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of Tier. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. **Note:** The term MAJCOM, when used in this publication, refers to all MAJCOM, Field Operating Agencies (FOA), Direct Reporting Units (DRU), Air Reserve Component and ANG organizations, unless otherwise indicated.

SUMMARY OF CHANGES

This publication has been substantially revised and must be reviewed in its entirety. Significant changes include: update of organizational nomenclature to reflect AF Medical Service (AFMS) reform above the MAJCOM level, removal of major portions of **Chapter 1**, which is now merged with the previous contents of a revised **Chapter 2**. **Chapters 2-7** have been reorganized and the entire document has been condensed into 6 chapters. The terms home station and installation medical response were replaced with Installation Medical All Hazard Response (IMAHR). In addition, the *following* guidance was added: medical logistics readiness requirements planning and resourcing process guidance; critical Bioenvironmental Engineering, Education and Training Office, and Chemical, Biological, Radiological and Nuclear (CBRN) Force Health Protection Officer roles and responsibilities; additional Medical Readiness Committee (MRC) members/agenda topics; Air Education and Training Command (AETC)as training quota managers for the Medical Readiness Management Course; clarification of the medical contingency response plan (MCRP) coordination process.

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Chapter 1

ROLES AND RESPONSIBILITIES

1.1. Overview.

1.1.1. The AFMS provides seamless health service support to AF and combatant commanders and assists in sustaining the performance, health and fitness of every Airman in-garrison and while deployed within or outside the United States in support of global operations. This capability is summarized by the phrase "global medical readiness" which includes the full spectrum of medical operations such as, medical deployment operations and support to installation deployers, humanitarian assistance, all hazard response, and global health engagement to support building partnerships and stability operations. It also includes the necessary planning, training, and readiness support functions, such as readiness reporting, associated with these operations. Components of this global system are fully integrated, with forward-deployed health services, and en-route care to facilities providing comprehensive, definitive medical care.

1.1.2. The foundational emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapidly responding medical capability, which is tailored to meet specific requirements, whether within the boundaries of the installation or across the globe. The AFMS promotes and advocates the optimization of human performance sustainment and enhancement, including the optimal integration of human capabilities with operational systems. To achieve the mission, the AFMS developed processes to support expeditionary strategies, emergency management, medical readiness training and resourcing, manpower and equipment force packaging, patient movement and global medical operations plans and reporting.

1.1.3. Special Command Considerations.

1.1.3.1. Limited Readiness Capability (LRC) Units. Typically, LRC units are medical functional flights or small medical squadrons that do not provide the full scope of readiness capabilities or resources found in a typical Medical Group. They do not normally have assigned standard deployable unit type codes (UTCs), and may not be required to form all standard installation medical all hazard response teams. LRC units are often assigned to non-medical squadrons or to groups (e.g., Air Base Squadrons, Mission Support Groups or Air Base Groups). In some cases, LRC units may report directly to the wing. MAJCOM Surgeons identify and designate appropriate units within their MAJCOM as LRC units in Medical Readiness Decision Support System (MRDSS).

1.1.3.2. Installation medical all hazard response. AF medical units worldwide plan for conducting their home station and expeditionary missions simultaneously. Home station missions include, but are not limited to protecting the installation population; reducing harmful effects; assisting in the sustainment of critical missions; medical surveillance; CBRN detection and analysis; patient decontamination; and installation medical all hazard response. To accomplish home station missions medical units provide teams of individuals trained and equipped to provide specialized response to a wide range of events, from minor accidents to large scale hazardous materials and CBRN events.

Installation medical all hazard response teams may also be referred to as MCRP teams by units required to develop and maintain an MCRP.

1.2. AF Surgeon General (AF/SG).

1.2.1. Develops medical readiness policy and issue guidance and procedures to implement policy.

1.2.2. Advocates for, obtain, and allocate resources for medical readiness activities.

1.2.3. Integrates AFMS readiness capabilities with other AF and Joint capabilities at the development and planning stages.

1.2.4. Establishes and disseminate readiness training, employment, and assessment guidance.

1.2.5. Establishes the Medical Readiness Panel by charter to plan, program, and budget for medical readiness resources.

1.2.6. Interfaces with the Defense Health Agency (DHA) on AFMS readiness requirements, support, policy, and to advocate for AF medical units as necessary.

1.2.7. Approves the Medical Resourcing Letter (MRL), identifying AFMS UTC (personnel and war reserve materiel) and installation medical all hazard response asset apportionment.

1.3. Director, Medical Manpower Personnel and Resourcing (AF/SG1/8).

1.3.1. Establishes medical force development guidance.

1.3.2. Provides policy related to training, recruitment and retention of AFMS personnel.

1.3.3. Establishes threshold manning levels required to support contingency requirements using planning tools including the Critical Operational Readiness Requirement.

1.3.4. Programs sufficient forces and funding to meet evolving readiness requirements.

1.3.5. Serves as consultant/advisor to the AFMS and DHA on the development of training affiliation agreements to support readiness training

1.4. Director, Operational Medicine and Research (AF/SG3/4).

1.4.1. Develops medical readiness doctrine, guidance, and policy.

1.4.2. Recommends medical readiness strategies to the AF/SG.

1.4.3. Ensures MRDSS is funded and maintained, and continues to be enhanced as AFMS readiness mission requirements evolve.

1.4.4. Formulates the AFMS air expeditionary force strategy and provide policy and guidance for UTC posturing, and medical force presentation.

1.4.5. Designates the Director, Expeditionary Medical Policy and Operations (AF/SG3/4X) to:

1.4.5.1. Maintains the MRL, ensuring expeditionary medical capabilities are balanced across the entire Air & Space Expeditionary Force Construct.

1.4.5.2. Coordinates with MAJCOM medical functional area managers to ensure maximum support for the AFMS UTC posturing strategy.

1.4.5.3. Develops policies for medical support of the Air Expeditionary Force, Joint Staff taskings, and requests for forces from combatant commands.

1.4.5.4. Provides functional oversight and guidance to MAJCOM Medical Readiness Offices (MAJCOM/SGX) on all aspects of medical readiness, to include policies, procedures, and publications; deployment and operational information and taskings; training development and opportunities; and installation medical all hazard response.

1.4.5.5. Publishes and maintain this instruction and its associated self-assessment communicator within the management internal control toolset in accordance with AFI 33-360 and AFI 90-201*, The AF Inspection System.* Manage and maintain the AFI 41-106 Toolbox on the AF Medical Readiness SharePoint® Site. Collects, tracks and evaluates change requests and publishes changes to this instruction as required.

1.4.5.6. Chairs the Medical Readiness Panel. Provides oversight of the readiness requirements planning and resourcing process including: management of the program objective memorandum requirements change process, managing program objective memorandum requirements in the Program Objective Memorandum Grid application across the Fiscal Years to reflect approved changes, and Reconciliation of Program Objective Memorandum requirements to the MRL and identification of disconnects to the Manpower and Equipment Force Packaging Responsible Agencies for correction.

1.4.5.7. Designates an AFMS MRDSS Functional Proponent as the lead point of contact for MRDSS activities, policies and procedures AFMS-wide. Establishes the MRDSS Configuration Control Board by charter to validate and prioritize proposed baseline software changes. The AFMS MRDSS Functional Proponent functions as the MRDSS Configuration Control Board Chairperson.

1.4.5.8. Establishes the Readiness Training Oversight Committee by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements. Charters for the Readiness Training Oversight Committee and its sub-working groups can be found on the AF Medical Readiness SharePoint® site. Sub-working groups to the Readiness Training Oversight Committee include:

   1.4.5.8.1. The Exercise Oversight Working Group, which is chaired by the Readiness Training Oversight Committee Chair and is responsible for planning, coordinating, and overseeing the AFMS exercise program. Units with unique or extensive exercise requirements beyond the scope of unit funding may submit their proposals through their parent MAJCOM.

   1.4.5.8.2. The Comprehensive Medical Readiness Program (CMRP) Committee, which is chaired by the AF/SG's Lead Consultant, is responsible for reviewing Category I and Category II training criteria presented by the specialty consultants and career field managers, coordinating CMRP checklist changes through the Readiness Training Oversight Committee, and approving CMRP checklist implementation instructions prior to publication.

1.4.5.9. Establishes the Medical Preparedness and Response Oversight Committee by charter. The committee will plan, budget, coordinate and oversee AFMS ability to meet CBRN readiness requirements and ensure the AFMS is prepared to meet all hazard

mission requirements. The charter can be found on the AF Medical Readiness SharePoint® site.

1.4.5.10. Appoints a Program Element Manager (PEM) for the Defense Health Program. The Medical Readiness Panel PEM, as the primary advocate for medical readiness funding will:

1.4.5.10.1. Provide medical readiness program requirements to the Medical Readiness Panel for approval and submit the Panel's recommendations to the AFMS Group and, when applicable, through the AFMS Corporate process.

1.4.5.10.2. Provide annual financial plans for all budget activity numbers to the Medical Readiness Panel Chair to include analyses and recommendations for the coming fiscal year.

1.4.5.11. Follows the AF Installation and Mission Support Center program objective memorandum process to develop Total Force Options in support of strategy and planning efforts to be integrated through the Installation Support Panel and AF Corporate Structure.

1.4.5.12. Appoints a member of the AF/SG3/4X staff to manage and coordinate the Total Demand List/Readiness Requirements List (TDL/RRL) in concert with key stakeholders, such as AF Medical Readiness Agency Operational Medical Logistics and the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies. Identifies readiness requirements, potential risk and risk mitigation strategies.

1.4.5.13. Provides Service-level policy, management, and oversight of: medical readiness programs; strategic partnerships; operational medical logistics; plans and operations in the deployed environment; emerging mission support requirements.

1.4.5.14. As the Associate Corps Chief for Readiness, establishes the criteria for award of the "R" AF Specialty Code (AFSC) prefix for medical personnel, for inclusion in the AF Officer Classification Directory and AF Enlisted Classification Directory. Develops a process to identify MAJCOM or higher staff positions eligible for the "R" AFSC prefix.

1.4.5.15. Determines medical readiness training requirements for medical service corps (MSC) officers. Develop and maintain the 041AX CMRP checklist.

1.5. AF Medical Readiness Agency, Operational Resourcing Division.

1.5.1. Designates a PEM for line of the AF program element (PE) 28036F, for medical counter-CBRN (MC-CBRN) to provide programming requirements to the Medical Readiness Panel and facilitate flow of MC-CBRN funds to MAJCOM comptrollers for distribution.

1.5.2. Designates a PEM for AF working capital funds (fund code 4930) for UTC materiel requirements and line of the AF operating and maintenance funds (fund code 30) for maintenance and sustainment support services. Facilitates an annual portfolio management workgroup meeting each December to produce the AFMS war reserve materiel prioritized program objective memorandum position. Documents the meeting outcome in the AF medical logistics web enabled spend/production plan database application.

1.5.3. Provides oversight and guidance to the readiness requirements planning and resourcing process, which includes:

1.5.3.1. Creating a knowledgeable, cross-functional decision process that enables and tracks the execution of AFMS readiness programs.

1.5.3.2. Capturing the capability requirements needed by combatant commanders to support joint war fighting medical support.

1.5.3.3. Focusing resource needs for organize, train and equip functions.

1.5.3.4. Providing a validation mechanism to review requirements and apply resources.

1.5.3.5. Communicating AF/SG intent regarding application of resources.

1.6. AF Medical Readiness Agency, Medical Operations Division, Medical Readiness Branch (SG3X).

1.6.1. Advises, through the International Health Specialist Program Director, AF/SG on international health strategy, current operations and global health engagement activities, and other pertinent international health issues to support the AFMS force development process. Represents AF/SG in matters related to international health, as requested. Identifies, trains, and equips members in accordance with AFI 44-162, *International Health Specialist (IHS) Program and Global Health Engagement (GHE).*

1.6.2. Advises the AF/SG on doctrine and futures analysis issues to support AFMS programs.   Coordinate medical tactics, techniques and procedures (TTP) doctrine development, synthesize national strategic guidance into AFMS concepts, collect and disseminate medical readiness lessons learned.

1.6.2.1. Deployment lessons learned. Provides policy guidance for the AFMS post-deployment questionnaire process to obtain feedback from recently deployed personnel concerning their deployment training and preparation.   Reviews post-deployment questionnaires and provide feedback to appropriate responsible offices, such as MAJCOMs, MEFPAK Responsible Agencies, and/or the Readiness Training Oversight Committee for tracking, decision making and resolution. Provides deployment lessons learned that address comprehensive medical readiness program (CMRP) Category I or Category II training to the CMRP Committee.

1.6.2.2. Installation Medical All Hazard Response Lessons Learned. Provides feedback from post-response and exercise evaluations and lessons learned to appropriate responsible offices and tracks open items to resolution.

1.6.2.3. Joint and Service capabilities based assessments. Provides lessons learned support to initial capabilities document for a materiel solution, or doctrine, organization, training, material, leadership, personnel, and facilities change recommendation for a non-materiel solution or a change to an existing joint capability, as appropriate.

1.6.3. Provides a forum for MAJCOMs to present lessons learned and assist in assigning lessons learned to the appropriate working group, organization, or governing body.

1.6.4. Provides functional oversight of the consultant balanced deployment program.

1.6.5. Provides policy, in collaboration with the AF/SG Consultants, Corps Directors and Career Field Managers for the CMRP.

1.6.6. Provides oversight to AFMS specialty consultant and career field manager readiness functions, to include:

1.6.7. Supports the CMRP by chairing the CMRP Committee, which reviews Category I and Category II criteria and approves CMRP checklist changes before they are published.

1.6.8. Maintains the CMRP flowchart outlining criteria for creating/reviewing CMRP items on the AF Medical Readiness SharePoint® Site.

1.6.9. Works with specialty consultants, corps directors and career field managers to ensure CMRP checklists are reviewed annually and updated as necessary.

1.6.10. Analyzes clinical and administrative operations in AF medical units to identify gaps in readiness skills and recommendations on how best to achieve those skills.

1.6.11. Manages the readiness analysis comprehensive evaluation program and other collaborative projects to provide data on the level of preparedness to execute AF missions. This includes working directly with consultants, career field managers and medical units on complex analysis of CMRP Category I and II requirements, joint and external partnership currency workload, recapture of clinical currency cases, and other data-driven activities.

1.6.12. Posts CMRP checklist updates in MRDSS and checklist updates on the AFMS Knowledge Exchange site after approval by the CMRP Committee.

1.7. AF Medical Readiness Agency, Medical Operations Division, Operational Medical Logistics Branch (SG4)

1.7.1. Submits war reserve materiel funding requests, provide management, execution direction and oversight to support of war reserve materiel consolidated storage and deployment center operations, in accordance with established memoranda of understanding.

1.7.2. Provides medical logistics policy, procedures, management, and execution for medical contingency materiel programs in accordance with AFI 25-101, *Air Force War Reserve Materiel Policies and Guidance*, AFMAN 41-209, *Medical Logistics Support*, and AFI 41-201, *Managing Clinical Engineering Programs*.

1.7.3. Provides policy, guidance and requirements management for the AFMS war reserve materiel force health protection program, which includes the biological and chemical warfare countermeasures and anti-malaria programs.

1.7.4. Oversees the execution and management of the war reserve materiel integrated product team as outlined in the readiness requirements planning and resourcing process.

1.7.5. Provides medical materiel product support management and sustainment for war reserve materiel in accordance with AFI 63-101, *Integrated Life Cycle Management*.

1.8. AF/SG Consultants, Corps Directors and Career Field Managers.

1.8.1. Provide functional support for the CMRP. Develop AFSC-specific CMRP checklists by:

1.8.1.1. Determining AFSC and clinical knowledge and performance skills required for deploying personnel. Determine AFSC training frequency requirements considering the air expeditionary force deployment cycle, training platform constraints, the perishability of required skills, duration of associated certifications, and lessons learned. Identify

checklist tasks that require sustained medical and readiness training (SMART) regional currency site or centers for sustainment of trauma and readiness skills (C-STARS) attendance and, in coordination with the United States AF School of Aerospace Medicine develop associated curricula.

1.8.1.2. Developing, maintaining, refining and validating CMRP Category I and Category II training requirements and training sources utilizing the CMRP flowchart posted on the AF Medical Readiness SharePoint® Site. Submit new or revised CMRP checklists and accompanying implementation guidance to the CMRP Committee for approval. Provide implementation guidance to the unit AFSC functional training managers for all new, updated, corrected, or revised CMRP checklists, as determined by the CMRP Committee. Implementation guidance will provide the following, at a minimum:

1.8.1.2.1. A description, summary and/or rationale for the changes.

1.8.1.2.2. Specific instructions for each task if prior CMRP Category I and Category II checklist training may be credited toward the new/revised tasks. If prior training will not be credited, provide a timeline or suspense for accomplishing the new training.

1.8.1.2.3. Instructions for handling tasked deployers who may be unable to accomplish new CMRP training requirements prior to deploying.

1.8.2. Review CMRP Category I and Category II checklists annually for currency and provide changes or a status update to the CMRP Committee no later than the anniversary date of the existing checklist.

1.8.3. Review the global/consultant CMRP training gap analysis report in MRDSS quarterly to monitor gap analyses inputted by unit AFSC functional training managers. Maintain and distribute a list of current training sources and facilitate completion of CMRP training gaps. Elevate CMRP gap challenges to the CMRP Committee as necessary to identify new or modify existing training programs to mitigate training deficiencies.

1.8.4. Manage requests for CMRP training exemptions on a case-by-case basis and document approved exemptions in MRDSS. CMRP exemptions may be granted for individuals who routinely meet the requirements associated with a specific task as part of their regular duties and therefore do not need to accomplish the training. For example, an Air Reserve Component (ARC) surgeon who works in a Level I trauma center in his civilian job might be exempted from certain CMRP Category I or Category II tasks. Exemptions expire based on the CMRP task frequency. For example: an exemption for a task accomplished every 36 months will expire when the task becomes due again at the 36 month point.

1.8.5. Review post-deployment questionnaires containing CMRP training feedback. Identify potential training deficiencies and formulate corrective actions.

1.8.6. Support the consultant balanced deployment process, ensuring deployment requirements are met with the most qualified individuals with critical operational readiness specialties from across the AFMS. This concept supports uninterrupted home station health care operations and maximizes individual career development and growth. Refer to the AFMS posturing and sequencing guidance for additional information.

1.9. MAJCOM Commanders. MAJCOM commanders will support MAJCOM Surgeons and Installation medical commanders in executing their expeditionary and in-garrison medical readiness missions.

1.10. Component MAJCOM Surgeons/Component Numbered AF Surgeons.

1.10.1. Use the Deployed Medical Treatment Facility Functional Verification and Hand-off Tool, maintained on the AF Medical Readiness SharePoint® Site, to:

1.10.1.1. Assess and monitor clinical quality standards in the deployed unit.

1.10.1.2. Confirm mission ready status upon initial establishment of a deployed medical facility (key workbook Tabs titled SGH/SGN/SGP, security, logistics and facilities).

1.10.2. Evaluate building partnerships, building partnership capacity, and stability operations against developed measures of effectiveness. Measures of effectiveness are linked to a specified end state objective and are specific, measurable, attainable, realistic, and timely.

1.10.3. Ensure lessons learned from site visits are provided to higher headquarters, identifying capability gaps and deficiencies that may require changes to existing organize, train, and equip policies and functions.

1.10.4. Schedule deployed medical treatment facility site visits to focus on specific areas of interest, subject to combatant commander approval.

1.11. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies.

1.11.1. Develop UTCs to meet expeditionary requirements. Appoint pilot units for each UTC. Develop UTC mission essential tasks based on force presentation or for stand-alone UTCs.

1.11.1.1. Prepare a playbook for each UTC, consolidating incremental UTCs into a single playbook for each medical air expeditionary task force-force module operational capabilities package, as appropriate. The playbook will serve as a consolidated resource for all information regarding the UTC, to include personnel and equipment detail, mission capability statement, concept of operations, tactics, techniques, and procedures, UTC weapons and arming requirements, and UTC mission essential task lists.

1.11.1.2. Coordinate timelines and provide oversight and guidance on UTC development and modernization to designated pilot units. Ensure pilot units review UTC weapons requirements biennially and update the weapons and munitions forecasting table on the AF Medical Readiness SharePoint® Site as necessary.

1.11.1.3. Ensure medical readiness requirements are represented in strategic planning, sponsored medical modernization research and development efforts, program objective memorandum development/deliberations; integrated product teams and high performance team capability gaps and requirement identification.

1.11.1.4. Plan and coordinate field development evaluations, as necessary, for the potential fielding of UTCs, platforms, or installation medical all hazard response equipment with appropriate pilot units, other MAJCOMs or agencies, as appropriate.

1.11.2. Manage war reserve materiel requirements, by:

1.11.2.1. Providing oversight, configuration management, direction and tasking authority for AFMS war reserve materiel stored at consolidated storage and deployment centers.

1.11.2.2. Verifying combatant commander requirements and task war reserve materiel assets for deployment as necessary in coordination with the consolidated storage and deployment center leadership and associated wing/installation deployment officers.

1.11.2.3. Verifying war reserve materiel deployment taskings and coordinate all requests to deploy war reserve materiel for training or exercises.

1.11.2.4. Providing recommendations and input to the war reserve materiel spend plan process to ensure appropriate funding to support sustainment, reconstitution, modernization and production requirements of UTCs.

1.11.2.5. Identifying UTC sustainment lifecycle costs in accordance with AFI 63-101.

1.11.2.5.1. The total demand list will include all requirements cited in all combatant commander plans. At least once every two years, the AF/SG functional area manager and MEFPAK responsible agencies will conduct a meeting with each component to complete a detailed assessment of combatant commander plans to ensure all requirements are accurately described and accounted for on the total demand list. Annually, the AF/SG functional area manager will validate with each component that requirements in the total demand list have not changed. Any theater expeditionary capability not supported by an AFMS deployable capability should be identified for potential development.

1.11.2.5.2. Apply AF/SG strategic planning guidance, derived from joint strategic capabilities plan, war and mobilization plan, and defense planning guidance, to the total demand list to develop the readiness requirements list. The readiness requirements list will be vetted, approved and coordinated through the AF and AFMS corporate process. The final readiness requirements list will be presented to the AF/SG for approval and will become the presentation of forces/capability for the combatant commanders and guide resource programming.

1.11.2.5.3. Once approved, and prior to the annual war reserve materiel portfolio management workgroup meeting, ensure the AF medical logistics web enabled spend/production database accurately reflects the most current readiness requirements list. Upon approval of the annual war reserve materiel portfolio, update the MRL to reflect changes to listed equipment UTCs.

1.11.3. Manage CMRP Category III training requirements for assigned UTCs or operational capabilities packages.

1.11.3.1. Advocate for funding requirements for training and exercises to the Readiness Training Oversight Committee, Exercise Oversight Working Group, as appropriate.

1.11.3.2. Designate a training scheduler for the Formal Training Management Scheduler (FTMS) within MRDSS to manage scheduling of course attendees.

1.11.4. Coordinate with appropriate joint training agencies, AF agencies, and MAJCOM/SG to ensure medical participation in major exercises, including Joint Chiefs of Staff exercises, in accordance with AFMS guidance.

1.11.5. Comply with responsibilities outlined in **paragraph 1.9** of this instruction.

1.11.6. Air Combat Command (ACC), as the MEFPAK Responsible Agency for medical ground-based unit type codes (UTCs) and the lead MAJCOM for the Installation Medical All Hazard Response program, supports AF/SG3/4 by:

1.11.6.1. Developing a spend plan for equipment refresh and central maintenance/procurement contract requirements for PE 28036F. Maintaining allowance standards, AF tactics techniques and procedures (TTP), mission essential tasks and expeditionary standards, training requirements and quota management. Every 24 months, reviewing: tactics techniques, procedures and mission essential tasks; training requirements and evaluating alternate training sources.

1.11.6.2. Overseeing PE 28036F spend plan development as well as central maintenance/procurement contract requirements.

1.11.6.3. Overseeing the response training and assessment program. Leading development and maintenance of program tools (e.g., tactical drill development and maintenance), Knowledge Exchange site, implementation guidance and training.

1.11.7. Air Mobility Command (AMC), as the MEFPAK Responsible Agency for en-route care, the patient movement items program, and the en-route care safe-to-fly program, supports AF/SG3/4 by:

1.11.7.1. Providing program management direction and oversight for the patient movement items program in support of the Commander, United States Transportation Command, managing all patient movement items center operations, recycling of patient movement items and supporting operational support and training platforms.

1.11.7.2. Providing gatekeeper services for aeromedical evacuation and patient movement airworthiness/safe-to-fly testing, and determines the priorities for airworthiness testing conducted by the Aeromedical Test Lab, Wright Patterson AFB, OH. Other agencies will contact AMC/SGXM to request airworthiness testing performed by the Aeromedical Test Lab.

1.12. MAJCOM Surgeons.

1.12.1. Ensure medical units are properly organized, trained, and equipped to carry out all aspects of their readiness missions.

1.12.2. Assist units with the implementation of AF medical readiness guidance.

1.12.3. Oversee the MAJCOM Medical Readiness Office (or standing force headquarters equivalent) in:

1.12.3.1. Identifying MAJCOM medical readiness program resource requirements for inclusion in the MAJCOM budget. Advocate for resource requirements to the Medical Readiness Panel.

1.12.3.1.1. Providing MC-CBRN program oversight at the MAJCOM level to include distribution of funding and other resources.

1.12.3.1.2. Designating a MAJCOM resource advisor for PE 28036F (PE 58036F for Air National Guard). Coordinating with the PEM for AF PE 28036F.

1.12.3.1.3. Coordinating with ACC for MC-CBRN program requirements, issues, training quotas and consultative support.

1.12.3.2. Interfacing with DHA intermediate level organizations on MAJCOM-related medical readiness issues, as necessary.

1.12.3.3. Assisting unit medical readiness offices in resolving medical readiness program issues.

1.12.3.4. Reviewing unit MCRPs, or equivalent for LRC units, prior to publication to validate medical response capabilities and verify compliance with AF directives.

1.12.3.5. Collecting and evaluating readiness guidance change requests from subordinate units.

1.12.3.6. Maintaining situational awareness of subordinate Federal Coordinating Center capabilities by reviewing annual self-assessment checklists and exercise after action reports. Coordinating support for Federal Coordinating Center staff assistance visits and National Disaster Medical System (NDMS) bed availability reporting, as scheduled or requested, with AF/SG3/4X.

1.12.3.7. Designating a MAJCOM representative to MRDSS Configuration Control Board. This individual will:

1.12.3.7.1. Be the MAJCOM's MRDSS expert.

1.12.3.7.2. Provide support to unit system administrators. Assist units with MRDSS data entry and contact the MRDSS Help Desk if technical assistance is required.

1.12.3.7.3. Create, review, and delete user accounts as appropriate, and ensure accuracy and positive control of sensitive information contained within the MRDSS.

1.12.3.7.4. Review/vet suggestions for improvement or changes to MRDSS prior to submission to the MRDSS Program Office for registration and tracking.

1.12.3.8. Ensuring subordinate unit MRDSS data quality, identify trends and compliance.

1.12.3.9. Designating a MAJCOM-level Formal Training Management Scheduler (FTMS) for MRDSS.

1.12.3.10. Providing consultative mentorship and functional support to subordinate unit medical readiness offices. Mentorship and functional visits require unit commander approval and installation inspector general gatekeeper coordination.

1.12.3.11. Supporting Inspector General compliance and inspections.

1.12.3.12. Appointing a MAJCOM Functional Area Manager. In addition to roles and responsibilities outlined in AFI 10-201, *Force Readiness Reporting*, AFI 10-401, *Air Force Operations Planning and Execution*, and AFI 10-403, *Deployment Planning and Execution*, the MAJCOM Functional Area Manager will:

1.12.3.12.1. Ensure the accuracy of the MRL within MRDSS and the UTC Availability (UTA) database. Update the UTA database within 30 days of implementing MRL changes involving UTCs identified as reportable.

1.12.3.12.2. Coordinate with MEFPAK responsible agencies as necessary regarding UTC manning, equipment, and training requirements.

1.13. Air Education and Training Command (AETC).

1.13.1. Medical Modernization Division (AETC/SGR).

1.13.1.1. Serves as advisor to the AFMS on use of patient simulators and distance learning for development and sustainment of expeditionary clinical skills.

1.13.1.2. Obtains on-site simulators and qualified simulator staff to execute trauma skills sustainment training in support of capabilities-based training mission essential task objectives. Provide oversight of contracted simulation personnel at trauma skills training sites.

1.13.1.3. Provides support to education and training personnel to integrate blended learning approaches to enhance cognitive, psychomotor and affective based training at the individual, team and unit levels.

1.13.1.4. Develops standardized clinical simulation scenarios to enhance delivery and assessment of training to meet capability-based training mission essential task objectives.

1.13.2. Medical Readiness Division (AETC/SGX). Manages quotas and scheduling for the Medical Readiness Management Course.

1.14. AF Materiel Command (AFMC), 711th Human Performance Wing, United States AF School of Aerospace Medicine.

1.14.1. Supports the AF Medical Readiness Agency by effectively administering the SMART regional currency sites and C-STARS operating locations by: **(T-1)**

1.14.1.1. Collaborating with similar Joint sustainment programs for benchmarking purposes. **(T-3)**

1.14.1.2. Overseeing standardized program curricula for all SMART regional currency site or C-STARS locations. Monitoring these programs for quality and effectiveness, and work with the specialty consultants and career field managers to update the curricula as needed. **(T-1)**

1.14.1.3. Briefing the Readiness Training Oversight Committee annually on SMART regional currency site and C-STARS utilization, issues, and trends. **(T-3)**

1.14.2. Provides consultative services to all clinical sustainment training sites by:

1.14.2.1. Collaborating with AETC/SGU to establish clinical sustainment training programs and advocate for associated budget submissions as necessary. **(T-3)**

1.14.2.2. Monitoring execution of clinical sustainment training programs and establish associated inspection criteria. Compiling and reports data on all trauma skills sustainment training sites to AF/SG3/4X and MAJCOM/SGXs via the Readiness Training Oversight Committee. Compiling an annual training summary for AETC/SG. **(T-3)**

1.14.3. Completes required course resource estimates and submits them to the Force Development Panel for approval. **(T-3)** Once the Force Development Panel approves the Course Resource Estimates, submits the appropriate requests for funding and/or manpower, if necessary.

1.14.4. Reviews and evaluates new advanced clinical skills sustainment programs. **(T-3)**

1.14.5. Promotes medical research, particularly with expeditionary impact, across the military/civilian spectrum. **(T-3)**

1.14.6. Provides technical expertise and consultative reach back support for aerospace and operational medicine, occupational and environmental health, public health, epidemiology, nuclear/radiological response, and occupational health physics. **(T-2)**

1.14.7. Manages the individual proficiency analytical testing program, validating bioenvironmental engineering operator proficiency in accordance with 4B0X/43EX career field education and training plans, to ensure competencies are maintained in the performance of the bioenvironmental engineering mission. **(T-1)**

1.15. Medical Unit Commander. For Reg AF medical units, this is the Medical Treatment Facility (MTF) Commander, who is dual-hatted, and in that capacity, executes the duties, authorities, and responsibilities of both the Medical Treatment Facility Director and the Service Commander.

1.15.1. Maintains cognizance of all assigned readiness missions. Annually, or as changes occur, reviews the MRL and validates assigned missions. **(T-2)** Refer questions to the parent MAJCOM FAM and document the annual review in MRC minutes.

1.15.2. Includes input from the medical readiness office in the development of the business plan/quadruple aim performance plan and medical readiness training and exercise schedule. **(T-3)** For ARC units, this involves input into the annual training plan.

1.15.3. Approves the MCRP (or equivalent for LRC units) for publication after full coordination, establishing and maintaining the capability to provide installation medical all-hazard response, treatment, staging, and transport of casualties. **(T-1)**

1.15.4. Reviews and approves installation medical all hazard response memoranda of understanding/memoranda of agreement/mutual aid agreements with military and civilian agencies, after full coordination has been completed. **(T-1)** Contracts for installation emergency services should be coordinated with medical unit leadership for health service support input.

1.15.5. Establishes and maintains response capabilities and supports public health emergency requirements in accordance with AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological, And Nuclear (CBRN) Incidents*; AFI 10-2519, *Public Health Emergencies and Incidents of Public Concern*; AFI 10-2501, *AF Emergency Management Program,* and this instruction. **(T-1)** These capabilities may be provided organically, within the medical organization; through written agreement with other organizations in the local area; or through a combination of these methods. For units with less than three assigned laboratory personnel, laboratory biological detection capability is established through memoranda of understanding/memoranda of agreement/mutual aid agreement with a state or local lab.

1.15.6. Oversees the Comprehensive Medical Readiness Program (CMRP) by:

1.15.6.1. Ensuring assigned personnel meet all training requirements in applicable directives and this instruction. **(T-1)**

1.15.6.2. Ensuring military members assigned to the unit or to readiness currency duty locations outside the medical unit operational platform, whether they are aligned to DHA-led healthcare activities or operational readiness activities, maintain CMRP currency. **(T-1)** The Commander, with support from MAJCOMs and the AF Medical Readiness Agency, communicates currency status and gaps to the DHA Market as needed to balance requirements. Military members who cannot meet currency requirements will be provided a work center in an appropriate alternate setting as agreed upon by the MTF Director.

1.15.6.3. Ensuring personnel complete the appropriate level of medical chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) training as defined in the AFMS CBRNE training requirements matrix on the AF Medical Readiness SharePoint® Site, in the AFI 41-106 toolbox. **(T-1)**

1.15.6.4. Ensuring AFSC functional training managers develop plans for mitigating CMRP Category I and Category II training gaps. **(T-2)**

1.15.6.5. Granting credit for CMRP training that is accomplished by participation in a deployment or exercise. **(T-3)** For ARC units, medical unit commanders may grant credit for CMRP training accomplished as part of assigned duties at the member's civilian place of employment. Documentation must be provided as evidence for any training credited in this manner. Use the deployment return date or exercise end date update the date trained in MRDSS.

1.15.6.6. Certifying in MRDSS that individuals who are tasked to deploy have met all required readiness training requirements prior to each deployment. **(T-1)** This responsibility may be delegated in writing by the Service Commander to the first G-series commander in the deploying individual's chain of command. This role will not be further delegated.

1.15.6.7. Supporting the SMART and C-STARS programs. **(T-1)** Training platform and frequency requirements are provided on the CMRP checklists for affected specialties. Ensure assigned personnel capitalize on local clinical currency opportunities and take an active role in developing and maintaining training affiliation agreements with local medical facilities. Prioritize personnel for SMART regional currency site attendance.

1.15.7. Informs the DHA Market of medical readiness training and exercises that may impact delivery of the healthcare benefit (e.g., installation exercises, UTC-specific training). **(T-3)**

1.15.8. Informs the DHA Market of requests for forces involving personnel performing DHA healthcare missions, providing sufficient information with which to plan for backfill of personnel and/or coverage of other mission requirements. **(T-3)**

1.15.9. Forms and chairs the unit's MRC. **(T-2)** Conducts MRC meetings quarterly, at a minimum, with the membership and agenda topics listed in **Table 1.1.** **(T-2)** LRC units may incorporate the MRC into the Executive Management Committee, as appropriate. For this instruction, MRC refers to any committee charged with this function, unless specifically noted. MRC requirements are not applicable to deployed MTFs.

Table 1.1. MRC Membership and Agenda Topics.

Permanent Members	Agenda Topic	Briefs the Status of: (T-2)
Executive management team		
Medical Readiness Training Manager	Readiness Training	- CMRP Category III, UTC training - Other readiness training (e.g., Medical Readiness Management Course, Public Health Emergency Manager Course, Medical CBRN Training, etc.)
Medical Readiness Officer, Medical Readiness Manager, Medical Readiness NCO	Unit Readiness Status	- MRL changes (when applicable) - Medical readiness training and exercise schedule - MC-CBRN budget execution - Force readiness reports - MCRP, or equivalent - Medical input to installation plans
Unit Deployment Manager	Deployments	- UTC vacancies - Deployment taskings and activities - Individual deployability of assigned UTC members, such as the number of deployment availability (DAV) coded UTC personnel - Status of lessons learned from post-deployment after action reports
Medical Emergency Manager	Emergency Management	- Emergency Management Working Group meeting discussion points - Installation medical all hazard response mutual aid agreements - Installation, local or regional response partnership requirements, as necessary - Joint Commission emergency management standards evaluation

Permanent Members	Agenda Topic	Briefs the Status of: (T-2)
Wing Inspection Team Medical Representative	Exercises & After Action Reports	- Unit and installation exercise requirements - Results of exercises conducted since last meeting - Exercise credit for real world response - After-action reports, lessons learned and corrective actions from exercises and real world events - Open exercise findings, get-well plans and projected get-well dates
Public Health Emergency Officer (or representative)	Public Health Emergencies	- Collaborations with installation emergency management officials in preparing for, declaring, responding to, and recovering from a public health emergency, as necessary - Current public health and medical threats, as necessary - Required equipment and medications based upon current threats - Threat Working Group updates
Medical Logistics Officer (or representative)	Medical Logistics	- Assigned war reserve materiel, including force protection assets such as anti-malaria/cholera program and biological/chemical warfare antidotes, facility expansion assets, etc. - War reserve materiel maintained for other units - Get-well plans and projected get-well dates for any deficiencies

Permanent Members	Agenda Topic	Briefs the Status of: (T-2)
AFSC Functional Training Managers[1]	CMRP	- CMRP Category I and Category II training - CMRP gap analysis (completion dates will be tracked for each AFSC and documented in meeting minutes) - CMRP clinical gaps resolution efforts - CMRP gaps get-well plans and projected get-well dates
Installation Medical All Hazard Response Team Chiefs[2]	Installation medical all hazard response	- Team manning - Team checklists - CMRP Category IV training - Status of team equipment and supplies, inventory results - Response deficiencies and limiting factors - Get-well plans and projected get-well dates for any deficiencies - Overall assessment of the team's capabilities
Education and Training Officer (or representative)	CMRP	- Training affiliation agreements for CMRP - Use/participation rates for training affiliation agreements that are in place - Clinical simulation assets and scenarios
Additional Participants (as needed)		
CBRN Force Health Protection Officer		- Current CBRN health risks
Bioenvironmental Engineer (or NCO if no officers are assigned)		- Water and food vulnerability assessments - Toxic industrial chemical/material (TIC/TIM) assessment summary. **Note:** actual TIC/TIM assessment contents are classified

Permanent Members	Agenda Topic	Briefs the Status of: (T-2)
Public Health Officer (or NCO if no officers are assigned)		- Food vulnerability assessments - Medical surveillance and epidemiological investigations
Reserve Affairs Liaison (if appointed)		- Projected reserve annual tour schedule and training events
Resource Management Officer		- Readiness budget, to include MC-CBRN budget

[1] These individuals may provide updates on a rotating basis, or by exception, as long as the status of CMRP Category I, Category II, and identified gaps for each assigned specialty are briefed a minimum of once annually.
[2] These individuals may provide updates on a rotating basis, or by exception, as long as the status of each team, their training and equipment is briefed a minimum of once annually.

1.15.10. Funds participation in combatant commander-directed operations with appropriations specifically provided for that purpose. **(T-3)** Medical units may not use Defense Health Program appropriations for combatant commander-directed operations.

1.15.11. If the unit maintains war reserve materiel for other units, provides opportunities for those units to train and exercise with the equipment. **(T-3)** However, the host unit is not responsible for ensuring that training and exercising are accomplished. These events should be discussed in the MRC meeting to support project oversight.

1.15.12. When the base is host to ARC units with similar personnel UTCs, ensures they are given the opportunity to train with the host unit's UTCs; ARC medical units will coordinate training schedules with their Reg AF host medical unit. **(T-3)** Refer questions to the appropriate MEFPAK Responsible Agency through the parent MAJCOM.

1.15.13. Appoints a primary and alternate for each position listed below using MRDSS and track associated training requirements. **(T-3)** Additional written appointment letters are not required unless mandated by other directives or instructions.

1.15.14. Medical Readiness Officer, Non-Commissioned Officer, and Manager, as appropriate. These individuals are referred to collectively as the Medical Readiness Office within this instruction, unless a paragraph addresses one specific individual. Medical readiness office roles and responsibilities are addressed in **Chapter 2** of this instruction. The Medical Readiness Office serves Service-specific functions and reports directly to the MTF Director/Service Commander or Medical Unit Commander for ARC units.

1.15.15. Medical Emergency Manager (may be assigned to the Medical Readiness Office). Reference AFI 10-2519, for Medical Emergency Manager and Public Health Emergency Officer duties. **Note:** Not applicable to ANG units.

1.15.16. . Unit Deployment Manager (UDM).

1.15.17. Medical Readiness Training Manager. Users of the formal training management scheduler in MRDSS must be appointed in writing to the parent MAJCOM.

1.15.18. AFSC Functional Training Manager for each assigned AFSC. These individuals are typically the senior enlisted functional manager and senior officer for each assigned AFSC. For clinical Biomedical Sciences Corps officers, CMRP oversight is provided by the Chief, Medical Staff (SGH or equivalent), or the Chief, Aerospace Medicine (SGP), at ARC units.

1.15.19. Installation Medical All Hazard Response Team Chiefs.

1.15.20. Unit MRDSS System Administrators. These individuals provide MRDSS usage assistance to unit users. Additional duties and responsibilities are described in **paragraph 2.4** of this instruction,

1.15.21. UTC Team Chiefs or UTC Family Group Team Chiefs. Appoint team chiefs and alternates for each assigned UTC or a UTC family group leader and alternate for each group of UTCs. The decision to appoint team chiefs for individual UTCs or UTC family groups is at the discretion of the unit commander. UTC family groups may be comprised of multiple copies of the same UTC, or complimentary UTCs (e.g., FFPM1, FFPM2, FFPM3, etc.) based on unit necessity. **Note:** The Patient Decontamination Team, UTC FFGLB, requires the appointment of a UTC team chief and Non-Commissioned Officer in Charge (NCOIC). Additionally, pilot units are required to appoint team chiefs and alternates for their pilot UTCs.

1.15.22. Reserve Affairs Liaison. Each Reg AF medical unit will appoint a Reserve Affairs Liaison to manage training at the unit for attached ARC members. **(T-3)**

1.15.23. CBRN Force Health Protection Officer.

1.15.24. For ARC units, an Annual Tour Monitor and alternate, one of which must be a full-time medical staff member.

1.15.25. For NDMS-Federal Coordinating Centers, a Director and a Coordinator.

1.16. Education and Training Office.

1.16.1. Develops and maintain all training affiliation agreements for CMRP clinical currency and readiness skills training. **(T-3)**

1.16.2. Manages clinical skills simulation assets and scenarios. Schedules simulation sessions in collaboration with AFSC functional training managers to meet CMRP Category I requirements. **(T-3)**

1.16.3. Assists AFSC functional training managers in mitigating CMRP Category I and Category II training gaps and scheduling personnel for appropriate courses. **(T-3)**

1.16.4. Maintains an active MRDSS account and track accreditation and regulatory training requirements (e.g., basic life support, advanced cardiac life support, etc.) for all assigned medical personnel to include active duty, civilian and contract staff in MRDSS. **(T-3)**

1.17. Public Health Officer (043HX) or Public Health NCO (4E071/4E091). For ARC units, the full-time bioenvironmental engineering/public health office is responsible for providing full-time public health support. AFRC units with the aerospace medicine function are

responsible for this duty in conjunction with their host unit Public Health Officer or NCO. Individuals designated for this role may be assigned to another collocated reserve unit. Units without an assigned Public Health Officer or NCO should contact the parent MAJCOM Public Health Officer for guidance. These individuals will:

1.17.1. Perform medical intelligence functions in support of installation deployment operations. **(T-2)** Coordinates and work with Line of the AF intelligence personnel, the National Center for Medical Intelligence, and parent MAJCOM public health personnel to obtain a medical intelligence assessment. **(T-3)** Obtain information on health threats from infectious disease, poisonous/venomous flora and fauna, disease risks, environmental health hazards, industrial hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, and host nation CBRN warfare medical defense capabilities at deployment locations. **(T-3)** Prepare and present medical intelligence/force health protection briefings for all wing deploying forces during base deployment processing. **(T-2)**

1.17.2. Attend the Joint Medical Operations Course to gain perspectives on joint planning and use of medical threat assessments. **(T-3)** Priority for attendance should be officers filling positions that directly impact planning, e.g., combatant command, international health specialist, or National Center for Medical Intelligence positions. Final attendance selections will be made by AF/SG3/4X, based on justification, seat availability and duty assignment. For stand-alone AF reserve command installations, Bioenvironmental Engineering/Public Health Office Director or his/her designee will attend the course. For ANG, officers filling positions that directly impact National/Federal Emergency Management Agency Region planning will attend the course.

1.17.3. Attend Contingency Preventive Medicine Course, #B3OZY4XXX 0B1C. **(T-2)** The Public Health Apprentice, Officer, or National Center for Medical Intelligence course may be attended in lieu of the Contingency Preventive Medicine Course for ARC personnel performing medical intelligence functions.   For stand-alone AF reserve command installations, those personnel performing the Public Health Officer/Public Health NCO functions in the bioenvironmental/public health office may attend the Contingency Preventive Medicine Course or the National Center for Medical Intelligence course.

1.17.4. Serve as the functional advisor to the medical readiness office along with the Public Health Emergency Officer and the Medical Emergency Manager for planning, training, and execution of the unit installation medical all hazard response program. **(T-3)**

1.17.5. Perform food vulnerability assessments to support planning and recommended corrective actions in anticipation of, and in response to, an incident, in accordance with AFMAN 10-246, *Food & Water Protection Program.* Coordinate initial testing of foods suspected of deliberate bacterial contamination with the Office of Special Investigation, Security Forces Squadron, Laboratory Biological Detection Team, and the Public Health Emergency Officer to determine appropriate courses of action. **(T-0)**

1.17.6. Conduct medical surveillance in accordance with AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance,* and AFI 10-2519. Conduct baseline health surveillance data to assist in detecting all-hazard incidents (not applicable to ARC medical units). **(T-0)**

1.17.7. Conduct All-Hazard risk communication to installation personnel. **(T-2)**

1.17.8. Serve as a point of contact for the Installation Force Protection Working Group, Installation Emergency Management Working Group, Threat Working Group, and Vulnerability Assessment Teams. **(T-2)**

1.18. Bioenvironmental Engineer (043EX) or Bioenvironmental Engineering Technician (4B071/4B091). At AFRC installations, Bioenvironmental Engineer responsibilities are performed by the full-time bioenvironmental engineering/public health personnel, who may be aligned under the Medical Group, Mission Support Group or Wing. These individuals will:

1.18.1. Maintain an active Secret Internet Protocol Router account and access. **(T-2)**

1.18.2. Perform water vulnerability assessments in accordance with AFMAN 10-246, *Food and Water Protection Program*. Brief the results to the Force Protection Working Group, or equivalent, and other base agencies (i.e. Civil Engineering, Antiterrorism Officer, Security Forces, Public Health Emergency Officer), as necessary. **(T-2)**

1.18.3. Perform Toxic Industrial Chemical/Material Assessments. Briefs the results to the Force Protection Working Group, or equivalent, and other base agencies (i.e. Emergency Management, Fire Department, Antiterrorism Officer, Security Forces, Public Health Emergency Officer), as necessary. **(T-2)** Reviews and updates the Toxic Industrial Chemical/Material Assessment at least annually.

1.18.4. Provide exercise scenario bioenvironmental engineering representation in installation and unit level exercise planning. **(T-3)**

1.18.5. Ensure emergency response vehicle(s) can accommodate off-road transportation (e.g., 4x4 vehicle and trailer) for the bioenvironmental engineering response team (minimum 6 passengers) and mission essential protective and response equipment. **(T-2)**

1.18.6. Serve as the CBRN Force Health Protection Officer (Not applicable to ARC units) by: **(T-3)**

1.18.6.1. Providing CBRN health risk subject matter expertise to the Force Protection Working Group, Emergency Management Working Group, and Threat Working Group as needed.

1.18.6.2. Serving as CBRN health risk advisor to the commander.

1.18.6.3. Assisting installation medical all hazard response teams with CBRN training, as necessary.

1.18.6.4. Assisting the Medical Emergency Manager and Public Health Emergency Officer with CBRN aspects of medical planning.

1.18.6.5. Identifying potential health risks to mission execution due to hazards, threats, and vulnerabilities linked to critical assets at the installation.

1.18.6.6. Working in collaboration with installation response forces (i.e. Emergency Management, Fire, Security Forces, Public Health Emergency Officer) and the installation intelligence community to enhance training and preparation for unit response.

1.18.6.7. If assigned to a high threat area, maintaining an active top secret/sensitive compartmented information security clearance. **(T-3)**

1.18.6.8. Completing Incident Command System 300 course and Bioenvironmental Engineering Readiness and Deployment Skills (BERDS) training within 12 months of appointment. **(T-2)**

1.18.6.9. Working with the intelligence community to develop a working knowledge of area threats and vulnerabilities derived from human interactions, signals, imagery, measurement and signature intelligence and other surveillance methods. **(T-3)**

1.18.6.10. Overseeing air, water, and soil sampling for CBRN health risk surveillance and ensure samples are forwarded to supporting laboratories for identification. **(T-3)**

1.19. NDMS Federal Coordinating Center Director. For units designated as an NDMS Federal Coordinating Center, this individual will be the medical unit commander and is responsible for overseeing the execution of the federal coordinating center and NDMS patient reception missions. **(T-0)**

1.20. NDMS Federal Coordinating Center Coordinator. For units designated as an NDMS Federal Coordinating Center, this individual will be a mid- to senior-level officer and is responsible for managing day-to-day operations and the alert and activation of the federal coordinating center and associated NDMS patient reception areas. **(T-3)** In addition, this individual will:

1.20.1. Develop a patient reception area plan. Submits the plan to the parent MAJCOM/SGX for review prior to publication. **(T-3)** Refer to the AF Medical Readiness SharePoint® Site for additional information on developing patient reception area plans.

1.20.2. Complete and submits an annual federal coordinating center patient reception area self-assessment checklist to the parent MAJCOM/SGX and AFMRA/SG3X. **(T-2)** Self-assessment checklists can be found in Annex Q of the NDMS Federal Coordinating Center Guide.

1.20.3. Provide an annual orientation to NDMS partner medical facilities, Patient Reception Teams, as well as representatives of local emergency management agencies, emergency medical services, police, and fire services. **(T-3)**

1.20.4. Conduct a patient reception exercise annually, with a full-scale exercise once every two years. **(T-0)** Submit after action reports to HQ AMC/SGX and AFMRA/SG3X within 30 days of exercise completion. **(T-3)**

1.20.5. Participate in NDMS bed reporting exercises. **(T-0)** Submits after action reports to HQ AMC/SGX and AFMRA/SG3X within 30 days of exercise completion.

1.21. Reserve Affairs Liaison. This individual serves as the single point of contact for supported ARC Medical Unit Annual Tour Monitor(s) for any questions and/or issues regarding annual tour training at their medical unit. In addition, this individual will: **(T-3)**

1.21.1. Upon request, provide to AFRC a list of unit training activities and AFSCs that can be supported for annual training.

1.21.2. Evaluate training plans received and approve annual tours based on, but not limited to, the feasibility of requested training, availability of trainers, medical unit capabilities, etc. Plan and coordinate access to medical readiness training for reserve medical unit personnel based on training requirements outlined in the training plan.

1.21.3. Provide reporting instructions to the supported reserve medical unit and assists with unit in-processing.

1.21.4. Review annual tour after action reports and provide recommendations for improvement to the reserve medical unit Annual Tour Monitor, as necessary.

1.21.5. Review the AFRC Annual Tour Guide posted on the AF Medical Readiness SharePoint® site for duties and requirements.

1.21.6. Refers to the AFRC/SG Annual Tour Guide, located on the AFRC Nursing Services Kx Site, for Reserve Annual Tour Monitor roles and responsibilities.

1.22. Installation Medical All Hazard Response Team Chiefs.

1.22.1. Prepare and maintains the team's response checklists. Plan for all potential response scenarios, including incidents with CBRN aspects. **(T-3)**

1.22.2. Maintain team equipment in accordance with AFMAN 41-209 and AFTTP 3-42.32, *Homestation Medical Response to Chemical, Biological, Radiological and Nuclear (CBRN) Events*. **(T-2)**

1.22.3. Conduct team training and/or assigns trainers, as necessary, to ensure all team members receive hands-on training annually. **(T-2)** Installation medical all hazard response training requirements are listed on the team training matrix, posted on the AF Medical Readiness SharePoint® site. Additional team-specific training requirements are listed in **Chapter 3** of this instruction. Ensures make-up training is conducted for individuals who miss training events, within 60 days of return from leave, deployment, etc. **(T-2)**

1.22.4. Ensure personnel assigned to response teams designated to use 886 assets are trained in accordance with AFTTP 3-42.32. **(T-1)**

1.22.5. Incorporate response training and assessment program tactical drills in the development of team lesson plans and training events, as applicable. **(T-3)**

1.22.6. Support the Wing Inspection Team Medical Representative by providing team related scenario inputs and objectives for medical-specific exercises, as necessary. **(T-3)**

1.22.7. Maintain an active MRDSS account and documents team training for assigned personnel in MRDSS or designates a team member to accomplish this task. **(T-2)**

1.22.8. Specific installation medical all hazard response team chiefs listed in **Table 3.4** or **3.5** will:

1.22.8.1. Be responsible for maintaining assigned installation medical all hazard response assemblages. **(T-3)**

1.22.8.2. Designate a team representative to work with the Medical Logistics Flight to manage the team's assemblage. Although medical logistics is responsible for maintaining assemblage data in Defense Medical Logistics Standard Support (DMLSS), team chiefs are responsible for ensuring the readiness status of assigned assemblages. **(T-3)**

1.22.8.3. Conduct an inventory of team equipment and supplies annually, and anytime it is used for an exercise or real world event, in accordance with AFMAN 41-209. Medical logistics and/or a contracted logistics inventory team, the team chief and team members

will perform the inventory. The annual inventory requirement may be met with a post-exercise or post-event inventory as long as all required actions are accomplished. **(T-3)**

1.22.8.4. Conduct training for team members and operational testing of assigned response assets once annually, at a minimum, in conjunction with an exercise or inventory. **(T-2)**

1.22.8.5. Units that maintain response assets are not authorized to decrease allowance standard levels but may supplement assigned assets based on threat assessments, medical unit capabilities or limiting factors. Submit requests for increases to response assets to the MRC. Ensure the request is documented in meeting minutes and forwarded to the parent MAJCOM/SGX for final approval. **(T-2)** **Exception**: LRC units may modify assigned assemblages to provide appropriate capability with prior parent MAJCOM/SGX approval.

1.22.8.6. Review AFTTP 3-42.32 annually. **(T-3)**

1.22.9. For LRC units, prepares and maintains unit response procedures and supporting checklists, based on unit capabilities. Individuals designated to provide medical response support to the installation will complete all associated training. **(T-2)**

1.22.10. Reserve medical units that maintain the Bioenvironmental Engineering (886H) assemblage will: **(T-2)**

1.22.10.1. Direct the full time Bioenvironmental Engineering Office to maintain the assemblage (not applicable to Ft. Worth Naval Air Station and Pope Field).

1.22.10.2. Ensure assigned personnel are trained in accordance with this instruction and AFTTP 3-42.32. Members will also be trained to perform health risk assessments and to enter the warm/hot zone using the self-contained breathing apparatus.

1.22.10.3. Collect, package, ensure chain-of-custody, and transport biological samples.

1.23. UTC Team Chiefs or UTC Family Group Leaders.

1.23.1. Assist the commander in verifying that assigned UTC members complete all required training prior to deploying. **(T-3)**

1.23.2. Ensure all assigned UTC members review the UTC tactics, techniques and procedures, mission capability statements, mission essential task lists, training requirements and assigned allowance standards prior to each applicable deployment vulnerability period. Maintain an active MRDSS account and document the review in MRDSS. **(T-3)**

1.24. AFSC Functional Training Managers.

1.24.1. Review new or revised CMRP checklists upon receipt. Follow checklist implementation guidance provided by the specialty consultant, corps director or career field manager. **(T-2)**

1.24.2. If/when CMRP Category I and Category II applies, perform a Category I and Category II training gap analysis annually and anytime training requirements or unit capabilities change. **(T-1)** Gap analyses will identify those training needs which cannot be met within the unit or in the local geographic area thorough a training affiliation agreement or special training event, and require TDY travel/funding. Identifying items as gaps does not

relieve members of completing the training requirements, but may require assistance from the education and training office or the specialty consultant/career field manager. Document the gaps in MRDSS and review gapped items every 90 days to verify if they are still gaps and update the gap analysis date as necessary. **(T-1)**

1.24.3. Develop a plan for assigned personnel to complete Category I and Category II CMRP training, including gapped tasks. **(T-2)**

1.24.4. Conduct or oversee CMRP Category I and Category II training, grant credit for CMRP Category I or Category II training accomplished during technical school for new accessions, and document CMRP Category I and Category II training using the checklists in MRDSS. **(T-1)**

1.24.5. Reference **Chapter 4** of this instruction for additional CMRP guidance.

Chapter 2

THE MEDICAL READINESS OFFICE

2.1. Staffing.

2.1.1. The Medical Readiness Office is the hub of readiness activities at the unit level. Personnel assigned to this office manage programs spanning the full range of global expeditionary medical operations and all-hazards activities, such as installation medical all hazard response, continuity of operations, defense support to civil authorities, and mission assurance. Ideally, there should be a minimum of three full-time personnel assigned to the Medical Readiness Office to meet program requirements. For LRC units, there should be a minimum of two full-time personnel assigned to the Medical Readiness Office. However, local commanders have the flexibility to manage assigned readiness staff as necessary to meet tactical mission needs. For the ARC units, "full-time" refers to traditional reservists/guardsmen filling the Medical Readiness Officer or Medical Readiness NCO roles.

2.1.2. The four primary positions/roles in the Medical Readiness Office are the Medical Readiness Officer or Medical Readiness Manager (if the officer position is filled by a civilian), Medical Readiness NCO, Unit Deployment Manager, and the Medical Emergency Manager. Depending on the size of the facility and scope of the readiness mission, the Medical Readiness Officer may be appointed on a part-time basis. In this instance, a third enlisted member or civilian should be assigned to meet the three-person minimum staffing recommendation.

2.1.3. Due to the high operations tempo in unit Medical Readiness Offices, additional duties, such as security manager, must not be assigned to Medical Readiness Office staff.

Note: Not applicable to ANG unless office personnel are drill status guardsman.

2.1.4. Medical readiness is a core competency for the 041AX officers and the 4A0X1 enlisted personnel. Therefore, Medical Readiness Officers and Medical Readiness NCOs should be individuals who possess those AFSCs, whenever possible. However, these positions may be filled by other AFSCs, as staffing realities dictate.

2.1.5. Unit level medical readiness enlisted personnel may apply to be awarded the 325 special experience identifier if they are assigned to a 325 special experience identifier position on the unit manning document. To be awarded the 325 special experience identifier, individuals must also successfully complete the Medical Readiness Management Course and serve one continuous year in the Medical Readiness Office. Requests for award of the 325 special experience identifier must be coordinated by memorandum through the parent MAJCOM/SGX. **(T-2)** Unit level medical readiness positions are not authorized the "R" AFSC prefix. **Note:** ANG Regional Medical Planners Officer (RMPO) positions may be coded with the "R" prefix.

2.2. Training.

2.2.1. Reg AF personnel assigned to the Medical Readiness Office must successfully complete the Medical Readiness Management Course. The Medical Readiness Officer, Manager and any enlisted personnel assigned to 325 special experience identifier coded positions will attend within six months of assignment to the position. **(T-2)** ARC Medical

Readiness Officers, Managers and NCOs will attend within 18 months of assignment. **(T-2)** All remaining Medical Readiness Office personnel may attend as the course schedule and quotas permit. Personnel should work in the medical readiness office for a minimum of three continuous months prior to attending the Medical Readiness Management Course for optimal learning experience.

2.2.2. Individuals must be assigned to their appointed positions in MRDSS and complete the personnel management and deployment management MRDSS training prior to requesting a Medical Readiness Management Course quota. **(T-3)** Medical Readiness Management Course attendance is scheduled using the Formal Training Management Scheduler in MRDSS, in accordance with the Medical Readiness Management Course scheduling guidance posted on the AF Medical Readiness SharePoint® Site.

2.3. Unit MRDSS System Administrators.

2.3.1. Create unit-level user accounts, reviews and deletes accounts that are no longer required, and ensures positive control of sensitive information contained within the MRDSS. **(T-3)** Larger medical treatment facilities should consider designating a second Unit MRDSS System Administrator in the Education and Training (E&T) office to specifically manage Education and Training accounts.

2.3.2. Contact the parent MAJCOM MRDSS representative for assistance or guidance. **(T-3)**

2.3.3. Provide recommendations for updates or changes to MRDSS to the parent MAJCOM MRDSS representative for consideration by the MRDSS configuration control board. **(T-3)**

2.4. Unit Medical Readiness Training Manager.

2.4.1. Schedules readiness training for assigned personnel. **(T-2)**

2.4.2. Tracks and documents readiness training in MRDSS. **(T-2)** Medical Readiness Management Course and formal UTC courses are scheduled using the Formal Training Management Scheduler function within MRDSS.

2.5. Unit Deployment Manager (UDM).

2.5.1. Manages personnel UTC assignments and ensure those personnel are trained and equipped to accomplish the UTC mission. Medical UDMs will: **(T-2)**

2.5.1.1. Identify personnel to fill UTC positions, in coordination with the unit AFSC functional manager and unit commanders, using the control AFSC for enlisted personnel and duty AFSC for officers. Ensure the best AFSC, grade, and skill level match in accordance with the UTC mission capability statements, the Medical Supplement to the War Mobilization Plan Volume 1, and AFI 10-403. Make personnel UTC assignments and update deployment preparedness information using MRDSS.

2.5.1.2. Update duty status changes for UTC personnel in MRDSS. The MRDSS expired deployment availability code report should be run monthly to verify currency of personnel deployment availability codes.

2.5.1.3. Provide newly assigned UTC members with a copy of applicable UTC tactics, techniques and procedures, manpower force element listing, training requirements, allowance standards, and a copy of **Attachment 2** of this instruction (electronic copies are acceptable).

2.5.1.4. Conduct pre-deployment activities, to include:

2.5.1.4.1. Verifying the individual duty status and deployment availability to determine if tasked individuals are available to deploy (e.g., there are no discriminating legal, security, medical, or administrative factors that may render the member ineligible to deploy).

2.5.1.4.2. Updating the tasked members' anticipated deployment date and estimated tour length in MRDSS. Update the data if/when changes occur (e.g., if the individual ultimately deploys on a different date or the deployment is cancelled).

2.5.1.4.3. Scheduling and/or monitor completion of pre-deployment training.

2.5.1.5. Conduct post-deployment activities, to include:

2.5.1.6. Obtaining any training documentation from returning deployers.

2.5.1.7. Updating the individual deployment return date in MRDSS.

2.5.1.8. Notifying AFSC functional training managers and installation medical all hazard response team chiefs of returning deployers.

Note: Refers to AFI 10-401, AFI 10-403, and the Installation Deployment Plan for additional UDM guidance.

2.6. Additional Medical Readiness Office Functions.

2.6.1. Conducts unit planning activities. **(T-3)**

2.6.1.1. Manages the preparation, coordination, publication, and distribution of the MCRP in accordance with **Chapter 3** of this instruction.

2.6.1.2. Develops, coordinates and maintains copies of installation medical all hazard response mutual aid agreements.

2.6.1.3. Reviews installation plans to ensure medical unit roles and capabilities are included.

2.6.2. Conducts medical readiness in- and out-processing in MRDSS for assigned personnel. **(T-2)** Develops an in-processing checklist that includes: UTC assignment and deployment requirements; installation medical all hazard response team assignments and training requirements; names and contact information of assigned installation medical all hazard response and UTC team chiefs and AFSC functional training managers; and a review of the individual's current training status and requirements.

2.6.3. Manages weapons authorizations for assigned UTCs in accordance with the Weapons and Munitions Forecasting Table posted on the AF Medical Readiness SharePoint® Site. **(T-3)**

2.6.4. For pilot units, maintains pilot unit program management oversight and acts as liaison to the MEFPAK Responsible Agency. **(T-2)**

2.6.5. Provides oversight of the Response Training and Assessment Program, establishing preparedness priorities and assisting the Wing Inspection Team Medical Representative in the development of exercises using capability-based objectives. **(T-3)**

2.6.6. Provides oversight and support to Installation Medical All Hazard Response Team Chiefs. Appoints team members using MRDSS. **(T-2)**

2.6.7. Maintains the medical readiness training and exercise schedule, incorporating all training and exercise requirements in this instruction, as well as readiness training and exercises under installation purview. **(T-2)** This planning tool may be adjusted as training and exercise opportunities become available or change. There is no prescribed format for the medical readiness training and exercise schedule, however a recommended template is provided on the AF Medical Readiness SharePoint® Site. The schedule should be flexible and incorporate all readiness training requirements listed in this instruction, as well as other AFIs, and provides a comprehensive list of all planned exercises for a period of 24 months. All planned exercises that require individual or unit participation should be included in the medical readiness training and exercise schedule. Use the wing/base exercise schedule as a starting point to capitalize on available exercise opportunities and avoid conflicts in planning.

> 2.6.7.1. Coordinates the medical readiness training and exercise schedule with MCRP team chiefs, AFSC Functional Training Managers, and the Wing Inspection Team.

> 2.6.7.2. Presents the schedule to the MRC for approval prior to the end of the calendar year, and whenever changes are made. **Note:** Deployed MTFs are not required to maintain a medical readiness training and exercise schedule.

2.6.8. Manages the MC-CBRN budget, in coordination with medical logistics and the resource management office, and in accordance with guidance in AFMAN 41-120, *Medical Resource Management Operations*, and AFTTP 3-42.32. **(T-2)** For ANG units, the MC-CBRN funding is through PE 58036F. For AFRC units, funding for 886H assets is provided through PE 58211F.

2.7. Medical Readiness Decision Support System (MRDSS). MRDSS provides enhanced global visibility of medical materiel, personnel, and their training to allow for the efficient management and deployment of those assets. MRDSS is the official system of record for the management of expeditionary medical personnel and readiness resources for the AFMS. It is the single authoritative source for medical readiness training for all medical personnel and for UTC posturing. The governing directive for MRDSS use is this instruction.

> 2.7.1. Access. Only authorized medical personnel, units, and other individuals requiring access for official use, are granted access to MRDSS. The data it contains will not be released nor provided in whole or in part outside the AFMS or supporting agencies without prior approval by the content owner, AF/SG3/4X.

> 2.7.2. Classification. Data contained within MRDSS is considered for official use only (FOUO). Although it contains the raw statistical data used to compile classified force readiness reports, it does not contain, report, collect, or display all the data elements for a UTC, nor does it include supporting remarks or allow for unit commander assessment of the ability of a unit, UTC or installation to perform its missions.

> 2.7.3. Data Currency. The Medical Readiness Office will ensure the accuracy and currency of MRDSS data at all times. **(T-1)**

Chapter 3

MEDICAL CONTINGENCY RESPONSE PLAN (MCRP)

3.1. Purpose.

3.1.1. The MCRP is the Medical Unit Commander's plan to support installation response to emerging threats, major accidents, natural disasters, conventional attacks, terrorist attacks including small or large scale CBRN attacks. The plan also addresses deployment support activities, emergency preparedness, mitigation, emergency response, and installation recovery following an incident.

3.2. Content.

3.2.1. All MCRPs will include the items listed in **Table 3.1** in the basic plan and the annexes in **Table 3.2.** **(T-2)** Additional annexes and guidance may be included as necessary, based on the unit mission, capabilities, vulnerabilities and threats specific to the installation.

3.2.2. To capitalize on common efficiencies and optimize planning and execution, MCRP annexes should mirror the Installation Emergency Management Plan structure. Reference AFI 10-2501 and AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures,* for installation plan guidance. Annexes should also include prepare, response and recovery common core activities, as applicable, to identify specific unit actions to threats listed in **Table 3.2.**

Table 3.1. Basic Plan.

Title	Describes
General Instructions	Organizational structure, conditions of execution, references, and assumptions
Planning Factors	Description of the factors used in planning for a medical response. Some items that may be included are population at risk, unit designation (inpatient/outpatient) and other things such as capabilities and hours of operation; how the unit partners with the community as part of the hospital coalition or consortium
Preparedness/Mitigation	Procedures for augmenting supplies, equipment and personnel during emergencies; actions the unit will undertake to mitigate or the retrofitting measures before disasters to lessen the severity or impact a potential disaster may have on its operation; plans for use of SG05 and SG06 supplies and pharmaceuticals. Outline the roles of the Medical Emergency Manager and Public Health Emergency Officer in preparedness and mitigation
Internal & External Coordination	Unit (internal) coordination and installation response partners (external); mutual aid agreements and other pre-coordination activities with local hospitals and community response partners

Title	Describes
Command and Control	Organizational structure used for response (Incident Management System/Incident Command System); roles of the Medical Emergency Manager and Public Health Emergency Officer
Communication	Information flow and procedures for command and control including: internal/external communication, reporting requirements, maintaining situational awareness, operating log of events and preparing/submitting input for the common operating picture
Recovery	Procedures for an orderly return to normal operations; roles of the Medical Emergency Manager and Public Health Emergency Officer in recovery activities
Recalls	Recall response standards, procedures for activation and assembly
Medical Continuity of Operations	Procedures for medical continuity of operations, to include functions of the Information Systems Disaster Response Team. List and prioritize mission essential functions. Do not include potentially classified information

Table 3.2. Minimum Required MCRP Annexes.

Annex	Describes
A – Major Accidents	Procedures for response to major accidents, such as nuclear weapons accidents, hazardous materials spills, aircraft accidents, fires, etc. as appropriate based on local vulnerabilities/threats specific to the installation; activation of installation medical all hazard response teams
B – Natural Disasters	Procedures for response to natural disasters, such as earthquakes, wildfires, extreme heat and cold, hurricanes, tornadoes, floods, etc. as appropriate, based on local vulnerabilities/threats specific to the installation; activation of installation medical all hazard response teams
C – Enemy CBRNE Attack	Procedures for units in medium and high threat areas. Not applicable to units in low threat areas unless directed by the MAJCOM.
D – All Hazards	Actions based on the all hazards risk management process. Reference AFI 10-2501 for more information
E – Internal Emergencies	Procedures for responding to internal facility emergencies, such as fire, power outage, structural damage, flooding, active shooter, hostage/combative person, evacuation, shelter-in-place, hazmat spill, patient surge, infant/child abduction, and bomb threat. Refer to medical continuity of operations procedures outlined in the basic plan.

Annex	Describes
F – Patient Support and Casualty Management	Maximum anticipated patient population during contingencies, projected changes in availability of medical services, including curtailment of routine services, and patient redistribution
	For inpatient medical treatment facilities, casualty management procedures for specific work centers, to include casualty flow within the facility and transportation of casualties to the medical treatment facility. Additionally, describe patient administration tracking procedures for patients transferred/sent to other facilities.
	For outpatient units, field treatment/expedited transfer procedures from the incident site and patient administration tracking procedures for patients dispersed to downtown facilities
	The facility's aeromedical evacuation role, including procedures to be used in the event of an unanticipated diversion of aeromedical evacuation missions to the base, or the unplanned requirement to support patients, both inpatient and outpatient, remaining overnight.
Z – Distribution	See paragraph 3.8

3.3. Installation Medical All Hazard Response Planning.

3.3.1. Establish installation medical all hazard response teams based on local capabilities and mission requirements. **(T-2)** A list of standard teams assembled from multiple flights or functional communities that perform roles outside of normal duties is provided in **Table 3.3** Additional local teams may be created based on unique unit capabilities, threats and missions.

3.3.1.1. If a unit maintains installation medical all hazard response assets, they must form the corresponding team, as listed in **Table 3.4. (T-2)** Exceptions include the pharmacy and bioenvironmental engineering, who typically respond as a flight or duty section. The pharmacy is responsible for providing pharmaceuticals for immediate medical response and integrating supplies from the 886E assemblage into the field response and clinical team assets (includes 886J, 886K and 886L assemblages). The pharmacy also provides oversight on the use of SG06, pandemic influenza pharmaceuticals.

3.3.1.2. Team chiefs will prepare response checklists for their teams, validate checklist adequacy as part of an exercise, and review them annually. **(T-3)** Checklists should be maintained separately from the MCRP to facilitate updates.

3.3.1.3. Units that are not required to prepare a MCRP will develop and maintain response checklists in support of installation emergency response plans. **(T-3)**

3.3.2. Team chiefs will maintain assigned assets in accordance with AFMAN 41-209. Assemblages must be easily accessible, properly stored and operational at all times. Deviations to assigned standard response assets must be coordinated with the parent MAJCOM. **(T-2)**

Table 3.3. Standard Installation Medical All Hazard Response Teams.

Team	Functions
Medical Control Center	- Medical unit communication and coordination focal point; - Maintain events and casualty status logs; - Track casualties, patients, manpower, equipment and supplies through the entire event lifecycle, as required.
Laboratory Biological Detection Team	- Identify biological agents of concern in environmental samples (not applicable to units that do not maintain the 886I assemblage); - Minimum team composition is a laboratory officer or civilian equivalent (team chief) and one enlisted 4T lab tech or civilian medical laboratory technician; - This team is required if the unit maintains the 886I assemblage for CBRN incident response.
Information Services Disaster Response Team	- Support medical continuity of operations by reacting to disasters or downtime, preventing, and detecting data loss or compromise from further intrusion, recovering and maintaining information systems, and coordinating with outside agencies to restore critical systems; - Assess damage to information systems hardware, software, and data; - Notify various agencies (e.g., AF Computer Emergency Response Team, MAJCOM, Legal Office, Public Affairs, etc.); - Ensure the unit meets current information operations condition levels checklists; - Deny access to or shutting down vulnerable systems; and maintaining and prioritizing a list of critical systems and associated administrators of those systems. **Note:** This team may be combined with the Medical Control Center Team.

Team	Functions
Triage Team	- Primary team - provide triage of patients arriving at the medical treatment facility; - Secondary team - provide re-triage after patient decontamination, when activated; - Team is required if the unit maintains the 886K assemblage for CBRN incident response.
Clinical Team	- Provide patient support and casualty management; - Receive, provide, or arrange for medical treatment of patients; - Establish procedures to safely manage patients within the facility. In facilities where there is adequate staffing to support separate Minimal, Delayed and Immediate Teams, separate teams may be formed. In this situation, the immediate team chief is responsible for the 886L, SG05 and SG06.
Patient Decontamination Team	- Provide patient decontamination prior to entry into the medical treatment facility or transport to another medical facility; - Team is required if the unit maintains the 886A assemblage for CBRN incident response.
Disaster Mental Health Team	- Provide mental health services to patients and families, hostage negotiation consultation as well as support for first and emergency responders; Reference AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*, for additional guidance.
Manpower and Security Team	- Support wing/installation terrorist threat response and carry out force protection condition actions for the medical facility; - Deployment and management of manpower team members during an emergency; - The Manpower and Security Decontamination Support Team is a sub-team of this team that is specifically designated and trained to support patient decontamination operations; - Team is required if the unit maintains the 886M assemblage for CBRN incident response.

Team	Functions
Patient Support and Casualty Management	- Responsible for patient dispersions when necessitated by events such as unit deployment, natural disasters, facility damage, casualty overload; - Provide treatment and stabilization in order to save life, limb or eyesight, prevent increasing injury or disability while awaiting transport to the next level of definitive care.

3.3.3. **Table 3.4** lists installation medical all hazard response assets, which exceed those necessary for normal day-to-day operations for Reg AF units. These assets may also be used to support an influx of patients, or to supplement response capabilities. **Table 3.5** applies to ANG units only.

Table 3.4. Regular AF Installation Medical All Hazard Response Assets.

Assemblage	Used by:
886A, Patient Decontamination[1]	Patient Decontamination Team
886E, Pharmacy Response	Pharmacy
886H, Bioenvironmental Engineering	Bioenvironmental Engineering
886I, Laboratory Biological Detection	Laboratory Biological Detection Team
886J, Field Response	Field Response Team
886K, Triage	Triage Team
886L, Clinical	Clinical Team
886M, Medical Manpower/Security[2]	Manpower/Security Team
886P, Public Health	Public Health
[1] Ensure sufficient additional personnel are appointed and trained to support continuous operations and team member work/rest cycles. The 886A assemblage has sufficient personal protective equipment for up to 24 personnel. [2] An additional manpower/security decontamination support team may be established if necessary.	

Table 3.5. Air National Guard Installation Medical All Hazard Response Assets.

Assemblage	Responsible Team Chief	Assigned to	Team Composition
976A, Patient Decontamination[1]	Patient Decontamination	Non-collocated ANG units. Collocated units will be assigned	1 full-time medical AFSC and 11 full-time non-medical AFSCs

Assemblage	Responsible Team Chief	Assigned to	Team Composition
	Team Chief	to support Reg AF host unit teams as needed	team members
976H, Bioenvironmental Engineering	Bioenvironmental Engineering Flight Chief	ANG units who have Bioenvironmental Engineering Staff	All full-time Bioenvironmental Engineering staff
976K, Triage	Triage Team Chief	Materiel only, no personnel	No manpower, materiel for responders only
976P, Public Health	Public Health Flight Chief	ANG units with Public Health Staff	All full-time Public Health staff
1 Ensure sufficient additional personnel are appointed and trained to support continuous operations and team member work/rest cycles. The 886A assemblage has sufficient personal protective equipment for up to 24 personnel.			

3.4. Special Planning Considerations.

3.4.1. LRC units and deployed medical treatment facilities are not required to prepare an MCRP. However, these units will conduct a realistic assessment of their installation medical all hazard response capabilities and incorporate associated procedures into the Installation Emergency Management Plan or equivalent. **(T-2)** Clearly identify the unit's capabilities, roles and responsibilities in support of a collaborative installation response, including support agreements, as appropriate. Ensure assigned personnel are trained and record this training in MRDSS. Local team training requirements may be added to MRDSS for tracking purposes. Contact the MRDSS Help Desk for assistance.

3.4.2. ARC and aeromedical evacuation units collocated with a Reg AF medical units are considered available medical resources and may, with prior coordination, be included in the MCRP as such.

3.4.3. Units in multi-service or multi-unit areas (e.g., San Antonio or Colorado Springs) will develop an integrated MCRP. Integrated MCRPs will outline procedures for a unified response to a citywide event or incident, interaction between units and with local emergency management officials, as well as training and response asset maintenance. **(T-2)**

3.5. Medical Continuity of Operations.

3.5.1. Medical continuity of operations involves the evacuation and dispersal of patients from the medical treatment facility as rapidly and safely as possible, temporarily staging them in a pre-designated location if necessary, and providing continued medical care only until dispersal activities are complete. Medical continuity of operations does not include relocating vast amounts of supplies and personnel to an alternate location for the purpose of

continuing routine patient care, although units that have the capacity or responsibility to continue to provide routine services installation populations should plan to do so.

3.5.2. Core mission essential functions that must be addressed in the MCRP include: command, control, communications, computers and information, to include relocation and continuity of medical command and control, as well as information sharing with beneficiaries, staff, and higher headquarters; patient support, to include facility evacuation, dispersal, transportation, tracking, and pandemic response, at a minimum; staff support, to include evacuation, dispersal, and accountability; medical response activities, to include critical installation support. **(T-0)** Units may add additional mission essential functions based on unique missions, capabilities, and beneficiary population needs. List and prioritize all mission essential functions in the MCRP. **(T-0)**

3.5.3. Reference AFI 10-208, *Continuity of Operations (COOP) Program*.

3.6. Coordination.

3.6.1. All offices and agencies tasked to support installation medical all hazard response must coordinate on the MCRP. **(T-2)** The coordination process begins with an internal unit review, followed by external agencies, resulting in a draft plan for MAJCOM review. If unable to obtain coordination from an off-base agency, use a memorandum for record to document attempts to gain formal coordination. **(T-3)**

3.6.2. Submit a copy of the draft MCRP to the parent MAJCOM/SGX for review prior to publication, after all coordination with other agencies has been completed and the plan has been approved by the MRC. **(T-3)** MAJCOM/SGXs will accomplish plan reviews within 60 days; concurrence is implied if no MAJCOM comments are received within that period.

3.6.3. Once all required coordination and the MAJCOM review are completed and all associated comments adjudicated, the MCRP is presented to the unit commander for final approval and signature. Ensure the date of approval is captured in the minutes from the next scheduled MRC meeting. **(T-2)**

3.7. Review.

3.7.1. The MCRP and supporting checklists must be reviewed annually by installation medical all hazard response team chiefs and the MRC. Incorporate any necessary changes and document the review in the committee minutes. **(T-3)**

3.7.2. The MCRP will be rewritten every three years, or when there is significant change in unit or wing missions or capabilities, whichever occurs first. **(T-2)**

3.7.3. Coordinate all changes with all affected agencies and distribute them according to the original plan distribution. **(T-3)**

3.8. Distribution.

3.8.1. Distribute copies of the MCRP and appropriate checklists to each organization that plays a role in its execution. **(T-3)**

3.8.2. The Medical Readiness Office will maintain additional copies for the alternate command and control location and the installation emergency operations center, as appropriate. **(T-3)**

3.9. Support Agreements. Support to the unit from off-base agencies must be coordinated in the form of a support agreement, in accordance with AFI 25-201, *Intra-Service, Intra-Agency, and Inter-Agency Support Agreements Procedures*. **(T-2)** Do not duplicate existing agreements and contracts.

Chapter 4

COMPREHENSIVE MEDICAL READINESS PROGRAM (CMRP)

4.1. Training Philosophy.

4.1.1. The CMRP divides medical readiness training into categories that allow for the application of requirements to specific specialties, personnel, and missions across the full spectrum of AF military medical operations. Category I, Clinical Currency, and Category II, Readiness Skills Training, are levied using CMRP checklists developed by specialty consultants, corps directors and career field managers. Category III, UTC Training, is levied using the Category III Guide maintained on the AF Medical Readiness SharePoint® Site. Category IV, installation medical all hazard response training, consists of standardized training required for all like teams across the AFMS as well as unit-specific response training.

4.1.2. A list of training requirements that may be met through attendance of formal courses, such as Basic Medical Readiness Training and Commissioned Officer Training, is provided in the Medical Readiness Training Equivalency Matrix on the AF Medical Readiness SharePoint® Site, in the AFI 41-106 Toolbox.

4.2. Initial Medical Readiness Training.

4.2.1. Airmen are trained to initial proficiency upon entry into the AF, or join the AF with verifiable AFSC-specific credentials. Enlisted personnel receive initial medical readiness training through Expeditionary Medical Readiness Course or Basic Expeditionary Medical Readiness Training, in conjunction with their AFSC-awarding courses. Officers receive initial medical readiness training through Commissioned Officer Training, which includes Total Force Officer Training, Reserve Commissioned Officer Training courses, or a commissioning program such as the service academy or Reserve Officer Training Corps

4.2.2. Curricula for these courses provide the initial medical readiness training elements listed in **Table 4.1** at a minimum.

Table 4.1. Initial Medical Readiness Training Topics.

Training Element	Description
Air Expeditionary Force Concept/Structure	Familiarization of current air expeditionary force concepts
The Deployment Cycle	Phases of deployment, pre-deployment, initial deployment, build up, sustainment, termination/re-deployment
Combat Stress Control	Signs and symptoms of stress, treatment and assistance

Training Element	Description
AFMS Concept of Operations	AFMS mission, DoD medical capabilities, joint operating concepts, medical support for stability operations, homeland defense and defense support of civil authorities, threats and potential battlefield environments (including site security, law of war and the Geneva Conventions, force protection, anti-terrorism measures)
Casualty Movement	Casualty evacuation concepts, litter carries, aeromedical evacuation familiarization
Shelter Assembly	Unpacking, erecting, tearing down and repacking the shelter system as well as site clean-up
Field Sanitation and Hygiene, Disease Prevention	Occupational and environmental hazards, diseases and countermeasures, waste disposal, force health surveillance
Installation Medical All Hazard Response	Medical emergency management and response utilizing an all hazards approach, public health emergencies, MCRP and local support agreements

4.3. Non-standard Training Situations.

4.3.1. Training while deployed. Personnel are required to be fully trained prior to deployment. Therefore, deployed units are not expected to conduct medical readiness training. However, personnel should take full advantage of any training opportunities provided, to include joint training with coalition partners, sister services, and host nation medical forces. Upon return to home station, members may request credit for training accomplished during deployment, with appropriate documentation.

4.3.2. Students. Individuals in "student" status, for the purposes of this instruction, include: students, interns, residents, fellows, and those enrolled in Health Professions Scholarship Program or similar programs. Members in a student status are exempt from all medical readiness training requirements. However, participation in local readiness training events and exercises is highly encouraged.

4.3.3. Institutional Forces. Personnel assigned to higher headquarters, such as a MAJCOM and the Air Staff will complete the CMRP requirements identified in this instruction when assigned to a standard deployable UTC, or when tasked to deploy.

4.4. Training Documentation .

4.4.1. All medical readiness training will be documented in MRDSS. **(T-2)** Medical personnel who do not work within a medical unit (e.g., Squadron Medical Element personnel) are tracked in MRDSS by associating their unit's personnel accounting system code (PASCODE) with the supporting medical unit within MRDSS. Doing so will ensure personnel do not affect unit training statistics. For remotely located medical personnel (e.g., recruiters), the nearest medical unit will assume responsibility for tracking their training. **(T-3)** **Exception:** AF Special Operations Command (AFSOC) Operational Support Medicine Flights and AFSOC medical personnel assigned to Special Tactics Groups/Squadrons track their own training in MRDSS.

4.4.2. Electronic Training Record. Prior to enlisted member deployments, AFSC functional training managers will review and print CMRP checklists and AF Form 1098, *Special Task Certification and Recurring Training*, and upload these documents into the member's electronic training record. **(T-3)** Upon the member's return to home station, the AFSC functional training manager will annotate relevant training accomplished during the deployment in the electronic training record and upload any additional documentation provided by the member. **(T-3)**

4.5. CMRP Category I, Clinical Currency for Readiness.

4.5.1. Clinical Currency for Readiness is defined as fundamental clinical skills, usually obtained through medical education and in-garrison care, that form the foundation of the CMRP and applies to all medical personnel with clinical specialties who are required to have up-to-date clinical skills. Clinical currency tasks are defined by specialty consultants and career field managers and may involve tracking the number of patients or procedures (volume, acuity, and diversity) to advance along the currency continuum. There are multiple venues for maintaining clinical currency including, but not limited to, local training affiliation agreements, SMART regional currency site and C-STARS.

4.5.2. For 3-level officers and above, and 5-level enlisted members and above with Category I requirements, Category I training must be current at all times. **(T-1)** Any Category I training that will expire during a deployment vulnerability period must be re-accomplished prior to entry into the deployment vulnerability period. Likewise, any licenses, credentials or certifications that will expire during a projected deployment vulnerability period must be re-accomplished or renewed prior to entering the deployment vulnerability period. **(T-1)**

4.5.3. Privileged providers and non-privileged medical professionals will also follow AFI 44-119, *Medical Quality Operations,* and AFI 44-102, *Medical Care Management* and DHA policies. Representatives from the Education and Training office will validate and track Education and Training requirements for military members, civilians, and assigned contractors in MRDSS. **(T-2)** Larger facilities may designate an MRDSS Unit System Administrator in the Education and Training office specifically to manage Education and Training office accounts.

4.6. CMRP Category II, Readiness Skills Training.

4.6.1. Readiness Skills training is the AFSC-specific skills that allow an Airman to perform the full scope of duties associated with their specialty in a deployed setting. Personnel will complete Category II training for their control AFSC for enlisted or duty AFSC for officers. **(T-2)** Contact the appropriate specialty consultant or corps director to determine Category II training requirements for commanders on G-series orders.

4.6.2. Personnel who are not assigned to a standard deployable UTC, but who are assigned to a Type I or Type II unit and possess a critical AFSC, or an AFSC that is required on a standard deployable UTC at that unit, will complete Category II training. **(T-2)** Reference the CMRP matrix on the AF Medical Readiness SharePoint® Site for unit types.

4.6.3. Personnel who do not meet the criteria described in **paragraph 4.6.1** or **4.6.2** will accomplish Category II training just-in-time, upon receipt of a deployment tasking, unless directed otherwise by the specialty consultant, corps director, or career field manager. **(T-2)**

4.6.4. Personnel who are utilized as authorized substitutes on a standard UTC will complete Category II training for the AFSC they are filling on the UTC, in addition to Category II training required for their own AFSC. **(T-2)** Waivers or exemptions to this policy must be approved by the specialty consultants, corps directors or career field managers for both AFSCs. In addition, specialty consultants, corps directors or career field managers may provide additional guidance or training requirements for unique substitution circumstances. **Exception**: For UTCs that allow AFSC neutral substitutions (e.g., FFGLB, FFDDR and FFHSR), and National Guard Bureau approved substitutions on FFGK2 and FFGK3, substitutes complete Category II training for their own AFSC only.

4.6.5. For personnel required to complete Category II, the training must remain current at all times, according the frequency identified on the CMRP checklist. Any Category II training that will expire during the individual's deployment vulnerability period must be re-accomplished prior to entering the deployment vulnerability period. **(T-2)**

4.7. CMRP Category III, UTC Training.

4.7.1. UTC Training is specific to a UTC and enables personnel assigned to the UTC to accomplish its mission. UTC formal courses provide the training elements listed in **Table 4.2** at a minimum.

Table 4.2. Minimum UTC Formal Course Curricula Requirements.

Training Element	Description
Threats and potential battlefield environments	Disease prevention; field sanitation and hygiene; operations in a CBRN environment
Operational concepts of operations	AFMS mission, DoD medical service capabilities, medical support of stability operations; homeland defense and defense support of civil authorities; potential battlefield environments
Operational command, control, and communications	Activities that use information systems to facilitate day-to-day operations in support of expeditionary missions, including the use of radio communications, information management/ information technology
Preventive medicine, including field sanitation and hygiene	Personal hygiene, food and water handling, waste disposal (human and medical); operational measures for countering endemic disease; prevention of non-battle injuries; countering disease vectors in field and urban environments; environmental health threats; force health surveillance
Combat stress control	Familiarization with basic principles of combat stress control; leadership, communication, unit morale and cohesion, and individual psychosocial stressors, associated with deployment
Identification and treatment of endemic infectious diseases	Recommended immunizations and prophylaxis prior to deployment; endemic infectious diseases; partner nation medical systems and local resources

Training Element	Description
Identification and treatment of traumatic injuries	Clinical aspects of medical management of casualties and disease non-battle injuries; gunshot wounds, vascular, neurological, orthopedic, maxillofacial, and hypo/hyper thermal stress injuries; burns, bandaging, and splinting; hypovolemic shock; eye injuries; use of blood products
Recognition and management of chemical, biological, radiological, nuclear, and explosive injuries	Expected injuries/illnesses; moving CBRN patients through the deployed facility in a safe, effective manner

4.7.2. Personnel assigned to standard deployable UTCs will complete Category III initial and sustainment training in accordance with the following paragraphs and the Category III guide posted on the AF Medical Readiness SharePoint® Site. **(T-2)** All required Category III training will be accomplished prior to, and must remain current throughout, an individual's deployment vulnerability period. Any training that will expire during a deployment vulnerability period must be re-accomplished prior to entering the deployment vulnerability period. Personnel who are required to maintain a high state of readiness (assigned an air expeditionary force indicator of YR) will complete training no later than six months after assignment to the UTC. **(T-2)**

4.7.2.1. Personnel who are not assigned to a standard deployable UTC but are tasked to deploy on one must complete all Category III training for the tasked UTC prior to deployment. **(T-2)**

4.7.2.2. Personnel assigned to a standard UTC who have attended a UTC formal course will remain on that UTC for a minimum of 36 months. Exceptions are separation/retirement, permanent change of station, long-term medical profile/deferment, pending medical, legal or administrative action would otherwise disqualify the member from a deploying. **(T-3)**

4.7.2.3. For UTCs that do not have a formal UTC course, Category III training consists of reviewing the UTC tactics, techniques and procedures, mission capability statements, mission essential task lists, and assigned allowance standard.

4.7.2.4. Individuals assigned to UTC FFCCT and FFTCT will also meet all requirements outlined in AFTTP 3-42.51, *Critical Care Air Transport Teams*. **(T-1)**

4.8. CMRP Category IV, Installation Medical All Hazard Response Training.

4.8.1. Installation medical all hazard response training is part of the readiness currency continuum conducted at the unit, and ensures members are proficient with assigned equipment and can execute assigned response duties. Training is required for all members assigned to support installation medical all hazard response, and will be tailored to the mission and unit capabilities. **(T-2)** At a minimum, training will include familiarization with plans and procedures, response checklists, and assigned equipment using the response training and assessment program tools. **(T-2)** Sustainment training is accomplished annually and includes hands-on refresher training with assigned equipment and the demonstrated proficiency on the wear of required respiratory protection.

4.8.2. Hazardous materials training requirements established by AFI 10-2501 and Occupational Safety and Health Administration best practices is required for First Receivers and First Responders on an annual basis. **(T-2)** This training is implemented in the AFMS as follows:

4.8.2.1. Enhanced First Responder Awareness. This training is a hazardous materials first responder awareness course designed specifically for the Field Response Team, ambulance drivers, and Disaster Mental Health Team.

4.8.2.2. First Receiver Awareness. This training is a hazardous materials first responder awareness course designed specifically for medical first receivers. First receiver awareness training is required for all personnel who work in the medical facility who may have contact with contaminated patients, their belongings, equipment, or waste. The commander may use discretion in deciding if personnel who aren't likely to come in contact with patients, require this training. Bioenvironmental engineering personnel are not required to accomplish this training.

4.8.2.3. Combined First Receiver Awareness and Operations Training. This training is a combined hazardous materials first receiver awareness and operations course and is required for personnel who have a designated role in or around the decontamination zone outside the medical facility. Members must successfully complete both the didactic and hands-on training with personal protective equipment to meet the initial training requirement. Annual requirements can be met with a demonstration of competencies during an exercise, tactical drill or real-world response.

4.8.2.4. Hazardous Materials First Responder Operations. All bioenvironmental engineering personnel require hazardous materials operations level training and DoD certification.

4.8.3. All personnel required to utilize respiratory protection will be enrolled in the respiratory protection program in accordance with AFI 48-137, *Respiratory Protection Program*. **(T-0)**

4.8.4. Laboratory Biological Detection Teams maintaining polymerase chain reaction analyzers will have at least two members current in the requirements for each assigned asset at all times. Requirements include completion of the corresponding formal course (one-time only) and compliance with the proficiency/competency program every 12 months by each member. **(T-1)**

Chapter 5

EXERCISES

5.1. Exercise Requirements.

5.1.1. Non-medical exercise requirements, listed in AFI 90-201, are met by participating in installation exercises. If the installation does not accomplish all exercises listed in AFI 90-201, medical units are not expected to accomplish them independently. However, if installation exercises that are conducted do not adequately test the medical unit's capabilities (for example, the exercise stops at the entrance to the medical facility), develop internal exercise scenarios to supplement or extend the exercise to adequately test medical unit procedures. **(T-3)** Make every effort to maximize participation in exercises while minimizing disruptions to patient care.

5.1.2. The following are medical-specific exercise requirements:

5.1.2.1. Recalls.   Recall exercises demonstrate the unit's ability to respond to a contingency situation. Acceptable recall response standards are generally established by the installation. If no installation standard exists, the MRC will establish the standard. Conduct each of the following recall types at least once annually: Installation Medical All Hazard Response Teams, UTCs, deployment support teams, and unit-wide. The unit-wide recall may alternate annually between remote reporting (such as by telephonic voice or text only) and report-to-duty. Recalls may be combined with other exercises, as appropriate. **Note:** While communication outage recalls are not required, units should identify a communication loss strategy in the MCRP.

5.1.2.2. Installation Medical All Hazard Response. Units that publish MCRPs are required to conduct installation medical all hazard response exercises twice annually. **(T-0)** Units that do not publish MCRPs, but provide input to equivalent installation response plans, must also exercise this capability in concert with installation exercises. **(T-0)** Exercise scenarios may be combined as part of a comprehensive exercise, as functionally appropriate to support realistic scenarios and response. Scenarios should address likely vulnerabilities, to include information technology and power outages, and must support the assessment of logistics, human resources, training, policies, procedures, and protocols. Incorporate tasks from the unit's core mission essential task list in the defense readiness reporting system (DRRS) into exercise objectives and evaluation criteria, to the greatest extent possible.

5.1.2.2.1. At least one of the two annual installation medical all hazard response exercises must include an influx of simulated patients in sufficient numbers to adequately test the organization's resources and reactions under stress. **(T-3)**

5.1.2.2.2. At least one of the two annual installation medical all hazard response exercises will be designed as an escalating event in which the local community is unable to provide support. Tabletop exercises are acceptable in meeting the community portion of this exercise. **(T-3)** 5.1.3. Comply with after action reporting and documentation requirements in accordance with **paragraph 6.4** of this instruction for all exercises. **(T-3)**

5.2. Exercise Credit.

5.2.1. Medical units may take exercise credit for a real world response of similar scope and magnitude to the exercise requirement. For example, a real world response to a bus accident with multiple casualties utilizing several installation medical all hazard response teams may satisfy a major accident exercise requirement.

5.2.2. Credit may be taken only when objectives are met for the specific exercise type and must be approved by the MRC. **(T-3)**

5.3. Special Exercise Considerations.

5.3.1. LRC units will work with their wing/base/installation IG (or equivalent) to determine the best way to conduct required exercises. Exercises should be combined with sister service or wing/base/installation exercises to the greatest extent possible. Exercise scenarios must be developed collaboratively to test medical response capabilities as they would realistically be employed. **(T-3)**

5.3.2. Deployed Medical Treatment Facilities are not expected to plan or conduct large-scale exercises on their own; however, they will conduct a unit-wide recall, or personnel accountability exercise, every three months. **(T-3)**

Chapter 6

READINESS REPORTING

6.1. Resource Readiness Reports.

6.1.1. Resource readiness reporting is accomplished using the AF input tool in DRRS. Medical units report personnel (total and critical), training, equipment and supplies on-hand in accordance with the AF tables in DRRS and AFI 10-201. Medical training and equipment and supplies data is fed to the AF input tool by MRDSS.

6.1.2. Medical unit commanders (or senior designee) will review and submit the resource readiness report in accordance with AFI 10-201. For ARC commanders who are unable to personally submit the report, the unit administrator will print out a copy of the easy read and obtain the commander's signature on it for their records. Retain the signed easy read for the current plus two previous years. **(T-2)**

6.2. Capability Readiness Assessments.

6.2.1. Capability readiness assessments are accomplished in DRRS and focus on the full scope of the unit's mission assessed against mission essential tasks. Unit commanders will assess unit mission capabilities in accordance with AFI 10-201, and the following: **(T-2)**

6.2.1.1. For deployment mission essential tasks, consider the deployability, availability, and training of personnel assigned to deployable UTCs and readiness of assigned war reserve materiel. War reserve materiel maintained for other units will be assessed by those units.

6.2.1.2. Units with more than one instance of a UTC will assess the mission as a whole.

6.2.1.3. For units with fragmented (shared/split) UTCs, the parent/supported unit, as the "owner" of that mission, assesses the capability as a whole. Supporting units (those providing UTCs or manpower to another) will not assess their portion(s) of that mission in their capability readiness assessment. **Note:** This is different from resource readiness reporting, in which a unit reports on the readiness of all assigned resources.

6.2.1.4. For in-place/generation/installation medical all hazard response missions, consider the availability of all assigned unit personnel, to include military members, civilians, and contractors who support the mission, as well as their required training (e.g., UTC and response training), when assessing mission capability.

6.2.1.5. Assessment of the installation medical all hazard response mission should be informed by response training and assessment program tactical drills, wing/medical response plans, exercise after action reports, team status, and equipment availability. Use this information to assess the unit's overall unit installation medical all hazard response capability against likely hazards and threats.

6.2.2. MAJCOM Functional Area Managers will update the unit's core mission essential task list anytime the unit's MRL or mission changes, or when a new AFMS core mission essential task list has been published.

6.2.3. All reporting medical units will include a monthly overall unit mission assessment comment comparing the unit's resource readiness C-level to the capability readiness assessment. If the resource readiness C-level aligns with the capability readiness assessment level (e.g., resource readiness is C-1 and capability readiness is Y-Green) state so in the comment. If the resource readiness C-level does not align with capability readiness assessment (e.g., resource readiness is C-3 and capability readiness is Y-Green) explain the rationale for the difference in ratings in layman's terms. **(T-3)**

6.3. Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C).

6.3.1. The MEDRED-C provides information on unit operational status during deployed (Part A) and in-garrison (Part B) contingency operations. , as well as unusual occurrences (e.g., natural disaster, prolonged power outage, civil unrest, CBRN events or other emergencies). MEDRED-Cs are submitted using the input tool provided in DRRS.

6.3.2. Reference the MEDRED-C guide on the AF Medical Readiness SharePoint® Site for additional information.

6.4. After Action Reports.

6.4.1. Accomplish after action reports after deployments, contingencies, and exercises, in accordance with AFI 10-1302, *Air Force Lessons Learned Program*. **(T-3)** After action reports are intended to be more than a summary of unit activities. Examples may be found on the AF Medical Readiness SharePoint® Site.

6.4.1.1. Deployment After Action Reports. Deployed medical unit commanders will collect input from assigned personnel and compile a consolidated after action report covering the time period of their command prior to return to home station. After action reports should be submitted in the Joint Lessons Learned Information System at the appropriate classification level. **(T-2)** Instructions for using the system and sample after action reports can be found on the AFMS Knowledge Exchange lessons learned page.

6.4.1.2. In-Garrison After Action Reporting. The Medical Readiness Office will compile after action reports after each exercise or real world incident within 30 days of the event, only if medical inputs are not fully incorporated into an installation level after action report. **(T-3)** After action reports for real world incidents will be submitted in the Joint Lessons Learned Information System. Examples of in-garrison after action reports can be found on the AFMS Knowledge Exchange lessons learned page.

6.4.2. The MRC will review all after action reports, identify best practices, lessons observed, and formulate corrective actions. These corrective actions will be tracked in the minutes until resolved. Unit commanders will elevate issues that cannot be resolved at the installation level to the parent MAJCOM/SGX. **(T-2)**

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Title 5 United States Code, Section 552a, as amended, *The Privacy Act of 1974*

10 U.S.C. § 8013, *Secretary of the Air Force*

DoDI 3020.52, *Department of Defense Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Preparedness Standards,* 18 May 2012

DoDI 6010.22, *National Disaster Medical System (NDMS),* 14 April 2016

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AFI 10-1302, *Air Force Lessons Learned Program,* 30 Jul 2019

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AFI 10-208, *Continuity of Operations (COOP) Program,* 10 October 2018

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AFI 10-401, *Air Force Operations Planning and Execution,* 7 December 2006

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AFI 25-201, *Intra-Service, Intra-Agency, and Inter-Agency Support Agreements Procedures,* 18 October 2013

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AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control,* 29 May 2014

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AFI 48-137, *Respiratory Protection Program,* 12 September 2018

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AFI 90-201*, The AF Inspection System,* 20 Nov 2018

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AFMAN 41-120, *Medical Resource Management Operations,* 28 August 2019

AFMAN 41-209, *Medical Logistics Support,* 4 January 2019

AFPD 41-1, *Health Care Programs and Resources,* 3 October 2018

AFPD 41-2, *Medical Support,* 17 May 2018

AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological and Nuclear (CBRN) Incidents,* 15 October 2013

AFTTP 3-42.51, *Critical Care Air Transport Team,* 7 April 2015

NDMS Federal Coordinating Center Guide

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 1098, *Special Task Certification and Recurring Training*

Abbreviations and Acronyms

ACC—Air Combat Command

AETC—Air Education and Training Command

AFI—AF Instruction

AF—Air Force

AFMAN—AF Manual

AFMC—AF Materiel Command

AFMRA—AF Medical Readiness Agency

AFMS—AF Medical Service

AFSC—AF Specialty Code

AFSOC—AF Special Operations Command

AFTTP—AF Tactics, Techniques and Procedures

AMC—Air Mobility Command

ARC—Air Reserve Component (includes ANG and AFR)

BERDS—Bioenvironmental Engineering Readiness and Deployment Skills

CBRN—Chemical, Biological, Radiological and Nuclear

CBRNE—Chemical, Biological, Radiological and Nuclear and High-Yield Explosives

C-MAJCOM—Component Major Command

CMRP—Comprehensive Medical Readiness Program

C-NAF—Component Numbered Air Force

C-STARS—Centers for Sustainment of Trauma and Readiness Skills

DMLSS—Defense Medical Logistics Standard Support

DRRS—Defense Readiness Reporting System

FTMS—Formal Training Management Scheduler

IMAHR—Installation Medical All Hazard Response (formerly Home Station Medical Response (HSMR))

LRC—Limited Readiness Capability

MAJCOM—Major Command

MC-CBRN—Medical Counter-CBRN

MCRP—Medical Contingency Response Plan

MEDRED-C—Medical Report for Emergencies, Disasters and Contingencies

MEFPAK—Manpower and Equipment Force Packaging [System]

MRC—Medical Readiness Committee

MRDSS—Medical Readiness Decision Support System

MRL—Medical Resourcing Letter

MTF—Medical Treatment Facility

NCO—Noncommissioned Officer

NCOIC—Noncommissioned Officer in Charge

OPR—Office of Primary Responsibility

PASCODE—Personnel Accounting System Code

SMART—Sustained Medical and Readiness Training

TTP—Tactics, Techniques and Procedures

UDM—Unit Deployment Manager

UTC—Unit Type Code

Terms

Defense Support of Civil Authorities (DSCA)—Refers to DoD support, including federal military forces, DoD civilians, DoD contractors, DoD agencies and components, for domestic emergencies, designated law enforcement and other activities.

Disease Prevention—Encompasses the prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological, chemical, physical or psychological threats or stressors found at home station and during deployments.

Federal Coordinating Center (FCC)—A facility located in a metropolitan area of the United States or Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic National Disaster Medical System (NDMS) Patient Reception Areas.

Installation Medical All Hazard Response—Term that encompasses the full spectrum of installation medical all hazard response activities, including medical contingency response, defense support of civil authorities, civil support, and all-hazards disaster response.

Limited Readiness Capability (LRC)—LRC units are 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. LRC units include, but are not limited to, tenant units on bases where at least two Services share resources and ARC medical units. LRC units are often assigned to non-medical squadrons or to groups (e.g., Air Base Squadrons, Mission Support Groups or Air Base Groups). In some cases, the LRC units may report directly to the wing. MAJCOM Surgeons identify and designate appropriate units within their MAJCOM as LRC units through the MRL in MRDSS. The LRC designation does not apply to Aeromedical Evacuation units.

Patient Reception Area (PRA)—A geographic locale containing one or more airfields, bus stations, adequate patient staging facilities and local patient transport assets to support patient reception and transport to pre-identified, non-federal, acute care NDMS hospitals. NDMS hospitals provide definitive care for victims of a domestic disaster, emergency, or military contingency.

Attachment 2

APPLICATION OF THE LAW OF WAR

A2.1. General.

A2.1.1. AF medical personnel may deploy as either noncombatants or combatants. The protections afforded under the Geneva Conventions are different for each category, and therefore, medical personnel should verify their status and the consequences of that status prior to deployment. Compliance with this guidance is mandatory.

A2.2. Noncombatants.

A2.2.1. Medical personnel are considered noncombatants if they are *exclusively engaged* in performing medical duties. This includes supporting duties such as medical records, administration, disease prevention, and the variety of missions performed by bioenvironmental engineering and public health personnel for the purposes of prevention of disease/sickness through health risk assessment and control.

A2.2.2. Noncombatants may carry weapons for self-defense, defense of patients, or defense of other noncombatants such as their co-workers. However, medical personnel may not engage in actions that are harmful to lawful enemy combatants, such as offensive military operations, convoy operations, or laying minefields, without losing their noncombatant status for the duration of their deployment and subjecting themselves to being targeted by the enemy.

A2.2.3. If captured, true noncombatants are considered *retained personnel* and not *prisoners of war*.

A2.3. Combatants.

A2.3.1. Medical personnel may deploy as combatants and as such are prohibited from appearing as noncombatants while deployed in a combatant capacity. This means that while serving in a combatant role:

A2.3.1.1. Medical personnel will not wear the large red cross armband. **(T-0)**

A2.3.1.2. Medical personnel will not carry a common access card displaying a red cross. **(T-0)**

A2.3.1.3. Medical personnel are not entitled to special protection against enemy attacks. (In this scenario, medical personnel are lawful targets.)

A2.3.1.4. Upon capture, medical personnel in combatant roles are considered *prisoners of war* rather than *retained personnel*. However, the capturing force may elect to use the captured medical personnel in their medical capacity instead. In that event, the medical personnel would be entitled to the same treatment as retained personnel.

A2.4. Disclaimer.

A2.4.1. This guidance is not intended to answer all possible scenarios for medical-legal issues relating to combatants and noncombatants. Additional information is provided on the AF Medical Readiness SharePoint® Site.

A2.4.2. Air Force Operations and International Law (AF/JAO) should be consulted for answers to specific questions.