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The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for expeditionary medical support capability. AFTTP 3-42.77 provides tactics, techniques, and procedures for the following unit type codes (UTCs):

FFGST, Ground Surgical Team (GST)

FFGS1, Ground Surgical Equipment

The doctrine in this document is authoritative but not directive. It applies to all Air Force military and civilian personnel, including Air Force Reserve Command and Air National Guard units. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication*. Route AF 847 through the appropriate functional chain of command and parent major command. Ensure that all records created as a result of the processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW the Air Force Records Disposition Schedule located in the Air Force Records Information Management System. 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.

Chapter 1

INTRODUCTION

1.1. Purpose. This publication provides the tactics, techniques, and procedures for the Ground Surgical Team (GST). The GST provides the initial surgical and post-surgical critical care capability for the Air Force Expeditionary Medical Support (EMEDS) construct. The team can also operate independently in austere locations forward of an established medical treatment facility (MTF). This publication focuses on the team's stand-alone and crisis response capabilities. It provides a source document for developing standardized policies, operating procedures, training programs, and allowance standards. Operation plans and regional guidance provide more specific information that amplify and tailor the guidance contained in this publication. See AFTTP 3-42.71, *Expeditionary Medical Support (EMEDS) and Air Force Theater Hospital (AFTH),* for more information on EMEDS operations.

1.2. Background. Recent operational challenges supporting forces in forward locations combined with emerging doctrine on contested battlespace concepts prompted the Air Force Medical Service (AFMS) to reevaluate its portfolio of deployable medical assets and aeromedical evacuation platforms. Limited medical infrastructure and long travel distances to the nearest trauma care capability within the United States Africa Command and remote parts of United States Central Command areas of responsibility have led to an increased requirement for small-scale, mobile surgical teams able to provide area support for conventional and special operations forces. These evolving and growing combatant command mission requirements far exceed the available assets in the AFMS inventory. The Air Force Surgeon General (USAF/SG) tasked the three manpower and equipment force packaging (MEFPAK) responsible agencies (MRAs) to review their current unit type code (UTC) portfolios and identify areas where similar training and mission sets could be leveraged.

    1.2.1. GST Development. In 2016, the Air Combat Command (ACC), Air Mobility Command, and Air Force Special Operations Command MRAs and select subject matter experts partnered to develop a next generation small surgical team. ACC identified three existing UTCs from the EMEDS construct that could be modified to meet these new requirements without jeopardizing current operational requirements.

    1.2.2. UTC Changes. The GST replaces FFMFS, Mobile Field Surgical Team (MFST), and FFEP1, Expeditionary Critical Care Team (ECCT), on the EMEDS Health Response Team (HRT) and FFEP5, Surgical Augmentation Team, in EMEDS+25.

1.3. Evolution of Air Force Forward Surgical Capabilities. The 20-person Flying Ambulance Surgical Trauma (FAST) team was one of the Air Force's first prototypes for delivery of life-saving trauma care closer to combat casualties. Developed in response to the 1983 U.S. Marine barracks bombing in Beirut, the FAST capability was fielded in 1984 in United States Air Forces Europe. Lessons learned from operations in Grenada, Panama, Iraq, Somalia, and the Balkans in the mid-1980s to early 1990s led to the development of the five-person MFST in 1995. The MFST served as the smallest and most mobile Air Force module for the provision of advanced emergency medical and surgical care.

    1.3.1. EMEDS Mission. In the late 1990s, Joint and Air Force doctrine shifted toward a four-phased continuum of care focused on rapid evacuation of casualties and smaller in-theater

MTFs. Following the Air Force's transition to an Aerospace Expeditionary Force concept in 1998, the USAF/SG tasked ACC with development of a modular and scalable theater hospitalization capability. In September 1999, the USAF/SG approved the EMEDS and AFTH concept of operations. The MFST provided the core surgical and emergency medicine capability, and the ECCT provided the core perioperative and critical care capability.

1.3.2. Unconventional Medical Support Missions. The early part of Operations IRAQI FREEDOM and ENDURING FREEDOM brought increasing requirements for unconventional mission support. The combatant commands frequently requested MFST support as the team's small size and mobility were well matched to the mission. In 2003, five MFSTs were transferred to AFSOC to more effectively support their specialized training requirements. The remaining MFSTs remained allocated to ACC to support EMEDS requirements.

Chapter 2

CAPABILITIES

2.1. Mission. The GST provides damage control surgery, damage control resuscitation, and emergency care of injured or critically ill patients in dynamic, austere environments outside of established support and patient movement capabilities. Its primary mission is to stabilize and prepare patients for casualty evacuation (CASEVAC). The team can perform up to 10 surgical interventions and provide postoperative patient holding for up to three patients at a time for a maximum of 12 hours without resupply.

2.2. Scope of Care. The GST performs damage control and emergency medicine interventions required to save life, limb, and eyesight and stabilize critically injured patients for transport. A stabilized patient is defined as airway protected, hemorrhage controlled, shock treated, and fractures stabilized. The team is skilled in multi-system trauma, blunt and penetrating trauma, shock and hemorrhage control, respiratory and airway management, limited management of thermal injuries, limb revascularization, stabilization of fractures, and major wound debridement. Surgical techniques focus on hemorrhage control and minimal fluid administration until bleeding is controlled. Weight restrictions limit the amount of crystalloid and blood products available for fluid resuscitations.

2.2.1. Blood Supplies. The GST has limited type-specific emergency whole blood collection and transfusion capability. No formal blood grouping, typing, or crossmatching capability is available. Uncrossmatched Group O packed red blood cells and Group AB or A fresh frozen plasma or liquid plasma, if available, will be issued for all casualty care.

2.2.2. Laboratory. The GST has no formal laboratory capability. Lab testing is limited to waived or moderate complexity testing to include provider performed microscopy.

2.2.3. Medications. Supplies are limited to essential emergency medical care and resuscitative surgery pharmaceuticals.

2.2.4. Radiology. Radiographic imaging is limited to handheld sonography testing.

2.3. FFGST, Ground Surgical Team. Table 2.1 lists the manpower detail for FFGST. All team members provide cross-functional support as needed commensurate with their skill levels and training. See Chapter 3 for more information on deployment and employment.

Table 2.1. FFGST Manpower Detail.

AFSC	Title	Grade	Quantity
045S3	Surgeon	04	1
045A3	Anesthesiologist	04	1
041A3	Health Services Administrator	04	1
044E3	Emergency Services Physician	04	1
046N3E	Critical Care Nurse	04	1
4N171	Surgical Service Craftsman		1
			Total: 6

AFSC	Title	Grade	Quantity
Note: Air Force Specialty Code (AFSC), grade, and skill-level substitutions are in accordance with (IAW) the mission capability statement, *War and Mobilization Plan, Volume 1 (WMP-1), Air Force Medical Service (AFMS) Supplement*, and Air Force Instruction (AFI) 10-403, *Deployment Planning and Execution*.			

2.4. FFGS1, Ground Surgical Equipment. FFGS1 provides initial supplies and equipment in scalable, man-portable field packs configured to support 3, 6, or 10 damage control surgeries in austere environments. The equipment set can be tailored down to meet unique operational requirements. See the allowance standard (AS 938Q) for a current list of equipment. Allowance standards are maintained on the Air Force Medical Logistics Allowance Standard Management System (**https://medlog.us.af.mil/apps/medlog/#home** [account required]).

Chapter 3

OPERATIONS

3.1. Pre-Deployment.   Team members should work closely with the medical readiness office to prepare for deployment and review pertinent deployment information. This information may include reporting instructions, pre-deployment training requirements, force protection threats, and intelligence reports. Deploying personnel are responsible for following the pre-deployment requirements outlined in AFI 10-403.

3.2. Deployment. The GST is the smallest deployable Air Force module for delivery of advanced emergency medical and surgical care. The team deploys with man-portable field packs configured to support rapid setup. UTC team chiefs should assess the deployability of assigned equipment UTCs with medical logistics personnel and identify shortfalls. Deploying commanders should ensure an adequate number of personnel are qualified in pallet build-up and cargo handling procedures (to include hazardous, protected, and classified cargo) to serve as cargo increment monitors during deployment and redeployment IAW AFI 24-602V2, *Preparation and Movement of Air Force Cargo*, even if equipment is not co-located with the team. **Note:** Most EMEDS equipment within the continental United States (CONUS) is stored at consolidated storage and deployment centers.

> 3.2.1. Hazardous Cargo. Hazardous cargo is subject to Defense Transportation Regulation (DTR) 4500.9-R-Part III, *Mobility*, AFMAN 24-204, *Preparing Hazardous Materials for Military Air Shipments*, and host nation requirements. The health services administrator or surgical service technician typically serves as a certifying official and should be trained in packing, handling, and inspection procedures.

> 3.2.2. Protected Cargo. Protected cargo includes controlled substances, items vulnerable to theft, and weapons and ammunition. The anesthesiologist typically serves as the controlled medical item custodian. The controlled medical item custodian should witness and verify the packaging of medically controlled items. At the deployed location, controlled items should be stored in locked rooms or containers and managed IAW AFI 41-209, *Medical Logistics Support.* Units are responsible for assigning primary and alternate weapons and ammunition couriers to ensure security and accountability during transit IAW AFI 31-101, *Integrated Defense*, and AFI 21-201, *Munitions Management.*

> 3.2.3. Classified Cargo. Classified material should be packaged, marked, safeguarded, and transported IAW AFI 16-1404, *Air Force Information Security Program.* Units are responsible for assigning appropriately cleared and trained couriers to accompany classified material.

3.3. Employment. The GST can provide initial stabilization within 15 minutes of arrival at the employment location and reach full mission capability within 30 minutes. The team operates from shelters of opportunity if not attached to an established EMEDS or other MTF.   In austere locations, the team may need to change locations multiple times on short notice. Optimally, the GST should operate from a location with adequate security and ECS/BOS to complete their mission. Table 3.1 lists the most common employment scenarios.

Table 3.1. Employment Scenarios.

Tasking	Description
Forward deployment	The GST may be tasked to deploy from an EMEDS location to temporarily support operations in austere locations without immediate access to damage control surgery and resuscitation capabilities.
Standalone medical operations	The GST may function as the sole medical resource in a number of scenarios such as contested environments, humanitarian assistance, disaster relief, and unconventional operations.
Surge augmentation	The GST may deploy to provide surge augmentation for other deployed medical capabilities. The team and equipment set can be used to increase operative and postoperative care capabilities.

3.3.1. Team Member Roles and Cross-Functional Support. Each member of the GST provides a specific skill set and performs a unique function. Team integrity should be maintained to the maximum extent possible. Due to the small size of the team and unique mission, all team members (clinical and non-clinical) should have a basic understanding of each team member's role and be prepared to provide cross-functional support as needed commensurate with their skill levels and training.

3.3.1.1. Anesthesiologist. The anesthesiologist provides perioperative anesthesia care to surgical patients to include preoperative evaluation and resuscitation, intraoperative anesthetic management, postoperative stabilization, sedation, pain management, and preparation for transport. The anesthesiologist also provides hemodynamic and respiratory support, sedation, and pain management for non-surgical candidates. The anesthesiologist serves as the GST's controlled substances officer and is responsible for maintaining the team's medication supply. The anesthesiologist may assist with preoperative and postoperative clinical care and help maintain the GST's blood supply inventory.

3.3.1.2. Critical Care Nurse. The critical care nurse is responsible for emergency care, perioperative nursing, postoperative critical care, and preparation of patients for transport. The critical care nurse manages the GST's blood supply and may assist the anesthesiologist in maintaining the team's controlled substances supply.

3.3.1.3. Emergency Services Physician. The emergency services physician in collaboration with the general surgeon is responsible for initial resuscitation, triage, pre-hospital care, advanced critical care life support, and trauma support. Responsibilities include basic management of toxicological emergencies, minor surgical stabilization procedures, and limited management of thermal injuries. The emergency services physician may assist the general surgeon in surgery, provide postoperative support, and help prepare patients for transport.

3.3.1.4. General Surgeon. The general surgeon in collaboration with the emergency services physician is responsible for initial resuscitation, triage, pre-hospital care, advanced critical life support, and trauma support. Responsibilities include evaluation and treatment

of traumatic injuries and surgical diseases, performance of minor and major surgical procedures (to include damage control surgery), and critical care of traumatically injured and postoperative patients.

3.3.1.5. Health Services Administrator. The health services administrator is the only non-clinical position on the team. The health services administrator is responsible for command and control (C2), logistics, communications, CASEVAC coordination, reporting, and administration functions. As the plans and readiness officer, the health services administrator needs to fully understand and be able to communicate the team's capabilities, limitations, and unique planning considerations at the tactical and operational level.

3.3.1.6. Surgical Service Craftsman. The surgical service craftsman is responsible for managing the operating room capability and serves as the general surgeon's primary technician assistant. Responsibilities include prepping patients for surgery, managing surgical instrument sets, and overseeing surgical instrument sterilization. The surgical service craftsman serves as equipment custodian and assists the health services administrator with ordering medical supplies.

3.3.2. CASEVAC. The GST operates in areas without close aeromedical evacuation support. The GST health services administrator is responsible for coordinating CASEVAC through the host unit or appropriate theater patient evacuation control center IAW theater policy. Patients should be transported with their medical records, personal effects, and medically essential items. The GST is not equipped to furnish the medical equipment and supplies required to support patients during transport. The attending physician is responsible for ensuring that all necessary forms are completed IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*.

3.3.3. Documenting Patient Care. Medical personnel are responsible for documenting the care provided to U.S. personnel IAW Department of Defense Instruction (DODI) 6490.03, *Deployment Health,* AFI 41-210, and theater surgeon policy. Patient encounter data should be filed electronically through Theater Medical Information Program – Air Force (TMIP-AF) if network access is available. If access to TMIP-AF is not available, paper forms should be used. Examples include SF 600, *Chronological Record of Medical Care*, DD 1380, *Tactical Combat Casualty Care (TCCC) Card*, DD 3019, *Resuscitation Record,* and AF 3899, *Aeromedical Evacuation Patient Record*.

3.3.4. Care for Enemy Prisoners of War (EPW). If tasked to treat an EPW, the GST should coordinate with security forces or equivalent authority to provide armed guards for prisoners. Following essential care, EPWs are transferred to host nation or U.S. Army EPW management authorities. See Joint Publication (JP) 3-63, *Detainee Operations*, for guidance.

3.3.5. Reporting Requirements. Team chiefs are responsible for submitting required operational reports IAW AFMAN 10-206, *Operational Reporting (OPREP),* and specific combatant commander, joint force commander (JFC), and commander, Air Force forces (COMAFFOR) requirements. Team chiefs are responsible for submitting after-action reports and lessons learned IAW AFI 10-204, *Participation in Joint and National Exercises,* and AFI 90-1601, *Air Force Lessons Learned Program.*

3.3.6. Maintenance and Disposition of Records. Records associated with GST operations should be maintained and disposed of IAW AFI 33-364, *Records Disposition–Procedures and*

Responsibilities, and AFMAN 33-363, *Management of Records*. Patient medical records, personally identifiable information, and protected health information are managed and protected IAW AFI 33-332, *Air Force Privacy and Civil Liberties Program,* and AFI 41-210. Medical personnel are responsible for complying with Public Law 93-579 (as amended) Privacy Act of 1974, Public Law 104-191 (as amended) Health Insurance Portability and Accountability Act (HIPAA) of 1996, Freedom of Information Act, Drug Abuse and Treatment Act, and Comprehensive Alcohol Abuse amendments.

3.4. Redeployment. The team can repack its equipment and supplies and be ready to redeploy to a new location within 30 minutes. The health services administrator is responsible for chain of custody and redeployment of equipment. Before departure, team chiefs should provide the Air Force Forces Surgeon General (AFFOR/SG) with shipment status and a copy of the shipping documents.

Chapter 4

COMMAND AND CONTROL (C2) RELATIONSHIPS

4.1. C2 Definitions. C2 is the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. (Source: *DOD Dictionary of Military and Associated Terms*).

  4.1.1. Operational Control (OPCON). OPCON is the authority to perform those functions of command over subordinate forces involving organizing and employing commands and forces, assigning tasks, designating objectives, and giving authoritative direction necessary to accomplish the mission (Source: *DOD Dictionary of Military and Associated Terms*). OPCON should be exercised through the commanders of subordinate organizations, such as subordinated JFCs and Service or functional component commanders. Normally, JFCs exercise OPCON of assigned and attached Air Force forces through the COMAFFOR (Source: Air Force Doctrine Annex 3-30, *Command and Control*).

  4.1.2. Tactical Control (TACON). TACON is the authority over forces that is limited to the detailed direction and control of movements or maneuvers within the operational area necessary to accomplish missions or tasks assigned (Source: *DOD Dictionary of Military and Associated Terms*). TACON provides sufficient authority for controlling and directing the application of force or tactical use of combat support assets within the assigned mission or task (Source: Air Force Doctrine Annex 3-30).

  4.1.3. Administrative Control (ADCON). ADCON is the direction or exercise of authority over subordinate or other organizations with respect to administration and support (Source: *DOD Dictionary of Military and Associated Terms*). It includes control of resources and equipment, personnel management, and discipline. Normally, the COMAFFOR exercises ADCON over assigned Air Force personnel and at least those elements of ADCON that are necessary to ensure mission accomplishment over those Air Force personnel attached to the Air Force component commander (Source: Air Force Doctrine Annex 3-30).

4.2. C2 Structure in EMEDS Operations. C2 for expeditionary medical units is through line of the Air Force commanders. Air Force elements deployed into a theater are typically aligned under the command of the COMAFFOR. The COMAFFOR exercises ADCON responsibilities for assigned and attached Air Force forces IAW Air Force Doctrine Volume 3, *Command*. GST personnel operate under the local direction of the deployed expeditionary unit commander (usually the EMEDS or AFTH commander).

4.3. C2 Structure in Standalone Operations. The GST operates under the C2 structure established by the joint task force (JTF) or air expeditionary task force to which it is assigned. Upon arrival in theater, the GST should request a chain of command briefing from the JTF/SG or AFFOR/SG office. Usually, the COMAFFOR retains ADCON. The Service component retains OPCON, and the ground force commander retains TACON.

Chapter 5

COMMUNICATIONS AND INFORMATION SYSTEMS

5.1. Communications Requirements. The GST is not equipped with the communications infrastructure needed for independent operation and relies on host base communications units. The team requires access to the Defense Switched Network, secure voice communications, Non-classified Internet Protocol Router Network (NIPRNET), and Secret Internet Protocol Router Network (SIPRNET) to communicate patient conditions and patient movement requirements. See Attachment 2 for more information on communications requirements.

5.2. Communications Equipment. The GST deploys with a satellite/iridium phone. These devices are allocated IAW the allowance standard and operational requirements. They are primarily used during deployment and redeployment phases and to augment established communications infrastructure in austere environments.

5.3. Computer Systems. The computer issued to the GST includes the DOD Standard Desktop Configuration and applications for managing patient encounter data and ordering medical supplies.

5.3.1. Armed Forces Health Longitudinal Technology Application (AHLTA)-Theater. AHLTA-Theater is the electronic health record management system for theater environments. It maintains much of the same design and functionality as the AHLTA system used at MTFs in CONUS and sustaining bases. AHLTA-Theater transmits data to a central theater database called the Theater Medical Data Store (TMDS). In low to no communication environments, data is stored locally and forwarded when Internet connectivity is restored.

5.3.2. Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM). DCAM is the primary order management system for deployed medical units providing unit-level support. DCAM provides a store and forward capability to support low to no communication environments.

5.3.3. Specialty-Specific Applications. Team members may have access to the specialty-specific applications listed in Table 5.1.

Table 5.1. Specialty-Specific Applications.

Application	Purpose	Availability
Joint Trauma System	Trauma care management and documentation	Web application
Medical Situational Awareness in the Theater	Medical surveillance	SIPRNET system
Theater Medical Data Store	Blood operations and electronic health record management	Web application
Transportation Command Regulating and Command and Control Evacuation System	Medical regulating and patient movement tracking	Web application

5.4. Information Assurance (IA) Policy. GST personnel should understand and follow IA procedures, to include communications and computer security, IAW AFI 17-130, *Cybersecurity Program Management,* AFMAN 17-1301, *Computer Security (COMPUSEC)*, and associated Air Force IA guidance.

5.5. Helpdesk Support and System Maintenance. Contact the AFFOR/SG for assistance with computer hardware upgrades and maintenance, software updates, and helpdesk support.

Chapter 6

INTEGRATION AND INTEROPERABILITY

6.1. Integration and Interoperability with Other Systems. The GST may support elements of an air expeditionary force, components of the aeromedical evacuation system, joint medical counterparts, Special Operations Forces, and other federal and civilian agencies. In some instances, theater planners may request medical support for beddown locations not associated with a typical air expeditionary force or ECS/BOS infrastructure. The GST functions as an integral part of the supported unit and should participate in mission planning and briefings. The GST is expected to leverage and work in conjunction with other medical assets that may be attached to the supported unit (for example, in a mass casualty event). In certain situations, the GST may combine with another medical asset for the duration of the mission or for a limited basis to create a theater medical capability (for example, co-locating a GST with a medical evacuation element).

6.2. Expeditionary Combat Support (ECS)/Base Operating Support (BOS) Requirements. The GST deploys with limited organic capability and requires ECS/BOS. ECS/BOS requirements include (but are not limited to) billeting, shelter, messing and other consumable materials, power, water, ice, latrines, showers, laundry, waste management, exterior lighting, transportation (to include ambulances and general purpose vehicles), fuels, vehicle maintenance, equipment maintenance, general supplies, contracting, information and communications systems support, mortuary affairs, public affairs, chaplain, linguist, personnel and vehicle decontamination, and security. ECS/BOS may be provided using the host base's capabilities, deployable bare base systems, and contracted civilian support. See Attachment 2 for quantified estimates on required support.

Chapter 7

SECURITY

7.1. Security Roles and Responsibilities.   Medical personnel are non-combatant assets, and along with medical equipment, have protected status under the Geneva Conventions and the Law of Armed Conflict. Medical personnel and war reserve materiel assemblages are protected IAW AFI 31-101. Current threat assessments provided by the combatant commander and local threat conditions established by the JTF, air expeditionary wing, or air expeditionary group commander dictate all local security measures. GST members are responsible for ensuring security measures are in place to protect patients and personnel. GST personnel are responsible for following personal protection measures outlined in AFI 31-101, area of responsibility security briefings, established force protection requirements, and local guidance. GST personnel follow theater arming instructions as directed by reporting instructions and theater guidance.

7.2. Physical Security. Security forces guard medical facilities only if deemed necessary as part of the Integrated Defense Plan. If the threat changes, security forces may appoint an augmented detail to provide force protection and entry control (for example, a mass casualty event). The supported unit provides security for any patient determined to require a security detail or escort. The GST does not have the manning to provide this layer of security.

7.3. Operations Security (OPSEC). GST personnel are responsible for protecting mission-critical information (to include medical or casualty information) IAW theater policy and AFI 10-701, *Operations Security (OPSEC)*. Classified information should be transmitted by secure means and protected IAW AFI 16-1404. Situation reports, medical surveillance, site locations, and compiled patient data are examples of information that may be classified.

7.4. Security of Weapons and Ammunition. Weapons and ammunition should be secured IAW AFI 31-101 and local procedures. In austere environments where access to an armory may not be available, GST members are responsible for safe storage of weapons and ammunition. GST members should coordinate with the supported unit on local weapons handling guidance. Considerations include rules for engagement on searching and clearing patients of weapons and explosives, who is allowed to carry weapons into the medical treatment area (e.g., medical facility, shelter of opportunity), and security measures for handling the discovery of unauthorized weapons or explosives.

Chapter 8

TRAINING

8.1. Medical Readiness Training Requirements. Personnel assigned to a GST UTC should complete individual, deployment, and unit training requirements IAW AFI 41-106, *Medical Readiness Program Management,* and MRA guidance. Examples include Readiness Skills Training, chemical, biological, radiological and nuclear emergency preparedness and response, clinical AFSC training, and information management/information technology. Completion of all medical readiness training and equivalency training should be documented in the Medical Readiness Decision Support System. Theater-unique training requirements are identified in deployment reporting instructions or line remarks.

8.2. UTC Formal Training. GST personnel should complete in-residence formal training upon initial assignment to the UTC and IAW the AFMS Medical Readiness Category III Training Guide. UTC team integrity should be maintained to the maximum extent possible.

   8.2.1. Ground Surgical Team Training – Austere Phase 1. This course provides foundational training on how to function as a small surgical team. It focuses on allowance standard familiarization, individual and cross-functional team roles and responsibilities, clinical practice guidelines, and scenario-based training. The course is held at the Center for Sustainment of Trauma and Readiness Skills (C-STARS) in Baltimore, MD.

   8.2.2. EMEDS HRT Course.   This course provides field operational training for commissioned officers and enlisted personnel assigned to specific EMEDS UTCs. The course is held at the Camp Bullis Medical Readiness Training site, Joint Base San Antonio, TX.

   8.2.3. Ground Surgical Team Training – Austere Phase 2. This capstone field exercise provides realistic field operational training tied the team's mission essential tasks and deployment scenarios. The course is held at the Camp Bullis Medical Readiness Training site, Joint Base San Antonio, TX.

8.3. Mission Essential Task Lists (METLs). METLs are designed to help assess, measure, and report a unit's ability to perform its mission. Personnel are expected to be proficient in the EMEDS Core METLs as well as their UTC-specific METLs. Core METLs and UTC-specific METLs are available on the ACC/SG MEFPAK Playbook at **https://cs2.eis.af.mil/sites/12173/default.aspx** or from the ACC/SGX training branch.

8.4. Pallet Buildup Training. Pallet buildup training is required for the health services administrator (041A) and surgical service technician (4N1) positions. Training is conducted at the base level. Personnel attend refresher training as needed.

8.5. Hazardous Cargo Training. Hazardous cargo training is required for the health services administrator (041A) and surgical service technician (4N1) positions. Training is conducted at the base level. Personnel attend refresher training as needed.

8.6. Weapons Training. Weapons training requirements are outlined in AFI 36-2654, *Combat Arms Program*, and AFI 41-106. The team deploys IAW theater commander weapons policy.

Chapter 9

LOGISTICS

9.1. Medical Logistics Support. The GST may deploy to environments with limited medical logistics support. Planners should ensure the team deploys with adequate medical supplies and equipment to support independent operational requirements. Austere missions may not allow or require establishment of a resupply mechanism. When resupply is required, medical planners establish resupply through a variety of mechanisms, which may include support from a host MTF, in-country embassy or military assistance group, or main operating base. When deployed in support of a major regional conflict, the conventional health support system provides medical logistics support. Prior coordination with the supported JTF/SG or AFFOR/SG helps ensure adequate medical logistics support is available. See AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System,* for more information on medical logistics support.

9.2. Supplies and Equipment. The ground surgical equipment set (FFGS1/AS 938Q) consists of man-portable field packs designed to support up to 10 damage control surgeries. It is designed for short-duration, single missions. The equipment set is configured in three increments that offer some degree of built-in resupply. Increment 1 provides the initial durable and non-durable items to handle 1-3 surgical cases. It consists of 6 bags (A1, A2, B1, B2, C, E). Increment 2 provides supplemental non-durable items to handle an additional 3 surgical cases (patients 4-6). It consists of 3 bags (G1, G2, G3). Increment 3 is packed identically to increment 1 except the durable items are removed, and non-durable items are added to handle 4 surgical cases (patients 7-10). It consists of 6 bags (H1, H2, H3, H4, H5, H6). Resupply or reconstitution of supplies can be done by line item, sub-package, or increment. For example, if the durable items are still functional, the team can alternate increment 2 and increment 3 packages to replenish supplies. The health services administrator is typically responsible for resupply functions. Team members should contact the medical logistics office for assistance with reviewing the allowance standard.

ROBERT I. MILLER
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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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SF 600, *Chronological Record of Medical Care*

Abbreviations and Acronyms

ACC—Air Combat Command

ADCON—Administrative Control

AFFOR—Air Force Forces

AF—Air Force (form)

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMS—Air Force Medical Service

AFSC—Air Force Specialty Code

AFTH—Air Force Theater Hospital

AFTTP—Air Force Tactics, Techniques, and Procedures

AHLTA—Armed Forces Health Longitudinal Technology Application

BOS—Base Operating Support

C2—Command and Control

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

CASEVAC—Casualty Evacuation

COMAFFOR—Commander, Air Force Forces

COMPUSEC—Computer Security

CONUS—Continental United States

DCAM—DMLSS Customer Assistance Module

DD—Department of Defense (form)

DMLSS—Defense Medical Logistics Standard Support

DOD—Department of Defense

DODI—Department of Defense Instruction

DTR—Defense Transportation Regulation

ECCT—Expeditionary Critical Care Team

ECS—Expeditionary Combat Support

EMEDS—Expeditionary Medical Support

EML—Expeditionary Medical Logistics

EPW—Enemy Prisoner of War

FAST—Flying Ambulance Surgical Trauma (team)

GST—Ground Surgical Team

HIPAA—Health Insurance Portability and Accountability Act

HRT—Health Response Team

IA—Information Assurance

IAW—In Accordance With

JFC—Joint Force Commander

JTF—Joint Task Force

MEFPAK—Manpower and Equipment Force Packaging

METL—Mission Essential Task List

MFST—Mobile Field Surgical Team

MRA—MEFPAK Responsible Agency

MTF—Medical Treatment Facility

NIPRNET—Non-classified Internet Protocol Router Network

OPCON—Operational Control

OPR—Office of Primary Responsibility

OPSEC—Operations Security

RDS—Records Disposition Schedule

SG—Surgeon General

SIPRNET—Secret Internet Protocol Router Network

TACON—Tactical Control

TMDS—Theater Medical Data Store

TMIP-AF—Theater Medical Information Program – Air Force

USAF—United States Air Force

USAFRICOM—United States Africa Command

USCENTCOM—United States Central Command

UTC—Unit Type Code

WMP—War and Mobilization Plan

Attachment 2

EXPEDITIONARY COMBAT SUPPORT (ECS) REQUIREMENTS

Table A2.1. Expeditionary Combat Support (ECS) Requirements.

GST ECS REQUIREMENTS	
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.	
	FFGST (Personnel) **FFGS1 (Equipment)**
MOVEMENT REQUIREMENTS **Calculations IAW AFPAM 10-1403 and DTR 4500.9-R-Part III**	
Pallets (#)	1
C-130 (# aircraft)	1
C-17 (# aircraft)	1
C-5A (# aircraft)	1
M871 (# flatbed semitrailers)	1
M872 (# flatbed semitrailers)	1
SITE PREPARATION	
Square Footage (slight grade required)	
Tents (#)	
ECUs (#)	
Note: The GST operates from a shelter of opportunity when not attached to an EMEDS or equivalent deployed medical facility.	
BASIC EXPEDITIONARY AIRFIELD RESOURCES (BEAR) REQUIREMENTS	
Latrine/Showers (# staff)	6
Billeting (# staff)	6
# Officers	5
# Enlisted	1
Meals (# meals/day) (= # staff x 3 meals/day)	18
Laundry (lbs/week) (=32 lbs/person/week)	192
Ice (lbs/day) (= 4.4 lbs/person/day)	26.4
Potable Water (gal/day) (= # staff x 10 gal/day)	60
Power (kW)	6
Power with CP-EMEDS (kW) (3-phase)	
Note: The GST allowance standard includes a 1.5 kW generator intended for initial operating capability and emergency backup power only.	
CIVIL ENGINEERING REQUIREMENTS	

GST ECS REQUIREMENTS	
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.	
	FFGST (Personnel) FFGS1 (Equipment)
Medical/Biohazard Waste	
Liquid (gal/day) (= 0.7 x potable water rate)	42
Solid (lbs/day) (= 4 lbs x #staff)	24
LOGISTICS REQUIREMENTS	
Petroleum, Oils, Lubricants	
Diesel Fuel (gal/day) (= 8.33 gal/hr x 24 hrs)	
Diesel Fuel, CP-EMEDS Mode (gal/day)	
Unleaded Fuel (gal/day) (10kW generator)	
Vehicles	
Vehicle Maintenance Support	
Vehicle Requirements	
Material Handling Equipment	
COMMUNICATIONS AND INFORMATION SYSTEMS REQUIREMENTS	
Communication Equipment	
Phone (# lines) (**Note:** None organic; external support required)	2
Satellite/Telemedicine (# equipment)	1
Land Mobile Radios (# equipment) (**Note:** None organic; external support required)	2
Secure Telephone Equipment (# lines) (**Note:** None organic; external support required)	Access required
Information Systems and Network Support	
Laptop (# equipment)	1
Printers (# equipment)	
Server Suite (# equipment)	
SIPRNET Access	Access required

GST ECS REQUIREMENTS	
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.	
	FFGST (Personnel) **FFGS1 (Equipment)**
NIPRNET Access	1 Cat 6E drop required
Operating System/Office Suite	DOD SDC
RAM/Hard Drive	ITT standard
Clinical Applications	TMIP-AF
Required Port Number/Protocol Access (TCP/UDP)	21/TCP; 443/TCP; 8080/TCP
CHAPLAINCY SERVICE SUPPORT	
	Required
SECURITY FORCES SUPPORT	
	Required if not co-located on Air Base