situations when access to the installation is limited or restricted. **(T-0)**.

5.2.3. MAJCOM SGX will review and track installation SNS access procedure MOUs and provide an annual status report to the HAF MEM. **(T-1)**.

**5.3. Mass Prophylaxis Point of Dispensing.** A POD rapidly distributes and administers medication regimens, to identified populations, via mass prophylaxis or vaccination clinics and educates recipients about the risks and benefits of the medical countermeasure regimen during a public health emergency. This section does not apply to an ANG GMU. For the ANG guidance, refer to **Chapter 6** of this instruction.

5.3.1. IAW DoDI 6200.03, military installations are prohibited from serving as open PODs for SNS assets. **(T-0)**. An open POD is open to the public and available to all members of the local community who arrive for treatment. Installations may not provide medical countermeasures to non-beneficiary populations.

5.3.2. Installations are required to serve as closed PODs for SNS assets. **(T-0)**. A closed POD is only available to certain target populations. Target populations for installations to consider include initial victims or cases, emergency responders, critical and mission-essential personnel, population working on the installation, or the entire beneficiary population at risk.

5.3.3. All Air Force installations will incorporate an mass prophylaxis plan as part of the disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**. Mass prophylaxis plan is available from AFMSA/SG3XC, via sending an email to the following mailbox: usaf.pentagon.af-sg.mbx. [afmsa-sgx-workflow@mail.mil](mailto:afmsa-sgx-workflow@mail.mil) (see **paragraph 2.2.5.4.6**).

#### **5.4. Receiving, Staging, and Storage (RSS) Sites.**

5.4.1. Air Force installations are authorized to serve as RSS sites. The decision to serve as an RSS sites must be made by the Installation Commander. **(T-1)**. The decision process must consider RSS site requirements, installation ability to operate an RSS site during a public health emergency or incident of public health concern, and the population the RSS site serves. **(T-1)**. For ANG guidance, refer to **Chapter 6** of this instruction.

5.4.1.1. Costs and manpower requirements associated with becoming an RSS site should be incurred by the installation (and not the MTF).

5.4.1.2. All installations that will serve as an RSS site must develop an MOU/MOA, separate from any other SLTT health agency MOUs/MOAs, signed by the Installation Commander, and complies with DoDI 4000.19 requirements **(T-1)**.

5.4.2. Installations that agree to serve as an RSS site must gain approval prior to signing the MOU/MOA. **(T-1)**. The Installation Commander must report the request to serve as an RSS site through their chain of command to the Secretary of the Air Force (SAF) for approval. **(T-0)**. ANG units will coordinate RSS site approval requests through their chain of command, their JFHQ-State, and ANG, not through the DoD. **(T-1)**.

**5.5. Overseas Installations.** Air Force OCONUS installations, through the home station medical response program, have an initial public health emergency response capability.

5.5.1. Should a public health emergency or incident of public health concern at an OCONUS Air Force installation exceed medical countermeasure capabilities, follow the procedures outlined in **paragraph 5.1.3**. **(T-0)**.

5.5.1.1. The installation will need to specify the amount and type of materials required and describe the scope and details of the public health emergency.

5.5.1.2. The request for SNS must be made through the installation's chain of command to the Geographic Combat Commander, who will forward the request to the Secretary of Defense. **(T-1)**.

5.5.2. All OCONUS Air Force installations will develop plans to operate a closed POD capable of servicing the installation's beneficiary population. **(T-1)**. The mass prophylaxis plan must be incorporated into the installation IEMP 10-2. Contact AFMSA/SG3X for template (see [paragraph 2.2.5.4.6](#)). **(T-1)**.

## Chapter 6

### AIR NATIONAL GUARD

**6.1. Purpose.** This chapter specifies the role of the ANG and the GMU in planning for, and responding to public health emergencies or incidents of public health concern. The following paragraphs identify the roles and responsibilities of key stakeholders.

**6.2. Co-located Installations.** At co-located installations where Active Duty is host and ANG Wings/Groups/Units are tenant, Guard personnel and resources will support the host installation's public health emergency planning, preparedness, and response as described in the host's IEMP 10-2 and host-tenant support agreements. At a minimum, tenant ANG Wings/Groups/Units will: **(T-2)**.

6.2.1. Support host installation efforts to prepare for, respond to, and recover from public health emergencies or incidents of public health concern.

6.2.2. Comply with installation directives to respond to and recover from the public health emergency or incident of public health concern and sustain mission operations.

6.2.3. Participate in host installation disease containment and public health emergency response training and exercises. **(T-2)**.

6.2.4. Provide personnel data to the host unit for inclusion in the installation mass prophylaxis plan. This data will include:

6.2.4.1. A list of mission essential ANG positions and the number of personnel assigned to these positions who are critical to executing ANG mission essential functions and operations.

6.2.4.2. The number of non-mission essential ANG personnel.

6.2.5. Participate on the host installation EMWG. **(T-2)**.

6.2.6. Provide ANG manpower, as allowed and appropriate, to the installation to prepare for, respond to, and recover from public health emergencies or incidents of public health concern.

**6.3. Stand-alone Air National Guard Medical Units.** Stand-alone, Limited Readiness Capability GMUs, do not have the resident capability or personnel to fully prepare for, respond to, and recover from a public health emergency or incident of public health concern. This limitation necessitates support and interdependence between the installation and SLTT government agencies (e.g., state or regional health department), civilian emergency medical system, and airport municipals and heavy reliance on civilian agency/local authority MOUs/MOAs for emergency response. In addition, the following assumptions and limiting factors apply to ANG GMUs:

6.3.1. Population served. A stand-alone ANG installation is responsible for protecting the health and well-being of military and civilian employees assigned to the installation; it is not responsible for the beneficiaries or dependents of those assigned with the exception of Psychological Health (see paragraph 6.4.9.1). The installation will focus on maintaining mission accomplishment and satisfying deployment taskings during all phases of a public health emergency or incident of public health concern. **(T-1)**.

6.3.2. Response. A stand-alone ANG installation does not have the guaranteed capability to provide an installation PHEO to respond to public health emergencies or incidents of public health concern. Instead, a PHEO-POC will be assigned as a liaison between the ANG PHEO and/or ANG Command PHO and the installation to convey guidance to respond to a public health emergency or incident of public health concern. **(T-1)**. The PHEO-POC will be a Drill Status Guardsman, typically serving in a military status only during unit training assemblies and annual tours. **(T-1)**. If available, the installation PHEO-POC will be placed in a military status when responding to a public health emergency. **(T-1)**. When not available, the Medical Administration Officer or GMU Senior Health Technician, will serve as the PHEO-POC. **(T-1)**.

6.3.3. Isolation and Quarantine. State health authorities have the primary role in imposing and enforcing quarantine as specified under state law with the use of civilian forces. ANG installations are expected to establish agreements or protocols with SLTT government agencies for assessing individuals suspected of being affected by or exposed to the disease of concern, and providing isolation or quarantine, as necessary.

6.3.4. Treatment and Ambulances. ANG GMUs are not MTFs and do not possess, maintain, or operate ambulances, nor are they authorized to provide medical treatment. ANG installations are dependent upon local communities for response to medical or other public health emergencies. IAW AFI 41-106, *Medical Readiness Program Management*, GMUs or ANG installations will have MOUs/MAAs with local civilian agencies to provide medical transport, treatment, and other emergency services. **(T-2)**.

6.3.5. Passenger Screening. Stand-alone ANG installations responsible for air passenger terminal operations for flights arriving directly from overseas destinations (i.e., international flights) do not have the capability to screen passengers or receive, isolate, and/or quarantine arriving passengers with disease symptoms or those suspected of having been exposed to a contagious disease. These installations are dependent upon the local community and will have an MOU/MOA with local civilian agencies that is coordinated and approved through SLTT government agencies, or an MOU/MOA directly established with SLTT government agencies to provide these functions. **(T-2)**.

6.3.6. Mass Prophylaxis Point of Dispensing. Stand-alone ANG installations are dependent upon the local community and will have an MOU/MOA with SLTT government agencies to provide a POD. **(T-1)**. If the installation and SLTT government agencies work jointly to operate a POD on the installation, it will be a closed POD. **(T-0)**. The MOU/MOA may direct ANG personnel to receive services from a POD operated by SLTT government agencies at an off-installation site in the local area. The ANG unit will provide personnel data to the SLTT government agencies, as appropriate, for inclusion in POD plans. **(T-1)**. This data will include a list of mission essential Guard positions and the number of personnel assigned to these positions who are critical to executing ANG mission essential functions and operations. **(T-2)**.

6.3.7. Receiving, Staging, and Storage Sites. While stand-alone ANG installations are authorized to serve as a CDC RSS site, they are not resourced to support a RSS. Consequently, the Installation Commander, in consultation with the installation PHEO-POC and other applicable persons (e.g., SAS, MDG/CC, MDG/SGP, MSG/CC, SJA, JFHQ), and approved by the joint surgeon (ANG-JSG) and Air National Guard Air Surgeon (ANG/SG), should make the decision to serve as an RSS site deliberately and judiciously. The Installation Commander must report the request to serve as an RSS site through their chain of command to the SAF for approval. **(T-0)**.

6.3.7.1. The decision to serve as an RSS should be made deliberately and must consider established site requirements, the ability of the installation to operate the site during a public health emergency or incident of public health concern, and the populations that the material at the site is intended to cover. **(T-0)**. Other factors to be considered prior to applying to be a CDC RSS include the availability of 24-hour security to safeguard stockpiles of supplies, environmentally-controlled warehousing, physical security of the installation, 24-hour access to manpower, and transportation vehicles.

6.3.7.2. Costs associated with becoming and maintaining the RSS are incurred by the installation. See **Chapter 5** for SNS planning requirements.

6.3.8. Medical Emergency Manager. Stand-alone ANG installations do not have a MEM. Instead, the Medical Administration Officer or GMU Senior Health Technician will cover MEM roles and responsibilities, as the MEM-POC, to the extent that the GMU is authorized, organized, trained, and equipped to provide. Installation MEM issues should be directed to the ANG MEM for coordination and direction. **(T-1)**.

6.3.9. Communication. Since a public health emergency or incident of public health concern may occur during time periods that do not coincide with a Unit Training Assembly, Installation PA, in coordination with the installation PHEO-POC, will develop and communicate public health advisories and messages tailored to ANG personnel residing on the installation at the time of the event and those members at their home of record who are not in a military status. **(T-1)**.

#### **6.4. Roles and Responsibilities.**

6.4.1. Air National Guard Public Health Emergency Officer (ANG PHEO). The Chief of Aerospace Medicine (ANG/SGP) is designated the ANG PHEO and serves as the primary ANG PHEO Consultant. **(T-1)**. Further the ANG PHEO will:

6.4.1.1. Complete PHEO training requirements listed in **paragraph 2.3.6.1.8**. **(T-1)**.

6.4.1.2. Provide expertise and guidance as needed to states and Wing(s). **(T-1)**.

6.4.1.3. Maintain contact information for all State PHEOs. **(T-1)**.

6.4.1.4. Provide ANG-specific guidance on disease containment planning and public health emergency response activities to supplement guidance from OSD, Air Force, and JFHQ-State, as necessary. **(T-0)**.

6.4.1.5. Coordinate information and requirements with OSD, Air Force, JFHQ-State, and ANG installations during public health emergencies. **(T-0)**.

6.4.1.6. Coordinate with the ANG Crisis Action Team to disseminate formal communications to installation command centers.

6.4.2. Alternate Air National Guard Public Health Emergency Officer. The Air National Guard Public Health & Prevention Branch (ANG/SGPM) or similar Government Schedule (GS) equivalent will assume the role of alternate PHEO and accomplish training as directed in [paragraph 2.3.6.1.8](#). **(T-2)**.

6.4.3. Air National Guard Medical Emergency Manager. The ANG/SG will appoint a qualified service member (E-8 or above) or GS equivalent (GS-10 or above) to serve as the MEM consultant for the ANG. **(T-1)**. The ANG MEM will:

6.4.3.1. Complete MEM training requirements listed in [paragraph 2.3.6.2.5](#). **(T-2)**.

6.4.3.2. Provide expertise and guidance to ANG installations on conducting emergency response actions. **(T-1)**.

6.4.3.3. In concert with the ANG PHEO, provide ANG-specific guidance on public health emergency preparedness and planning activities to supplement guidance as necessary. **(T-1)**.

6.4.4. State Air Surgeon. As the State PHEO, the SAS is the state's senior military medical officer and is charged with creating and facilitating an ANG medical response framework within the state. In the SAS's absence, the state's senior ranking medical official/officer will act as the PHEO. **(T-1)**. The SAS will:

6.4.4.1. Complete PHEO training requirements (see [paragraph 2.3.6.1.8](#)) within two years of assuming State PHEO duties. **(T-1)**.

6.4.4.2. Provide state-wide military medical capability, military medical resources availability, agent-specific information, risk communication, and situational awareness status reports to the governor, the Adjutant General, ANG-JSG, ANG/SG, and local GMU. **(T-1)**.

6.4.4.3. Coordinate with other SASs within Federal Emergency Management Agency and Emergency Management Assistance Compact regions to identify and coordinate regional military medical response capabilities and operations as needed. **(T-0)**.

6.4.4.4. Coordinate all public health emergency activities with JFHQ-State and with ANG (ANG PHEO or ANG MEM), as necessary. **(T-0)**.

6.4.4.5. Determine prioritization of limited stocks of vaccine and other medical countermeasures, in coordination with the ANG PHEO and IAW applicable HAF guidance.

6.4.4.6. Establish contact with ANG/SGP or ANG throughout all stages of a public health emergency or incident of public health concern. **(T-1)**.

6.4.5. Air National Guard Installation Commanders will:

6.4.5.1. Review and approve installation specific disease containment and public health emergency response guidance within IEMP 10-2 and associated MOUs/MOAs with appropriate SLTT government agencies. **(T-2)**. At a minimum, coordinate on MOUs/MAAs/EMACs with signatories. **(T-2)**.



6.4.5.2. Designate, in writing, an installation PHEO-POC. **(T-0)**.

6.4.5.2.1. Ensure the PHEO-POC is provided the time and support required to accomplish his/her mission. **(T-0)**.

6.4.5.2.2. Enable the PHEO-POC to complete required PHEO training listed in [paragraph 2.3.6.1.8](#) by budgeting and providing resources (e.g., via TDY for in-person training) to include the ability to telecommute for computer-based distance learning. **(T-1)**.

6.4.5.3. Appoint EMWG as office of primary responsibility for and to monitor development of disease containment and public health emergency response guidance within IEMP 10-2. **(T-2)**.

6.4.5.3.1. An EMWG sub-working group (i.e., All-Hazards Planning Response Team) will incorporate installation disease containment and public health emergency response guidance into the IEMP 10-2 and ensure installation-wide functional organizations will provide function-specific guidance. **(T-1)**.

6.4.5.3.2. Exercise the disease containment and public health emergency response guidance within IEMP 10-2 IAW AFI 90-201 *The Air Force Inspection System*, Table A2.1. Wing Commander's Inspection and Exercise Requirements. **(T-2)**.

6.4.6. Public Health Emergency Officer-Point of Contact. The Installation Commander will appoint any Title 5 provider or full-time MDG member with a medical AFSC as the PHEO-POC. The PHEO-POC will: **(T-2)**.

6.4.6.1. Possess the fundamental knowledge of federal, state, and local response capabilities, counter-disease planning, public health emergency management, and epidemiological investigation; as well as the experience necessary to facilitate information flow with the SAS or coordinate response efforts in the SAS's absence. **(T-2)**.

6.4.6.2. Assist with MOU/ Mutual Aid Agreements and IEMP 10-2 checklist development, and serve as a member of the EMWG and Threat Working Group. **(T-2)**.

6.4.6.3. Advise the Installation Commander on relevant public health laws, regulations, and policies. **(T-2)**.

6.4.6.4. Ensure notification of the SAS, GMU Commander, and ANG/SGP in the event of a public health emergency or incident of public health concern and ensure recommended and proper control measures are addressed. **(T-1)**.

6.4.6.5. Coordinate response strategies for disease containment and other public health emergency countermeasures with civilian agencies. **(T-1)**. Confirm responses are consistent and as outlined in applicable MOUs/MAAs (or other documents) for the protection of military installations, facilities, and personnel. **(T-2)**.

6.4.7. Installation Director of Psychological Health ensures timely and appropriate mental health care for personnel as needed IAW established local directives. **(T-2)**. Specifically, the Installation Director of Psychological Health (DPH) will:

6.4.7.1. Develop local partnerships and policy to include MOUs/MOAs with community resource providers, crisis response, and local intervention procedures, providing access to services that can assist with DMH preparedness and response and sustain the psychological health of ANG Airmen and families. **(T-2)**.

6.4.7.2. Serve as liaison between the military and non-military community agencies, including medical agencies, schools, shelters, child care, and family support centers. **(T-2)**.

## Chapter 7

### AIR FORCE RESERVE

**7.1. Purpose.** This chapter specifies the role of the Air Force Reserve in planning and preparing for, and responding to public health emergencies or incidents of public health concern. The following paragraphs identify the roles and responsibilities of key stakeholders.

**7.2. Co-located Installations.** At co-located installations where Regular Air Force is host and Reserve Wing/Groups/Units are tenant, Reserve personnel and resources will support the host installation's public health emergency planning, preparedness, and response as described in the host installation's IEMP 10-2 and host-tenant support agreements. **(T-1)**. At a minimum, tenant Reserve Wings/Groups/Units will:

7.2.1. Support host installation efforts to prepare for, respond to, and recover from public health emergencies or incidents of public health concern. **(T-1)**.

7.2.2. Comply with installation directives to respond to and recover from the public health emergency or incident of public health concern and sustain mission operations. **(T-1)**.

7.2.3. Participate in host installation disease containment and public health emergency response training and exercises. **(T-1)**.

7.2.4. Provide personnel data to the host installation for inclusion in the installation mass prophylaxis plan. This data will include: **(T-2)**.

7.2.4.1. A list of mission essential Reserve positions and the number of personnel assigned to these positions who are critical to executing Reserve mission essential functions and operations. **(T-3)**.

7.2.4.2. The number of non-mission essential Reserve personnel. **(T-3)**.

7.2.5. Participate on the host installation EMWG. **(T-3)**.

7.2.6. Provide Reserve manpower, as allowed and appropriate, to the host installation to prepare for, respond to, and recover from public health emergencies or incidents of public health concern. **(T-2)**.

**7.3. Stand-alone Air Force Reserve Installations.** Stand-alone Air Force Reserve Installations do not have the resident capability or personnel to fully prepare for, respond to, and recover from a public health emergency or incident of public health concern. This limitation necessitates support and interdependence between the installation and SLTT government agencies (e.g., state or regional health department), civilian emergency medical system, and airport municipalities and heavy reliance on civilian agency/local authority MOUs/MAAs for emergency response. In addition, the following assumptions and limiting factors apply to AFR stand-alone installations:

7.3.1. Population served. A stand-alone Air Force Reserve Installation is responsible for protecting the health and well-being of military and civilian employees assigned to the installation; it is not responsible for the beneficiaries or dependents of those assigned. **(T-2)**. The installation will focus on maintaining mission accomplishment and satisfying deployment taskings during all phases of a public health emergency or incident of public health concern.

7.3.2. Response. A stand-alone Air Force Reserve Installation does not have the guaranteed capability to provide an installation PHEO to respond to public health emergencies or incidents of public health concern. If available, the installation PHEO will be Traditional Air Force Reserve member, typically serving in a military status only during unit training assemblies and annual tours. **(T-2)**. AFRC/SG encourages the installation PHEO to be available for public health emergencies or incidents of public health concern response at any time. If available, the installation PHEO will be placed in a military status when responding to a public health emergency. The AFRC PHEO Consultant and/or AFRC PHO, are available to provide public health emergency guidance to the installation.

7.3.3. Command Relationships Since installation PHEOs are assigned to the RMU with the Aeromedical Medicine Enterprise Package and BE/PHO personnel are assigned to the installation's MSG, a concerted effort is required to create a synergistic and integrated preparedness and response approach between the installation PHEO and BE/PHO. As the full-time public health subject matter experts on the installation, the BE/PHO will be proactive in planning, preparing for, and responding to public health emergencies or incidents of public health concern. **(T-1)**.

7.3.4. Diagnosis, Isolation, and Quarantine. Stand-alone Air Force Reserve Installations, by design and policy, do not have authorization and resources for diagnosing disease and providing isolation and/or quarantine procedures or facilities. State health authorities have the primary role in imposing and enforcing isolation and quarantine as specified under state law with the use of civilian resources. Air Force Reserve Installations are expected to establish agreements or protocols with SLTT government agencies for assessing individuals suspected of being affected by or exposed to the disease of concern, and providing isolation or quarantine, as necessary. **(T-1)**.

7.3.5. Treatment and Ambulances. RMU with the Aeromedical Medicine Enterprise package are not MTFs and do not possess, maintain, or operate ambulances, nor are they authorized to provide medical treatment. Stand-alone Air Force Reserve Installations are dependent upon the local community to respond to medical or other emergencies and, IAW AFI 41-106, will have MOUs/MOAs with local civilian agencies, coordinated and approved through SLTT government agencies, to provide medical transport, treatment, and other emergency services. **(T-1)**.

7.3.6. Passenger Screening. Stand-alone Air Force Reserve Installations responsible for air passenger terminal operations for flights arriving directly from overseas destinations (i.e., international flights) do not have the capability to screen passengers or receive, isolate, and/or quarantine arriving passengers with disease symptoms or those suspected of having been exposed to a contagious disease. These installations are dependent upon the local community and will have an MOU/MOA with local civilian agencies that is coordinated and approved through SLTT government agencies, or an MOU/MOA directly established with SLTT government agencies to provide these functions. **(T-1)**.

7.3.7. Mass Prophylaxis Point of Dispensing. Stand-Alone Air Force Reserve Installations are dependent upon the local community and will have an MOU/MOA with SLTT government agencies to provide a POD. **(T-0)**. If the installation and SLTT government agencies work jointly to operate a POD on the installation, it will be a closed POD. **(T-0)**. The MOU/MOA may direct AFR personnel to receive services from a POD operated by SLTT government agencies at an off-installation site in the local area. The AFR unit will provide personnel data to SLTT government agencies, as appropriate, for inclusion in POD plans. **(T-0)**. This data will include a list of mission essential Reserve positions and the number of personnel assigned to these positions who are critical to executing AFRC mission essential functions and operations. **(T-0)**.

7.3.8. Receiving, Staging, and Storage Sites. While stand-alone Air Force Reserve Installations are authorized to serve as an RSS site, they are not resourced to support an RSS. **(T-0)**. Consequently, the Installation Commander will make the decision to serve as an RSS site deliberately and judiciously. The Installation Commander must report the request to serve as an RSS site through their chain of command to the SAF for approval. **(T-0)**.

7.3.9. Medical Emergency Manager. Stand-alone Air Force Reserve Installations do not have a MEM. The BE/PHO and the Ground RMU with Aeromedical Medicine Enterprise Senior Air Reserve Technician may share the MEM roles and responsibilities to the extent that they are authorized, organized, trained, and equipped to provide. It is recommended the BE/PHO take lead and the Ground RMU with Aeromedical Medicine Enterprise Senior Air Reserve Technician provide support as needed to ensure full collaboration.

7.3.10. Disaster Mental Health Response. Stand-alone Air Force Reserve Installations do not have DMH Response Teams. AFR DPH will formulate partnerships, develop MOU/MOA, and serve as liaison between military and non-military community agencies (e.g., medical agencies, schools, shelters, child care, and family support centers) providing access to services that can assist with DMH response and sustain the psychological health of AFR Airmen and families. **(T-1)**. AFR DPHs will develop local policy to include MOU/MOA with community resource providers, crisis response, and local intervention procedures. **(T-1)**.

7.3.11. Communication. Since a public health emergency or incident of public health concern may occur during time periods that do not coincide with a Unit Training Assembly, installation PA, in coordination with the installation PHEO will develop and communicate public health advisories and messages tailored to AFRC personnel residing on the installation at the time of the event and those members at their home of record who are not in a military status. **(T-3)**.

#### **7.4. Roles and Responsibilities.**

7.4.1. Air Force Reserve Command Surgeon General. AFRC/SG will appoint, in writing, the AFRC PHEO Consultant.

7.4.2. Air Force Reserve Command Chief Medical Operations Division. AFRC/SGO will designate the AFRC PHEO Consultant and secure AFRC/SG appointment, in writing, of AFRC PHEO Consultant.

7.4.3. Air Force Reserve Command Public Health Emergency Officer Consultant. The PHEO Consultant is the AFRC POC for disease containment planning and public health emergency response. In this role, the AFRC PHEO Consultant will:

- 7.4.3.1. Complete PHEO training requirements listed in [paragraph 2.3.6.1.8](#).
- 7.4.3.2. Provide expertise and guidance as needed to Air Force Reserve Installations/Wings.
- 7.4.3.3. Maintain contact information for all Installation PHEO-POCs.
- 7.4.3.4. Provide AFRC-specific guidance on disease containment planning and public health emergency response activities to supplement guidance from OSD and Air Force, as necessary.
- 7.4.3.5. Coordinate information and requirements with OSD, Air Force, and Air Force Reserve Installations during public health emergencies.
- 7.4.3.6. Coordinate with the AFRC Crisis Action Team to disseminate formal communications to installation command centers.
- 7.4.4. Air Force Reserve Command Medical Readiness Division. AFRC/SGX will deliver guidance and support to the BE/PHO and/or RMU Senior Air Reserve Technician, as applicable.
- 7.4.5. Air Force Reserve Command Public Health Officer. AFRC PHO will assist the AFRC PHEO Consultant in accomplishing their disease containment and public health emergency roles and responsibilities.
- 7.4.6. Air Force Reserve Command Director of Psychological Health. AFRC DPH will:
  - 7.4.6.1. Assist the AFRC PHEO Consultant in accomplishing their disease containment and public health emergency roles and responsibilities relevant to mental health.
  - 7.4.6.2. Provide mental health expertise and guidance, as needed, to installation DPH to prepare and respond to public health emergencies and incidents of public health concern.
  - 7.4.6.3. Maintain a list of installation DPH names and contact information, and provide the list to the AFRC PHEO Consultant on an annual basis.
- 7.4.7. Air Force Reserve Command Emergency Management Program Manager. AFRC Emergency Management Program Manager will coordinate with the AFRC PHEO Consultant to provide AFRC-specific disease containment and public health emergency response guidance to the Installation Emergency Manager, as necessary.
- 7.4.8. Air Force Reserve Command Installation Commander will:
  - 7.4.8.1. Review and approve installation specific disease containment and public health emergency response guidance within IEMP 10-2 and associated MOUs/MOAs with appropriate SLTT government agencies. **(T-2)**. At a minimum, coordinate on MOUs/MAAs/EMACs with signatories. **(T-1)**.
  - 7.4.8.2. Appoint the installation PHEO-POC as designated by the RMU Commander. **(T-0)**.
    - 7.4.8.2.1. Ensure the PHEO-POC is provided the time and support required to accomplish his/her mission. **(T-0)**.

- 7.4.8.2.2. Enable the PHEO-POC to complete PHEO training listed in [paragraph 2.3.6.1.8](#) by budgeting (e.g., via TDY for in-person training) and providing resources (i.e., funding such as Reserve Personnel Appropriation and Reserve Management Periods) to include the ability to telecommute for computer-based distance learning. **(T-1)**.
- 7.4.8.3. Appoint EMWG as office of primary responsibility for and to monitor development of disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.
- 7.4.8.3.1. An EMWG sub-working group (i.e., All-Hazards Response Planning Team) will incorporate installation disease containment guidance into the IEMP 10-2 and ensure installation-wide functional organizations provide function-specific disease containment guidance. **(T-1)**.
- 7.4.8.3.2. Exercise disease containment and public health emergency response guidance within IEMP 10-2 IAW AFI 90-201, *The Air Force Inspection System*, Table A2.1. Wing Commander's Inspection and Exercise Requirements. **(T-1)**.
- 7.4.8.4. Appoint an Installation DPH. **(T-1)**.
- 7.4.9. Collaborate with PHEO, PHO, Wing Plans (XP), and EMWG members to create, update, and revise the installation's disease containment and public health emergency response guidance within IEMP 10-2 Installation Wing Plans and Programs (or local equivalent). **(T-1)**. On behalf of the Installation Commander, Wing XP will:
- 7.4.9.1. Ensure the Ground RMU with the Aeromedical Medicine Enterprise Package designates a PHEO-POC and the Installation Commander, in turn, appoints, in writing, the PHEO-POC. **(T-1)**.
- 7.4.9.2. Ensure PHEO-POCs complete (i.e., via TDY for in-person training and telecommute for computer-based distance learning) PHEO training listed in [paragraph 2.3.6.1.8](#). **(T-1)**.
- 7.4.9.3. Ensure and provide resources (e.g., funding for TDY, any costs related to computer-based distance learning) to enable BE/PHO staff to take the PHEO and/or MEM training, as applicable, outlined in [paragraph 2.3.6.1.8](#) and [paragraph 2.3.6.2.5](#) **(T-2)**. If the RMU Senior Air Reserve Technician is supporting the MEM roles and responsibilities, provide resources (e.g., funding for TDY, any costs related to computer-based distance learning) to enable MEM training. **(T-2)**.
- 7.4.9.4. Ensure the EMWG establishes, appoints members, and convenes the All-Hazards Response Planning Team to develop and update disease containment and public health emergency response guidance within IEMP 10-2. **(T-1)**.
- 7.4.9.5. Delegate BE/PHO as lead author, in writing, and updating as necessary, the disease containment and public health emergency response guidance within IEMP 10-2. **(T-3)**. Ensure the BE/PHO receives support from EMWG members and key stakeholders/subject matter experts (SME) within their respective career fields (e.g., PHEO-POC, RMU with Aeromedical Medicine Enterprise Package Senior Air Reserve Technician, Security Forces, Mortuary Affairs, Force Support Squadron, Command Post, Civil Engineer, Logistics Readiness, Chaplain, DPH, JA) necessary to develop the guidance including:

- 7.4.9.5.1. Attending and actively participating in EMWG meetings (i.e., virtual or face-to-face). **(T-1)**.
- 7.4.9.5.2. Writing/providing to the BE/PHO, within assigned suspense dates, their respective functional area updates to disease containment and public health emergency response guidance for inclusion in the IEMP 10-2. **(T-2)**.
- 7.4.9.5.3. Reviewing, revising, and approving drafts and final versions of disease containment and public health emergency response guidance within IEMP 10-2. **(T-2)**.
- 7.4.9.6. Coordinate timely review and approval of IEMP 10-2 and updates by all appropriate installation stakeholders/SMEs and final review, approval, and signature by the Installation Commander. **(T-2)**.
- 7.4.9.7. Ensure, and assist as needed, stakeholders/SMEs in coordinating with SLTT, government, and civilian agencies to prepare, coordinate, approve, and sign MOUs/MOAs necessary to respond to public health emergencies and incidents of public health concern. **(T-1)**.
- 7.4.9.8. Coordinate and secure timely review and approval of MOUs/MOAs by installation IEMP 10-2 stakeholders/SMEs and review, approval, and signature of the Installation Commander. **(T-1)**.
- 7.4.9.9. Direct the BE/PHO to plan, develop, and conduct the annual disease containment and public health emergency response exercise. **(T-1)**.
- 7.4.9.10. Delegate to the PHEO-POC responsibility for assisting the BE/PHO in preparing and exercising the disease containment and public health emergency response guidance within IEMP 10-2. **(T-3)**.
- 7.4.9.11. Schedule, convene, and invite required installation senior leadership, installation key stakeholders/SME, and SLTT government and civilian agencies, as appropriate, to attend and/or participate in annual disease containment and public health emergency response exercise. **(T-0)**.
- 7.4.9.12. Ensure wing inspection team evaluates and documents the public health emergency response exercise IAW AFI 90-201. **(T-1)**.
- 7.4.10. Installation Bioenvironmental Engineer/Public Health Office. BE/PHO will:
  - 7.4.10.1. Complete PHEM training. **(T-1)**.
  - 7.4.10.2. Support the Installation Commander, indirectly via the PHEO-POC when available, accessible, and in a military status; or directly in the absence of an available and accessible PHEO-POC, during response to a public health emergency or incident of public health concern. **(T-2)**.
  - 7.4.10.3. Develop local partnerships and prepare MOUs/MOAs with SLTT government and civilian agencies for support during public health emergencies and incidents of public health concern. **(T-1)**. Support needed may include diagnosis, isolation and quarantine, passenger screening (i.e., installations responsible for air passenger terminal operations for flights arriving directly from overseas destinations), and mass prophylaxis POD.



7.4.10.4. Plan, develop, and conduct, with PHEO-POC support, the annual installation disease containment and public health emergency response exercise. **(T-1)**.

7.4.11. Public Health Emergency Officer-Point of Contact. Installation PHEO-POC will:

7.4.11.1. Complete required PHEO training per [paragraph 2.3.6.1.8](#). **(T-1)**.

7.4.11.2. When available, accessible, and in a military status, support the Installation Commander during response to and recovery from public health emergencies or incidents of public health concern. **(T-1)**.

7.4.11.3. As a member of the EMWG, assist the BE/PHO in writing the installation disease containment and public health emergency response guidance within IEMP 10-2. **(T-2)**.

7.4.11.4. Support BE/PHO in planning, developing, and conducting the annual installation disease containment and public health emergency response exercise. **(T-3)**.

7.4.12. Director of Psychological Health. The installation DPH will:

7.4.12.1. Develop local partnerships and policy to include MOUs/MOAs with community resource providers, crisis response, and local intervention procedures, providing access to services that can assist with DMH preparedness and response and sustain the psychological health of AFR Airmen and families. **(T-1)**.

7.4.12.2. Serve as liaison between the military and non-military community agencies, including medical agencies, schools, shelters, childcare, and family support centers. **(T-3)**.

7.4.13. Reserve Medical Unit Commander. The installation RMU commander with Aeromedical Medicine Enterprise Package will:

7.4.13.1. Designate the installation PHEO-POC and secure, in writing, Installation Commander appointment of the installation PHEO-POC. **(T-0)**. The primary PHEO-POC must be a senior AFMS officer with a clinical degree (e.g., MD, DO, or DVM) and with some experience in public health or preventive medicine. **(T-1)**.

7.4.13.2. Through the BE/PHO and RMU Senior Air Reserve Technicians, provide MEM-related support for public health emergency and incident of public health concern planning, preparedness, response and recovery to the extent that the RMU is authorized, resourced, organized, trained, and equipped to deliver. **(T-2)**.

WARREN BERRY, Lieutenant General, USAF  
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**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

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### ***Prescribed Forms***

None

### ***Adopted Forms***

AF Form 847, *Recommendation for Change of Publication*

### ***Abbreviations and Acronyms***

**AAR**—After-Action Reports

**AF/A1**—Deputy Chief of Staff for Manpower, Personnel, and Services

**AF/A2**—Deputy Chief of Staff for Intelligence, Surveillance, and Reconnaissance

**AF/A3**—Deputy Chief of Staff for Operations

**AF/A4**—Deputy Chief of Staff for Logistics, Engineering, and Force Protection

**AF/JA**—Air Force Judge Advocate General

**AF/SG**—Air Force Surgeon General

**AFI**—Air Force Instruction

**AFMAN**—Air Force Manual  
**AFMS**—Air Force Medical Service  
**AFMSA**—Air Force Medical Support Agency  
**AFPD**—Air Force Policy Directive  
**AFR**—Air Force Reserve  
**AFRC**—Air Force Reserve Command  
**AFTTP**—Air Force Tactics, Techniques, and Procedures  
**ANG**—Air National Guard  
**ANG-JSG**—Air National Guard Joint Surgeon  
**ANG/SG**—Air National Guard Air Surgeon  
**ANG/SGP**—Air National Guard Chief of Aerospace Medicine  
**ANG/SGPM**—Air National Guard Public Health Flight  
**ARC**—Air Reserve Component  
**ASD(HA)**—Office of the Assistant Secretary of Defense, Health Affairs  
**ASD(HD&GS)**—Assistant Secretary of Defense for Homeland Defense and Global Security  
**BE**—Bioenvironmental Engineering  
**CBRN**—Chemical, Biological, Radiological, and Nuclear  
**CDC**—Centers for Disease Control and Prevention  
**CFR**—Code of Federal Regulations  
**DLN**—Department of Defense Laboratory Network  
**DMH**—Disaster Mental Health  
**DoD**—Department of Defense  
**DoDD**—Department of Defense Directive  
**DoDI**—Department of Defense Instruction  
**DPH**—Director of Psychological Health  
**DRU**—Direct Reporting Unit  
**DSCA**—Defense Support of Civil Authorities  
**EMWG**—Emergency Management Working Group  
**GCP**—Global Campaign Plan  
**GS**—General Schedule  
**GSU**—Geographically-Separated Unit  
**GMU**—Guard Medical Unit

**HAF**—Headquarters Air Force  
**HHQ**—Higher Headquarters  
**HN**—Host Nation  
**HPCON**—Health Protection Condition  
**IAW**—In Accordance With  
**ICS**—Incident Command System  
**IEMP**—Installation Emergency Management Plan  
**JFHQ**—State—Joint Forces Headquarters-State  
**MAJCOM**—Major Command  
**MDG**—Medical Group  
**MDG/CC**—Medical Group Commander  
**MDG/SGP**—Medical Group/Chief of Aerospace Medicine  
**MEM**—Medical Emergency Manager  
**MOA**—Memorandum of Agreement  
**MOU**—Memorandum of Understanding  
**MSG**—Mission Support Group  
**MSG/CC**—Mission Support Group Commander  
**MTF**—Medical Treatment Facility  
**OCONUS**—Outside the Continental United States  
**OSD**—Office of the Secretary of Defense  
**PA**—Public Affairs  
**PHEM**—Public Health Emergency Management  
**PHEO**—Public Health Emergency Officer  
**PHEO-POC**—Public Health Emergency Officer-Point of Contact  
**PHO**—Public Health Officer  
**PI&ID**—Pandemic Influenza and Infectious Disease  
**POC**—Point of Contact  
**POD**—Point of Dispensing  
**PPE**—Personal Protective Equipment  
**RMU**—Reserve Medical Unit  
**ROM**—Restriction of Movement  
**RSS**—Receiving, Staging, and Storage

**SAF/FM**—Assistant Secretary, Financial Management and Comptroller

**SAF/PA**—Director of Public Affairs

**SAS**—State Air Surgeon

**SJA**—Staff Judge Advocate

**SLTT**—State, Local, Tribal and Territorial

**SNS**—Strategic National Stockpile

**UCMJ**—Uniform Code of Military Justice

### *Terms*

**All—hazards Approach**—A methodology to develop emergency management strategies for all different types of potential incidents. “All-hazards” include any incident, natural or manmade that warrants action to protect life, property, health, and safety of military members, dependents, and civilians at risk, and minimize any disruptions of installation operations.

**Antiterrorism**—Defensive measures used to reduce the vulnerability of individuals and property to terrorist acts, to include limited response and containment by local military forces.

**CBRN Incident**—The deliberate or inadvertent release of chemical, biological, radiological, or nuclear devices with potential to cause significant numbers of casualties and high levels of destruction.

**Communicable Disease**—An illness due to an infectious agent or its toxic product, which may be transmitted from a reservoir to a susceptible host either directly as from an infected person or animal or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

**Disease Vector**—An organism, such as an insect, that transmits disease-causing pathogens.

**First Responders**—Firefighters, law enforcement and/or security personnel, and emergency medical personnel who provide the initial, immediate response.

**Incident of Public Health Concern**—An infectious disease (natural, accidental, or deliberate) likely to significantly impact the ability of the DoD to maintain mission assurance or likely to result in significant increases in request for DoD assistance.

**Installation**—A grouping of facilities, located in the same vicinity, which support particular functions. Installations may be elements of a base.

**Installation Commander**—The individual responsible for all operations performed by an installation.

**Limited Readiness Capability**—Medical functional flights and small medical squadrons that do not provide the full scope of readiness capabilities or resources found in a typical medical group. Stand-alone AFR and ANG units are considered LRCs.

**Medical Emergency Manager (MEM)**—An individual appointed by the MDG/CC from Medical Readiness or other appropriate office who supports the Wing Commander, PHEO, and the Installation Emergency Manager. The MEM is responsible for medical specific actions required to plan for, respond to, recover from, and mitigate the impacts of all hazards (including but not limited to the public health and medical needs of victims during and after an attack, disaster, or other incident/accident). The term MEM as it applies at the MAJCOM level is used to point out the consultant who insures execution of AFMS policy on Public Health Emergencies and Incidents of Public Health Concern. The individual provides guidance and reach back capability for installation MEMs and advocates for medical specific and public health equities in support of the overarching Air Force Emergency Management Program.

**Memorandum of Agreement (MOA)**—An agreement that defines areas of responsibility and agreement between two or more parties, normally at headquarters or MAJCOM level. MOAs normally document the exchange of services and resources and establish parameters from which support agreements may be authorized.

**Memorandum of Understanding (MOU)**—An umbrella agreement that defines broad areas of mutual understanding between two or more parties, normally at MAJCOM or higher level.

**Morbidity**—Any departure, subjective or objective, from a state of physiological or psychological well-being.

**Mortality Rate**—A measure of the frequency of occurrence of death in a defined population during a specified interval of time.

**Natural Disaster**—An emergency posing significant danger to life and property that results from a natural cause.

**Non-Military Personnel**—Civilian personnel, dependents of military or civilian personnel, contractors, and other individuals visiting or who are present on an Air Force installation.

**National Response Framework**—Guides how the Nation conducts All-Hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, states, the federal government, private-sector and non-governmental partners apply these principles for a coordinated, effective national response. It describes special circumstances where the federal government exercises a larger role, including incidents where federal interests are involved and catastrophic incidents where a state would require significant support. It allows first responders, decision makers, and supporting entities to provide a unified national response.

**Public Health Emergency**—An occurrence or imminent threat of an illness or health condition that may be caused by a biological incident, manmade or naturally occurring; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; natural disaster; chemical attack or accidental release; radiological or nuclear attack or accident; or high-yield explosives that pose a high probability of a significant number of deaths, serious or long-term disabilities, widespread exposure to an infectious or toxic agent, and/or healthcare needs that exceed available resources.

**Public Health Emergency Officer (PHEO)**—An individual selected by the MTF Commander and appointed by the Wing Commander. This is one of the key subject matter experts who will serve as a resource to help guide the Installation Commander during incidents of a public health emergency or incidents of a public health concern.

**Quarantinable Communicable Disease**—Consistent with Executive Order 13295, as amended by Executive Order 13375, includes Cholera or suspected Cholera, Diphtheria, infectious Tuberculosis, Plague, Smallpox, Yellow Fever, Severe Acute Respiratory Syndrome, Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Congo-Crimean, South American, and others not yet isolated or named), and influenza caused by novel or re-emergent influenza viruses that are causing, or have the potential to cause, a pandemic. Any subsequent changes to Executive Order 13295 are automatically incorporated into this definition.

**Quarantine**—Voluntary or compulsory separation and ROM of persons who are not ill but have been exposed to an infectious agent and therefore may become infectious, for the purpose of preventing or limiting the spread of disease.

**Restriction of Movement (ROM)**—Limiting personnel movement to prevent or limit the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation; isolation; and/or quarantine.

**Social Distancing**—Intervention applied to specific groups, an entire community, or a region designed to reduce interactions and thereby transmission risk within the group. Examples include implementing altered work schedules (e.g., telework, staggered shifts) and replacing face-to-face meetings with teleconferences.

**Working Quarantine**—Persons are permitted to work but must observe activity restrictions while off duty. Monitoring for fever and other symptoms before reporting for work is usually required. Use of appropriate PPE while at work is required.

**Strategic National Stockpile (SNS)**—A national repository of medicine and medical supplies maintained by the CDC. The SNS supplements overwhelmed or depleted state and local medical materiel to protect the American public if there is a public health emergency or incident of public health concern (e.g., CBRN incidents, natural disasters, industrial accidents, terrorist attacks, and contagious disease outbreaks) severe enough to cause local supplies to run out.

**Terrorism**—The calculated use of unlawful violence or threat of unlawful violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological.

**Vulnerability**—The susceptibility of a nation or military force to any action by any means through which its war potential or combat effectiveness may be reduced or its will to fight is diminished.

**Zoonotic Disease**—A disease that can be transmitted from animals to people or, more specifically, a disease that normally exists in animals but that can infect humans. There are multitudes of zoonotic diseases that are caused by bacteria, viruses, or parasites. Zoonotic diseases can be acquired from vector, food, or water sources or through direct contact with animals. Zoonotic diseases can cause a wide variety of symptoms such as diarrhea, muscle aches, and fevers, and can be life threatening.



**Attachment 2****TEMPLATE: DECLARATION OF A PUBLIC HEALTH EMERGENCY**

**A2.1. General.** The content that follows will be added to installation or wing letterhead (as appropriate) with the necessary information completed in the italicized fields contained within brackets. The document will be signed by the Installation Commander. Upon signing, the information therein must be communicated to the installation population using the most effective and timely means available (e.g., featured at a Commander's Call, an e-mail from the commander to the base population, photocopies of the memorandum handed out at the gates, closed-circuit television announcement). Additional guidance or information on the public health emergency will be formulated by the PHEO and attached to this memorandum prior to distribution. The content should be altered, as necessary, for use in overseas areas depending on the Status of Forces Agreements, basing arrangements, or other understandings with local officials. **(T-0)**.

Figure A2.1. Template: Declaration of a Public Health Emergency.

MEMORANDUM FOR RECORD	{DATE}
FROM: {Wing or Installation Commander Designation}	
SUBJECT: Declaration of a Public Health Emergency	
<p>1. I have been notified by my Public Health Emergency Officer (PHEO) of a possible public health situation on our installation involving {agent or disease name} that requires immediate action. Based on the PHEO's recommendations and the results of a preliminary investigation, I am declaring a public health emergency IAW AFI 10-2519, <i>Public Health Emergencies and Incidents of Public Health Concern</i>. This declaration will terminate automatically 30 days from the date of this memorandum unless it is renewed and re-reported, or terminated sooner by myself or a senior commander in the chain of command.</p> <p>2. The installation PHEO and medical personnel are hereby directed to identify, confirm, and control this public health emergency utilizing all the necessary means outlined in AFI 10-2519. To implement my direction, the PHEO may issue guidance that affects installation personnel and property, and other individuals working, residing, or visiting this installation (e.g., closing base facilities, restricting movement, or implementing quarantine for select individuals).</p> <p>3. The installation command and the PHEO will coordinate activities and share information with state, local, tribal and territorial {Note: for OCONUS commands, replace "state, local, tribal and territorial" with "host nation"} officials responsible for public health and public safety to ensure our response is appropriate for the public health emergency. Shared information may include personally identifiable health information only to the extent necessary to protect the public health and safety.</p> <p>4. Any person who refuses to obey or otherwise violates an order during this declared public health emergency will be detained. Those not subject to military law will be detained until civil authorities can respond. Violators of procedures, protocols, provisions, and/or orders issued in conjunction with this public health emergency may be charged with a crime under the UCMJ and/or under, United States Code, Section 271. Pursuant to 42 U.S.C. 271, violators are subject to a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
{NAME IN ALL CAPS, Rank}, USAF Public Health Emergency Officer {Wing or Installation Designation}	

**Attachment 3****TEMPLATE: NOTICE OF QUARANTINE**

**A3.1. General.** The content that follows will be added to installation or wing letterhead (as appropriate) with the necessary information completed in the italicized fields contained within brackets. The document will be signed by the PHEO, and photocopies will be provided to all individuals subject to quarantine. A copy of the Declaration of a Public Health Emergency (**Attachment 2**) signed by the Installation Commander will be attached. Any supporting information or guidance deemed necessary can also be attached to this notice. The content should be altered, as necessary, for use in overseas areas depending on the Status of Forces Agreements, basing arrangements, or other understandings with local officials. **(T-0)**.

Figure A3.1. Template: Notice of Quarantine.

	<i>{DATE}</i>
MEMORANDUM FOR INDIVIDUALS SUBJECT TO QUARANTINE	
FROM: Public Health Emergency Officer (PHEO), <i>{Wing or Installation Designation}</i>	
SUBJECT: Notice of Quarantine	
<p>1. In response to a declared public health emergency by the Installation Commander, this is a formal notice that we are invoking quarantine procedures. As the installation's PHEO, I am providing you the following directions and information on the situation:</p> <p><i>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order.}</i></p> <p><i>{A brief statement of the facts warranting the quarantine.}</i></p> <p><i>{Conditions for termination of the order.}</i></p> <p><i>{Specified duration of quarantine.}</i></p> <p><i>{The place or area of quarantine.}</i></p> <p><i>{No contact with non-quarantined individuals except as approved by the PHEO.}</i></p> <p><i>{Symptoms of the subject disease and a course of treatment.}</i></p> <p><i>{Instructions on the disinfecting or disposal of any personal property.}</i></p> <p><i>{Precautions to prevent the spread of the subject disease.}</i></p>	
<p>2. Any persons subject to quarantine have the right to contest the reason for quarantine. Information supporting an exemption or release can be provided to me or one of my designated representatives, who will provide the information to the Installation Commander (or a designated representative) for final determination. The total time from submission to response will not exceed 24 hours.</p>	
<p>3. Procedures for the declaration of a public health emergency, quarantine, and the actions prescribed above are found in Department of Defense Instruction 6200.03, <i>Public Health Emergency Management Within the Department of Defense</i>, and AFI 10-2519, <i>Public Health Emergencies and Incidents of Public Health Concern</i>. It is DoD and Air Force policy that military installations, property, and personnel and other individuals working on, residing on, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, and/or orders detailed in this memorandum may be charged with a crime under 42 USC Section 241d and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
<p>4. A wide range of professionals, in addition to myself, are working hard to ensure you receive the highest quality medical care and are released from quarantine as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.</p>	
	<p><i>{NAME IN ALL CAPS, Rank}</i>, USAF          Public Health Emergency Officer  <i>{Wing or Installation Designation}</i></p>
<p>Attachment:          Declaration of Public Health Emergency</p>	

**Attachment 4****TEMPLATE: NOTICE OF ISOLATION**

**A4.1. General.** The content that follows will be added to installation or wing letterhead (as appropriate) with the necessary information completed in the italicized fields contained within brackets. The document will be signed by the PHEO, and photocopies will be provided to all individuals subject to isolation. A copy of the Declaration of a Public Health Emergency (**Attachment 2**) signed by the Installation Commander will be attached. Any supporting information or guidance deemed necessary can also be attached to this notice. The content should be altered, as necessary, for use in overseas areas depending on the Status of Forces Agreement, basing arrangements, or other understandings with local officials. **(T-0)**.

Figure A4.1. Template: Notice of Isolation.

	{DATE}
MEMORANDUM FOR INDIVIDUALS SUBJECT TO ISOLATION	
FROM: Public Health Emergency Officer (PHEO), {Wing or Installation Designation}	
SUBJECT: Notice of Isolation	
<p>1. Due to your diagnosis of {specify communicable disease of concern}, this is a formal notice that we are invoking isolation procedures. As the installation's PHEO, I am providing you the following directions and information:</p> <p><i>{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order. }</i></p> <p><i>{A brief statement of the facts warranting the isolation. }</i></p> <p><i>{Conditions for termination of the order. }</i></p> <p><i>{Specified duration of isolation. }</i></p> <p><i>{The place or area of isolation. }</i></p> <p><i>{No contact with non-isolation individuals (except as approved by the PHEO) or protocols for individuals entering isolation premises. }</i></p> <p><i>{Symptoms of the subject disease and a course of treatment. }</i></p> <p><i>{Precautions to prevent the spread of the subject disease. }</i></p>	
<p>2. Any persons subject to isolation have the right to contest the reason for isolation. Information supporting an exemption or release can be provided to me or one of my designated representatives, who will provide the information to the Installation Commander (or a designated representative) for final determination. The total time from submission to response will not exceed 24 hours.</p>	
<p>3. Procedures for the declaration of a public health emergency, isolation, and the actions prescribed above are found in Department of Defense Instruction 6200.03, <i>Public Health Emergency Management Within the Department of Defense</i>, and AFI 10-2519, <i>Public Health Emergencies and Incidents of Public Health Concern</i>. It is DoD and Air Force policy that military installations, property, and personnel and other individuals working on, residing on, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, and/or orders detailed in this memorandum may be charged with a crime under Title 42 United States Code Section 271 and subject to punishment of a fine up to \$1,000 or imprisonment for not more than one year, or both.</p>	
<p>4. A wide range of professionals, in addition to myself, are working hard to ensure you receive the highest quality medical care and are released from isolation as soon as possible. These actions are necessary to safeguard the health of your loved ones and ensure the safety of the general public.</p>	
	<p><i>{NAME IN ALL CAPS, Rank}</i>, USAF  Public Health Emergency Officer  <i>{Wing or Installation Designation}</i></p>
<p>Attachment:  Declaration of Public Health Emergency</p>	