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EN ROUTE CRITICAL CARE

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This instruction implements Department of Air Force Policy Directive (DAFPD) 48-1, *Aerospace and Operational Medicine Enterprise*, and is consistent with DAFPD 10-29, *Worldwide Aeromedical Evacuation Operations*, by establishing administrative and operational responsibilities and procedures for aeromedical transport of critically ill or injured patients. This instruction provides guidance for management, qualification, training, operations, and logistic sustainment activities in support of air transport of critically ill or injured patients across the range of military operations. This publication applies to all military and civilian personnel of the Regular Air Force, Air Force Reserve, and Air National Guard. This publication does not apply to the United States Space Force. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Title 10 United States Code Section (U.S.C.) 9013, Secretary of the Air Force, and Executive Order 9397 (SSN), as amended. The applicable System of Records Notice, F036 AF PC C, Military Personnel Records System, is available at: **https://dpcld.defense.gov/privacy/SORNS.aspx**. Ensure all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication*; route the AF Form 847 through the appropriate chain of command and parent major command (MAJCOM). This publication may be supplemented at any level, but all direct supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance

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SUMMARY OF CHANGES

This document has been substantially revised and needs to be completely reviewed. Major changes include removal of all references to the clinical validation committee, the addition of the Fundamentals of Critical Care Course; updates to specific major command and pilot unit responsibilities, changes required by DAFI 33-360, and updates to the acronyms, references and attachments.

Chapter 1

ENROUTE CRITICAL CARE

1.1. Overview. Air Mobility Command (AMC) Office of the Command Surgeon (SG) establishes the principles for system-wide organization, equipment, training, and clinical standards for the air transport of critically injured and or ill patients or en route critical care (ERCC). ERCC represents unit type codes (UTC), and non-UTC special medical transport capabilities, organized, trained, and equipped to provide advanced, complex medical en route care in the aerospace environment. Total Force, multi-command and joint-service coordination ensure standards for ERCC to include: capabilities, personnel, training and mission support requirements, medical care standards for in-flight care, individual and team performance and ERCC continuous process improvement.

1.1.1. Aeromedical evacuation (AE) refers to the Air Force system providing time-sensitive en route care to patients to and between medical treatment facilities. En route care refers to transitory medical care including AE, patient holding and staging capabilities during transport from the site of injury or onset of disease, through successive capabilities of medical care, to a medical treatment facility to meet the needs of the patient.

1.1.2. ERCC capabilities include the Air Force Medical Critical Care Transport (FFCCT) UTC – Critical Care Air Transport Team (CCATT) as well as several non-UTC special medical attendant teams such as the Extracorporeal Membrane Oxygenation (ECMO) Team, Neonatal Intensive Care Unit (NICU) Teams, US Army Burn Teams, etc. CCATT includes limited pediatric transport capability. This instruction applies to the organization, mission, scope, practice, and requirements for USAF ERCC UTCs.

1.2. Critical Care – Resuscitative Care. Critical care medicine focuses on the provision of life or organ support in patients who are critically injured or ill and who require extensive monitoring, continuous care and treatment, as well as interventions to sustain life. Resuscitative care encompasses the aggressive management of life and limb-threatening injuries through interventions including emergency medical treatment, advanced trauma management, and life saving surgery to enable a patient to tolerate transport to the next level of care. For the purpose of this instruction, “critical care” encompasses all aspects of resuscitative and critical care such as provided in medical treatment facilities equipped with intensive care units and/or emergency departments. Common equipment in intensice care units includes mechanical ventilators, cardiac monitors, defibrillators, dialysis equipment, equipment for the constant monitoring of bodily functions, intravenous lines, feeding tubes, nasogastric tubes, suction pumps, drains, and catheters, as well as a wide assortment of drugs to treat the primary condition(s) during hospitalization.

1.3. En Route Care Capability. According to Joint Publication (JP) 4-02, *Joint Health Services*, the purpose of an en route care (ERC) capability is the continuation of care during movement (evacuation) without clinically compromising the patient’s condition. Patient movement (PM) involves transient medical care as well as patient holding and staging during transport. This includes from the site of injury or onset of disease, through sequential capabilities of medical care, to a medical treatment facility that can meet the needs of the patient. Each

Service component is responsible for an organic PM capability for evacuation from point of injury to initial treatment at a health care facility.

1.4. En Route Critical Care Concept. The addition of an ERCC capability on aircraft adds a revolutionary dimension to evacuation missions. With augmentation by ERCC teams, the AE system serves as a distributive medical treatment facility, a flying hospital, along a seamless en route system of ever-increasing medical capability from the point of injury to the rehabilitation medical facility. Specially-trained ERCC medical personnel care for critically injured and/or ill patients while in-transit to a medical treatment facility providing focused medical treatment and/or a higher level of medical care than the patient's originating location. This capability ensures the level of life-sustaining medical care for critically ill and injured patients during transport by air does not diminish and in most cases projects the level of care of the receiving Medical Treatment Facility (MTF) to the embarkation point. This specialized mission requires medical professionals specifically skilled and experienced in the practice of critical care.

1.5. En Route Critical Care Mission. ERCC teams are a limited, rapidly deployable resource available in selected situations to supplement patient movement capabilities. ERCC teams expand the scope of medical care provided to critically ill and/or injured patients who require damage control resuscitation, life-saving interventions, or continuous stabilization and advanced care during transport in either an intra- or inter-theater mission support role. One or more ERCC teams may be employed with AE or ERC units based on operational requirements.

1.5.1. When deployed in support of Mobility Air Force missions, ERCC UTCs may be assigned or attached to an AE expeditionary element and become an Operations Group capability, within the expeditionary AE element command structure. ERCC UTCs are able to transport critically ill or injured patients utilizing a variety of aircraft platforms.

1.5.2. En route critical care UTCs are designed to be flexible in response and are employed across the full spectrum of operations. This includes Aerospace Expeditionary Force (AEF) operations ranging from in-garrison care to homeland security, Defense Support of Civil Authorities (DSCA) to worldwide humanitarian relief, small-scale contingencies through major theater war, and any other operational tasking where the unique ERCC skill set is required.

1.6. ERCC Teams Capabilities and Compositions (Personnel UTCs).

1.6.1. Grade and skill level substitutions are authorized per AFI 10-403, *Deployment Planning and Execution,* and the USAF War Mobilization Plan V1 (WMP-1), *Air Force Medical Service Supplement*. Exception of substitution policy requires AMC/SG approval.

1.6.2. ERCC personnel are not trained to interface with aircraft systems, and the team should be supplemented with appropriate service-specific personnel capable of interfacing between the ERCC team, equipment and the airframe's crew and systems.

1.6.3. Critical Care Air Transport Team (CCATT) UTC FFCCT, in conjunction with the CCATT equipment package UTC FFCC4, provides care for a maximum patient load of up to three high-acuity patients, or up to six lower-acuity, stabilized patients; loads are dependent on patient acuity levels.

1.6.3.1. The members of this team are specially trained to provide critical care during aeromedical transport. UTC FFCCT has no stand-alone electrical, mechanical or oxygen equipment. Introduction of untreated or unstable patients degrades team capability and depletes resources unless augmented.

1.6.3.2. A pediatric equipment augmentation kit, UTC FFCC2, provides equipment and supplies to the FFCC4 equipment UTC when the team is required to transport pediatric patients.

1.7. ERCC Special Medical Attendant Teams – Capabilities and Compositions (non-UTC).

1.7.1. Non-UTC ERCC Special Medical Attendant Teams augment ERCC UTCs by providing the subspecialty knowledge and skill required to care for special patient populations. With the exception of the NICU capability, they do not represent "stand alone" ERCC capability and should be tasked with an ERCC UTC.

1.7.2. ECMO is a heart-lung bypass device which circulates and oxygenates the blood to support life while giving patients with complex cardiac conditions or diseased or damaged lungs a chance to heal. An ECMO capability is comprised of physicians, nurses, and technicians specially trained in the utilization of ECMO technology. The number of personnel transporting a patient depends on the acuity and medical treatment needs of the patient. An ECMO capability may be composed of US Air Force and/or other Service personnel.

1.7.3. NICU Team. A NICU team is a non-UTC ERCC capability that provides advanced respiratory and critical care transport expertise specific to the physiology and pathophysiology of the neonate and young infant. A NICU team is uniquely qualified to monitor and manage patients with severe respiratory and multisystem compromise in transit to a definitive care destination.

1.7.4. US Army Institute of Surgical Research Burn Transport Team (Burn Team). The US Army Burn Team is a specialized medical attendant team able to provide en route care to severely burned patients requiring advanced, continued trauma and post-operative care to a dedicated burn center for definitive treatment.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Air Force Surgeon General (AF/SG). AF/SG is primarily responsible for developing and coordinating health care policy for the Air Force Medical Service. The AF/SG also coordinates and aligns health care programs and services to integrate with other Services' medical departments and the Office of the Assistant Secretary of Defense for Health Affairs (OASD-HA). AF/SG is responsible for organizing, training and equipping AF medical forces.

2.2. Pacific Air Forces (PACAF) Command Surgeon (SG). PACAF/SG is the theater Air Component Surgeon for United States India-Pacific Command (INDOPACOM). In conjunction with the theater Air Mobility Division (AMD), PACAF/SG oversees patient transportation for the Pacific theater to include US Forces Korea (USFK) and US Forces Japan (USFJ).

2.3. United States Air Forces Europe (USAFE) Command Surgeon (SG). USAFE/SG is the theater Air Component Surgeon for United States European Command (EUCOM). In conjunction with the theater AMD, USAFE/SG oversees patient transportation for the European theater. USAFE also supports Africa Command (AFRICOM)/SG.

2.4. United States Transportation Command (USTRANSCOM) (USTC). The Commander, USTC, is the Department of Defense (DoD) single manager for implementing policy and standardizing procedures and automated information system requirements for global PM. This is accomplished in coordination with the Geographic Combatant Commanders through the Defense Transportation System and in accordance with DoD Instruction (DoDI) 6000.11, *Patient Movement*.

2.4.1. The USTRANSCOM Surgeon orchestrates strategic, operational and tactical guidance on patient movement; guides unity of effort, total interoperability and standardization between patient movement requirements centers (PMRCs) to ensure optimal fusion of expediency and patient safety, and provides clinical and administrative support to PMRCs during peacetime and contingency operations, and maintains trained patient movement joint service enablers ready to deploy anytime, anywhere.

2.4.2. PMRCs clinically and administratively validate Patient Movement Requests (PMRs) through the TRANSCOM Regulating and Command & Control Evacuation System per DoDI 6000.11.

2.5. Air Mobility Command (AMC). AMC is the Air Force component command of USTC. AMC is the lead major command for organization, training, equipping and management of forces for the global AE mission.

2.5.1. AMC Command Surgeon (SG). AMC/SG serves as the AE program medical director, responsible for the overall supervision and quality of medical care provided worldwide by aeromedical evacuation. AMC/SG is the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agent for ERCC capabilities establishing the principles for system-wide organization, equipment, training, operations, and clinical standards for the air transport of critically injured and/or ill patients. AMC/SG collaborates with AMC Directorate of Operations (A3) to ensure medical operations and aircrew operations are fully integrated.

2.5.1.1. AMC/SG En Route Medical Care Division (SGK). Establishes clinical policy and procedures for AE and clinical standardization and training of AMC medical personnel assigned to AE or patient movement duties. AMC/SGK is the primary point of contact for ERCC issues and development of Air Force ERCC capabilities. AMC/SGK directs clinical oversight and standards development for ERCC to ensure a unified, system-wide, enroute critical care transport capability. AMC/SGK is the central manager for the ERCC operational support flier program. AMC/SGK maintains the AF portal ERCC webpage.

2.5.1.2. AMC/SG Medical Plans and Readiness Division (SGX). Serves as the MEFPAK Director. AMC/SGX coordinates the development of Tactics, Techniques, and Procedures (TTPs), Mission Capability (MISCAP) statement, and Mission Essential Task Lists (METLs) Allowance Standards, Logistics Detail, and Medical Readiness Laydown requirements for ERCC capabilities.

2.5.1.3. AMC/SG designates ERCC UTC Pilot Units. Pilot units provide clinical, technical, manpower, equipment, and operational expertise and consultation in the development and enhancement of ERCC UTC capability. AMC/A3-AE will select AE Pilot Units in coordination with AMC/SG. **(T-2).**

2.5.2. AMC A3X and A5X. AMC A3X and A5X branches function as the execution and contingency planners, respectively, of the AMC Component-Major Command (C-MAJCOM); they are also the AF component within AMC which executes Commander United States Transportation Command (USTRANSCOMCC) assigned missions.

2.5.2.1. The AMC C-MAJCOM includes its commander, AMC/CC, identified staff, the 618th Air Operations Center (AOC), and all assigned forces. A3X, A5X and the AOC, support the AMC/CC through the full range of air mobility operations at the operational and tactical levels in world-wide operations. The AMC/CC also retains responsibility as Commander of Air Force Forces (COMAFFOR).

2.5.2.2. The COMAFFOR delegates operational control (OPCON) to AMC/Directorate of Operations and tactical control (TACON) to 618 AOC/CC of the AMC assigned forces and Air Reserve Component (ARC) available forces made available for allocation and execution. A3X and A5X plans, coordinates and directs AE execution for real-world and exercise requirements and coordinate laydown of AE forces. A3X and A5X develop component-level war planning and AE planning support for USTRANSCOM in support of Combatant Command (CCMD) operational plans and contingency plans under the authority of Joint Staff contingency planning tasks.

2.5.2.3. A3X and A5X collaborate with USTRANSCOM and AMC to identify AE capabilities based on available resources to include organic assets and gained AF Reserve Command and Air National Guard (ANG) assets. A3X and A5X collaborate with PACAF and USAFE A3 for AE forces to coordinate AE support for real world, exercise and operational and contingency plan support.

2.5.3. The 618 AOC is the tasking and execution agency for Global AMC AE missions and requirements. AOC representatives consult with USTRANSCOM Surgeon to refine and assess the feasibility of CCMD requirements. The 618 AOC provides centralized Command and Control (C2) of all AMC global air mobility operations and acts as the single point of

contact for AMC operations. A critical enabling feature of 618 AOC is its robust C2 system, which allows 618 AOC to schedule, task, manage, coordinate, control, and execute air mobility missions globally. This system includes fixed and deployable en route mission support forces. Through the Global Transportation Network, 618 AOC is able to track the status and location of personnel and cargo, otherwise referred to as in-transit visibility.

2.6. Installation Commander.

2.6.1. Wing commanders exercise command over all units and personnel in their wing establishing programs, policies and procedures within the wing in support of unit objectives and missions.

2.6.2. Medical Group or Medical Squadron Commanders enable AF mission execution by providing mission-ready medical personnel and capabilities and developing healthy Airmen and families. Medical units provide health services for all supported members and sustain the readiness skills of assigned medical personnel.

2.7. Integration in Air Mobility Operations. C2 functions exercised over ERCC PM missions are consistent with those for all air mobility missions and are conducted in accordance with the C2 processes described in JP 3-17, *Air Mobility Operations*. AE assets are integrated within the inherent mobility structure established to support airlift operations through the AMD to the wing and down to the assigned expeditionary AE element. The Operational Order (OPORD) provides the guidance for assigned ERCC capabilities to support evacuation platforms other than AE.

2.8. Contingency Operations.

2.8.1. Air Force Forces (AFFOR) Theater Command Surgeon (SG). The AFFOR/SG is responsible for the quality of medical care provided within the area of responsibility (AOR).

2.8.2. The Director of Mobility Forces (DIRMOBFOR), the COMAFFOR and/or Joint Forces Air Component Commander's (JFACC) are continuing authority for air mobility operations within an AOR coordinating with all commands and agencies both internal and external to the joint force. The DIRMOBFOR is normally under administrative control of the COMAFFOR and is normally a senior officer with an extensive background in air mobility operations and is familiar with the AOR. The DIRMOBFOR provides, on behalf of the COMAFFOR, guidance to the AMD on air mobility matters, but such guidance should be responsive to the timing and tempo of operations managed by the AOC director.

2.8.3. AMD. The AMD plans, coordinates, tasks, and executes the air mobility mission. The AMD is located in the AOC in the deployed environment and is directed by the DIRMOBFOR. Among the AMD's many responsibilities, it coordinates air refueling, airlift and AE planning, tasking, and scheduling to support inter-theater and intra-theater air operations. The AMD also ensures intra-theater air mobility missions are visible in the AMC standard command and control system, and is reflected in the Air Tasking Order. The AMD remains under the control of the AOC director who manages the execution of operations for the COMAFFOR.

2.8.4. AE Control Team (AECT). The AECT provides operational control for aeromedical elements directing and managing oversight of missions originating and terminating within the assigned theater of operations. The AECT is the operational center for overall planning, coordinating and directing of all theater AE forces.

2.8.5. Deployed ERCC UTCs supporting AE forces are organized within the constructs of the Air and Space Expeditionary Task Force and are tailored based on the size and scope of the operation. C2 of theater AE forces in contingency operations is defined in the warning/execution/operation order (WARNORD/EXORD/OPORD). AE assets may be under the OPCON of the Joint Force Commander through the JFACC and, when not appointed as the JFACC, the COMAFFOR for administrative control.

2.8.6. When ERCC teams are deployed for contingency operations in support of a Geographic Combatant Commander, the ERCC teams may fall under the OPCON and TACON of the JFACC/COMAFFOR exercised through the Director of Mobility Forces for Air, and may be assigned to a deployed ERC evacuation element. When deployed in direct support of AMC AE operations, ERCC teams fall under the OPCON or TACON of the 618 AOC, Tanker/Airlift Control Center (TACC). 618 AOC coordinates the management and expectation of ERCC teams with the AMC/SG. Command relationships are defined in the warning/execution/deployment order. When tasked for a non-traditional en route critical care role, the team may not necessarily be assigned to an AE unit or Operations Group, but may be aligned under a different execution and command and control organization.

2.8.7. AF Theater ERCC Director. During major contingency operations, the Geographic Combatant Commander may establish a Theater ERCC Director to oversee en route critical care operations within the region. This position will be filled by a qualified AF CCATT physician. **(T-2).** In coordination with AMC/SGK, the HQ AF/SG CCATT Consultant will select a qualified individual for the position from a list of candidates maintained by the consultant. **(T-2).** Generally, the Theater ERCC Director will be assigned to the Air Force Forces (AFFOR)/SG staff.

2.8.7.1. The Theater ERCC Director serves as an advisor to CCMD Surgeon (CCMD/SG) and AFFOR/SG for the development, utilization, and optimization of a theater-wide en route critical care capability. This includes ERCC UTCs and other non-UTC en route critical care teams, as well as other special and coalition medical critical care air transport capabilities. The Theater ERCC Director serves as an authoritative consultant to the AECT on the utilization of ERCC teams. The Theater ERCC Director also serves as a consultant to the Validating Flight Surgeon (VFS) regarding clinical considerations for critical care transport but does not validate PMRs. Validation authority is the responsibility of the VFS.

2.8.7.2. The Theater ERCC Director will meet the same pre-deployment training and currency requirements as other personnel deploying within the FFCCT UTC. **(T-2).** The Theater ERCC Director will be provided operational support flier (9C) aeronautical orders (AOs) allowing him or her to travel to locations with deployed ERCC assets as needed and in coordination with AFFOR/SG. **(T-2).** To evaluate the clinical operations of the AOR en route critical care system, the Theater ERCC Director is authorized to participate in intra-theater or inter-theater AE missions and has the same priority as ERCC teams and AE crews to return to the point of origin at the conclusion of these missions.

2.8.8. AE Element CCATT/ERCC Director. When deployed, one or more FFCCT may be attached or assigned to a deployed expeditionary AE element. The AE element commander will appoint a unit CCATT or ERCC Director for management and oversight of all assigned ERCC teams and to serve as team liaison to and for the AE command section. **(T-2).** In garrison, UTCs will report to the respective squadron, group or wing commander. **(T-2).** The CCATT/ERCC Director reports directly to the AE element commander and is integrated into the AE element executive leadership structure at the equivalent level of the Director of Operations and the Chief Nurse. The unit CCATT/ERCC Director will be a physician, who may be of lesser rank but has greater CCATT experience. **(T-2).** The CCATT/ERCC Director will be responsible for managing each of the ERCC teams assigned to the AE element, establishing the rotational schedule, reviewing clinical processes, act as liaison with local ground medical treatment facility to establish processes for critical care clinical sustainment, and be the mediator for all other team issues. **(T-2).**

2.8.9. Team Chief. During mission execution, the physician on the ERCC team is the team chief and the clinical authority for patients assigned to the team; and, with the other team members, is responsible for documenting and providing care. The physician may be called upon to consult and/or assist in the care of other patients under the direct care of the AE crew on board. Any participation by the physician in the care of a patient assigned to the AE crew will be documented on the AE patient medical record and a Department of Defense (DD) Form 2852, *Patient Movement Event Near Miss Report* or *Joint Patient Safety Report (JPSR) Worksheet.* **(T-0).** The JPSR Worksheet may be found on the AMC AE Portal/Patient Safety. For non-AE missions (no Medical Crew Director (MCD) or AE Crewmembers (AECMs) on board), the ERCC Team Chief will ensure the documentation is accomplished. **(T-0).** Significant change in status will be communicated to the C2 agency and Patient Movement Requirements Center (PMRC) (if regulated patient) governing the mission. **(T-2).** When in-flight, the ERCC team works with and receives mission operational direction from the MCD or non-AE platform comparable member (e.g., Combat Search and Rescue Pararescue Jumper, DUSTOFF Senior Flight Medic, etc.).

Chapter 3

EN ROUTE CRITICAL CARE UTC ASSIGNMENT

3.1. ERCC Team Candidate Selection.

3.1.1. In medical units with assigned ERCC UTCs, the commander is responsible for evaluating personnel nominated to the ERCC UTC for competency and ensuring ERCC UTC-assigned personnel are clinically experienced, trained and equipped for this vital mission. Commanders are also responsible for maintaining the clinical capability of assigned ERCC teams to provide medical care during transport of critically ill or injured patients in support of war operations, humanitarian assistance, homeland security and defense operations, disaster response, and other taskings. Commanders screen assigned medical personnel holding the primary or allowable substitution Air Force Specialty Codes (AFSCs) for nomination to an ERCC UTC position. ARC ERCC UTC assignments may be determined at the time of accession. ARC medical unit commanders with ERCC UTCs are responsible for ensuring timely training and sustained clinical competence of all ERCC UTC-assigned personnel.

3.1.2. Candidates for ERCC UTC membership are world-wide qualified and able to meet the requirements for physician, nurse, or technician positions (respectively) as set forth in **paragraph 3.2**

3.2. Team Member Qualifications.

3.2.1. Candidates will hold one of the primary or allowable substitution AFSCs as directed in the respective ERCC UTC MISCAP. **(T-1).** All candidates for ERCC UTC assignment should demonstrate independent critical thinking abilities, effective communication, team dynamics and time management skills. Candidates must have a volunteer letter on file, meet physical standards for Operational Support Flier (OSF) (refer to AFI 48-123, *Medical Examinations and Standards*), and have a minimum of a Secret security clearance. **(T-1).** After meeting all requirements, candidates obtain OSF status (refer to AF Manual (AFMAN) 11-402, *Aviation and Parachutist Service*).

3.2.2. Physician applicants nominated for assignment to an ERCC UTC will be compliant with 44Y Comprehensive Medical Readiness Program (CMRP) requirements. **(T-1).** Physicians will be current in Basic Life Support and Advanced Cardiac Life Support (ACLS) through the end of the scheduled course. **(T-1).** One-time Advanced Trauma Life Support course completion is required. Current Pediatric Advanced Life Support course is desired. Physician applicants should include a copy certificate for each applicable certification held.

3.2.3. Nurse. Nurses nominated for assignment to an ERCC UTC will hold a duty AFSC of 46N3E, Critical Care Nurse or 46N3J, Emergency Trauma Nurse. **(T-1).** To be fully qualified, they will have one year of critical care experience. **(T-1.)** The Critical Care/Emergency Trauma Nursing (CC/ETN) Course may count toward the one year of experience. Within six months prior to the course, the nurses must have experience with arterial blood gas interpretation and basic ventilator management, knowledge and management of invasive lines, interpretation and application of laboratory results data, fluid and blood product management, and resuscitation standards for hemodynamic monitoring and titration of vasoactive intravenous medications. **(T-1).** Nurses will demonstrate

knowledge in pharmacology of commonly used medications in the respective UTC allowance standard (AS) to include, but not limited to: medication dose and use, contraindications, management and clinical indication for medications. **(T-1).**

3.2.3.1. Nurses will be current with Basic Life Support, ACLS, as well as Advanced Trauma Care for Nurses or Advanced Trauma Life Support Course; or Trauma Nurses Core Course. **(T-1).** It is highly recommended nurses have a certification in critical care nursing, emergency room nursing or flight nursing. Completion of the Air Force's Emergency/Critical Care Nurse Fellowship or Essentials of Critical Care Orientation is recommended. Nurse applicants should include a copy certificate for each applicable certification held.

3.2.3.2. Nurses will maintain a current copy of CMRP checklist for the primary nurse AFSC position listed in the MISCAP for the respective ERCC UTC, plus the CMRP checklist for qualifying AFSC currently held. **(T-1).**

3.2.4. Cardiopulmonary Technician. Cardiopulmonary Technicians nominated for assignment to an ERCC UTC must be experienced in mechanical ventilation (to include arterial blood gas interpretation, troubleshooting techniques, and capnography), medications, airway management, ARDSnet and lung protective ventilation and hemodynamic monitoring. **(T-1).**

3.2.4.1. Cardiopulmonary Technicians will be credentialed as Certified or Registered Respiratory Therapists and be current in Basic Life Support and ACLS.

3.2.4.2. Cardiopulmonary technician applicants will include a copy certificate for each applicable certification held**. (T-1).**

Chapter 4

OPERATIONS

4.1. ERCC Scope of Care. ERCC teams provide advanced specialty medical capability to evacuate critically ill and/or injured patients requiring surgery, resuscitation or advanced care during transport. Patients requiring transport by an ERCC team include those requiring damage control resuscitation, intensive nursing care, constant monitoring, mechanical ventilation, frequent therapeutic interventions, or other medical or surgical interventions vital to sustain life limb and eyesight during movement of the patient. A wide variety of adult and pediatric patients with serious medical and surgical conditions may potentially require transport by ERCC teams.

4.1.1. ERCC patients are usually in a state of hemodynamic, physiological flux, including patients whose resuscitation may still be in evolution. Prior to transport, the role of the ERCC team is to assess the patient's ability to tolerate air transport and prepare the critically ill and/or injured patient for movement. If at all possible, the CCATT team should conduct medical rounds on the patient the night before transport. This allows time for the sending facility to prepare the patient for flight, obtain medications, etc.

4.1.2. Transfer to Patient Movement Items (PMI) equipment may occur whenever it is feasible for the patient. PMI is medical equipment, tested and certified for use on Air Force and Army transportation platforms (e.g., ventilators, vital sign monitors, infusion pumps, and defibrillators,) and durable supplies (e.g., litters, mattress pads, and backrests) required to support the patient during evacuation. The ERCC UTC normally originates with a patient from a nearby or co-located MTF located at a theater ERC hub. The ERCC team chief is responsible for ensuring the ERCC team is aware of and complies with mission show and take off times. ERCC teams may also be transported from an ERC hub to forward locations to pick up patients for transport to higher levels of care. The ERCC team accompanies the patient from the originating facility to the aircraft and continues to monitor and intervene during in-flight operations as required. At the end of the mission, the ERCC team accompanies the patient from the aircraft to the destination facility, if operationally feasible.

4.2. Range. ERCC UTCs are designed to be flexible in response and may be employed to move critically injured or ill patients across the spectrum of operations. This includes AEF operations ranging from in-garrison care to homeland security, DSCA for worldwide humanitarian relief, small scale contingencies through major theater war, and any other operational tasking where this unique patient care skill set is required. Movement may occur on any appropriate platform and may include regulated or unregulated patients.

4.3. Force Health Protection. Global engagement requires forces to rapidly deploy in different parts of the world at a moment's notice. Medical personnel may potentially operate in chemical, biological, radiological or nuclear hazard environments. People, systems, and facilities of supporting bases are essential to the launch, recovery, and sustainment of aerospace platforms, usually as part of an AEF. AF medical services are crucial to base defense and resumption of operations during a wide spectrum of AEF operations. ERCC teams will be deployed with required training and individual protective equipment to counter threats. **(T-0).** When deployed or performing an active mission in-garrison, ERCC teams are exposed to the same conditions as

the members of the unit they are supporting and will be provided the same level and type of personal protective equipment as outlined in the reporting instructions. **(T-3).**

4.4. Mission Essential Items.

4.4.1. When flying on any mission, ERCC UTC members will have, at minimum, the following items on hand.

4.4.2. Identification card; dog tags, appropriate aeronautical order. **(T-1).**

4.4.3. North Atlantic Treaty Organization, Air Tasking Order, Temporary Duty, and/or deployment orders as applicable. **(T-1).**

4.4.4. Government Travel Card. **(T-1).**

4.5. ERCC UTC and Special Medical Attendant Team Relationship with AECMs and En Route Care Crewmembers. Personnel assigned to ERCC UTCs are not considered a part of the AE aircrew UTC, FFQDE, and are not rated or non-rated aircrew members. ERCC UTC members are operational support fliers. Non-UTC members of ERCC special medical attendant teams are classed as medical attendants. (**Note**: refer to AFI 11-401, *Aviation Management*, for guidance on rated flight surgeons performing ERCC duty). ERCC personnel are vital members of the USAF's en route medical care capability during deployments and patient transport missions. When assigned or attached to AE or ERC units, the AE or ERC unit commander is responsible for effective communication, coordination and integrity, and will ensure ERCC teams are supported. **(T-3).**

4.5.1. During missions utilizing ERCC UTC teams or ERCC special medical attendant teams to transport patients via AE, the MCD has OPCON over all aspects of the AE mission. The ERCC senior team physician is the team chief and has clinical authority of the assigned patient(s) during the mission. The ERCC team chief updates the MCD on any changes in the patient's clinical status and directs requests for changes in any aspect of the flight (i.e., cabin altitude or flight plan), to the MCD. For in-garrison ERCC UTCs not assigned to support AE, the gaining organization C2 is responsible for ensuring effective integration of ERCC members into the unit and the unit's mission.

4.5.2. During missions utilizing ERCC teams to transport patients on non-AE ERC missions (i.e., casualty evacuation, medical evacuation, etc.), the senior aircraft crewmember has OPCON over the mission. The senior ERCC team member has clinical authority of the assigned patient(s) during the mission. The ERCC team chief updates the senior aircraft crewmember on any changes in the patient's clinical status and directs requests for changes in any aspect of the flight (i.e., cabin altitude or flight plan) to the senior aircraft crewmember. It is the responsibility of the senior aircraft crewmember and the ERCC Team Chief assigned to a particular ERC mission to ensure team cohesiveness and integrity between ERCC teams and the flight crew. For ERCC teams assigned to support ERC units, gaining organization C2 is responsible for ensuring effective integration of ERCC members into the unit and the unit's mission.

4.6. Support. ERCC teams receive all base support from the unit of attachment. During deployment operations, the gaining unit is responsible for providing all required support for the ERCC teams including billeting, food, water, shelter, transportation, medical oxygen support, communication and coordinate resupply of medical equipment and supplies, and any other items determined essential for the ERCC teams to accomplish their mission.

4.6.1. Unit type code FFEC1, *Expeditionary Support Package*, has been designed to provide essential basic shelter and equipment storage for ERCC teams and AECMs deployed to secure, forward airfields in support of tactical operations where their presence exceeds requisite shelter-support capability at the host site.

4.6.2. If a patient transport mission terminates at a location different from the host unit's or deployed unit's location, the AECT or applicable C2 agency ensures integrity between aircrew members, ERCC team members, and support personnel will be maintained until all have returned to the point of origin. If the ERCC team members are separated from the flight crew, the ERCC team chief is responsible to ensure required support by contacting the base command post and controlling C2 agency (i.e., 618 AOC, AMD). The ERCC team chief ensures the originating unit command administration is advised of latest travel information, plan, limitations, and obstacles to returning to point of origin. **(T-2).**

4.7. Tasking and Employment.

4.7.1. ERCC Team Utilization for Regulated Critical Care Patients. ERCC teams are a limited, rapidly deployable resource available in selected situations to enhance patient movement capability. A PMRC VFS validates the necessity for ERCC patient movement. The request for ERCC teams to support a patient movement requirement comes through a coordinated effort among the originating, sending physician, PMRC VFS destination accepting physician and Theater ERCC director as required. The sending physician requests the need for an ERCC team on the PMR. Following review of the PMR, the VFS either concurs with the request or collaborates with the sending physician to arrive at a final determination.

4.7.2. The VFS also has the option to require an ERCC team, even if not originally requested by the sending physician. In the case of complex ERCC patient movements, the PMRC VFS collaborates with the Theater ERCC Director, sending physician, accepting physician, and the transporting ERCC physician when planning and coordinating a patient's transfer. Consultation between the sending physician, ERCC team physician, the PMRC VFS and/or the Theater ERCC Director is required prior to mission execution to determine the appropriate provider mix to transport neonatal and pediatric critical patients.

4.7.3. Non-Critically Ill and/or Injured Patients. The PMRC validates patients whose condition require a medical attendant regardless of the presence of an ERCC team on a mission. ERCC teams are only responsible to provide care for the patient(s) validated as requiring an ERCC team for transport. The assignment of additional non-critical patients to an ERCC team substantially reduces the capability of the ERCC team to provide care for assigned critical care patients. Should a mission be diverted en route to pick up additional critically injured or ill patients, the ERCC team may not be able to continue to provide care for a non-critical patient. Such non-critical patients should be validated with a medical attendant.

4.7.4. Unregulated Critical Care Patients. ERCC tasking for unregulated patient movement may be supported by fixed or rotary wing evacuation platforms. Tasking may be initiated by different means. Intelligent tasking either by medical assessment or defined protocols should be used to assess the appropriateness of utilizing ERCC capabilities organized, trained, and equipped to assess, resuscitate and treat unstable casualties for specific missions. In some situations, operational constraints limiting C2 visibility of casualties or potential casualties medical condition may require proactive assignment of ERCC capabilities to an evacuation mission.

4.7.4.1. These operating environments may require AE assets to evacuate patients from locations where the ability to generate and evaluate PMRs utilizing the AE system is ineffective or impossible. The role of ERCC providers on these missions includes those of accepting physician and/or medical authority.

4.7.4.2. When security or operational conditions exist requiring casualties to be moved immediately, the patient may be moved without prior PMRC validation. However, a VFS or designated medical authority clears the ERCC patients for transport. In each case, the MCD contacts AECT prior to taxi in order to correct the manifest and the total number of personnel on board. The AECT then notifies the PMRC.

4.7.5. Mission Tasking. Once the requirement to transport a critically injured or ill patient has been determined, the ERCC team may be tasked by the theater AECT, 618 AOC AE cell, or other ERC PM control agencies through the respective command chain for the required mission. Requirements for support are based on expected casualties, location, available medical capability, and ERC requirements. The number and mix of personnel are based on the requirement identified at execution.

4.7.5.1. Tasking ERCC teams for AE missions mirrors the same process as for AE crews. In determining the extent of a requirement for ERCC assets, the AECT considers capabilities and maximum patient loads with regard for acuity of patients and potential care requirements. The AECT consults with the Theater ERCC Director for expert critical care clinical guidance when ERCC teams are tasked.

4.7.5.2. High acuity patients are generally stabilizing or stabilized patients requiring mechanical ventilation, multiple vasoactive medications, ongoing resuscitation, or other advanced treatment modalities.

4.7.5.3. Low acuity patients are generally hemodynamically stable but require hemodynamic monitoring and some form of more intensive care such as titration of vasoactive medications, ventilator management, monitoring of intracranial pressure, etc.

4.7.6. Pediatric or Neonatal Transports. During operations where ERCC teams are utilized, it may be necessary to transport pediatric patients. UTC FFCC4 does not provide equipment to support pediatric patients. A pediatric equipment augmentation kit, UTC FFCC2, has been developed which provides additional equipment or supplies to FFCC4 equipment to support FFCCT when a team is required to transport pediatric patients.

4.7.6.1. If transport of pediatric patients is anticipated during operations, one or more of these augmentation kits should be requested by the combatant commander. Consultation between the sending physician, ERCC team physician, Theater ERCC Director and the PMRC VFS is required prior to mission execution considering such factors as patient

acuity, transport care requirements, age, weight, and size of patient to determine the ideal support necessary to transport pediatric critical patients.

4.7.6.2. A NICU team is notified for AE missions when neonatal requirements have been identified for patient movement from the originating station. These are extremely limited assets typically tasked to support limited, specific beneficiary or humanitarian transports. A NICU team is generally utilized to transport patients from birth up to three months old. The limiting factor in determining a "maximum or minimum" patient age of three months is the size of the transport isolette.

4.7.7. Non-Standard Regulated En Route Care Missions. For patient transports with an ERCC team utilizing smaller, space-limited airframes such as C-21, C-12, HH-60, etc., the evacuation platform crew may be constrained due to weight and space limitations. In cases of extensive patient care and support requirements, an ERCC team may be required to move a patient without an AECM or other medical crewmember. In such cases, prior approval will be obtained from MAJCOM (COMAFFOR when applicable) or A3 with mission execution authority (refer to AFI 11-202, V3, *Flight Operations*) for regulated evacuations. **(T-2).** MAJCOM COMAFFOR or A3 should be informed the ERCC team members are not aircrew and are not qualified to interface with any aircraft systems or portable oxygen systems or configure the interior of an aircraft to accept patients independent of AECMs.

4.7.7.1. ERCC ASs do not include patient therapeutic liquid oxygen (PTLOX) or a portable frequency converter. ERCC members are not qualified to operate a spectrum unit (C21), PTLOX or portable frequency converters independent of AECMs. In cases where the use of PTLOX or frequency converter is not required, the ERCC team operates under the auspices of the on-board front-end crew and only operates the equipment using battery power. When PTLOX or a frequency converter is required for the mission, a qualified AECM will be assigned to the mission for interface between aircraft systems and medical equipment. **(T-3).**

4.7.7.2. ERCC team members will communicate the amperage requirement for equipment brought on board, what equipment may operate on aircraft (400Hz) power, and what equipment must use a frequency converter when plugged in. **(T-3).** A crewmember qualified in the particular aircraft will brief the ERCC team on ground operations, flight safety, egress, loading and unloading, etc. **(T-3).** It is the responsibility of the ERCC team chief to ensure members are adequately briefed prior to the mission. It may also be necessary to pare and tailor ERCC team personnel and/or equipment. The ERCC team physician, in coordination with the tasking authority, evaluates the mission requirements to ensure patient and mission needs are met with the appropriate team and equipment complement utilized.

4.7.8. Non-AE Missions. ERCC teams may be utilized on any patient transport of critically ill or injured patients in order to save life, limb or eyesight on opportune aircraft (In Accordance With [IAW] AFI 11-401). Platforms include, but are not limited to, rotary wing aircraft, CV-22, C-212, C-23, HC-130, coalition nation aircraft, and other aircraft of opportunity. Support for critically injured and/or ill patients is a priority but should be systematically weighed against over-arching theater requirements, mission risk and threat conditions, and the appropriateness and availability of other assets to move the patient(s).

ERCC personnel may transport critically ill or injured patients on non-AE missions when operational or patient requirements dictate.

4.7.8.1. Utilization of ERCC teams on non-AE missions should be approved through the theater command and control agency governing theater ERCC. ERCC teams are not required to fly with AECMs on non-AE missions. For ERCC UTCs trained for unregulated missions, this approval can be assumed by the tasking of the UTC to the TACON of an unregulated evacuation asset. ERCC teams will follow directions of the assigned aircraft crew on factors pertaining to operating on-board the particular aircraft. **(T-3).** Prior to transporting patients on non-AE missions, ERCC members must be properly oriented and equipped for these missions, and briefed on ground operations, flight safety, egress, patient loading/unloading, etc. by a crewmember qualified in the particular aircraft. **(T-3).**

4.7.8.2. The ERCC team physician, in close coordination with the tasking authority, evaluates the mission requirements to ensure patient and mission needs are met with whatever team and equipment complement is utilized. The theater command and control agency governing ERCC ensures an alternate oxygen and electrical source that is approved for use on that aircraft is available if required as ERCC team members are not qualified to operate PTLOX or portable frequency converters. The ERCC team utilizes the oxygen and electrical source used by the aircraft medical crewmember. In cases where there is no medical crewmember support, the ERCC team operates medical equipment on battery only.

4.7.9. Peacetime Taskings. Peacetime refers to other than war support contingency operations taskings that may include, but are not limited to, President of the United States support, special operations support, within continental United States (CONUS), outside continental United States (OCONUS) beneficiary transports, and DSCA (i.e., hurricane evacuation, humanitarian assistance or disaster response, etc. These taskings could be of short notice and may be brief or extended in duration.

4.7.9.1. Peacetime ERCC missions within the U.S. India-Pacific Command (INDOPACOM) and U.S. European Command (EUCOM) AORs are managed by the respective AF supporting commands and/or assigned numbered air force. ERCC UTC assignments in these AORs represent unique multi-operation assignments when stationed at bases within EUCOM and INDOPACOM (i.e., Landstuhl Regional Medical Center). ERCC team members are designated “enablers”, to include those also considered “joint service enablers” when working at a joint service MTF while carrying out ERCC duties. ERCC teams’ primary responsibility is to be fully prepared for ERCC operations. The definitions for “on-call”, “alert” and “work/rest cycles” are distinctly different from exclusively deployed CCATTs assigned to an AE unit. Unit commanders will be cognizant of duty and rest cycles for ERCC teams assigned to the theaters. **(T-3).**

4.7.9.2. Disaster Relief. During DSCA operations such as pre- and post-hurricane landfall evacuations, or other disaster response operations, patients must be transported via local community transportation assets to a patient staging area established at or near an aerial port of embarkation suitable for handling large mobility aircraft. **(T-2).** An on-call schedule for CONUS ERCC teams required to support DSCA operations has been established by AMC/SGX and distributed to all MAJCOM and units with ERCC UTCs

assigned. ERCC teams do not leave the vicinity of the aerial port of embarkation to be transported to area medical treatment facilities or long-term care facilities to receive patients, but receive their patients from the staging activity at the aerial port of embarkation. Consideration must be given to establishing a ground patient staging or holding capability able to provide care for critically ill and/or injured patients at the aerial port of embarkation until ERCC teams arrive to transport patients out of the area. **(T-2).**

4.7.9.3. Aerial port of embarkation critical care staging assets have pre-positioned critical care equipment and supplies, same as in the ERCC kit, to support critically ill and/or injured patients awaiting transportation. Patients are transported via mobility aircraft to pre-determined medical treatment facilities located near established aerial port(s) of debarkation. ERCC teams may or may not transport patients from the aerial port(s) of debarkation to nearby MTFs. Ideally, transport services capable of providing care for critically ill and/or injured patients should receive critically injured or ill patients at the aerial port(s) of debarkation and transport the patients to nearby MTFs without degradation in the level of care. This enables ERCC teams to "quick-turn" back to the aerial port of embarkation to facilitate the swift evacuation of additional patients. Careful attention must be paid to the proper work or rest cycle management of ERCC teams during disaster operations. **(T-3).** Team members must be rested and fully able to care for their patients. **(T-3).** ERCC teams will be provided proper rest during these operations (refer to **paragraph 4.8**). **(T-3).**

4.7.9.4. DoD Healthcare Beneficiary Patient Transports. Prior to the start of Operation IRAQI FREEDOM, CCATTs routinely conducted beneficiary patient transport on AE missions within CONUS and OCONUS. On occasion, ERCC teams may still be tasked to support a beneficiary patient transport mission. This may occur more frequently in the European and Pacific theaters, but includes CONUS and other theaters as well. When an ERCC team is required for a beneficiary patient transport mission, the patient's originating medical treatment facility contacts the respective PMRC. The PMRC in coordination with the AE C2 then contacts the closest medical facility with ERCC capability to support the transport.

4.8. ERCC Work or Rest Cycle (Team Endurance).

4.8.1. General. The work or rest cycle for ERCC teams does not equate to aircrew crew duty time and should not be used for mission planning purposes. The guidelines herein are to be used to assess the ability of team members to continually provide optimal patient care for the duration of the mission, as well as to ensure ERCC team members are given adequate time for rest/recovery prior to subsequent mission taskings or returning to point of origin.

4.8.2. To ensure adequate time for rest and/or sleep cycles for ERCC teams, a rotational schedule is established among the ERCC teams at a particular location. The ERCC Director at the ERC element establishes the rotational schedule and communicates the schedule to the AE Operations Team or equivalent. In special circumstances, this rotational schedule may be disrupted according to the flow of patients or when the ERCC Director (or designee, if not available) determines that it is medically or operationally necessary to accomplish the mission successfully.

4.8.3. Contingency (i.e., Wartime, DSCA or Humanitarian) Operations. Under typical operating conditions, the standard work cycle for the ERCC teams is 16 hours. The 16-hour work period begins with show time for mission preparation. The work period ends when the team has delivered the patient(s) to the next level of care, the receiving facility has assumed care responsibilities for the patient, and all duties have been completed (to include replenishment of supplies and kits, pallet building when required, etc.). For ERCC teams, a minimum rest and duty policy should define no more than 16 hours of duty in a 24-hour time frame or scheduling multiple team members to allocate a rotation of tending the patient and resting. ERCC members will not consume alcoholic beverages within 12 hours of the beginning of the work period. **(T-2).**

4.8.4. Non-contingency Individual Beneficiary Transports. When the ERCC team originates at the same medical treatment facility as the patient being transported, the 16-hour work period begins four hours prior to scheduled take off. When the ERCC team is transported via aircraft to another facility (pre-positioned) to pick up a patient, the work period begins three hours prior to scheduled take off of the pre-positioning leg.

4.8.5. Under certain circumstances, such as delays en route due to an aircraft maintenance issue, the ERCC team chief may extend the work period beyond 16 hours in order to meet patient care requirements, to a maximum of 24 hours without outside coordination with the governing C2 agency. The team chief should consider potential benefits (including minimizing remain overnight stops and continuity of patient care) and potential harm (due to delay or fatigue). When extending the work period, the ERCC team chief notifies the MCD or Pilot-In-Command who will notify the governing C2 agency (i.e., AECT, 618 AOC/TACC or assigned AOC). **(T-2).**

4.8.5.1. Prior to the work period and throughout a mission, the ERCC team chief is responsible for continual assessment of the team's health and mental and physical abilities to safely complete a mission and provide optimum critical care. The ERCC team chief should also consider the ability of the entire team to rest when not engaged in patient care. The appropriateness of the team resting in shifts while engaged in patient care, the team's response to fatigue countermeasures, and individual team member factors affecting operational risk management.

4.8.5.2. At any point, if the team is assessed as unsafe, the ERCC team chief notifies the MCD or Pilot in Charge who will coordinate ERCC mission re-tasking with the AE Operations Team, AECT or 618 AOC/TACC or other appropriate C2 as applicable. **(T-2).**

4.8.6. There may be times (i.e., inclement weather, winds, crew duty day, etc.) when an AE mission remain overnight at locations where local medical care is less capable than the care provided by the ERCC team. The ERCC team may be required to continue caring for the patient, impacting work or rest cycles. The local MTF commander (or equivalent), MCD, and ERCC team chief should collectively determine the optimal solution to satisfy competing requirements. In instances where the ERCC team's work period is projected to or has exceeded the 16-hour period, the ERCC team chief has the authority to determine if any of the ERCC team members are in need of rest and authorizes rest if deemed necessary.

4.8.7. It is the responsibility of the AE or ERC element to assist the ERCC team in returning to the duty location of the team (point of origin) as soon as the team has had time for rest and replenishment and or reconstitution of expended supplies. For inter-theater missions, the ERCC team should be allowed eight hours of uninterrupted sleep at the destination, prior to returning to their point of origin in the theater or area of operations. When teams are allowed to sleep at the destination, teams are more capable of flying again once they return to their duty location.

4.8.8. The local commander will ensure the ERCC team whose total work period has extended beyond 24 hours, inclusive of mission support, positioning or de-positioning for a mission receives a minimum 12 hours of uninterrupted rest prior to returning to their primary duty location. **(T-2).**

4.8.9. Any ERCC team returned to the point-of-origin duty location within 24 hours from show time of the originating mission may be returned without a rest period. When this occurs, the local commander will ensure the team receives a minimum 10 hours of continuous restful activities including an opportunity for at least 8 hours of uninterrupted sleep during the 12 hours immediately prior to a mission. **(T-3). Note**: Rest period begins after release from return to point of departure **(T-2).**

4.8.10. In coordination with the Theater En Route Critical Care Director, if one is designated for the operation, the AECT/AOC may re-task an ERCC team for patient transport prior to returning the team to its home station, to support theater requirements. When an ERCC team is re-tasked for patient transport immediately following completion of a previous mission, the total duty day, inclusive of mission support and patient care activities should not extend beyond 24 hours. If operational requirements prompt the re-tasking of an ERCC team in this manner, the ERCC team chief assesses whether the team is mentally and physically able to complete the mission. If the team is assessed as unsafe, the team chief notifies the Theater ERCC Director, who, in turn, notifies the AE Operations Team and AECT to coordinate tasking for another ERCC team.

4.8.11. ERCC Work or Rest Cycle policy may be waived by the Theater En Route Critical Care Director (or AECT if a Theater En Route Critical Care Director is not appointed) when there is an operational requirement for a team to be returned sooner to the AOR, or to be re-tasked for a patient transport mission.

4.8.12. Alert ERCC Team. For an ERCC team sitting alert and awaiting a mission tasking, every effort should be made not to exceed 24 hours of continuous alert without at least 16 hours of rest with 8 hours of protected sleep prior to the next alert cycle. Alert is defined as the moment the PMRC or C2 communnicates to an ERCC member a mission is probable.

4.8.13. On-Call ERCC Team. For the in-garrison or enabler CCATT members, “on call” is a 24/7 shift without any assigned MTF responsibilities or work shifts. The ERCC member must be within the command-defined local area and ready for alert. **(T-3).** The defined local area must allow for takeoff from the flight line within 3 hours or less. **(T-3).** The ERCC director ensures subsequent coverage is available in the event the on-call team is alerted.

4.9. Flight Operations.

4.9.1. Assessment of Critical Care Patients in Permissive Environments. Prior to a regulated mission, the PMRC VFS works with the Theater ERCC Director, sending physician, accepting physician, VFS, and the transporting ERCC physician when planning and coordinating the patient's transfer. For critically ill or injured patients, assessment of the patient's clinical status for flight should be accomplished by the ERCC team at the originating medical treatment facility whenever feasible. Upon arrival at an MTF or staging location, the ERCC team: assesses the patient's clinical status for flight, performs required interventions, determines continuing in-flight care requirements, and recommends the need for critical care augmentation in flight. Patients should be transitioned to ERCC equipment and assessed for stability in an MTF environment when geographically feasible. Any interventions required to enhance stability for transport should be performed prior to transport. The transporting ERCC physician makes the final determination on transporation after the assessment, considering the patient's ability to tolerate transport and operational considerations.

4.9.1.1. For regulated evacuations, if the patient is not stable enough to transport, the ERCC physician consults with the sending physician and VFS to consider withdrawing the PMR and removing the patient from the flight manifest.

4.9.1.2. During AE missions, the transporting ERCC physician consults with the VFS from the location of patient origin if the number of patients or the acuity of patients exceeds the capability of the team. Deviations from maximum ERCC patient loads are at the discretion of the ERCC team physician and based on patient acuity, resources required and available, mission requirements, and any other factors affecting team ability to provide patient care without degrading capability. Deviations from tasked patient loads are coordinated with the VFS and communicated to the MCD prior to loading.

4.9.1.3. Allowance Standard Utilization. ERCC teams perform missions with complete equipment sets, regardless of the patient load, except on smaller, space-limited airframes. ERCC teams may pare and tailor equipment sets for use on smaller, space-limited airframes according to patient requirements. When considering paring and tailoring equipment for missions on space-limited airframes, the CCATT team chief, in consultation with the VFS and the mission tasking authority, considers unanticipated events to include but not limited to: patient requirements due to possible changes in patient condition, the possibility of receiving additional, unanticipated patients at the pick-up point, the possibility for mission re-tasking prior to return to home station, the possibility of diverting en route to pick up unexpected, additional patients, etc.

4.9.2. Assessment of Critical Care Patients in a Less Than Permissive Environments. ERCC personnel, especially those assigned to unregulated ERCC capabilities, may be required to evacuate patients from the point of injury or MTFs unable to provide required medical care for fresh or under-resuscitated casualties.

4.9.2.1. Operational factors may necessitate evacuation of patients that would normally be considered inadequately stabilized for patient movement. In these cases, ERCC personnel attempt to stabilize the patient prior to evacuation, if possible, and provide continued resuscitation en route to the nearest appropriate MTF.

4.9.2.2. ERCC UTC's tasked to support unregulated patient movement may augment or be re-tasked to support ERCC/AE UTCs in situations requiring long range pre-hospital evacuation of fresh casualties such as in anti-access/area denial environments.

4.9.3. ERCC Patient Assessment for Unregulated Patients. Due to the nature of unregulated patient movement, time for pre-mission medical planning is expected to be abbreviated. When operational constraints allow, ERCC personnel are expected to assess patient at the bedside and initiate ERCC movement from that point. As point of injury and some role 1 or 2 evacuations may require ERCC to receive patients at a trans-load location or from a casualty collection point site, ERCC teams may be expected to perform their initial assessment during evacuation.

4.9.4. AE Mission Responsibilities. The AE crew ensures all power and oxygen requirements are met and properly configured for ERCC patient requirements. The ERCC physician is responsible for all clinical decisions regarding critically ill patients under their care during patient movement, including notifying the MCD of any changes in patient status requiring collaboration through the AOC with the PMRC and VFS. The MCD incorporates the ERCC team's capabilities into pre-mission planning and briefings for patient emergencies, as appropriate.

4.9.5. ERCC physician on-board may be consulted at any time during a mission by the MCD/Flight Nurse to evaluate an AE patient who has exhibited a change in condition. If deemed necessary by the ERCC physician, primary responsibility for the care of the patient is transferred to the ERCC team and further care is documented on the AF Form 3899L, *Patient Movement Record En Route Critical Care*. Participation of the physician with any AE patient's care is documented on the AE patient medical record and a DD Form 2852 or JPSR worksheet.

4.9.6. During ground transportation at the completion of the mission, the patient is transferred to the receiving expeditionary medical platform or MTF via means with appropriate critical care capability.

4.9.7. ERCC Clinical Practice Guidelines (CPGs) and Joint Trauma System (JTS) CPGs. ERCC CPGs are developed and managed by the En Route Care Medical Director at AMC/SGK in collaboration with the CCATT community. CPGs are available, along with the JTS CPGs, on the JTS website.

4.10. Ground Operations.

4.10.1. Mission Support. ERCC teams should be included in duties related to expeditionary squadron or element deployment, employment, to include camp set-up, and re-deployment activities while maximizing operational mission readiness and appropriate work or rest cycles. Launch and recovery operations and standard aircraft configuration are the responsibility of AECMs or other service branch crewmembers or ground support personnel.

4.10.1.1. ERCC teams may assist trained, experienced personnel in aircraft configuration duties and other ground operations when authorized by the CCATT/ERCC Director (when appointed), when not on primary call and are governed by the work or rest rules. Before assisting, ERCC personnel must be fully oriented and trained in the performance of ground mission support duties and may perform these duties only under the supervision of, and in conjunction with, experienced ground support personnel. **(T-2).**

Under no circumstances will ERCC personnel be required to perform launch and recovery of aircraft, aircraft configuration, and other ground support activities without proper orientation and training and without experienced ground support personnel. **(T-2).**

4.10.1.2. AE or ERC units should regard the ERCC teams as expert critical care medical consultants, available to provide advice whenever questions arise about care of patients during transport. ERCC teams may provide clinical in-service training sessions to assigned AE or ERC element personnel, if requested, as operations allow.

4.10.2. Local MTF Assistance of ERCC teams. Critical care skills deteriorate quickly and must be practiced continuously in order to maintain the highest expertise and proficiency level. **(T-1).** AE or ERC element commanders should encourage assigned ERCC members to seek opportunities to assist personnel at a local MTF with the care of critical patients in order to maintain clinical currency and proficiency. ERCC personnel may supplement local MTF staff only when practical and not while on alert. This practice has the added benefit of providing the ERCC team with prior knowledge of the status and care requirements for patients whom they may be tasked to transport. The CCATT/ERCC Director coordinates assigned FFCCT teams to assist in a local MTF after approval from the AE or ERC element commander. The CCATT/ERCC Director is the primary liaison between AE or ERC C2 and other ground patient care facilities and determines involvement of ERCC personnel in local MTF assistance. ERCC personnel must not be scheduled for regular duty hours in a MTF due to the ever-changing nature of the flying environment. **(T-3).** Assistance in a local MTF will not interrupt work or rest cycle or mission-ready status. **(T-3).**

4.10.3. ERCC teams can assist in the support of non-ERCC patient reception and triage at an ERC staging location or other ERC patient interface point as befitting the team's clinical skills. The CCATT/ERCC Director should ensure this support does not interfere with their primary assigned duties, work or rest rule, and their mission-ready status.

4.11. Documentation. AF Form 3899L, will be used during transport of critically ill or injured patients to direct and record care. **(T-2).** A copy of the form accompanies each patient to ensure appropriate care is documented during transport and serves as the record of patient care while in the AE system. If additional AF Form 3899 attachments (e.g., A-K), are required, they should be used in addition to, not in place of, the AF Form 3899L. Examples include progress notes requiring additional space, additional medication sheets, detailed Input-Output recording, restraint use, or patient resuscitation. If available, copies of patient medical documentation including operative reports should be provided to the ERCC team chief. When applicable, use of electronic health documentation should be used in place of paper documentation whenever possible. ERCC teams are required to participate in the AE Patient Safety Program, (refer to AFI 48-107, V1, *En Route Care and Aeromedical Evacuation Medical Operations*).

4.12. CCATT Quality Improvement and Performance Improvement (QI/PI) Program. The CCATT QI/PI Program is a patient safety program and peer review activity under AFI 44-119, *Medical Quality Operations*, and 10 U.S.C. § 1102, Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants. AMC/SG has designated the CCATT Pilot Unit at the 59th Medical Wing as the central manager for the CCATT QI/PI Program.

4.12.1. It is the responsibility of the CCATT Pilot Unit to obtain all ERCC mission documentation and maintain a performance improvement platform to ensure safe patient transport. The goal of the program is to identify and correct patient care issues directly impacting patient outcome throughout the continuum of care. Identification of potential problems occurs through two primary channels: 1) CCATT QI/PI manager participates in the weekly clinical theater video teleconference identifying potential areas for improvement; 2) all pages of the completed AF Forms 3899 are sent to the 59th Medical Wing for each ERCC patient transported. After reviewing the documentation, the CCATT QI/PI manager enters data into the CCATT registry.

4.12.2. When an item for potential improvement is identified, a PI event is opened in the registry. At the completion of the investigation, the item is closed by the CCATT Pilot Unit Medical Director and feedback is provided to the involved CCATT/ERCC team. When the CCATT QI/PI manager identifies a global area for improvement, the manager forwards the information to AMC/SGK and the CCATT Initial and Advanced Course cadre for potential inclusion in the curriculum.

4.12.3. The CCATT Pilot Unit is the central collection point for all ERCC medical documentation. It is the responsibility of each ERCC team to forward medical documentation to the CCATT Pilot Unit on each patient transported during all operations and missions whether "peacetime" beneficiary movements, contingency, or disaster relief operations. When the ERCC team arrives at the destination medical treatment facility, after giving a patient report to the receiving facility, the team securely copies and scans the AF Form 3899L and supporting documentation, for each of their patients. The team will forward the copy of the medical documentation to the Pilot Unit via Fax (Defense Switched Network [DSN] 554-5053 or CML 210-292-5053) or via encrypted e-mail to: **ccattpilotunit.59mdw@us.af.mil** **(T-2).** Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 security statements will be included on all forms. **(T-0).** Faxes are received in a locked office with no through-access. The records are entered into the theater medical information system, and the QI/PI Manager uploads the documentation into the Joint Theater Trauma Registry for analysis, research, and tracking of trends.

4.12.4. If an ARC or ANG ERCC team is involved and a global issue for improvement is identified, AMC/SG will forward the feedback and/or information to ANG and AF Reserve Command Surgeons' offices. **(T-2).**

4.13. Security. Medical personnel and equipment are non-combatant assets. Personnel may be armed as dictated by theater instructions. Security for ERCC personnel and equipment is the responsibility of the host unit. All ERCC team members are issued and qualified on the assigned weapon for their UTC or position (refer to AFI 10-401, *Air Force Operations Planning and Execution* and AFI 41-106, *Air Force Medical Readiness Program*).

Chapter 5

OPERATIONAL SUPPORT FLYING

5.1. Operational Support Flier (OSF). Personnel assigned to ERCC UTCs are operational support fliers. ERCC team members are not considered, nor do they qualify to obtain, rated or non-rated aircrew status. Aircrew rules and instructions do not apply to OSF personnel. The exception to that is active flight surgeons holding an aircrew position indicator (API) 5 position performing duties as ERCC retain crewmember status. (refer to AFI 11-401).

5.1.1. Members of ERCC UTCs fly in OSF (non-crewmember) status and will comply with AFI 11-401 and AFMAN 11-402 **(T-1)**. In order to participate in flying activities, ERCC team members are medically qualified in accordance with AFI 48-123 and complete physiological training in accordance with AFMAN 11-403. Once these qualifications have been met, an ERCC UTC member may be placed on OSF status. Personnel may not be employed or deployed as a member of an ERCC UTC until all requirements for OSF status are met. As OSF, ERCC members may be eligible for hazardous duty incentive pay (HDIP).

5.1.2. Original Training**.** First-time Original Training typically occurs while attending the CCATT Initial Course. All ERCC UTC members must have a current and cleared DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*, in order to participate in and receive initial physiological (altitude chamber) training during the course. **(T-1).** Recurrent physiological training must be accomplished as required (refer to AFMAN 11-403). **(T-1).**

5.1.3. Host Aviation Resource Management (HARM) Office and Flight Record. Upon successfully completing the CCATT Initial Course and meeting the qualifications for OSF status, ERCC UTC members report to their home-station HARM or Squadron Aviation Resource Management (SARM) office with a copy of their certificate for the CCATT Initial Course, a copy of their current DD Form 2992 and their AF Form 1274, *Physiological Training.* The HARM office establishes a flight record folder for the member. Upon completing the CCATT Advanced Course, members bring a current copy of the course certificate to the HARM office to be added to the flight record folder.

5.1.4. CCATT members must be a volunteer to fly in accordance with AFMAN 11-402. **(T-1).** The member's volunteer letter (refer to **Attachment 5**), signed by the member and the member's supervisor will be forward to AMC/SGK prior to CCATT Initial training. **(T-2).** A copy will also be maintained in the member's readiness folder. **(T-2).** Due to the fact the ARC CCATT members volunteer for the ERCC UTC, an additional volunteer letter is not required for ARC personnel.

5.2. Flight Operations Protective Clothing and Equipment. ERCC UTC members will be properly equipped to perform duties in the flying environment to include issue of aircrew specific personal protective clothing items. **(T-0).** ERCC team members will have the same flight personal protective clothing, equipment, and individual protective equipment as the organic crews for the particular airframe or mission which ERCC UTC personnel are assigned or tasked. **(T-1).** Each ERCC UTC member will be provided the required protective clothing and equipment for flight operations to perform patient transport missions according to threat, mission and environmental conditions. **(T-0).** It is the responsibility of the home station unit commander

to ensure members assigned to the MTF and identified to fill ERCC position requirements are properly equipped for flight operations.

5.2.1. A list of initial-issue, minimum required protective clothing/equipment items for ERCC flight operations is shown in **Attachment 2** Commanders may approve these items for issue as organizational clothing and cite **Attachment 2** in their required written justification for the expenditure (refer to AFI 65-601V1, *Budget Guidance and Procedures*). Charge the cost of the distinctive uniforms, functional clothing and authorized alterations to the unit of assignment's Operational and Maintenance (O&M) type funds. If the member is assigned to the MTF, Defense Health Program (DHP) O&M may be used for their purchase.

5.2.2. A list of minimum-required protective clothing and equipment items for ERCC flight operations in support of combat or hostile actions is shown in **Attachment 3**. Items required for deployment or contingency operations cannot be funded from MTF DHP O&M funds and will be paid by Line (3400) funds. **(T-2).** Bases should establish a line Project Funds Management Record (PFMR) and RC/CC for the MTF to use to record these expenses.

5.2.3. Individual Body Armor (IBA) vs. Aircrew Body Armor. During combat or hostile action support operations, ERCC teams must deploy with National Institute of Justice (NIJ) Level IV Ballistic Individual Body Armor. **(T-3).** Aircrew Flight Equipment does not provide aircrew body armor to ERCC teams. Unlike the front-end and AE aircrew members, ERCC teams leave the aircraft and flight line area to retrieve patients, potentially directly exposing themselves to hostile elements, thus requiring a higher level of personal protection. If ballistic IBA is not provided by the supported Combatant Commander prior to or upon entry into the theater, ERCC team must acquire IBA beforehand. **(T-3).** IBA for contingency requirements is paid by Line (3400) funds (refer to AFI 65-601V1). NIJ Level-IV ballistic IBA should not be substituted with flak vest, as it does not provide the required level of protection. Additional information on body armor requirements may be found in **Attachment 3**.

5.3. Assignment of Aviation Service Code (ASC) 9C- Active-Operational Support (Non-crewmember). As operational support fliers, members of ERCC UTCs are authorized to perform inflight duties when on-board rotary or fixed-wing aircraft for training or real-world missions. Assignment of ASC "9C" in the Aviation Resource Management System (ARMS) authorize personnel to perform flights on-board aircraft and allow the team members to be listed on the flight authorization and perform duties on-board the aircraft. **Note:** When ERCC members are required to perform flight duties for periods greater than one month, the HARM office prepares AOs on AF Form 1887, *Aeronautical Order (PA) Aviation Service*. Copies of the AF Forms 1887 are provided to the deploying or in-garrison ERCC members.

5.3.1. In order to qualify for assignment to ASC "9C" to support patient transport missions, members must**: (T-1).**

5.3.1.1. Have completed the CCATT Initial Course; one-time attendance (a copy of the training certificate sent to the HARM). **(T-1).**

5.3.1.2. Have a current OSF physical with DD Form 2992, which is an annual requirement. **(T-1).**

5.3.1.3. Have a current AF Form 1274; after original training, flying personnel complete refresher training once every five years. **(T-1).**

5.3.1.4. Have completed, and maintain currency in, the CCATT Advanced Course; required every three years for Regular Air Force, every four years for ARC (a copy of the current training certificate sent to the HARM). **(T-1).**

5.3.2. ASC "9C" assignments are requested in writing with a letter signed by the ERCC team's home-station unit commander (refer to AFMAN 11-402). **Note:** Unit commanders may submit requests to the HARM through email in lieu of a written letter. A single letter or email listing all names is authorized. If members OSF duties spans multiple months, the request letter or email specifies inclusive dates for each month.

5.3.2.1. The HARM office updates ARMS accordingly to cover the duration of the deployment or the in-garrison mission. Requests should be presented to the HARM office well in advance of the date assignment of the ASCs to allow for proper processing. When requested in advance, the HARM office can ensure individual data summaries are prepared in time to accompany the member to the deployed location. It is the responsibility of the home-station to ensure ERCC teams deploy with an individual data summary.

5.3.2.2. Air Reserve Component (ARC) ERCC UTC members must be on mobilization orders or active duty in order to be on AOs in support of flying real-world patient transport missions. **(T-1).**

5.3.3. Non-interference AOs for Training and/or Exercises. Regular Air Force and ARC ERCC teams participating in training flights to train on their medical equipment kits must be on non-interference AOs for the duration of the training activity in order to participate in the training flight(s) (refer to AFI 11-401). **(T-1).** This applies to training flight activities conducted during the CCATT Advanced Course, Joint Readiness Training Center, Theater Aeromedical Evacuation System exercises, local training flights, or similar training flight activities. Non-interference AOs allow the ERCC teams to be listed on the flight authorization and permit them to set up their medical equipment and perform training during the flight. If an ERCC team member reports to a training flight activity without non-interference AOs, they are not be able to participate in the training activities during flight. ERCC teams may fly on familiarization flights without AOs if approved as per AFI 11-401, but are not listed on the flight authorization, nor may they set up equipment and conduct training during the flight. ERCC teams must meet and maintain the qualifications for OSF status in order to be on non-interference AOs. **(T-1).** When on non-interference AOs, members do not log time nor are eligible for HDIP; completion of Air Force Technical Order (AFTO) Form 781, *ARMS Aircrew/Mission Flight Data Document* is not required.

5.3.3.1. The process for requesting non-interference AOs mirrors the process for requesting OSF AOs for normal ERCC missions; non-interference AOs are requested in writing with a letter signed by the ERCC team's home station unit commander. Check respective MAJCOM supplements for additional guidance on requesting non-interference AOs, as applicable. The letter must clearly state the request is for non-interference AOs. **(T-1).** The AOs should be requested to cover the duration of the course, exercise, or other particular training activity. When flying with non-interference AOs, OSF personnel do not log time and are not eligible for incentive pay.

5.3.3.2. AF Form 1887. OSF AOs are only valid for a calendar month at a time and expire the last day of each month, unless an earlier termination date is known. New AOs are published monthly for those members who need to be on AOs for extended periods. When ERCC members require AOs for periods greater than one month, the HARM office prepares the AOs on AF Form 1887 and gives the deploying or in-garrison ERCC members sufficient AOs required for the duration of their deployment.

5.3.3.2.1. **Exception:** The CCATT-OSF Program is funded on a fiscal year basis. When a member's deployment stretches from one fiscal year into the next, the HARM office supplies AOs effective through the last day of the fiscal year. As the central manager for the CCATT-OSF Program, AMC/SGK requests program allocations each fiscal year through AMC/A3 NLT 15 June. AMC/A3 consolidates man-month requirements into two categories, officer and enlisted, and sends the request to AF/A3XM NLT 15 July. In turn, AMC/SGK provides new fiscal year program allocations to each HARM office supporting ERCC teams. Excess allocations from the prior fiscal year may not be carried into the following fiscal year. HARM offices turn in excess or unused CCATT-OSF program allocations to AMC/SGK who turns in the excess/unused allocations to AMC/A3 at the end of each fiscal year.

5.3.3.2.2. Home unit HARM offices forward man-month usage to AMC/SGK by the 10^{th} day of the following month the man-months were used.

5.3.4. AFTO Form 781**.** As OSF, ERCC members are authorized to log flight time on AFTO Form 781. AFTO Form 781 is the source document for recording and reporting operational flight information for each individual authorized to take part in a mission. This form is the primary record of both personnel and aerospace vehicle flying hours. It is also the official record to validate pay eligibility for qualified members required to fly.

5.3.4.1. Logging Flight Time. In order to qualify for HDIP for any particular month, ERCC members log a minimum of four hours of Primary flight time within that month, or the appropriate fractional time required to qualify for partial HDIP if member is on orders for less than 30 or 31 days (DoD 7000.14R, *Financial Management Regulations (FMRs)*, V7A, *Military Pay Policy - Active Duty and Reserve Pay*). Only Primary time logged counts toward credit for HDIP; ERCC teams only log Primary time when actually performing patient care duties on-board the aircraft. ERCC members may not "bank" flying time or carry time over from one month to another in order to meet the minimum required to qualify for HDIP. 5.3.4.2. Pre-positioning en route missions to pick up patients requiring medical care will be logged as "Other" time when patients are not on board the aircraft (refer to AFI 11-401). **(T-1).** (For example: An ERCC team is tasked to fly to pick up a patient downrange. On the en route mission to pick up the patient, the ERCC team logs "Other" time. Primary time is logged on the leg when the patient is on board the aircraft and the ERCC team provides medical assistance in-flight.) Complete AFTO Form 781 (refer to AFI 11-401).

5.3.4.2. Member(s) list duties performed on the back of AFTO Forms 781 in the remarks section. The completed AFTO Form 781 must be submitted to the supporting SARM member at the deployed location or to the ERCC team's home station HARM office in a timely manner, preferably at the end of each mission, but not later than the fifth day of

the month following the month in which a mission was flown. **(T-2).** AFTO Forms 781 not turned in on time, may result in a member not receiving flight time credit or HDIP for the month during which the corresponding mission was flown. Under no circumstances are AFTO Form 781's to be held until the end of an extended deployment before being turned in to the HARM office. On AE missions, ERCC teams may coordinate with the MCD to ensure proper documentation on the AFTO Form 781.

5.3.4.3. Logging Flight Time on Non-AE Missions on Other Than USAF Aircraft. When transporting patients on non-AE missions on non-USAF aircraft, ERCC team members carry their own AFTO Form 781. After the mission, complete the AFTO Form 781 and turn it in to the supporting SARM at the deployed location or to the ERCC team member's home station HARM, whichever is appropriate. The Remarks section of the form should include a statement such as, *"CCATT transported "#" patient(*s*) via US Army UH-60; I certify this is a true and verifiable statement."[Signed]*; or similar wording as appropriate.

5.3.4.4. Partial Team. On occasion, a patient may not require a full ERCC team complement, or there may be other operational constraints where less than a complete ERCC team complement may be tasked to transport a patient. It is not necessary for the whole team to be tasked for the mission to be considered an ERCC mission. Individuals flying without the full team complement fly with active AOs, log time and may qualify for HDIP.

5.3.4.5. Signature on AFTO Form 781. The aircraft commander, senior OSF member of the team, and MCD (when on AE missions) ensure OSF personnel fly only on missions requiring performance of valid in-flight duties and confirm Primary flying time is logged only during portions of the mission when valid in-flight duties are performed. Aircraft commander or senior OSF member ensure actual duties performed are documented in the remarks section of the AFTO Form 781, and certify by signing under the remarks section. ERCC members should include their home station HARM/SARM base, DSN phone number, and fax number, if known, in the remarks section on the back of the (original and extract) AFTO Form 781. **Note**: AOs alone do not authorize a member to fly and log time for entitlement to incentive pay. Time spent in observation, familiarization, or point-to-point travel (except for pre-positioning legs) is not logged on the AFTO Form 781.

5.4. Aviation Service Code (ASC)/Flying Authorization Duty Code**.** The assigned ASC for ERCC members performing duties as operational support fliers is "ASC 9C." The flying authorization code for ERCC teams on OSF is "FZ" per AFI 11-401.

5.4.1. Active flight surgeon on ERCC UTC (refer to AFI 11-401). Active flight surgeons in an API 5 position may be employed as ERCC UTC members provided they also hold one of the qualifying AFSCs required for ERCC duty as outlined in the UTC MISCAP statement and Manpower Force packaging document. Active flight surgeons log "FS" crew position and primary-time duty credit, record "ASC 8A", and may qualify for Aviation Incentive Pay.

5.4.2. Inactive flight surgeon on ERCC (refer to AFMAN 11-402)**.** Inactive flight surgeons, those in an API 0 position – may also be employed as ERCC UTC members provided they hold one of the qualifying AFSCs as outlined in the UTC MISCAP. Because they are rated officers, their ASC remains "8J" (based on no API 5 or no Aviation Incentive Pay authorized), their AOs reflect a "flight activity code 8" (rated officer performing non-crew

duty), and they log flight authorization duty code "FZ" time on ERCC missions (refer to AFI 11-401). Following this guidance, inactive flight surgeons employed on ERCC UTCs are authorized HDIP, if otherwise qualified.

5.5. Flight Authorization. The unit providing the AE or ERC crew originating with a live mission or an ERCC training mission is responsible for adding the ERCC team members on the flight to the manifest of the aircrew flight authorization after validating members have current AOs. For an ERCC team joining the mission en route, the MCD or equivalent validates members have current AOs, ensures the members' names are handwritten onto the flight authorization and ensures flight time is logged (refer to AFI 11-401).

Chapter 6

TRAINING

6.1. Introduction. Initial, advanced, and recurrent training are required in order to maintain the operational and clinical proficiency of ERCC UTC-assigned personnel. All ERCC UTCs share CCATT Initial and CCATT Advanced Courses as the foundation-level qualifying courses. ERCC UTC members will not be employed or deployed in an ERCC UTC capacity unless they meet all initial and recurrent training requirements. **(T-1).**

6.2. Unit ERCC Coordinator. The unit Medical Readiness office is responsible for:

6.2.1. The central point of contact within the unit for all matters pertaining to ERCC teams' interface with the unit, parent MAJCOM, Pilot Unit, MEFPAK and higher headquarters for ERCC issues.

6.2.2. Establishing and maintaining training folders for each ERCC UTC member assigned and ensuring all requirements are appropriately listed and tracked in the Medical Readiness Decision Support System.

6.2.3. Ensuring all initial and sustainment training requirements are scheduled to be met/current.

6.2.4. Initiating all required forms and documentation for all new ERCC UTC members.

6.2.5. Ensuring ERCC teams are properly equipped for patient movement missions.

6.2.6. Ensuring members are ready to deploy.

6.2.7. An ERCC Team Coordinator may be appointed by the Commander to fulfill these duties. This person should be appointed in writing by the medical unit commander. If an ERCC coordinator is appointed, notify AMC/SGK and AMC/SGX of the member's name and contact information to ensure appropriate distribution of information; e-mail: **amc.sgk@us.af.mil**. Key information distributed by AMC/SGK and SGX offices should include owning MAJCOM SGX offices for situational awareness. **Note:** This does not apply to ERC units when ERCC teams are temporarily assigned or attached. During deployments, when ERCC teams are assigned to an ERC element, a director is designated for local management of ERCC teams.

6.3. Entry into ERCC Training. Personnel are selected at the unit level for nomination and appointment to an ERCC UTC.

6.4. Training (refer to Attachment 4).

6.4.1. Training Pipeline. Training attendance priority should be given to those tasked in the AEF Tempo Band Construct to meet deployment requirements.

6.4.1.1. CCATT Initial Course**.** All ERCC UTC personnel (Regular AF, AF Reserve, and ANG) complete the CCATT Initial Course IAW AFI 41-106.

6.4.1.1.1. Physicians in a residency or fellowship at an MTF-based training program (not AF Institute of Technology sponsored) that awards an FFCCT applicable AFSC (IAW the FFCCT MISCAP), may attend CCATT Initial in their final year of training.

6.4.1.1.2. All Regular Air Force CCATT Initial students will have a "volunteer to fly" letter on file IAW **paragraph 5.1.4** **(T-2).**

6.4.1.1.3. All members coming from a residency or fellowship need a consultant letter stating the member is anticipated to move into a FFCCT assignment.

6.4.1.2. The Fundamentals of Critical Care Course is a highly encouraged, optional pre-requisite for the CCATT initial course. The course provides a standardized platform to prepare individuals for the CCATT initial course. AMC/SGK registers students for the on-line course a minimum of 30 days prior to the beginning date of the course. The course is open to total force personnel. AMC does not program for man-days for the ARC. If an individual non-validates at the advanced course, the Fundamentals of Critical Care Course will be completed prior to returning to the course to re-validate. **(T-2).** It may also be taken as a refresher course for the CCATT advanced course.

6.4.1.3. CCATT Advanced Course. All ERCC UTC personnel (Regular Air Force, AF Reserve, and ANG) complete the CCATT Advanced Course IAW AFI 41-106.

6.4.1.3.1. ERCC UTC members who are identified for deployment during the year in which they complete the CCATT Initial Course also will complete the CCATT Advanced Course prior to deployment. **(T-1)**

6.4.1.3.2. Every effort should be made to schedule all ERCC personnel to attend this UTC training *in advance* of their potential AEF Block assignment to ensure they are successful in course completion. Do not wait to schedule this course. Attendees who do not successfully complete the CCATT Advanced Course require remediation and re-attendance at the CCATT Advanced Course prior to deployment as an ERCC member. The remediation training plan is issued by the course director through USAF School of Aerospace Medicine/Academic Operations to AMC/SGK. AMC/SGK informs the owning MAJCOM SGX who in turn informs the Commander of the individual.

6.4.1.3.3. The course curriculum includes a field exercise involving static training and a flying training mission (when available). ERCC members attending the CCATT Advanced Course must be current in OSF requirements and have non-interference AOs on-hand to participate in flying training activities during the course. **(T-1).**

6.4.2. ERCC Flight Training**.** The primary objective of ERCC flight training is to develop and maintain the skills necessary for the effective employment of ERCC teams within the flight environment during all manner of contingencies and missions. The secondary objective is to ensure the successful integration of ERCC teams into ERC operations, primarily working alongside AECMs or organic crewmembers to transport patients.

6.4.3. Initial and subsequent flight training requirements for ERCC teams is met through formal course attendance. All ERCC teams are encouraged to seek additional flight training opportunities through participation in activities such as exercises or local unit training.

6.4.4. An AE crew must be on-board the aircraft during flight training activities involving UTC FFCCT teams (except on rotary wing aircraft). **(T-1).** ERCC teams must be on non-interference AOs to participate in any flight training activities. (refer to **Chapter 5**) **(T-1).**

6.4.5. ERCC Training Mission. ERCC flight training missions should be structured to achieve maximum training effectiveness for both ERCC teams and AE crews. ERCC Training Mission sessions should include at least one enplaning or deplaning event with occupied or weighted litter(s). Exercise scenarios should also include loading and exercising of the complete assigned UTC equipment kit to include set-up of medical equipment and appropriate patient treatment and transport scenario(s). Sessions should also include one aircraft emergency scenario under the direction of the MCD or Medical Crew Coordinator or organic crewmember equivalent. ERCC teams are highly encouraged to fly on AE training missions as available.

6.4.6. Operational Support Flier Training**.** All ERCC UTC personnel must complete the requirements for OSF status (refer to AFMAN 11-402). **(T-1).** ERCC UTC personnel must maintain currency in OSF requirements as long as they are assigned to an ERCC UTC. **(T-1).** Personnel may not be employed or deployed as ERCC members if they have not completed or are not current in OSF requirements. ERCC UTC members must be on OSF AOs in order to participate in flight activities on-board U.S. and coalition aircraft. **(T-1).**

6.4.7. Operational Exercises. Some sustainment training and CMRP checklist items may be completed during operational exercises. To receive credit, exercises have a written training plan outlining day-to-day objectives for the ERCC teams. The training plan will follow the ERCC UTC Mission Essential Task List. **(T-3).**

6.4.7.1. ERCC teams participating in exercises will participate with their associated equipment UTC. **(T-3).** The ERCC teams perform relevant tasks associated with the ERCC UTC Mission Essential Task List, e.g., mission planning, patient preparation, setting up and exercising their medical equipment, transport and treatment of simulated casualties or mannequins, etc. ERCC UTC members participating in exercises will be current in OSF requirements and have non-interference AOs on-hand to participate in training missions involving flying activities during the exercise. **(T-1).**

6.4.7.2. ERCC Team Observer Controller (OC) and/or Standards Evaluator (SE). A qualified ERCC OC/SE should be present for exercises (qualified ERCC team OC/SE is defined as any ERCC UTC member who has completed the CCATT Initial and Advanced Courses, and is current in all required training; Joint Readiness Training Center, deployment, and/or mission experience is preferred but not required. Standards and responsibilities of ERCC OC/SE are outlined in the ERCC Observer Controller/Standards Evaluator Pamphlet available from AMC/SGK. Requesting unit pays travel and expenses for individual(s) to participate in exercise as OC/SE. Availability of personnel to support OC/SE requests is at the discretion of the supporting unit. If OC/SE personnel are utilized, there should be at least one OC/SE per two ERCC teams, availability permitting. The exercise organizer(s) should develop a written training plan with relevant objectives for the ERCC team(s), following the ERCC UTC METLs. A reasonable effort should be made to secure qualified ERCC OC/SE personnel for the exercise(s).

6.4.8. Readiness Training. IAW AFI 41-106, all personnel are required to complete all readiness training.

6.4.9. High Risk of Isolation Training**.** High Risk of Isolation Training may be required by combatant commands as defined in the AOR OPORD. Training is accomplished as outlined in applicable theater reporting instructions. Consult the local Survival, Evasion, Resistance and Escape (SERE) specialist. The readiness office will maintain a copy of the training documentation in the individual's ERCC training record. **(T-1).**

6.4.9.1. DD Form 1833, *Isolated Personnel Report (ISOPREP).* ISOPREP forms are prepared for all high risk of isolation personnel. The ISOPREP contains information designed to identify and authenticate an evader by a recovery force. An Isolated Personnel Report is prepared by home-station intelligence personnel for deploying members prior to departure to an AOR where Isolated Personnel Report and High Risk of Isolation training is required. It contains personal data known only to the isolated individual and is used by recovery forces to positively authenticate the survivor.

6.4.9.2. An initial form is completed and then reviewed at least every six months. Once completed, the Isolated Personnel Report is classified Confidential and is maintained by the appropriate unit intelligence, SERE, or operations personnel.

6.4.10. N95 Mask Fit Testing and Training**.** ERCC personnel are potentially exposed to highly communicable diseases during patient care and transport. N95 respirators are Occupational Safety and Health Administration approved for personal protective equipment and provided in the AS. (refer to AFI 48-137; *Respiratory Protection Program).*

Chapter 7

LOGISTICS & EQUIPMENT

7.1. Aircraft Medical Equipment Operations.

7.1.1. Medical equipment and supplies are vital to the ERCC mission. There are many hazards associated with dynamic in-flight environmental conditions that are not encountered in fixed medical treatment facilities. Equipment used onboard aircraft must continue to operate properly under flight conditions. **(T-1).** It is essential that ERCC members know the capability and performance limitations of equipment items in the ERCC equipment UTCs.

7.1.2. All medical equipment intended for use during aircraft operations is tested, deemed airworthy and approved prior to use in the aircraft environment. Every effort should be made to utilize the medical equipment provided in the AS.

7.1.3. Some medical equipment is incompatible with the airborne environment. Medical equipment approved for use during aircraft operations is identified in AFMAN 10-2909, *Aeromedical Evacuation (AE) Equipment Standards*, and/or the *Aeromedical Evacuation Medical Equipment Compendium*. AMC ensures standardization for medical equipment used system-wide.

7.2. Medical Equipment Waiver Protocol. At times, patient medical requirements may necessitate the use of non-standard medical equipment that is not provided in the AS and has not been approved for flight. AMC/A3VM is the waiver authority for non-certified or non-standard medical equipment required for patient moves.

7.2.1. Waiver requests will be routed as follows: hospital or MTF notifies the appropriate PMRC; PMRC contacts appropriate C2 agency; C2 agency contacts 618 AOC AE Cell; AE Cell contacts AMC/A3VM. **(T-2).** A3VM consults with the AE Equipment Lab during their hours of operation. **(T-1).** Further consultation on aircraft impact of non-certified or non-standard equipment occurs with the Global Patient Movement Requirements Center VFS on duty.

7.2.2. Waiver will be obtained prior to use of non-certified or non-standard equipment onboard the aircraft and will apply only to that specific mission. **(T-2).** In order to prevent mission delays, verbal waivers may be obtained from AMC/A3VM (refer to AFMAN 11-2AEV3; *Aeromedical Evacuation Operations Procedures*).

7.3. Medical Equipment Malfunction or Failure. During flight operations on AE missions, ERCC teams will notify the MCD immediately when medical equipment malfunctions or fails during operation on a mission. **(T-2).** On return to home station or deployed location, the team notifies local or unit-supported medical maintenance organization of unusual or repeated equipment failure and safety incidents.

7.3.1. If equipment malfunctions or a failure occurs during an AE mission, the ERCC Team Chief, in collaboration with the MCD, ensures the following documentation and actions are accomplished: 1) complete AF Form 4449, *En Route Care Equipment Malfunction Report Tag*; if unavailable, complete AFTO Form 350, *Reparable Item Processing Tag*; 2) complete DD Form 2852 or JPSR worksheet. For non-AE missions (no MCD/AECMs on board), the ERCC Team Chief ensures the documentation is accomplished.

7.3.1.1. When medical equipment is found to be non-operational or operating outside of acceptable parameters, and troubleshooting attempts have failed to rectify the situation, disconnect the device and fill out AF Form 4449. Any ERCC team member or AECM may complete the form. Give a detailed description of the equipment problem and circumstances leading to the discovery of the problem. Include statement listing any attachment(s) to the device, and any effect on attachment(s) to the device. Attach the AF 4449 to the piece of equipment for turn-in. (Example description: "During pre-flight of 326M suction unit, tried to adjust suction to 100mmHg but only able to obtain 75mmHg with knob turned to max; normal should be 0 to 550mmHg"). It is important that all settings, dials, etc. be left as they were during the incident. Do not turn the knobs or change settings, if possible.

7.3.1.2. Upon arrival to home station or deployed location, immediately sequester and send tagged equipment and all accessories (cords, supplies, etc.) attached to the equipment to home station or deployed location medical maintenance organization. Medical maintenance impounds the equipment and conduct an investigation of the malfunction.

7.3.1.3. Completion of DD Form 2852 or JPSR worksheet. If available, photo document concern and attach to event report.

7.3.2. If an equipment malfunction occurs, the ERCC Team Chief and the MCD collaborate to complete, or direct completion of, DD Form 2852 or JPSR worksheet and document the issue immediately after the occurrence. For non-AE missions, the ERCC Team Chief ensures the documentation is accomplished. Upon return to home station or deployed location, the DD Form 2852 or JPSR Patient Safety Worksheet is turned in to the AE element Patient Safety Monitor who then enters the event into the AE Patient Safety Database tool. (**Note:** Anyone with knowledge of the incident may complete a DD Form 2852 or JPSR Patient Safety Worksheet). Additional information located in AFI 48-107, V1, Chapter 9.

7.3.2.1. Provide as complete a description of the malfunction as possible and the operating conditions when the malfunction occurred; identify make, model, serial number, AF Form 4368, *Scheduled Maintenance and Certification Label*, or DD Form 2163, *Medical Equipment Verification Certification*, information, and what other equipment or power was involved. Provide circumstances leading to the event and include any pertinent information such as: O_2 source, patient activity, turbulence, cabin altitude, trouble-shooting attempted, etc. Also, provide names of individuals involved and contact information.

7.3.2.2. When equipment malfunction affects the aircraft, the MCD notifies the Pilot In Command and provides details of the incident to facilitate mishap reporting. The MCD forwards the report through the Aviation Safety Action Program to AMC Safety. On non-AE missions, the ERCC Team Chief notifies the Pilot in Command and provide details of the incident.

7.4. ERCC Allowance Standards (AS). ERCC UTC equipment packages are to be used in conjunction with the standard AE or ERC in-flight kit to provide focused critical care capability.

7.4.1. ERCC UTC Sets. When ERCC UTCs deploy into a theater of operations, each personnel UTC is paired with an ERCC equipment kit to support patient transport missions. ERCC equipment UTCs are positioned at a location for each ERCC personnel UTC there.

7.4.2. Each team at a deployed location is assigned a kit. The team's primary responsibility is to inventory, maintain, and restock bag sets; and, ensure equipment is recharged between missions. PMI bar codes are attached to the ERCC equipment once in theater to facilitate tracking of those assets.

7.4.3. During continuous contingency support operations, ERCC teams may be deployed for limited time periods with subsequent, follow-on ERCC teams deployed in "rotations" in place of a previous team. In such cases, ERCC kits should be inventoried, re-stocked, and re-packaged as per the UTC pack-out guide, then handed over to the newly deployed ERCC team for use during their rotation period. Medication and supply outdates are identified in conjunction with the equipment and/or supply turnover. Unless otherwise directed, ERCC kits should remain at the deployed location until the end of the operation.

7.4.4. Standard Operations. While performing patient care duties, ERCC teams should utilize equipment from their ERCC kits to the fullest extent. When an ERCC team has exhausted equipment items from their assigned ERCC kit, the team should utilize equipment to the extent possible from the PMI system, if a PMI pool of equipment has been tasked and deployed to support an ongoing and sustained contingency operation. **Note:** This is only applicable at present to the CENTCOM AOR and any future contingency operations that may be established and ongoing. There is no PMI pool of equipment established for "peacetime" operations. Sending MTFs identify patient movement equipment requirements and durable supply items in the PMR.

7.4.4.1. When picking up multiple patients at a facility in a theater that is a PMI node, the sending facility provides additional PMI equipment in cases where the ERCC UTC AS is exhausted. The sending facility also provides non-standard theater-specific PMI-tracked items not on the ERCC UTC AS, as required for patient care (some examples include: negative pressure wound vacuum pumps, sequential compression devices, pain control pumps, etc.) with enough supplies to support the patient during flight.

7.4.4.2. When transporting multiple patients from a facility that is not a theater PMI node and the ERCC team anticipates its AS will be exhausted or that PMI equipment not on the ERCC UTC AS will be required to perform a safe transport, the ERCC team must bring the additional PMI from their originating location (i.e., PMI node). **(T-2).**

7.4.4.3. For situations in which ground time is limited due to the tactical situation, the ERCC team may trade equipment items from its AS for PMI in-kind (same make and model) items from the sending facility. This practice expedites patient assessment and packaging prior to transport, but it does not result in a net gain or loss of PMI for either the ERCC team or the sending facility. To ensure local equipment accountability and integrity is maintained, the sending facility and the ERCC team must coordinate the return exchange of equipment that is on different Defense Medical Logistic Support System accountable records. **(T-2).**

7.4.5. ERCC UTC ASs have defined capability to support specific types and numbers of patients.

7.4.5.1. FFCC4, Adult CCATT Kit. This UTC provides advanced specialty medical equipment to support personnel UTC FFCCT. Each UTC FFCC4 has the capability to support up to three high-acuity, ventilated patients or up to six lower-acuity, non-ventilated patients per intra- or inter-theater mission depending on patient acuity. A basic adult mission would require the adult kit with initial 72-hour capability. Each kit is only good for one mission support and will require replenishment at mission end. **(T-2).**

7.4.5.2. FFCCB, CCATT Equipment Resupply. This UTC provides the re-supply package to support FFCC4; it provides 15 days support for up to three basic FFCC4 packages.

7.4.5.3. FFCC2, ERCC Pediatric Equipment Augmentation. This UTC provides advanced specialty medical equipment and supply augmentation support to the FFCC4 equipment UTC specifically for transport of pediatric patients, except for a transport incubator. This kit provides single mission support for a maximum of two pediatric patients weighing < 15 kg and, a maximum of 2 pediatric patients weighing between 15 – 40 kg. Re-supply is provided within the AE system at staging locations or supported element.

7.4.5.4. Pediatric Support Operations. During operations where ERCC teams are utilized in support of critical care patient movements, there may be occasions when it is necessary to transport pediatric patients. UTC FFCC4 does not provide equipment to support pediatric patients. UTC FFCC2 was developed to provide additional equipment and supplies to UTC FFCC4 to support FFCCT when a team is required to transport pediatric patients. The FFCC2 AS should be deployed to theater hubs for pediatric transport. For every four FFCC4 kits deployed, one FFCC2 kit should also be deployed. Close coordination between the PMRC, the tasking authority, and the ERCC team considering such factors as patient acuity, transport care requirements, age, weight, and size of child is necessary in determining which team may be most appropriate for a pediatric transport mission.

7.4.5.5. FFEC1 Expeditionary Support Package. This UTC provides basic shelter to ERCC teams and AE crewmembers positioned at far-forward, secured airfields. Package is deployed with FFCCT and/or AE crewmembers (UTC FFQDE) when required to support a maximum of 30 personnel for 96 hours. Base operating support is required for food service, bio-environmental engineering, security, logistics, fuel, and civil engineering.

7.5. Pre-flight of Equipment. Pre-flight medical equipment prior to each mission as per process defined in AFMAN 10-2909. ERCC equipment with non-current calibration and servicing dates will not be used. **(T-2).** Equipment assets found to be out of service date will be immediately turned over to the host biomedical maintenance activity for service. **(T-2).** When deployed, teams are responsible to frequently assess assigned equipment operational capability and ensure adequate battery life. ERCC teams will ensure appropriate charging capabilities are available for equipment prior to declaring full operational capability. **(T-2).** Any item not listed in AFMAN 10-2909 or listed in the *Aeromedical Evacuation Medical Equipment Compendium* will require a waiver prior to flight. **(T-2).**

7.6. Narcotics Accountability. ERCC personnel will ensure accountability of narcotics (refer to AFI 48-107, V1, and local guidance or policy). **(T-1).**

7.7. Base Operating Support. Integration of deployed ERCC teams is critical to successful ERC operations. ERCC teams are not stand-alone units. The gaining AE or ERC unit are responsible for providing all required support to the ERCC teams, including billeting, food, water, shelter, power, transportation, medical oxygen support, computer support, and communications. During missions away from home base, ERCC teams receive base operations support from the appropriate en route element. UTC FFEC1 should be deployed when ERCC teams are engaged in a bare-base deployment with early-entry ERC forces without full logistical support from the gaining base.

7.8. Resupply and PMI. Teams coordinate with MTF or ERC medical logistics personnel for repair, maintenance or replacement of PMI. PMI maintenance issues should be coordinated with the Medical Equipment Repair element associated with the closest MTF. PMI is tracked by utilizing the PMI Asset Tracking System (PMI-ATS) when and where available. Accountability is maintained on a Custodian Receipt Locator List at the host MTF Defense Medical Logistic Support System under Responsibility Center/Cost Center XX5881 for all peacetime PMI operational assets.

7.8.1. All members will scan PMI assets each time a piece of PMI changes status (i.e., PMI-ATS codes: Quality Assurance (QA) for maintenance, OUT, and RDY, etc.). **(T-2).** ERCC team members are responsible for scanning all PMI prior to and after each mission. Sending MTFs not designated as PMI Nodes, will identify patient movement equipment and durable supply item requirements in the PMR and the ERCC teams are responsible for providing those items. **(T-2).** The sending MTF is responsible for providing a one-day minimum of medical supplies.

7.8.2. Patient Movement Item Asset Tracking System**.** Supported units actively scan equipment assets using PMI-ATS. These assets should be clearly labeled with PMI Radio Frequency Identification Data bar codes and scanned no less than monthly for in-garrison activities and at least every two to three days in a deployed area. All assets should be scanned each time they move in or out of the unit and/or change from RDY to QA status to provide in-transit visibility. Assets without labels (not bar coded) or needing additional labels must be identified and reported to: **hqamcpmi@us.af.mil** or the nearest PMI Center. **(T-1).** Labels are validated and, if approved, prepared and sent to the appropriate unit.

7.9. Operational CCATT Kit Program. AMC/SG MEFPAK Branch (AMC/SGXM) Support and Sustainment Guidelines for Regular Air Force & ARC Operational CCATT Kits:

7.9.1. General. AMC/SG provides initial outfitting of approved and validated operational UTC FFCC4 kit to support local, home-station CCATT training. These operational kits may be tasked to support live, real-world mission requirements. AMC/SG may also provide initial outfitting of a limited number of operational kits for other ERCC capabilities, such as formal training organizations. AMC/SG also provides supply replenishment and sustainment of those kits at no expense to the supported unit, with the following exceptions: narcotics and refrigerated items. Equipment maintenance support and repair or replacement of kit items is a local unit funded responsibility. This operational kit support program may be continued by AMC/SG as long as funding is available. AF Reserve Command and ANG must identify CCATT operational requirements to AMC/SGXM for budget programming in the Fiscal

Year Defense Program. **(T-1). Note:** ARC units requesting assignment of a CCATT Operational Kit should have a minimum of two UTC FFCCT members assigned. Assigned members will have completed, at a minimum, the CCATT Initial Course to be eligible for assignment of a CCATT Operational Kit to their unit. **(T-1).**

7.9.1.1. Operational kits will be maintained by the units to which they are assigned in a "Mission Ready" state. **(T-2).** Units will report the readiness status of these assets quarterly to their respective MAJCOMs and AMC/SGXM **amc.sgxm@us.af.mil**. **(T-2).** AMC/SGXM will provide guidance and report format via the Operational Kit CONOPS. **(T-2).**

7.9.1.2. The daily maintenance, equipment repair, and asset accountability is the responsibility of the assigned organization and its host medical treatment facility via a memorandum of Agreement or Understanding. Tracking and use of these additional operational kits will follow the same guidance as provided for FFCC4 War Reserve Materiel kits. Each supported organization must provide adequate storage, oversight, protection, management attention, and periodic inventory support to ensure proper maintenance of the kit. **(T-2).**

7.9.1.3. The operational kits are not War Reserve Materiel assets. It is understood, after periodic training activities, items in the kits may be expended or damaged during training, rendering the kit "Not Mission Ready" for a brief period. In such cases, expended or damaged items should be ordered, repaired and/or replaced, as per the guidance herein, as soon as possible after the training event. This is to ensure operational kits are returned to "Mission Ready" status expeditiously.

7.9.1.4. Operational kits are intended for frequent, active use to support local team training and exercise support, as well as operational mission use. On occasion, CCATTs may be tasked to deploy with an Operational CCATT Kit that is assigned to their home-station unit. Most likely, such occurrences would be in support of DSCA, disaster relief, or humanitarian operations. When deploying with an Operational CCATT Kit, CCATTs are responsible for inventory, maintenance, re-stocking and utilization of Operational Kits, just the same as during combat operations. However, Operational CCATT Kits do not remain during an event for use by any subsequent, deployed CCATT. When a CCATT is tasked to deploy with an Operational CCATT Kit from its home-station unit, the team should ensure the Operational CCATT Kit returns with the team upon re-deployment back to home-station.

7.9.2. Operational Kit Re-Supply and Sustainment. UTC FFCC4 consists of a series of bag and containers packed-out in accordance with Allowance Standard (AS) 887N. ASs can be found on the Air Force Medical Readiness Agency SGM AS website: **https://medlog.us.af.mil/** . Contact AMC/SGXM for supply replenishment for operational kits. Supply replenishment for CCATT Operational Kits will be furnished in the lowest unit-of-measure quantities. **(T-2). Exception:** AMC/SGXM does not furnish narcotics or refrigerated items in the operational kit. It is the unit's responsibility to establish appropriate supply support from their host unit for these items to include all Drug Enforcement Agency requirements.

7.9.2.1. A request for expendable supplies not on the FFCC4 AS is the responsibility of the local organization and will not be accepted or supported by AMC/SGXM. **(T-2).**

Supply replenishment orders should be placed as supplies are consumed, but not more frequently than once every week. Orders may be submitted via furnished shopping guide electronically via e-mail to the AMC/SGXM Operational Kit Support Program organizational account: SG/**SGXM.Opkits@us.af.mil**.

7.9.2.2. Telephone orders may be submitted (commercial 618-229-6952 or DSN 312-779-6952), but will be limited to 10 items or less due to the total number of items in the kit. **(T-2).** Shipments to the requesting units will be within 10 duty days after receipt of order and will usually be via the most economical method. **(T-2).** Premium transportation, such as Federal Express overnight, will require a commercial carrier account number, i.e., FEDEX or USPS, from the requesting activity. **(T-2).** During contingencies, resupply will be through the designated Theater Lead Agent for Medical Materiel. **(T-2).** Contact AMC/SGXM (DSN 779-6952/COM 618-229-6952) **amc.sgxm@us.af.mil** for additional information on unit procedures and responsibilities.

7.9.3. Medical Equipmentand PMI**.** Medical equipment furnished for this program belongs to the AF PMI Program and will be maintained on host medical treatment facility Medical Equipment Management Office accountable records on account XX5881 for global visibility. **(T-2).** Biomedical equipment maintenance services support will continue to be from the supporting activity and/or regional Medical Equipment Repair Center. **(T-2).** ARC units with an operational kit assigned will establish an appropriate Memorandum of Understanding or Memorandum of Agreement with their host medical treatment facility for maintenance of the PMI within the kit. **(T-2).** Expenses for normal repair and/or replacement due to loss or damage are the responsibility of the local unit. **(T-2).** Equipment accessories not maintained on the AS, or above the AS authorized quantity, will be the unit's responsibility to replace. **(T-2).** AMC/SG will provide the initial outfitting quantities of the equipment, program for replacements when a change in make and/or model is designated, and manage system-wide modifications to equipment based on the AS. **(T-2).**

7.9.4. QA Program**.** Scott PMI Center will help ensure all supporting units receive quality assurance action messages. **(T-2).** This includes recall notices and quality assurance messages from AF. This does not relieve the unit from responsibility of managing their own quality assurance program.

7.9.5. Return Goods Program**.** ARC units with operational kits assigned will process outdated or recalled drugs through their host medical treatment facility as per procedures defined in AFMAN 41-209, *Medical Logistics Support* and local policies or regulations. **(T-2).**

7.9.6. Annual Inventory. Inventory of the accountable CCATT kit operational equipment will be performed annually and reported to AMC/SGXM **amc.sgxm@us.af.mil** . **(T-2).**

7.9.7. Testing of the operational CCATT package will involve team members and is defined as a full set-up, turning equipment on, performing function checks, validating all equipment accessories are on-hand, ready available and in full operational condition. **(T-2).** Additionally, all expiration dated items will be checked for serviceability. **(T-2).** Replenishment supplies will be ordered and the CCATT package packed for future training or potential operational use. **(T-2).**

DOROTHY HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

10 U.S.C. § 9013, Secretary of the Air Force

Public Law 104-191, *Health Insurance Portability and Accountability Act*, 1996

DoD 7000.14R, *Financial Management Regulations (FMRs),* V7A, *Military Pay Policy – Active Duty and Reserve Pay*, May 2020

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JP 3-17, *Air Mobility Operations*, 05 February 2019

JP 4-02, *Health Service Support*, 28 September 2018

DAFPD 10-29, *Worldwide Aeromedical Evacuation Operations*, 13 February 2019

DAFPD 48-1, *Aerospace and Operational Medicine Enterprise*, 07 June 2019

DAFI 33-360*; Publications and Forms Management,* 6 August 2020

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

AFI 10-403, *Deployment Planning and Execution*, 17 April 2020

AFI 11-401, *Aviation Management*, 10 December 2010

AFI 16-1301, Survival, Evasion, Resistance and Escape (SERE) Program, 3 August 2017

AFI 33-322, *Records Management and Information Governance Program,* 23 March 2020

AFI 41-106, *Air Force Medical Readiness Program*, 29 July 2020

AFI 48-107, V1, *En Route Care and Aeromedical Evacuation Medical Operations*, pending

AFI 44-119, *Medical Quality Operations*, 16 August 2011

AFI 48-123, *Medical Examinations and Standards*, 5 November 2013

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

AFI 65-601V1, *Budget Guidance and Procedures*, 24 October 2018

AFMAN 10-2909, *Aeromedical Evacuation (AE) Equipment Standards*, 13 March 2019 with *Aeromedical Evacuation Medical Equipment Compendium*, current version

AFMAN 11-202V3, *Flight Operations,* 10 June 2020

AFMAN 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*, 19 October 2020

AFMAN 11-402, *Aviation and Parachutist Service,* 24 January 2019

AFMAN 11-403, *Aerospace Physiological Training Program,* 13 August 2020

AFMAN 41-209, *Medical Logistics Support*, 04 January 2019

USAF War Mobilization Plan-1, *Air Force Medical Service Supplement,* current version

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 1274, *Physiological Training*

AF Form 1522, *ARMS Additional Training Accomplishment Report*

AF Form 1887, *Aeronautical Order (PA) Aviation Service*

AF Form 3899A, *Patient Movement Record Progress Note*

AF Form 3899B, *Patient Movement Physician Orders*

AF Form 3899C, *Patient Movement Physical Assessment*

AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*

AF Form 3899E, *Patient Movement Intake/Output*

AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*

AF Form 3899G, *Patient Movement Restraint Observation Flowsheet*

AF Form 3899H, *Patient Movement Neurological Assessment*

AF Form 3899I, *Patient Movement Medication Record*

AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*

AF Form 3899K, *Patient Movement/In-Flight Resuscitation Flowsheet*

AF Form 3899L, *Patient Movement Record En Route Critical Care*

AF Form 4368, *Scheduled Maintenance and Certification Label*

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

AFTO Form 350, *Reparable Item Processing Tag*

AFTO Form 781, *ARMS Aircrew/Mission Flight Data Document*

DD Form 1833, *Isolated Personnel Report (IOSPREP)*

DD Form 2163, *Medical Equipment Verification Certification*

DD Form 2852, *Patient Movement Event/Near Miss Report*

DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*

Abbreviations and Acronyms

ACLS—Advanced Cardiac Life Support

AE—Aeromedical Evacuation

AECM—Aeromedical Evacuation Crewmember

AECT—Aeromedical Evacuation Control Team

AEF—Aerospace Expeditionary Force

AFI—Air Force Instruction

AFTO—Air Force Technical Order

AOs—Aeronautical Orders

AFFOR—Air Force Forces

AFMAN—Air Force Manual

AFPD—Air Force Policy Directive

AFSC—Air Force Specialty Code

AOC—Air Operations Center

AMC—Air Mobility Command

AMD—Air Mobility Division

ANG—Air National Guard

API—Aircrew Position Indicator

AOC—Air Operations Center

AOR—Area of Responsibility

ARC—Air Reserve Component

ARMS—Aviation Resource Management System

AS—Allowance Standard

ASC—Aviation Service Code

C2—Command and Control

CC—Commander

CCATT—Critical Care Air Transport Team

CCMD—Combatant Command

CPG—Clinical Practice Guidelines

C-MAJCOM—Component Major Command

CMRP—Comprehensive Medical Readiness Program

COMAFFOR—Commander Air Force Forces

CONUS—Continental or Contiguous United States

DD—Department of Defense

DHP—Defense Health Program

DIRMOBFOR—Director of Mobility Forces

DoD—Department of Defense

DSCA—Defense Support of Civil Authorities

DSN—Defense Switched Network

ECMO—Extracorporeal Membrane Oxygenation

ERC—En Route Care

ERCC—En Route Critical Care

EUCOM—European Command

FFCCT—Air Force Medical Critical Care Transport

HARM—Host Aviation Resource Management

HDIP—Hazardous Duty Incentive Pay

IAW—In Accordance With

IBA—Individual Body Armor

INDOPACOM—India-Pacific Command

ISOPREP—Isolated Personnel Report

JFACC—Joint Forces Air Component Commander

JTS—Joint Trauma System

JPSR—Joint Patient Safety Report

MAJCOM—Major Command

MCD—Medical Crew Director

MEFPAK—Manpower and Equipment Force Packaging

METL—Mission Essentil Task List

MISCAP—Mission Capability

MTF—Medical Treatment Facility

NICU—Neonatal Intensive Care Unit

NIJ—National Institute of Justice

OCONUS—Outside the Continental or Contiguous United States

OC/SE—Observer Controller/Standards Evaluator

O&M—Operations and Maintenance

OPCON—Operational Control

OPORD—Operations Order

OPR—Office of Primary Responsibility

OSF—Operational Support Flier

PACAF—Pacific Air Forces

PI—Performance Improvement

PM—Patient Movement

PMI—Patient Movement Item(s)

PMI—ATS—PMI Asset Tracking System

PMR—Patient Movement Request

PMRC—Patient Movement Requirements Center

PTLOX—Patient Therapeutic Liquid Oxygen

QA—Quality Assurance

QI—Quality Improvement

SARM—Squadron Aviation Resource Management

SERE—Survival, Evasion, Resistance, Escape

SG—Command Surgeon or Surgeon General

TACC—Tanker/Airlift Control Center

TACON—Tactical Control

USTRANSCOM—United States Transportation Command

USAFE—United States Air Force Europe

UTC—Unit Type Code

VFS—Validating Flight Surgeon

WMP—War Mobilization Plan

Attachment 2

INITIAL ISSUE - ERCC MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS

Table A2.1. Initial Issue - ERCC Minimum Individual Protective Clothing & Equipment For Flight Operations.

INITIAL ISSUE - ERCC MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS		
ITEM DESCRIPTION	**U/I**	**QTY**
Coveralls, Flying, Nomex (flight suit) or Occupational Camouflage Pattern (OCP) 2 piece fire resistant uniforms (Note 1)	EA	2
OCP Fleece Liner	EA	1
Boots, Flying	PR	1
Gloves, Flight, Nomex	PR	1
Gloves, insert, 8415-00-269	PR	1
Gloves, shell, 8415-00-261	PR	1
Jacket, Flight, CWU-36/P Summer	EA	1
Jacket, Flight, CWU-45/P Winter	EA	1
Drawers, Flyer's, heat resistant	PR	2
Undershirt, Flyer's, heat resistant	EA	2
Watch Cap, black,or dark blue or sage green (if issuing flight suit) or Watch Cap, Coyote Brown or Black (if issuing 2PFDU in OCP pattern)	EA	1
Reflective Belt, Safety	EA	1
Bag, Flyer's (helmet)	EA	1
Kit Bag, Flyer's (aka: "A/B/C" bag)	EA	1
Pants, Gortex	PR	1
Jacket, Gortex	EA	1
[1]Not intended to be an all-inclusive list of required clothing and equipment. This list addresses minimum required items for flight training and flight operations. Verify respective UTC MISCAP, TTP, or other applicable guidance for additional required items		

Attachment 3

CONTINGENCY SUPPORT ERCC MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS

Table A3.1. Contingency Support ERCC Minimum Individual Protective Clothing & Equipment For Flight Operations.

CONTINGENCY SUPPORT ERCC MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS		
ITEM DESCRIPTION (Note 1, 2 & 3)	**U/I**	**QTY**
[2, 3] Coveralls, Flying, Nomex (flight suit) or Occupational Camouflage Pattern (OCP) 2 piece fire resistant uniforms (refer to notes)	EA	3
[2,3]Boots, Flying, Desert (refer to notes)	PR	1
[2, 3] OCP Fleece Liner	EA	1
[2,3]Gloves, Flight, Nomex (refer to notes)	PR	1
[3]Gloves, insert, 8415-00-269	PR	1
[3]Gloves, shell, 8415-00-261	PR	1
[2,3]Jacket, Flight, CWU-36/P Summer or CWU-45/P Winter (refer to notes)	EA	1
[3]Drawers, Flyer's, heat resistant	PR	3
[3]Undershirt, Flyer's, heat resistant	EA	3
[3]Watch Cap, black, dark blue or sage green (if issuing flight suit) or Watch Cap, Coyote Brown or Black (if issuing 2PFDU in OCP pattern)	EA	1
Neckerchief, cotton, brown, tan or sage green	EA	1
[3]Reflective Belt, Safety	EA	1
[3]Bag, Flyer's (helmet)	EA	1
[3]Kit Bag, Flyer's (aka: "A/B/C" bag)	EA	1
[2, 3]Pants, Gortex, (refer to note)	PR	1
[2, 3]Jacket, Gortex (refer to note)	EA	1
Flashlight, blk finish, (e.g., Inova™ X5MT LED or equivalent)	EA	1
Multi-tool (e.g., Leatherman™, Gerber™, SOG™, Schrade™, or equivalent)	EA	1
Goggles, sun/sand/dust (e.g., Wiley X™ SG-1 or equivalent)	EA	2
Holster, for M-9 handgun (shoulder or hip)	EA	1
Backpack (e.g., "bug-out bag," rucksack-type, or equivalent)	EA	1
Trauma Shears	EA	1
[4]Ballistic IBA, Type-IV, IAW NIJ Standard 0101.06 Vest: minimum type III-A protection; Type III-A full side ballistic protection; front & back 10" X 12" plates, type IV protection; with appropriate outer shell; groin protector preferred option	EA	1
ADDITIONAL REQUIRED ITEMS		
Orders		
OSF Aeronautical Orders, DD Form 2992, AF Form 1274		

Physician Only: Transfer Brief
All other UTC-specific deployment, mobility and theater-required clothing and equipment
[1]Not intended to be an all-inclusive list of required deployment/mobility clothing and equipment. This list addresses minimum required items for deployed flight operations. Verify theater reporting instructions, line remarks, respective UTC MISCAP, TTP, or other applicable guidance for additional required items.
[2]Desert tan flight clothing is strongly preferred for deployed team members conducting missions within or into the Middle-East and/or Central Asia AORs. However, if desert tan flight suits are not available, green flight suits "may" be substituted, or current theater-specific color or pattern. Verify theater reporting instructions for color and pattern requirements. Flight suits and jackets should be of the same color. One additional flight suit to the initial issue is required for deployed operations.
[3]Do not issue if item was included in member's or team's initial clothing and equipment issue (Attachment 2). (**Note:** One additional flight suit to the initial issue is required for deployed operations.) Consider color requirements. No nylon undergarments.
[4]Type IV ballistic IBA is required for ERCC operations. Aircrew Flight Equipment does not issue aircrew body armor to ERCC, as for front-end and back-end aircrew members. Do not substitute aircrew body armor, flak vest or fragmentation vest as the protection level is not sufficient for ERCC operations. Units must supply ERCC personnel their own IBA for deployed operations, if not supplied in-theater.

Attachment 4

ERCC UTC CORE REQUIREMENTS MATRIX *(ADDITIONAL UTC-SPECIFIC REQUIREMENTS MAY BE IDENTIFIED IN OTHER GUIDANCE, I.E., AFI, AF TACTICS,TECHNIQUES, AMD PROCDURES, ETC.)*.

Table A4.1. ERCC UTC CORE REQUIREMENTS MATRIX.

ERCC UTC CORE REQUIREMENTS MATRIX ***(Additional UTC-specific requirements may be identified in other guidance, i.e., AFI, AF Tactics,Techniques, amd Procdures, etc.)***				
Requirement	**Frequency**	**Duration** **(may vary)**	**Definition**	**Remarks**
CCAT Initial course	One-time	12 days	The CCAT Initial Course is designed to orient Total Force personnel assigned to ERCC UTCs to the unique capabilities of the ERCC mission.	All ERCC UTC personnel attend the initial course.
CCAT Advanced course	UTC FFCCT: Every 36 months	14 days	The CCAT Advanced Course is designed specifically for personnel assigned to ERCC UTCs. This UTC training focuses on management and transport of critically injured or ill patients; with didactics on the aeromedical evacuation system culminating in a flight training exercise.	All ERCC UTC members complete the CCAT Advanced Course.
Basic Life Support	As applicable	As applicable	Mandatory for all personnel assigned to ERCC UTC.	All personnel assigned to an ERCC UTC will maintain current Basic Life Support. **(T-1**).
Advanced Cardiac Life Support	As applicable	As applicable	Mandatory for all personnel assigned to ERCC UTC.	All personnel assigned to an ERCC UTC will maintain current Advanced Cardiac Life Support. **(T-1).**

Flight Training	Refer to Remarks	Variable	The objective of flight training is to develop and maintain skills necessary for the effective employment of ERCC teams within the operational flight environment.	Completion of CCAT Initial Course and currency in OSF requirements is required prior to participating in flight training (outside of the CCAT Advanced Course). Must be on non-interference AOs to participate in flight training. **(T-1).** Initial and subsequent flight training requirements for Regular Air Force and ARC ERCC teams are normally met through attendance at the CCAT Advanced Course. All ERCC teams are encouraged to seek additional flight training opportunities through participation in activities such as exercises or local unit training.
Operational Support Flier Requirements				
Requirement	**Frequency**	**Duration** **(may vary)**	**Definition**	**Remarks**
OSF Physical – DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*	Annual	As applicable	Conveys medical qualification for flying or special operational duty.	Physiologic training standards (AFI 48-123), qualifies individuals for non-rated duties in ASC 9C (operational support flier).
Current AF Form 1274, *Physiological Training*	IAW AFMAN 11-403	2-day initial; 1-day refresher	Documents altitude chamber qualification and training.	Required for operational support fliers assigned ASC 9C. (AFMAN 11-403, *Aerospace Physiological Training*

				Program)
OSF Flying Volunteer Letter	IAW AFMAN 11-402 and AFI 48-107 V2	One time for career	OSF Volunteer letter signed by member and supervisor stating the member is a volunteer for flying duties. **Attachment 5**	Attachment 4 of this AFI.
Other Requirements				
Requirement	**Frequency**	**Duration**	**Definition**	**Remarks**
High Risk of Isolation	As applicable	As applicable	High Risk of Isolation training may be mandated for fliers involved in air operations over specific areas within or flying into a combatant command AOR during contingency operations. When so designated, the training requirement is identified by a combatant command in the AOR OPORD for the contingency.	Refer to AFI 16-1301. Training is conducted by a certified SERE instructor. It may be accomplished via briefer-led training or Secure Internet Protocol Router web-based training when available. Training is documented on AF Form 1522, ARMS *Additional Training Accomplishment Input,* and in block 24 of the Isolated Personnel Report (ISOPREP) Form..
Isolated Personnel Report	As applicable	As applicable	Department of Defense form (DD 1833) containing information designed to facilitate the identification and authentication of an evader by a recovery force. The Isolated Personnel Report is maintained on all High Risk of Isolation personnel.	Isolated Personnel Report is prepared by home-station Intelligence (A2) personnel prior to departure to an AOR.
N95 Mask Fit Testing and Training	Annual	As applicable	ERCC personnel are potentially exposed to highly communicable diseases during	Contact Occupational Health staff for support. (refer to AFI 48-137)

			patient care and transport. IAW AFI 48-107, V1 requirements, personnel must be medically cleared, fit-tested, and trained for wear of an N95 respirator prior to first use. **(T-1).**	

Attachment 5

OSF VOLUNTEER LETTER

12 Jan 2020

MEMORANDUM FOR MAJ JACK P. RYAN
AMC/SG IN TURN

FROM: 1st Lt JOHN DOE
1234 Base Dr
Scott AFB, IL 62225

SUBJECT: Volunteer Statement – En Route Critical Care Transport Team Assignment

1. In accordance with AFMAN 11-402, A*viation and Parachutist Service*, 24 Jan 2019, I confirm I am a volunteer and agree to enter training and accept assignment as a member of an En Route Critical Care Transport Team (Critical Care Air Transport Team (CCATT).

{2. If the ERCC individual has previously volunteered for frequent and regular flight duties, i.e., flight surgeon, flight nurse, aeromedical evacuation technician, by previously accepting and completing training, an additional volunteer statement is not required for Operational Support Flier duties. They are considered a volunteer.}

3. As a volunteer, I understand:

a. My duties will include aviation service as an Operational Support Flyer;

b. I will be required to participate in aerial flight activities on board a variety of aircraft platforms for training purposes and to perform patient transport.

c. I will be placed on an en route critical care Unit Type Codes (UTCs) and, in accordance with respective guidance/publications, as long as I am assigned to the UTC, I must maintain required training currencies, certifications, and a state of deployment readiness.

4. Unless permanently disqualified, I understand after completing training I will remain available for flying duties and may be directed to perform such duties at any time.

5. I understand I can withdraw as a volunteer from the En Route Critical Care Team, and if I am no longer a volunteer, I will be assigned to another UTC in accordance with the needs of the Air Force."

JOHN R. DOE, 1st LT, USAF, NC

Critical Care Nurse

1ST Ind to 1ST Lt John R. Doe, 12 Jan 2020, Volunteer Statement-En Route Critical Care Team Transport Assignment

MEMORANDUM FOR AMC/SG

On 12 Jan 2020, I met with 1st Lt John R. Doe and discussed the voluntary nature of an Operational Support Flier assignment. 1st Lt John R. Doe confirmed he~~/she~~ (is) ~~or (is not)~~ a volunteer, (is willing) ~~or (is not willing)~~ to enter into training, and (accept) ~~or (does not accept)~~ a CCATT assignment.

JACK P. RYAN, Major, USAF, NC

Flight Commander, Critical Care

*Unit Training/Deployment Manager or Readiness Officer scans the letter and forwards to **amc.sgk@us.af.mil** and place a copy in the members readiness folder.