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Tactical Doctrine

EXPEDITIONARY MEDICAL LOGISTICS (EML) SYSTEM

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The Department of the Air Force Tactics, Techniques, and Procedures (DAFTTP) 3-42 series of publications is the primary reference for expeditionary medical support capability. DAFTTP 3-42.8 provides tactics, techniques, and procedures for the Expeditionary Medical Logistics (EML) system and medical logistics unit type codes (UTCs). The doctrine in this document is authoritative but not directive. It applies to all civilian employees and uniformed members of the United States Space Force, Regular Air Force, the Air Force Reserve, and the Air National Guard. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using Air Force Form 847, *Recommendation for Change of Publication*. Route AF 847 through the appropriate functional chain of command and parent major/field command. Ensure that 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 of in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System.

SUMMARY OF CHANGES

This publication has been updated to reflect the redesignation of the Air Force Medical Operations Agency (AFMOA) as the Air Force Medical Readiness Agency (AFMRA). References to AFMOA have been deleted and replaced with the correct agency name and office symbol. This revision also adds information on the new Forward Distribution Medical Logistics Manpower Team (FFFDT) designed to establish and extend theater-level medical logistics support at major

hubs (**para 2.12.6**); clarifies the Air Force Medical Logistics Operations Center's (AFMLOC) role in supply chain management; and updates information on Theater Lead Agent for Medical Materiel (TLAMM) designations (**Chapter 6**). It incorporates general administrative changes throughout and should be reviewed in its entirety.

Chapter 1

INTRODUCTION

1.1. Purpose. This publication provides an overview of the Expeditionary Medical Logistics (EML) support system, Air Force deployable medical logistics capabilities, and tactics, techniques, and procedures for medical materiel and biomedical equipment technician (BMET) personnel assigned to medical logistics unit type codes (UTCs). It provides planners and medical personnel a general understanding of global logistics and distribution processes, as well as the challenges involved in deploying and sustaining the Air Expeditionary Force (AEF). This publication provides a source document for developing standardized policies, operating procedures, and training programs. Operation plans and regional guidance provide more specific information that amplify and tailor the guidance contained in this publication.

1.2. Mission. The EML system provides global support and sustainment to AEF medical forces across the full spectrum of operations. It provides time-definite resupply of materiel by synchronizing the flow of materiel, information, and funds from initial unit request to delivery. Through predetermined supply chains, focused logistics, and combat support concepts, it ensures delivery of tailored logistics packages to deployed medical personnel. It uses a pull process for resupply and a repair-and-return process for medical equipment maintenance to minimize inventory footprint and airlift requirements. The EML system incorporates commercial best practices to streamline the requisition process and eliminate or significantly reduce support structures. The Air Force Medical Readiness Agency/Medical Logistics Division is the office of primary responsibility for management and execution of the EML system and Air Force Medical Logistics Operations Center (AFMLOC), which are designed to provide crucial guidance to medical personnel during all phases of deployment.

1.2.1. Combat Support. The Air Force defines combat support as the foundational and crosscutting capability to field, base, protect, support, and sustain Air Force forces during military operations across the competition continuum. The EML system supports the three overarching principles of combat support as defined in Air Force Doctrine Publication 4-0, *Combat Support.*

1.2.1.1. Enable military operations across the competition continuum with effects supporting U.S. national interests at any time or place.

1.2.1.2. Provide essential mission support, leveraging the right mix of deployed and distributed footprint and reliable reachback to increase effectiveness and responsiveness.

1.2.1.3. Provide the ability to transition swiftly from home station to a deployed environment and between operational requirements.

1.2.2. Reachback is the process of obtaining products, services, and applications, or forces, or equipment, or material from organizations that are not forward deployed (Joint Publication [JP] 3-30, *Joint Air Operations*).

1.2.3. Focused Logistics. Focused logistics is the combination of information and logistics technologies to ensure required materiel arrives at the right time at the right place, every time, no matter where or what the level of conflict. It relies on rapid, reliable, and time-definite transportation systems to reduce the need for maintaining large quantities of on-hand stock.

Key capabilities include agile sustainment, logistics information fusion, theater logistics management, and force health protection.

1.2.3.1. Focused logistics relies on transportation and throughput. It requires careful analysis and confidence on the part of the combatant commander and continued access to ports. New transportation systems will enable the shift from supply-based systems to manufacturer direct or prime vendor delivery.

1.2.3.2. Focused logistics requires the services and combatant commanders to right size (and potentially reduce) their forward support footprint and rely on consistent resupply and precise delivery of essential support.

1.2.4. In-Transit Visibility. In-transit visibility is necessary to ensure the smooth flow of supplies and sustainment. Medical logistics personnel are responsible for establishing in-transit visibility procedures and nodes at all ports of embarkation, transit points, and ports of debarkation. Lack of in-transit visibility can cause loss of confidence in the supply system, create unnecessary ordering, and place an unnecessary burden on limited supply lines.

1.3. Threat. Medical logistics capabilities may be impacted by direct threats to the supply line as well as threats to U.S. forces, installations, and information systems.

1.3.1. Supply lines may be disrupted by combat-related activities, supply shortages, transportation delays, and the like. Transportation channels for focused logistics and reachback can be impacted by factors such as country customs and geographical and environmental conditions.

1.3.2. Medical facilities are potential targets of enemy actions to disrupt health service support response capabilities.

1.3.3. Data protection and integrated backup capability are especially important in maintaining medical asset visibility and facilitating materiel movement. Network Control Center information assurance programs provide information systems security support for deployed medical facilities. Deployed medical facilities abide by these as well as Air Force Forces/Air Expeditionary Task Force (AFFOR/AETF) Network Operations and Security Center – Deployed communications design architectures, operational rules of engagement, and major/field command preferred product lists to minimize the threat.

Chapter 2

ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

2.1. Air Force Surgeon General. The Air Force Surgeon General ensures medical units are sourced and supported with deployable medical assets to meet the full spectrum of military operations. The Surgeon General determines EML doctrine and policy and provides the required resources necessary to execute and sustain EML processes at the major/field command and unit levels.

2.2. Assistant Surgeon General, Health Care Operations. The Assistant Surgeon General, Health Care Operations, provides oversight authority for all aspects of training related to EML to include the incorporation of EML concepts into all applicable Air Force Medical Service (AFMS) education and training courses. The Assistant Surgeon General coordinates and consolidates program objective memorandum (POM) submissions to support EML execution, training, and war reserve materiel (WRM) requirements.

2.3. Air Force Medical Logistics Division. The Air Force Medical Logistics Division (AFMRA/SG4) is responsible for monitoring and reporting the supply chain process and communicating issues and solutions to the Surgeon General, major/field commands, AFFOR/SG staff, and Component Numbered Air Force Surgeon staff. The Division maintains the AFMLOC located at Ft. Detrick, Maryland, oversees the consolidated storage and deployment centers (CSDCs) based in the continental United States (CONUS), and oversees the Air Force assigned Theater Lead Agent for Medical Materiel (TLAMM) operations.

2.3.1. The AFMLOC is the center for Air Force Class VIII medical supply chain management. The AFMLOC coordinates with total force component medical planners and logisticians at the combatant commands to ensure medical requirements are identified in operations plans, exercises, and real-time operations. It is the primary point of contact for the Air Operations Center, the deployed unit, and the sustaining base on materiel and supply chain issues. The AFMLOC is responsible for medical logistics reachback in support of the AFFOR/SG and determines the strategy to support the medical logistics plans for its areas of responsibility.

2.3.1.1. The AFMLOC advises and supports the major/field commands, AFFOR Surgeons (AFFOR/SGs) staff on resource requirements for supply chain nodes and provides guidance on manpower assistance as appropriate.

2.3.1.2. The AFMLOC develops, publishes, and monitors guidance on medical supply chain management for the major/field commands and deployed medical units. The AFMLOC maintains information on airflow operations and logistics points of contact.

2.3.1.3. The AFMLOC tracks issues and coordinates resolution with various agencies and commands. **Note:** Air Mobility Command (AMC/SGXM) is the execution office and point of contact for all patient movement item (PMI) questions and issues.

2.3.2. The CSDCs hold consolidated medical equipment UTCs. The CSDCs provide a full range of medical logistics capabilities, enabling the execution of the EML supply chain.

2.3.2.1. The CONUS-based CSDCs are currently located at Port San Antonio, TX, Travis Air Force Base, CA, and Charleston, SC. They can accomplish the full range of

maintenance on most medical and non-medical equipment. Their strategic locations reduce the risk of loss and non-availability of airlift to opposite coasts.

2.3.2.2. The CSDC at Port San Antonio, TX, is the industrial operations center for Air Force medical logistics. It builds and modernizes all Air Force medical UTCs and serves as a PMI loan repair and return center (LRRC). It may serve as a sustaining base as part of Air Force global medical logistics support.

2.3.3. A TLAMM serves as a major theater medical distribution node and is the customer interface for medical logistics and supply chain management for the area of responsibility. The Chairman of the Joint Chiefs of Staff has designated AFMRA/SG4W (Port San Antonio, TX) as the TLAMM for United States Northern Command (USNORTHCOM) and United States Southern Command (USSOUTHCOM) and the 18th Medical Group at Kadena Air Base, Japan, as the TLAMM for United States Indo-Pacific Command (USINDOPACOM) (outside of Korea). See **Chapter 6, Integration and Interoperability,** for more information about the TLAMM.

2.4. Air Force Forces Surgeon (AFFOR/SG). The AFFOR/SG is responsible for AFFOR medical logistics in the area of responsibility. The AFFOR/SG staff identifies requirements for medical logistics manpower augmentation, documents medical logistics manpower shortfalls to supporting major/field commands, and coordinates logistics support plans with the AFMLOC. When medical logistics elements are assigned in the theater to support supply chain operations, the AFFOR/SG staff facilitates coordination between the elements and deployed medical personnel to ensure the deploying element and local commander have a clear understanding of the responsibilities and capabilities.

2.5. Air Mobility Command Surgeon (AMC/SG). The AMC/SG is the PMI Program Management Office responsible for worldwide asset management. The AMC/SGXM staff (in support of the United States Transportation Command Surgeon [USTRANSCOM/SG] and Component Numbered Air Force or Component Major/Field Command) identifies requirements for PMI, medical logistics manpower augmentation, and centralized asset procurement, management, reporting, and recycling. When medical nodes are assigned in theater or designated in support of theater PMI operations, the AMC/SGXM staff facilitates coordination between the Numbered Air Forces, elements, and deployed medical personnel to ensure the deploying element and local commanders have a clear understanding of the responsibilities and capabilities.

2.6. Medical and Operational Planners. Air Force medical and operational planners at the Component Numbered Air Force or Component Major/Field Commands ensure medical logistics requirements are identified in operations plans, exercises, and real-time operations. Key considerations include transportation and distribution, local oxygen support capability, local linen support, local disposal of medical and hazardous waste, and available power, fuel, and communications capability.

2.7. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRAs). To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MRA responsibilities to three major commands: Air Combat Command (ACC), Air Force Special Operations Command (AFSOC), and AMC. UTC pilot units work closely with the MRAs to construct and review UTCs, associated mission capability statements, manpower details, and allowance standards. The MRAs identify modernization requirements as input into the POM prioritization process. UTCs are dynamic and are continuously reviewed and

modified. Medical planners should consult with the appropriate MRA to obtain the most current information.

2.7.1. ACC is the MRA for ground medical support personnel and equipment UTCs and medical counter-chemical, biological, radiological, and nuclear (MC-CBRN) allowance standards.

2.7.2. AMC is the MRA for en route continuum of care UTCs, the PMI program, and the Air Force Safe-to-Fly (StF) program in respect to medical equipment items for rotary and fixed wing aircraft.

2.7.3. AFSOC is the MRA for special operations medical personnel and equipment UTCs.

2.7.4. Pacific Air Forces (PACAF) and United States Air Forces in Europe-Air Forces Africa (USAFE-AFAFRICA) maintain responsibility for theater-unique capabilities.

2.7.5. Air National Guard (ANG) maintains responsibility for ANG capabilities related to Title 32 United States Code operations. Title 10 United States Code operations are governed by the Regular Air Force MRAs.

2.7.6. AFMRA/SG4M functions as the MRA for force health protection assets.

2.8. Sustaining Base. The sustaining base provides reachback support to deployed medical units in the early stages of an operation. It augments the deployed medical unit's limited logistics capability by assuming the bulk of the supply chain's administrative, sourcing, and tracking functions. The AFFOR/SG staff determine the sustaining base in coordination with the AFMLOC.

2.8.1. Sustaining base responsibilities are normally assigned to large CONUS-based medical treatment facilities to leverage access to suppliers specializing in large-scale logistics support and in-house clinicians who can identify substitutes for unavailable medical items. A sustaining base may be located outside the continental United States (OCONUS) for supply chain expediency and cost effectiveness.

2.8.2. The sustaining base activates an extended workday or on-call operations center to respond to short-notice deployments. When activated, the sustaining base acts as the deployed medical unit's logistics link for the duration of the deployment or until a theater supply chain is established and fully operational. The sustaining base notifies the unit of substitutions and fills initial outfitting shortages identified by the deploying unit's home base.

2.8.3. The sustaining base meets equipment requirements through a combination of spare-parts procurement, replacement equipment procurement, and (potentially) centralized repairs and returns.

2.8.4. The sustaining base may activate pharmaceutical or medical-surgical prime vendor contract clauses to act as the primary ordering facility, providing direct resupply to deployed medical units.

2.9. Expeditionary Medical Support (EMEDS) Logistics Personnel. Medical materiel personnel (4A1X1) on expeditionary ground medical UTCs are responsible for managing the supply and equipment needs of an EMEDS facility or Air Force Theater Hospital (AFTH) as well as any PMI within the facility. BMET personnel (4A2X1) are responsible for biomedical equipment maintenance and facility management. See AFTTP 3-42.71, *Expeditionary Medical*

Support (EMEDS) and Air Force Theater Hospital (AFTH), for more information about EMEDS/AFTH capabilities and operations.

2.9.1. FFEP2, EMEDS Command and Control, includes one 4A171 and one 4A271 to provide initial medical logistics support for the EMEDS platform. This capability is part of the EMEDS Health Response Team (HRT) package.

2.9.2. FFEP3, 10-Bed Personnel Augmentation, includes one 4A151 and one 4A251. This capability is part of the EMEDS+10 package.

2.9.3. FFEP4, 25-Bed Personnel Augmentation, includes one 4A151. This capability is part of the EMEDS+25 package.

2.10. En Route Care Logistics Personnel. Medical logistics personnel on en route care UTCs are responsible for managing the deployed medical unit's supply needs. Medical materiel personnel (4A1X1) on aeromedical UTCs are responsible for managing the supply needs of an En Route Patient Staging System (ERPSS), Aeromedical Evacuation Squadron, designated supporting PMI center, or deployed PMI cell or node. See AFTTP 3-42.57, *En Route Patient Staging System*, for more information about capabilities and operations.

2.10.1. FFQCC, Command Squadron, includes one 4A171.

2.10.2. FFQCM, Aeromedical Evacuation Operations Team Augmentation, includes one 4A151.

2.10.3. FFQNT, Medical Operations Team, includes one 4A171.

2.10.4. FFQSC, Support Cell, includes one 4A171.

2.10.5. FFPPS, ERPSS Provider, includes one 4A171. The 10-bed ERPSS requires medical supply support to begin seven days after setup.

2.10.6. FFFPS, ERPSS 50, includes one 4A151 and one 4A271.

2.10.7. FFHPS, ERPSS 100, includes one 4A251.

2.11. Special Operations Logistics Support. AFSOC medical forces have limited logistics support capabilities. In many Special Operations Forces (SOF) operations, the short-term, clandestine, or low-visibility nature of the operation may not allow or require establishment of a resupply mechanism. Depending on the type of operation, AFSOC medics might receive support from the nearest conventional medical logistics unit or from local or regional resources as appropriate. Medical logistics are normally coordinated through the SOF medical plans officer.

2.11.1. For clandestine operations, AFSOC medical units deploy with adequate medical supplies and equipment to ensure they can support operational requirements. Should resupply be required, SOF medical planners establish resupply through a variety of mechanisms, which may include support from a host medical treatment facility, in-country embassy, military assistance group, home station, or main operating base. Predetermined PMI may need to be placed at forward or intermediate staging bases.

2.11.2. When located in a mature theater in support of a major regional conflict, AFSOC medics receive medical logistics support from the nearest conventional medical logistics unit. AFSOC medics should coordinate with the host medical treatment facility or the AFMLOC

before deployment to ensure adequate medical logistics training. The AFMLOC can also provide guidance and support for sustainment issues.

2.11.3. See AFTTP 3-42.6, *USAF Medical Support for Special Operations Forces*, for more information about AFSOC operations and medical logistics planning considerations.

2.12. Medical Logistics Support Capabilities. Medical logistics personnel may be assigned to various support UTCs to ensure the availability and operability of critical medical and surgical materiel. These UTCs typically deploy to an AFTH or equivalent facility at a strategic hub but can also be used to support other locations within a theater. Specific tasking for these UTCs should be addressed in line remarks. See the UTC Mission Capability Statement for more information on the UTC's mission and full manpower detail.

2.12.1. FFBMM, Biomedical Equipment Maintenance Team, provides one 4A271 and two 4A251s to support the existing biomedical equipment maintenance and facility management capabilities at an AFTH or equivalent medical facility. This team can also support operations at a PMI center, cell, or node or a TLAMM.

2.12.2. FFLG1, Medical Logistics Manpower Augmentation Team, provides one 4A171 and one 4A151 to support the existing medical supply capabilities at an AFTH or equivalent facility. This team can also support other logistics nodes, such as distribution hubs and military depots located near aerial ports of embarkation (APOE) or aerial ports of debarkation (APOD), a PMI center, cell, or node, or a TLAMM, to facilitate the flow of materiel and information.

2.12.3. FFLGM, Medical Logistics Management Team, provides one 041A3, one 4A171 and one 4A271 to support enduring operations at an established AFTH, TLAMM, or equivalent facility.

2.12.4. FFHA4, CT Scan Team, includes one 4A271 with specialized training in the repair and maintenance of CT equipment at an AFTH or equivalent facility.

2.12.5. FFGLB, Patient Decontamination Team, includes one 4A151 to manage the inventory, storage, and supply needs of the expeditionary medical patient decontamination team. This team deploys to areas with a CBRN threat.

2.12.6. FFFDT, Forward Distribution Medical Logistics Manpower Team, provides one 041A3, one 4A191, one 4A171, eight 4A151s, one 4A271, and one 4A251 to provide leadership and medical materiel support for TLAMM and other medical contingency operations. The team works to establish supply chain, distribution, storage, medical maintenance, customer support, and command, control, communications, and intelligence (C4I) capabilities to extend medical materiel support within a theater. The team can deploy to various distribution hubs, intermediate supply activities, military depots, and EMEDS or AFTH facilities to facilitate the flow of materiel and information.

2.13. Blood Support. Medical logistics personnel help expedite shipments and ensure proper storage and packaging of temperature-controlled blood products at Expeditionary Blood Transshipment Centers and at pre-positioned frozen blood stock locations. See AFTTP 3-42.711, *Blood Support Operations*, for more information about the blood program and blood support capabilities.

2.13.1. FFBD1, Frozen Blood Product Team, includes one 4A151.

2.13.2. FFBP1, Expeditionary Blood Transshipment Center, Module 1, includes one 4A171.

2.13.3. FFBP3, Expeditionary Blood Transshipment Center, Module 3, includes one 4A151.

2.14. Theater Support. Medical logistics personnel provide materiel management support for AFFOR/SG medical staff, provincial reconstruction teams, and other theater engagement teams.

2.14.1. FFMET, Medical Engagement Team, includes one 4A171.

2.14.2. FFSGQ, AFFOR Medical Staff, Increment 1, includes one 4A171.

2.15. Non-Medical and Special Operations Forces (SOF) Support. Medical logistics personnel may support non-medical expeditionary and SOF UTCs. Medical logistics personnel assigned to these UTCs provide medical logistics support only and function in non-combatant roles.

2.15.1. 7PRCS, Guardian Angel Combat Support, includes one 4A151.

2.15.2. 81RSG, Special Tactics Team Medical Supply, includes one 4A151.

2.15.3. 9AAB1, AFFOR Staff, includes one 4A191.

2.15.4. 9AAB2, AFFOR Limited Response Package (LRP), includes one 4A171.

2.15.5. 9AAB3, AFFOR Theater Response Package (TRP), includes one 4A171.

2.15.6. 9AFWD, Commander, Air Force Forces (COMAFFOR)/Joint Force Air Component Commander (JFACC) Forward Staff, includes one 4A191.

2.15.7. CT17F, 17AF AFAFRICA AFFOR Staff, includes one 4A171.

2.15.8. FFQE2, SOF Global Engagement Augmentation, includes one 4A171.

2.16. Patient Movement Item (PMI) Program. The objective of the PMI program is to sustain patient movement through the en route care system without diminishing the capability of forward medical units. The PMI program manages all designated PMI assets to ensure sufficient supplies and equipment are available to sustain multi-modal patient movement operations and provide for in-kind exchange when PMI accompanies a patient. USTRANSCOM is the PMI system manager (Department of Defense Instruction [DODI] 6000.11, *Patient Movement*; JP 4-02, *Joint Health Services*). The AMC/SG is responsible for resourcing, maintaining, and recycling PMI assets to support global contingency operations. The AMC Surgeon's Office Medical Readiness Logistics Branch (AMC/SGXM) provides program management and execution.

2.16.1. PMI is the equipment and supplies required to support patients during aeromedical evacuation such as litters, patient monitors, ventilators, and suction equipment. PMI is part of a standardized list of approved safe-to-fly equipment. The Global Patient Movement Joint Advisory Board approves PMI designated items.

2.16.2. All services will fund the original, initial quantities of approved PMI in-kind assets. PMI in-kind assets are defined as the exact medical equipment by type and model approved for patient movement. All services will maintain initial quantities of approved PMI in-kind equipment in their medical assemblages, kits/sets/outfits, or allowance standard. The program objectives are to ensure program standardization, enable proper recycling or replacement of medical equipment, and ensure operational capability is not diminished due to equipment shortfalls. PMI is not intended to supplement service assemblages for use in facilities.

2.16.3. Medical logistics personnel at PMI centers, cells, and nodes manage inventory availability, asset visibility, maintenance, flow of PMI through available transportation nodes, and timely asset recycling. PMI is tracked in the Patient Movement Item Asset Tracking System (PMI-ATS). PMI and PMI-ATS deploy in support of en route care, are managed and supplied by designated logisticians, and are co-located with aeromedical evacuation intra-theater and inter-theater interfaces to provide initial aeromedical evacuation operational capability, sustain patient movement operations, and minimize equipment turnaround time. See **Chapter 5, Communications and Information Systems,** for more information on PMI-ATS.

2.16.4. PMI center levels are based on projected casualty flow and time-phased recycling of PMI assets. Timely recycling is essential to maintain and contain total inventory investment. All services are responsible for tracking and returning PMI assets to the closest PMI center. The plan for a PMI exchange system as well as the return of evacuation equipment and PMI to the originating theater should be addressed in the respective combatant command and service component command operating plans.

2.16.5. PMI equipment is tested and certified for use on applicable service rotary and fixed-wing aircraft. Service en route care teams (i.e., Air Force aeromedical evacuation crews and critical care air transport teams) are trained to operate PMI equipment. Air Force Form 4033, *PMI/AE Certification Label*, or joint certification label is required to designate airworthiness certification for all PMI equipment. This certification label must be affixed to each piece of PMI certified equipment. Medical logistics personnel are responsible for ensuring PMI is barcoded, radio-frequency identification (RFID) tagged, recorded in PMI-ATS, available for patient treatment, tracked in transit, and recycled to medical facilities. If barcode or RFID tags are missing, contact the nearest PMI Center for replacement.

2.16.6. The sending medical facility is responsible for placing PMI on the patient. PMI levels at deployed medical facilities will be determined by local commanders after coordination and approval by the designated theater PMI lead and AMC/SGXM. The minimum prepositioned levels should be equal to or greater than three days of worst-case expected patient flow support requirements. PMI centers will recycle or replace PMI equipment used for patient movement to maintain the medical facility's approved patient movement levels.

2.17. PMI Support Teams. The medical logistics manpower augmentation team (FFLG1) and biomedical equipment maintenance team (FFBMM) provide the manpower to operate and manage a PMI center or cell. Medical materiel personnel manage PMI and are responsible for accountability, acquisition, recycling of equipment, shipment, and tracking PMI in PMI-ATS. BMETs provide maintenance and repair capabilities and are responsible for scheduled and unscheduled maintenance services and PMI-ATS updates. PMI equipment UTCs provide required equipment, supplies, and logistics tools. En route care units with PMI equipment levels will be supported by the same maintenance support personnel supporting the rest of the medical equipment assigned to the unit.

2.17.1. FFBM1 provides medical calibration and test equipment to perform scheduled and unscheduled maintenance on deployed PMI.

2.17.2. FFQP3 is a notional UTC comprised of PMI that can be tailored to the unique PMI equipment and supply needs of a deployed location.

2.17.3. FFQP4 is a deployable PMI-ATS used to track PMI at the deployed location.

2.18. Expeditionary Combat Support (ECS). Medical units deploy with limited organic capability and require ECS to support medical infrastructure and environment of care requirements. ECS is provided by Air Force, joint forces, coalition forces, or host nations and may include installation logistics, vehicles and transportation, civil engineering support, billeting, food services, communications, local oxygen support capability, local linen support, and local medical and hazardous waste disposal. ECS should be defined in operation plans, deployment orders, memorandums of understanding, and memorandums of agreement with the various ECS agencies.

Chapter 3

OPERATIONS

3.1. Pre-Deployment Logistics Support Planning. The AFFOR/SG staff provides the AFMLOC and deploying medical logistics personnel with information about intra-theater airflow, distribution nodes, operational funding, and other theater supply chain information. This information ensures development of the most efficient and effective supply chain for the operation. The AFFOR/SG staff establishes equipment and supply review policy to aid deployed commanders in validating requirements. This process ensures mission requirements can be met and that all activities in the supply chain are focused on procuring and distributing the necessary materiel.

3.1.1. The AFFOR/SG staff, in coordination with the AFMLOC and sustaining base, identifies the requirements for medical logistics manpower augmentation teams to support the plan. The AFFOR/SG staff begins the process of requesting the augmentation teams for deployment to the agreed-upon logistics nodes.

3.1.2. The sustaining base and the AFMLOC coordinate with USTRANSCOM and combatant command planners to ensure the most expeditious transportation nodes are used for sustainment. Commercial contract carriers are used to the maximum extent possible.

3.1.3. The AFFOR/SG establishes medical equipment repair guidance for deployed units in conjunction with AFMRA/SG4T. Medical equipment repairs and calibrations that cannot be done on-site may be provided by an Air Force Medical Equipment Repair Center (MERC), Army Forward Repair Activity–Medical (FRA-M), a designated TLAMM, or PMI cell. The AFFOR/SG staff coordinates required support agreements and provides deployed medical units with information on what services and equipment these activities provide and how to arrange for support.

3.1.3.1. A BMET personnel UTC can be requested to augment any of these activities to meet increased workload demands. The BMET can determine whether equipment can be repaired, calibrated locally, or needs replacement.

3.1.3.2. The supporting theater PMI center or cell can provide repair guidance for PMI. Theater PMI equipment is maintained on Department of Defense Activity Address Code (DODAAC) FM4444, Defense Medical Logistics Standard Support (DMLSS) account XX5881, at AMC/SGXM.

3.1.3.3. If these support options are unavailable, the loan repair and return center (LRRC) may be used to assist with repairs.

3.2. Deployed Medical Units. Medical units may deploy with one or more WRM assemblages to support the full range of military operations. Medical units should coordinate with the AFFOR, AFMLOC, and sustaining base to obtain specific instructions during all phases of the deployment. When tasked to deploy, medical logistics personnel should contact the AFMLOC to review the current theater medical supply chain for their deployed location.

3.2.1. Upon arrival in theater, the deployed medical unit initiates communication with the sustaining base and works with deployed information systems personnel to secure a permanent communications solution. The medical unit notifies the sustaining base of issues related to

supply maintenance and ensures that resupply requirements are identified and coordinated, including shipping addresses and a commercial address.

3.2.2. Communications and coordination among the deployed unit, AFMLOC, and sustaining base on materiel and maintenance issues are critical to meet EML time-definite delivery goals. Resupply priorities are classified as urgent (96 hours), immediate (7 days), or routine (30 days).

3.2.3. The deployed medical unit identifies shortfalls in personnel, equipment, and training and appoints a primary point of contact to communicate logistics issues with all nodes. This point of contact updates appropriate contingency and annual training or exercise schedules to ensure EML personnel, equipment, and training are incorporated to meet operational requirements. The point of contact informs line and medical personnel and commanders on the EML process and capabilities.

3.2.4. The deployed medical unit notifies the sustaining base or AFMLOC when required supplies are received. They may perform this update in the automated information system. This update ensures the transaction is closed in the Integrated Data Environment (IDE)/Global Transportation Network (GTN) Convergence (IGC).

3.2.5. Deployed medical logistics personnel should coordinate with the local operational contract support office to validate local vendors outside the pre-approved list and communicate with other medical units in the area to understand their mission and possible resupply requirements.

3.2.6. Deployed medical logistics personnel are responsible for managing medical materiel hazard alerts and recalls, equipment defects and materiel complaints, and incident investigations involving medical equipment and devices that may have caused harm to a patient or personnel in accordance with Air Force Manual (AFMAN) 41-209, *Medical Logistics Support.*

3.2.7. Deployed medical units with co-located en route care units receive replenishment of PMI equipment from the combatant command designated theater PMI center or cell. Supplies are procured through normal resupply channels.

3.3. Cargo Movement. Medical materiel and resupply should be transported by the most expedient and reliable lift method available. Medical logisticians and the transportation community work together to develop an executable medical cargo movement plan tailored to the mission and operational environment. They may establish contracted or partnership agreements to help ensure uninterrupted medical cargo movement. Cargo movement through the distribution chain requires full in-transit visibility. Tracking systems for commercial carrier and military transportation systems must be in place. Lack of in-transit visibility can result in delayed and lost shipments.

3.4. Redeployment and Reconstitution of Assets. Redeployment and retrograde guidance comes from a variety of sources, including the joint staff, combatant command, joint task force (JTF) commander, AFFOR/SG staff, other service component commands, and the AFMLOC. The AFFOR/A4 may choose to use redeployment time-phased force deployment data (TFPDD).

3.4.1. Serviceable supplies and equipment are redeployed only if there is an existing requirement elsewhere and it is cost effective to do so. The AFFOR/SG's staff may transfer excess supplies and equipment to another Air Force or service component command medical

facility in theater. Under certain conditions, excess medical property may be transferred to the Department of State or the host government.

3.4.2. Serviceable property that is not cost effective to retrograde and unserviceable property may be sent to the nearest Defense Logistics Agency (DLA) Disposition Services office supporting the theater.

3.4.3. Coordinate the redeployment and retrograde of PMI with AMC/SGXM and the theater AFFOR/SG. PMI equipment should not be sent to DLA Disposition Services unless directed by AMC/SGXM. Theater PMI rotator pool equipment is maintained on DODAAC FM4444, DMLSS account XX5881, at AMC/SGXM.

3.5. Sustainment. Each combatant command has a supporting TLAMM. The TLAMM is the deployed unit's primary contact for materiel and equipment support in theater. The designated sustaining reachback bases are available for emergencies and backup if the TLAMM is unable to provide support. The following acquisition options (listed in order of priority) are available if the designated TLAMM or sustaining reachback base is unavailable.

3.5.1. DLA Troop Support Prime Vendor Program.

3.5.1.1. Prime vendor distributed items include Distribution and Pricing Agreement (DAPA) items, Federal Supply Schedule items, prime vendor non-usage items, prime vendor committed volume or regional incentive agreements, and electronic commerce sources.

3.5.1.2. Also included are DLA medical contingency contracts sourced through Readiness Electronic Catalog (ECAT) in DMLSS.

3.5.2. DLA Troop Support ECAT.

3.5.3. Local purchase instruments such as blanket purchase agreements and indefinite delivery/indefinite quantity contracts.

3.5.4. Other electronic commerce and web-based ordering sites (e.g., Department of Veterans Affairs ordering sites, General Services Administration [GSA] Advantage, or DLA E-Mall).

3.5.5. DLA Troop Support Depot (centrally managed DLA depot stocked with military unique items).

3.5.6. Government purchase cards.

3.6. Materiel Management. Medical materiel personnel are responsible for organizing and providing life-cycle management of medical materiel, including pharmaceuticals, medical supplies, medical assemblages, and medical gases. The chief of logistics/director of logistics is responsible for all logistics operations in the activity and satellite activities to the extent authorized. These operational responsibilities include the following.

3.6.1. Acquisition, receipt, storage, issue, movement, maintenance, repair, and accountability of materiel and equipment.

3.6.2. Environmental services management, including housekeeping, textile care services (linen distribution and laundry services), and waste collection and disposal.

3.6.3. Facility management, including real property repair and maintenance, construction and renovations (minor/new), grounds maintenance, physical security, preventive maintenance, energy conservation, facility space utilization, and master planning.

3.6.4. Transportation management, including transportation coordination and justification and management of non-tactical vehicles.

3.6.5. Communication with the information management officer and plans and operations staff.

3.6.6. Contracting support coordination.

3.6.7. Excess materiel management.

3.6.7.1. The goal is to eliminate excess medical materiel, which is any materiel on hand that is no longer required to satisfy any mission requirement.

3.6.7.2. Ensure timely and cost-effective identification of excess materiel and equipment.

3.6.7.3. Report and advertise excess serviceable materiel for possible redistribution to other in-theater activities or units.

3.7. Medical Maintenance. Medical maintenance personnel are responsible for ensuring that medical equipment is serviceable, safe, and properly configured. They perform scheduled maintenance, unscheduled maintenance, equipment calibrations, and electrical safety inspections of medical and non-medical equipment used in patient care spaces in accordance with AFI 41-201, *Managing Clinical Engineering Programs*.

3.7.1. Electrical safety responsibilities include testing of isolated power systems and ground fault circuit interrupters (GFCIs). Deployed BMETs may assist the Chief of the Medical Staff and others responsible for in-service training by providing user training and education on electrical safety.

3.7.2. BMETs maintain and operate a medical equipment repair parts program; maintain a technical library with operator and service manuals for each piece of equipment; conduct acceptance inspections for new or transferred equipment; and implement organizational maintenance support for all medical devices used at the deployed location. BMETs perform pre-purchase evaluations of medical devices and advise on operational theory, underlying physiological principles, and safe clinical applications of biomedical equipment. BMETs perform medical equipment disposition actions in accordance with AFI 41-201 to include cooperating with Report of Survey investigations and ensuring the safe and proper disposal of hazardous material resulting from maintenance actions.

3.7.3. BMETs establish equipment data files for all maintenance significant equipment and document all maintenance actions performed throughout the equipment's lifecycle in accordance with AFI 41-201. This documentation includes results of electrical safety inspections, scheduled maintenance, unscheduled maintenance, and quality assurance reviews. Medical equipment service training, clinical applications (user) training, and in-service training is documented in accordance with AFMAN 41-209 upon completion.

3.7.4. BMETs comply with medical equipment tracking actions required by Public Law 105-115, *Food and Drug Administration Modernization Act of 1997,* when performing acceptance or disposition actions.

3.8. Theater Medical Maintenance Support. BMETs organic to the deployed medical facility or aeromedical evacuation unit perform most scheduled and unscheduled maintenance. Local or regional contract maintenance may be available from distributors of US-manufactured medical equipment. BMETs may also return medical equipment to the manufacturer for repair or calibration using the repair and return process through the TLAMM or designated reachback sustaining base. Other resources include the following.

3.8.1. Expeditionary Civil Engineer and Communications Squadrons provide infrastructure and communications equipment support.

3.8.2. Air Force TLAMMs have organic BMET capability or can rely on a regional MERC.

3.8.3. Army TLAMMs have FRA-Ms that can provide maintenance support for imaging, laboratory, and pulmonary equipment at deployed medical facilities.

3.9. Loan Repair and Return Centers (LRRCs). The LRRC program provides maintenance and temporary replacement for certain predetermined, critical medical equipment to mitigate potential impact to patient care capabilities at deployed medical facilities. LRRCs are located at AFMRA/SG4W, Port San Antonio, TX, Ramstein Air Base, Germany, and Yokota Air Base, Japan. The LRRCs maintain an inventory of critical medical equipment items (but not PMI). These critical items are usually one-of-kind equipment that would seriously disrupt patient care if not fully mission capable. LRRC equipment is listed in WRM Assemblage SG97 in the Air Force Medical Logistics Allowance Standard Management System. Equipment in this customer-owned assemblage is provided as a loaner for unserviceable in-theater equipment that is shipped out of the area of responsibility for service or repair. **Note:** Army TLAMMs might maintain an Operational Readiness Float of critical medical equipment. The Operational Readiness Float provides a similar capability to the Air Force's LRRC or reachback support.

3.10. Facility Management. Facility managers maintain the overall safe environment of the entire medical facility and are responsible for the following tasks:

3.10.1. Ensure the identification and correction of electrical safety hazards and coordinate with base civil engineering or contract service provider to ensure inspections of the power distribution and emergency power systems are performed and documented.

3.10.2. Coordinate with base civil engineering or contract service provider to correct power distribution system hazards identified through inspection.

3.10.3. Help perform functional and technical reviews of development documents and drawings.

3.10.4. Identify requirements for medical equipment and furnishings.

3.10.5. Direct acceptance inspections and construction surveillance.

3.10.6. Assist in transitional planning, initial outfitting, and post-occupancy efforts.

3.10.7. Advise on medical facility master planning and life-cycle management.

3.10.8. Conduct facility assessment studies to improve the functional use of space.

3.10.9. Perform engineering evaluations of building systems and components.

3.10.10. Provide consultant services for code interpretation and compliance.

3.10.11. Identify facility sustainment, restoration and modernization requirements, and advocate for project funding.

Chapter 4

COMMAND AND CONTROL RELATIONSHIPS

4.1. Command and Control of Medical Teams. Medical operations command structure is defined in warning, execution, operations, and task orders. Deploying personnel should receive a chain of command briefing before deployment.

4.1.1. Medical logistics personnel fall under the control of the supported unit. When augmenting an existing medical resource, medical logistics specialists report to the senior ranking medical officer or according to the established command structure.

4.1.2. When employed to augment existing EMEDS/AFTH assets, medical logistics personnel integrate into the supported unit's command structure.

4.2. Nodes. The primary nodes within the EML system include the AFFOR/SG or Component Major/Field Command, the deployed medical unit, and the sustaining base. Adjunct nodes include the prime vendor, JTF/SG, AFMLOC, AMC/SGXM (for PMI), and TLAMM. Depending on the node and method of transportation, the APOE/APOD may become critical adjunct nodes. Node enabling functions or processes include transportation, automated information systems technology, worldwide telecommunication capability (including satellite communication), network access, logistics manpower augmentation, and training.

Chapter 5

COMMUNICATIONS AND INFORMATION SYSTEMS

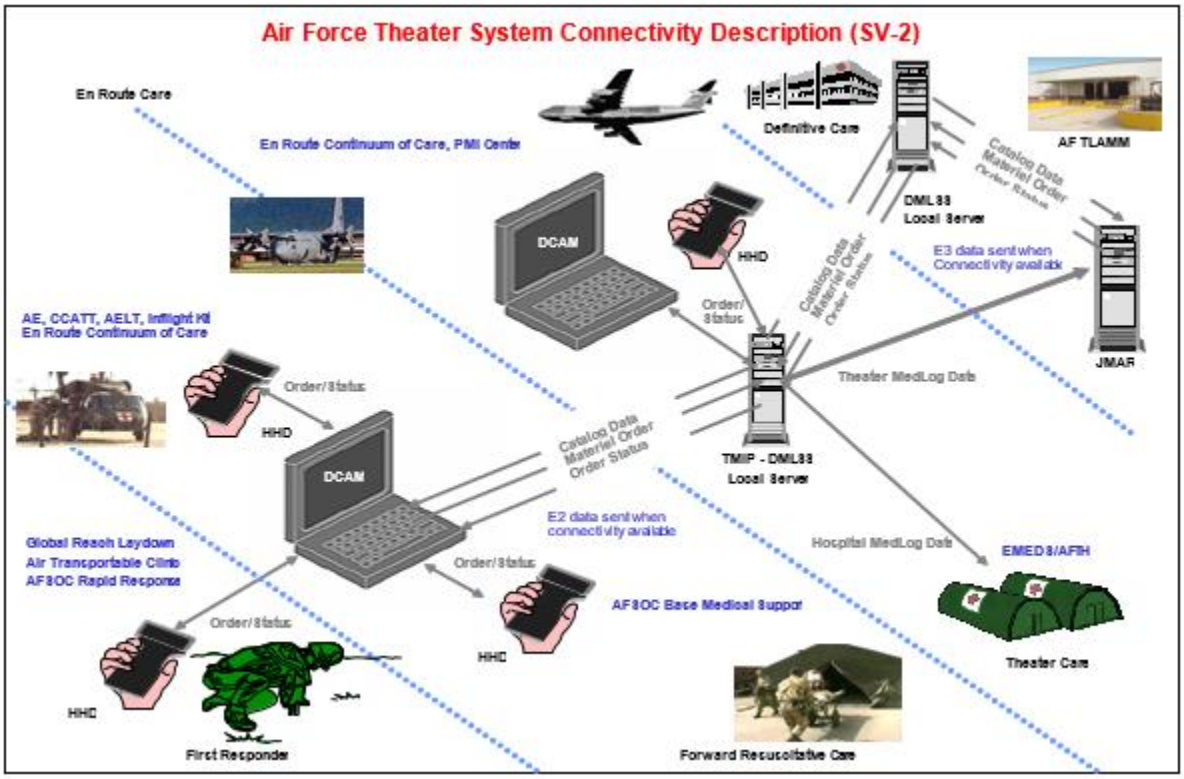
5.1. Communication Requirements. Medical logistics support relies heavily on information technology to track and maintain supplies, establish and sustain effective resupply, and ensure effective in-transit visibility of materiel. Reliable, worldwide communications are critical to the entire EML process. (See **Figure 5.1, Air Force Theater System Connectivity**.) Communication requirements should be an integral part of all operation planning documents.

5.1.1. The sustaining base and AFMLOC should ensure that deploying units have access to a remote access server. The remote access server provides an interim means for the deployed unit to electronically send requisitions (by satellite communications or other appropriate means) until the Expeditionary Communications Squadron can provide a permanent connectivity solution.

5.1.2. The sustaining base should establish a deliberate plan to connect the deploying unit with remote access capability before deployment. This plan should include pre-deployment testing of remote connectivity with the sustaining base.

5.1.3. Personnel should evaluate and incorporate technological enhancements into the EML process where beneficial. Data timeline criteria follows the Under Secretary of Defense (Acquisition, Technology, and Logistics) Implementation Plan for all military and commercial origin, in-transit, and receiving activities to report the arrival and departure of unit strategic and sustainment airlift movements, sustainment sealift movements, and intratheater and CONUS movements.

Figure 5.1. Air Force Theater System Connectivity.



5.2. Defense Medical Logistics – Enterprise Solution (DML-ES). The DML-ES program provides a DOD standard medical logistics portfolio for institutional and operational environments. The Defense Medical Logistics Proponent Committee, under the direction of the Defense Health Agency, Health Operations Director, is the functional proponent for the DML-ES program. All materiel within the EML system, to include initial response supplies, sustainment materiel, and medical equipment, is managed through a DML-ES application.

5.2.1. Defense Medical Logistics Standard Support (DMLSS). DMLSS is the primary information system used by the sustaining base, EMEDS/AFTH, and Air Force TLAMMs for asset management. DMLSS provides medical supply, medical equipment management and maintenance, assembly management, facility management, and customer support functions. It allows direct data entry and transmission of orders from remote locations to suppliers.

5.2.1.1. A DMLSS client server may be deployed to ground medical facilities at the EMEDS HRT level and above, as determined by the AFFOR/SG staff. EMEDS units without a DMLSS client server will access DMLSS through a hub and spoke mechanism in which they connect to the DMLSS server at a hub site (e.g., a larger medical facility) or are supported by a designated master ordering facility. Spoke sites with direct dial-in access can maintain and update their equipment and maintenance records and manage inventory. AFFOR/SG staff should coordinate with AFMRA/SG4 Logistics Support Systems staff for guidance in implementing a hub and spoke strategy.

5.2.1.2. The DMLSS infrastructure requires at a minimum: a Military Health System DMZ enclave, access to the .mil network, bi-directional access through ports 443 and 1521, and a secure, environmentally-controlled computer room or network control center.

5.2.2. DMLSS Customer Assistance Module (DCAM). DCAM is the primary order management system for tactical health service support units supported by the theater TLAMM. It supports deployed medical units providing unit-level (Role 1) support such as a squadron medical element, Air Transportable Clinic, rescue squadron, Red Horse team, and special operations medical teams. DCAM is laptop-based and provides a store and forward capability when communications are not available.

5.2.3. Joint Medical Asset Repository (JMAR). JMAR is a Web-based data repository that provides worldwide asset visibility for medical materiel.

5.2.4. Theater Enterprise Wide Logistics System (TEWLS). TEWLS is used by U.S. Army TLAMMs for theater-level Class VIII supply chain management. TEWLS supports intermediate medical logistics functions and consolidates national, regional, and deployed units into a single business environment. The Web-based version of TEWLS, Web Dynpro, lets users research real-time stock availability from the U.S. Army TLAMMs.

5.2.5. Medical Contingency Requirements Workflow (MCRW). MCRW is a workflow process management and medical materiel planning tool that leverages Defense Medical Logistics enterprise clinical and logistics data. It provides functionality to estimate surge and sustainment materiel requirements and shortfalls for planned combat, humanitarian assistance, and disaster relief operations. It provides the Defense Medical Logistics enterprise capability to perform a variety of medical materiel analyses, including sourcing, sales history, and Service assemblage health to reduce errors and identify the best commercially procurable materiel.

5.3. Theater Medical Information Program (TMIP). TMIP is a suite of DOD standard medical information systems for theater health service support operations. It provides applications for medical command and control, health care delivery, patient tracking, occupational and environmental health exposure tracking and surveillance, medical logistics, and blood management through the Joint Operational Medicine Information Systems (JOMIS) Program Management Office.

5.4. Patient Movement Item Asset Tracking System (PMI-ATS). PMI-ATS provides PMI asset visibility and tracking for deployed aeromedical evacuation units. AMC/SGXM is responsible for PMI-ATS operational control, advice, and counsel.

5.4.1. PMI-ATS provides near real-time information on PMI location, availability, and operational status. It supports timely recycling of PMI through accurate tracking processes and ensures the right equipment is in place at the right time. PMI-ATS supports over 90 sites worldwide.

5.4.2. PMI-ATS uses barcode and RFID technology to link uniquely identified medical equipment with its location and operational status at the point it was scanned. Barcodes and RFID tags are standardized for PMI and will be issued only at PMI centers and designated units or by AMC/SGXM. Users should ensure barcode and RFID labels are attached to all PMI equipment and loaded in PMI-ATS before operational use. The barcode label should include the AMC/SGXM phone number, 1-877-286-1931. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXM to obtain a new label. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and AMC/SGXM.

5.5. Integrated Data Environment (IDE)/Global Transportation Network (GTN) Convergence (IGC). USTRANSCOM's IGC provides a means to access transportation and deployment information. It integrates movement and schedule data from source systems and commercial transportation service providers and feeds this data into supply chain nodes to provide in-transit visibility.

5.6. Communications Planning Considerations. The EML system depends on reliable and timely data and voice communications to exchange information among customers, logistics support units, commercial suppliers, and transportation systems. While most theater medical logistics support systems operate in a non-classified communications environment, some customers (such as Special Forces) and processes (such as joint movement requests) require access to secure communications channels.

5.6.1. Medical logistics support plans should address the need for reliable data connectivity for supply chain management, especially for the earliest stages of deployment before theater communications capabilities are fully mature.

5.6.2. Medical logistics planners should coordinate closely with their J-6 and understand the communications plan for the operation. Planning considerations include the following.

5.6.2.1. Ability for customers to communicate requirements and receive status.

5.6.2.2. Ability for medical logistics units to communicate with customers as well as supporting theater and national-level organizations.

5.6.2.3. Ability for medical logistics units to share requirements and movement information with distribution management organizations and provide situational awareness to logistics and command and control systems.

5.6.2.4. Information security to include negotiation of firewalls.

5.6.2.5. Use of nonstandard communications capabilities, such as satellite.

5.6.2.6. Training, fielding, and in-theater support for hardware and software applications.

Chapter 6

INTEGRATION AND INTEROPERABILITY

6.1. Expeditionary Medical Support (EMEDS) Assemblages. Medical logistics operations at a deployed ground medical facility mirror the same mission support responsibilities as the home station medical facility. Medical logistics personnel assigned to an EMEDS/AFTH UTC should be familiar with this AFTTP as well as AFTTP 3-42.71. EMEDS assemblages deploy with a set number of days of supplies and may require resupply before the theater TLAMM can support it. An EMEDS facility can be equipped to requisition and receive supplies in a stand-alone mode from its sustainment base, another support base, or other sources of supply. AFMRA/SG4M can develop Air Force Class VIII sustainment requirements for specific operating plans.

6.2. Funding Sources. Stored operating supplies may be funded through Air Force Working Capital Fund (AFWCF) assets. As issued supplies are processed, the AFWCF is reimbursed with operation and maintenance (O&M) funds usually through a source of funding associated with an Emergency and Special Program (ESP) coded operation. Air Force assemblages are normally issued upfront using Line of the Air Force O&M funds to reimburse the AFWCF. When O&M funding is used for operating supplies, no reimbursement by customers is required.

6.3. Prime Vendors. The sustaining base and theater TLAMMs requisition the bulk of the pharmaceutical and medical-surgical supplies needed to support deployed medical units from prime vendors. Vendor contracts normally require vendors adhere to military standards and guidance for shipping items that require special handling such as hazardous, controlled, and refrigerated materiel.

6.4. Defense Logistics Agency (DLA). Department of Defense Directive (DODD) 5101.09E, *Class VIIIA Medical Materiel Supply Management*, designates the Director, DLA as the DOD Medical Materiel Executive Agent. The DLA is the major combat support agency that provides worldwide distribution support to the military departments and combatant commands across the full range of military operations, as well as to other DOD components, federal agencies, foreign governments, and international organizations. The DLA manages or distributes over 80 percent of the existing stock of defense materiel, including distribution of service owned stocks and nearly all of the fuel and petroleum products for military use. It is one of the largest components in the global distribution network. DLA responsibilities include the following.

6.4.1. Synchronize planning and execution of end-to-end medical supply chain activities.

6.4.2. Improve the identification and coordination of contingency medical materiel requirements.

6.4.3. Provide financial resources necessary to achieve materiel readiness and end-to-end supply chain operation.

6.4.4. Establish acquisition programs necessary to ensure availability of medical materiel to meet combatant commander requirements.

6.4.5. Establish, monitor, and report on medical supply chain performance.

6.4.6. Coordinate medical materiel requirements and national-level acquisition programs with other federal agencies, including the Department of Veterans Affairs, Department of Health and Human Services, and the Department of Homeland Security.

6.5. Single Integrated Medical Logistics Manager (SIMLM). A SIMLM is a mission assigned by a combatant commander to a service component command or JTF commander to provide medical logistics support to other services and designated multinational partners; promote supply chain efficiency; and minimize the theater medical logistics footprint. When directed, the SIMLM, in coordination with the joint force surgeon, DOD executive agent, and supporting TLAMM, will develop a health service logistics support plan. It will identify the additional requirements necessary to provide medical logistics support to all designated customers and effectively extend medical logistics support into the theater in support of forward medical elements. SIMLM planning and support responsibilities may include:

6.5.1. Planning Class VIII storage and distribution

6.5.2. Coordinating the Class VIII supply chain

6.5.3. Monitoring critical item status

6.5.4. Assessing theater Class VIII readiness

6.5.5. Planning medical maintenance and repair support

6.5.6. Planning and coordinating medical assemblage production, optical fabrication, medical gas production, and similar in-theater support

6.5.7. Coordinating support from foreign sources of supply

6.5.8. Planning and coordinating medical retrograde and redeployment

6.6. Theater Lead Agent for Medical Materiel (TLAMM). A TLAMM is the organization designated to support the combatant commands on behalf of the DLA Medical Materiel Executive Agent and coordinate supply chain management for the entire operating theater or area of responsibility. It is linked to the combatant commands, JTF/SG, AFFOR/SG, deployed medical units, sustaining base, and the AFMLOC. The TLAMM may be jointly staffed to provide customer support and distribution operations. The TLAMM supports the theater medical logistics manager in facilitating materiel movement and in providing medical asset visibility. The TLAMM supports all service components and designated multinational and nongovernmental customers. **Table 6.1** provides a list of the TLAMMs and SIMLMs and their supported combatant commands. TLAMMs can provide the following capabilities.

6.6.1. Class VIII materiel and inventory management.

6.6.2. Biomedical equipment maintenance.

6.6.3. Customer support and training.

6.6.4. Optical fabrication.

6.6.5. Medical materiel fielding.

6.6.6. Assembly and reconstitution.

6.6.7. Blood storage and distribution.

6.6.8. PMI storage, distribution, and maintenance.

Table 6.1. SIMLM and TLAMM Designations.

Combatant Command	TLAMM	SIMLM
EUCOM	USAMMCE	USAEUR
AFRICOM	USAMMCE	USARAF
CENTCOM	USAMMC-SWA	ARCENT (CFLCC)
INDOPACOM	18th Medical Group	USARPAC
INDOPACOM USFK	USAMMC-K	8th US Army (EUSA)
NORTHCOM	AFMRA/SG4W	ARNORTH
SOUTHCOM	AFMRA/SG4W	ARSOUTH

AFMRA/SG4W—Air Force Medical Readiness Agency/Medical Logistics Division
AFRICOM—US Africa Command
ARCENT—US Army Central Command
ARNORTH—US Army North
ARSOUTH—US Army South
CENTCOM—US Central Command
CFLCC—Coalition Forces Land Component Command
EUCOM—US European Command
EUSA—Eighth United States Army
INDOPACOM—US Indo-Pacific Command
NORTHCOM—US Northern Command
SOUTHCOM—US Southern Command
USAEUR—US Army Europe
USAMMC-K—US Army Medical Materiel Center-Korea
USAMMCE—US Army Medical Materiel Center
USAMMCE-SWA—US Army Medical Materiel Center-Southwest Asia
USARAF—US Army Africa
USARPAC—US Army Pacific
USFK—US Forces Korea

Chapter 7

TRAINING

7.1. Medical Readiness Training Requirements. Medical logistics personnel must complete individual training, deployment training, and medical contingency response plan training requirements in accordance with AFI 41-106, *Air Force Medical Readiness Program.* Additional training may be required to meet theater-specific requirements. Theater-unique training requirements are identified in deployment reporting instructions or tasking line remarks.

7.2. Mission-Specific Training. Mission-specific training should include, but is not limited to, hazardous material handling, cargo preparation, pallet building, logistics modules (LOGMODs), vehicle and materiel handling equipment operation, and software applications such as DCAM. Medical logistics personnel assigned to EMEDS UTCs are required to complete EMEDS deployment training in accordance with AFI 41-106 and the Comprehensive Medical Readiness Program (CMRP) Category III Training Guide.

7.3. Vehicle Operation Training. Operators of material handling equipment and other government motor vehicles must have a government driver's license and appropriate certification in accordance with AFI 24-301, *Ground Transportation.*

ROBERT I. MILLER
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Director, Medical Operations and Research

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 4033, *PMI/AE Certification Label*

Abbreviations and Acronyms

ACC—Air Combat Command

AE—Aeromedical Evacuation

AEF—Air Expeditionary Force

AETF—Air Expeditionary Task Force

AFAFRICA—Air Forces Africa

AFFOR—Air Force Forces

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMLOC—Air Force Medical Logistics Operations Center

AFMOA—Air Force Medical Operations Agency

AFMRA—Air Force Medical Readiness Agency

AFMS—Air Force Medical Service

AFSOC—Air Force Special Operations Command

AFTH—Air Force Theater Hospital

AFTTP—Air Force Tactics, Techniques, and Procedures

AFWCF—Air Force Working Capital Fund

AMC—Air Mobility Command

ANG—Air National Guard

APOD—Aerial Port of Debarkation

APOE—Aerial Port of Embarkation

BMET—Biomedical Equipment Technician

C4I—Command, Control, Communications, and Intelligence

CBRN—Chemical, Biological, Radiological, and Nuclear

COMAFFOR—Commander, Air Force Forces

CONUS—Continental United States

CMRP—Comprehensive Medical Readiness Program

CSDC—Consolidated Storage and Deployment Center

DAFTTP—Department of the Air Force Tactics, Techniques, and Procedures

DAPA—Distribution and Pricing Agreement

DCAM—DMLSS Customer Assistance Module

DLA—Defense Logistics Agency

DML-ES—Defense Medical Logistics-Enterprise Solution

DMLSS—Defense Medical Logistics Standard Support

DOD—Department of Defense

DODAAC—Department of Defense Activity Address Code

DODD—Department of Defense Directive

DODI—Department of Defense Instruction

ECAT—Electronic Catalog

ECS—Expeditionary Combat Support

EMEDS—Expeditionary Medical Support

EML—Expeditionary Medical Logistics

ERPSS—En Route Patient Staging System

ESP—Emergency and Special Program

FRA-M—Forward Repair Activity Medical (Army)

GFCI—Ground Fault Circuit Interrupter

GSA—General Services Administration

GTN—Global Transportation Network

HRT—Health Response Team

IDE—Integrated Data Environment

IGC—IDE/GTN Convergence

JFACC—Joint Force Air Component Commander

JMAR—Joint Medical Asset Repository

JOMIS—Joint Operational Medicine Information Systems

JP—Joint Publication

JTF—Joint Task Force

LOGMOD—Logistics Module

LRRC—Loan Repair and Return Center

LRP—Limited Response Package

MC-CBRN—Medical Counter-CBRN

MCRW—Medical Contingency Requirements Workflow

MEFPAK—Manpower and Equipment Force Packaging

MERC—Medical Equipment Repair Center

MRA—MEFPAK Responsible Agency

O&M—Operation and Maintenance

OCONUS—Outside the Continental United States

OPR—Office of Primary Responsibility

PACAF—Pacific Air Forces

PMI—Patient Movement Item

PMI-ATS—Patient Movement Item Asset Tracking System

POM—Program Objective Memorandum

RFID—Radio-Frequency Identification

SIMLM—Single Integrated Medical Logistics Manager

SG—Surgeon

SOF—Special Operations Forces

StF—Safe to Fly

TEWLS—Theater Enterprise Wide Logistics System

TFPDD—Time-Phased Force Deployment Data

TLAMM—Theater Lead Agent for Medical Materiel

TMIP—Theater Medical Information Program

TRP—Theater Response Package

USAFE-AFAFRICA—United States Air Forces in Europe-Air Forces Africa

USCENTCOM—United States Central Command

USINDOPACOM—United States Indo-Pacific Command

USNORTHCOM—United States Northern Command

USSOUTHCOM—United States Southern Command

USTRANSCOM—United States Transportation Command

UTC—Unit Type Code

WRM—War Reserve Materiel