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This instruction implements Air Force Policy Directive (AFPD) 48-1, *Aerospace & Operational Medicine Enterprise (AOME)*. This instruction applies to all active duty Air Force Special Operations Command (AFSOC) operational medical personnel, pararescuemen (PJ), and Combat Rescue Officer (CRO) personnel. This instruction applies to AFSOC gained Air Force Reserve Command (AFRC) and Air National Guard (ANG) units, this instruction does not apply to the USSF and units will comply with this instruction in applicable areas. This publication requires the collection and/or maintenance of information protected by the Privacy Act of 1974 authorized by Title 10 U.S.C., Sec 9013, Secretary of the Air Force. The applicable System of Records Notice (SORN) F033 AF D, Automated Orders Data System, available at: **https://dpcld.defense.gov/privacy/SORNS.aspx** AFSOC operational medical personnel are defined as medical personnel assigned to AFSOC medical unit type codes (UTCs), as well as other specific medical personnel assigned to AFSOC units (i.e. special tactics medical personnel). Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Instruction 33-322, *Records Management and Information Governance Program*, and disposed of in accordance with the Air Force Records Disposition Schedule located in the AF Records Information Management System. Refer recommended changes and questions about this publication to the OPR using DAF Form 847, *Recommendation for Change of Publication*; route DAF Forms 847 from the field through the appropriate functional chain of command. This publication may be supplemented at any level with OPR approval. Requests for waivers must be submitted to the OPR listed above for consideration and approval. The authorities

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SUMMARY OF CHANGES

This interim change revises AFSOCI48-1010 by updating the approval authority for operational use of Go/No-Go medications for aircrew members. A margin bar (|) indicates newly revised material.

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Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. Introduction and Overview. This Instruction highlights responsibilities at wing level and below and establishes procedures for all AFSOC operational medical personnel described in AFTTP 3-42.6, *USAF Medical Support for Special Operations Forces*, Chapter 3. AFSOC operational medical personnel, or "operational medics," are defined as medical Air Force Specialty Codes (AFSC) assigned to OSM and Special Warfare (SW) units, and any personnel assigned to an AFSOC UTC outside of the 1st Special Operations Medical Group (SOMDG), 27 SOMDG, 193 Medical Group (MDG), 137 MDG, and 919 Special Operations Medical Dental Squadron. Additionally, this instruction applies to AFSOC operational medical personnel involved in Global Health Engagement (GHE) operations. PJ and CRO personnel are not considered operational medical personnel as they have operational requirements outlined in their combatant AFSCs.

1.2. Waiver Authority. Requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority.

1.3. Organizational Responsibilities.

1.3.1. AFSOC Command Surgeon (SG). The AFSOC/SG is responsible for establishing, coordinating, and sustaining a medically ready AFSOC force and for organizing, training, equipping, and validating AFSOC medical forces for contingency medical support. As the air component surgeon to United States Special Operations Command (USSOCOM), the AFSOC/SG plans all Air Force medical support for AFSOC missions and serves as the principal Air Force medical service advisor to USSOCOM. AFSOC/SG is the waiver authority for all Command level requirements listed in this document.

1.3.2. 24 Special Operations Wing (SOW) Surgeon. The 24 SOW/SG serves as the Functional Area Manager within special tactics (ST), and provides advice and guidance to the SOW commander. The 24 SOW/SG is responsible for ensuring Special Tactics Group (STG) Surgeon and Special Tactics Squadron (STS) medical leaders comply with established medical policies. The 24 SOW/SG provides functional area review of medical unit reports and requests to higher headquarters, career mentoring to junior medical personnel, and oversight of evaluations, awards, and decorations for assigned medical personnel. The 24 SOW/SG also acts as liaison and consultant to AFSOC/SG for ST specific medical issues. At Special Tactics (ST) units, the 24 SOW/SG serves as the Functional Area Manager within, and provides advice and guidance to the SOW commander. The SOW/SG is responsible for ensuring Special Tactics Group (STG) Surgeon and Special Tactics Squadron (STS) medical leaders comply with established medical policies.

1.3.3. Special Tactics Group Surgeon (STG/SG). The STG/SG coordinates medical training and oversees appropriate medical equipment for flight surgeons (FS), medics, and PJs assigned to STG and the Special Operations Surgical Teams (SOST). The STG/SG plans medical support for special tactics missions and selection of special tactics candidates. The STG/SG fosters a good relationship with host Chief of Aerospace Medicine (SGP) and Flight and Operational Medicine Clinic (FOMC) to ensure STG medics are able to maintain their clinical skills and currencies by clinically and administratively supporting home station and deployed MTFs. The Surgeon should also maintain a good relationship with host Base Operational

Medicine Clinic (BOMC), as they accomplish fly-PHAs, deployments, ASIMS tasks, and upgrade training for STG members.

1.3.4. Medical Group Commander (MDG/CC). MDG/CC is responsible for oversight of all medical care on the installation. MDG/CC is the waiver authority for clinical currencies as established in this publication. This authority cannot be delegated.

1.3.5. Military Treatment Facility Chief of Aerospace Medicine (MTF/SGP). MTF/SGPs will oversee all activities related to flight and operational medicine in their MTF and will function as liaison between the MTF and all AFSOC embedded medics to include Ambulatory Care Units (ACU) and OSM flights. The MTF/SGP fosters good relationships with line medical assets and ensures OSM and ACU personnel are able to integrate with the host MTF.

1.3.6. Operational Support Medical Operations Flight Commander (OSM/CC). Duties include coordination with line leadership for appropriate employment of line medical assets and fostering a good relationship with host SGP and FOMC at the supporting military MTF. The OSM/CC ensures OSM personnel maintain their clinical skills and currencies by integrating clinic time at the host MTF.

1.3.7. OSM Medical Planner. OSM Medical Planners are Medical Service Corps officers serving as the unit medical planner and administrator ensuring management and oversight of War Reserve Materiel (WRM) projects, budget forecast and execution, training programs, readiness reporting, and currency of unit manning documents. Additionally, medical planners are integral to planning medical support for deliberate and contingency missions. Additionally, OSM medical planners will participate in all phases of operational exercise planning and execution.

Chapter 2

ADMINISTRATION OF MEDICAL ACTIVITIES

2.1. Command and Control (C2). For administrative and operational C2 in deployed settings, operational medical personnel shall follow C2 regulations per AFSOC/A3 guidance. For in garrison chain of command, the flying or operational Squadron commander (SQ/CC) retains administrative control, operational control, and punitive authority in accordance with the Uniform Code of Military Justice over operational medical personnel. Rating chain will be through the flying or operational squadron. **(T-3)**

2.2. Privileging Documentation. All healthcare providers (HCPs) will maintain a current copy of their medical credentials in their deployment folder. Likewise, IDMTs will maintain a copy of their current initial and sustainment training documentation via the electronic Total Force Training Record (TFTR). All IDMTs will hand carry these documents while deployed. If deployed to a location with medical facilities, HCPs and IDMTs will provide the medical facility commander with a copy of these documents. While deployed under USSOCOM orders, AFSOC operational medics assigned to line units remain within the special operations chain of command. However, AFSOC medical personnel will comply with co-located medical facility credentialing/privileging processes. The senior AFSOC physician at the deployed location will review Inter-facility Credentials Transfer Briefs and IDMT certification documents.

2.2.1. Non-privileged ACU assets. ACU assets discussed in this document refer only to the privileged providers. The work provided by the nonmedical assets is overseen by the line squadron chain of command.

2.3. Quality Assurance. The senior deployed AFSOC physician, or senior provider in absence of a physician, is responsible for medical quality assurance during deployments. Quality assurance will include peer review as described by the credentialing facility, both at home station and deployed. IDMT quality assurance will be completed IAW AFI 44-103, *The Air Force Independent Duty Medical Technician Program*.

2.3.1. After return from deployment, a copy of all chart review documentation (**Attachment 3**, Deployed QA Oversight Documentation Sample), will be forwarded to the host MTF for continued credentialing and privileging actions.

2.3.2. All AFSOC credentialed healthcare providers, to include Preservation of the Family and Force (POTFF), will participate in peer review and, when necessary, standard of care reviews under the direction of the credentialing MTF.

2.4. Reporting. Operational medical readiness reporting as it relates to deployments and exercise participation will be submitted via AAR or OSM Executive Activity Clinical Currency Report. Resource readiness reporting is accomplished IAW AFI 41-106 Chapter 6.

2.4.1. Send reports to the AFSOC Chief of Medical Readiness (AFSOC/SGX) organizational email boxes at the appropriate level of classification: NIPR: **afsoc.sgx@us.af.mil**, SIPR: **afsoc.sgx@socom.smil.mil**. Time-sensitive reporting should always include positive personal contact by telephone.

2.4.2. IAW AFI 90-1601, *Air Force Lessons Learned Program*, personnel participating in contingencies, exercises, and AFSOC rotational deployments outside of continuous Air and

Space Expeditionary Force (AEF) cycles will submit an After Action Report (AAR) to HQ AFSOC NLT 30 days, 60 days for Air Reserve Components (ARC) units, after the end of the event unless otherwise directed.

2.4.2.1. AARs should be submitted IAW theater, parent unit, or other local guidance, with courtesy notification to HQ AFSOC/SGX. When no such guidance exists, AARs should be submitted directly to HQ AFSOC/SGX. **Attachment 6** is the approved template.

2.4.2.2. Appropriate data repositories for AARs include, but are not limited to, the Joint Lessons Learned Information System for all types of events and observations and the Joint Trauma System Trauma Registry. Local guidance may mandate additional systems or processes.

2.4.2.3. In addition to the above mandatory reporting guidance, units and personnel should submit AARs whenever they make a significant observation that identifies a best practice or potential for poor outcome.

2.4.3. Executive Activity and Clinical Currency Quarterly Report. All operational AFSOC medical units will complete quarterly (Jan - Mar, Apr - June, July - Sep, and Oct - Dec) executive summaries describing unit deployments and activities at the unclassified level, and complete the Clinical Currency Report in **Attachment 4**. Requirements for the Clinical Currency Reports are outlined in the Training Tables available at: **https://usaf.dps.mil/sites/AFSOC-SG/SGX/SitePages/Home.aspx**. Reports are due NLT 15 days following the last day of the quarter to AFSOC/SGP and AFSOC/SGX, via NIPR, to **AFSOC.SGX@hurlburt.af.mil**. AFSOC/SGX will forward to all AFSOC/SG divisions.

2.4.4. Medical Logistics. All Geographically Separated Units will forward WRM Inventory Summary Letters upon completion of biennial WRM inventories, per AFMAN 41-209, *Medical Logistics Support* to the AFSOC Superintendent of Command Medical Logistics and The Deputy of the Medical Readiness Division (SGXL).

2.5. Line Embedded Medical Care Units. This applies to AFSOC ACUs**.** Adhere to guidance found in AFMAN 48-149, *Flight and Operational Medicine Program (FOMP)*. ACUs provide office-based medical and limited-scope mental health care, as well as spiritual and mental health resiliency support within designated squadrons, groups, and wings. The ACU facilitates care by seeing operators at their work-site. The advantages of this care model include improved access to care, enhanced understanding by the providers of the unique nature of the SOF mission and operations tempo, and an improved provider-operator relationship resulting in enhanced trust. ACUs are medically staffed areas in line units where pre-hab and early medical intervention is provided for active duty, ANG and Reserve personnel on active orders only. Although not a component of the MTF, ACUs will receive support and administrative oversight from the local MTF.

2.6. Medical Information Management. All patient encounters will be documented. All operational medical units must deploy with and use the laptop based Theater Medical Information Program (TMIP) to document electronic healthcare records (EHR) with the Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T) application, Battlefield Assisted Trauma Distributed Observation Kit (BATDOK), or similarly approved EHR documentation system to collect and document all patient encounters. Failure to appropriately document patient encounters both in garrison and deployed constitutes a serious breach in standard of care.

2.6.1. Patient encounters collected in TMIP or other EHR system will be uploaded to the Theater Medical Data System from the deployed location. AHLTA-T utilizes a unique store and forward capability that allows data to be stored in a local database until connectivity to the Internet is restored, at which time data is automatically passed to the central Theater database. If no connectivity is available the laptop may be connected at the first area of available communications or the records will need to be exported onto a government hard drive or CD and hand carried to home station for immediate upload to the Military Health System Clinical Data Repository.

2.6.2. TMIP Training. Each operational medical unit must designate in writing a primary and alternate Unit TMIP Administrator and at least five TMIP users to AFSOC/SGRI. AFSOC/SGRI will coordinate initial training for unit identified TMIP Administrators and TMIP Users. Unit TMIP Administrators will ensure deploying members are trained and proficient to use TMIP and have reach-back support to the unit TMIP Administrator. Sustainment of training will be the responsibility of the unit TMIP Administrator and will include TMIP familiarity, user training, system configuration, and troubleshooting.

2.6.3. All operational medical units will ensure UTC deployable computers are functional and loaded with TMIP before deploying. Any shortfalls or problems will be forwarded to AFSOC/SGX and AFSOC/SGRI for technical assistance.

2.7. Infection Control Responsibilities. Infection Control (IC) is managed IAW AFI 44-108, *Infection Prevention and Control Program*, and AFMAN 48-105, *Public Health Surveillance*.

2.7.1. In the deployed setting, the lead medical provider will ensure an active and current Infection Control Program at all care locations.

2.7.2. Report infection control discrepancies and inconsistencies to the flight commander, local MTF Infection Control Function Chairperson, MTF/SGH, and group or wing SG.

2.8. Medication Dispensing Devices (MDDs). ACUs and POTFF clinics outside of the MTFs will not use MDDs for storage or dispensing of controlled substances.

2.9. Ancillary Services. When lab and radiology services driven by care provided in the ACUs are available at the local MTF, the local MTF will provide them.

2.10. Self-Inspections. Self-inspection will be completed in Management Internal Control Toolset (MICT) following AF, Air Force Medical Readiness Agency (AFMRA), and AF Inspection Agency (AFIA) guidance. ACUs will undertake self-inspections at the frequency and in a manner as directed by AFIA guidance and instructions. At a minimum, two self-inspections are required annually. Line medical leaders will perform a self-inspection within 60 days of assuming the leadership role. The self-inspection program is one element of the quality program but does not cover all guidance applicable to the provision of medical care. All guidance applicable to the provision of medical care by Air Force providers also applies to the care provided by embedded medical assets.

2.11. Funding for Supplies. Funding for medical supplies for the ACU may be provided using Defense Health Program (DHP) funds as permitted by Air Force policy or through line funding. Non-disposable ACU medical supplies and equipment are funded using Line sources, and day-to-day disposable medical supplies are funded through DHP sources. ACU medical supplies will be

ordered through the MTF supply chain and the MTF will assist with ordering and procuring medical equipment and supplies as needed.

2.11.1. WRM funding is for deployed medical care. WRM supplies will be used in compliance with all guidance for WRM supplies and will not be used for ACU patients for in-garrison care. Expendable stock, such as medications, may be rotated out of WRM and used before its expiration date.

2.11.2. Qualified aviation personnel filling API-5 or Operational Support Flying billets are authorized to use their organization operations and maintenance (O&M) type funds as directed by their commanders or other competent authority IAW DAFMAN 65-601V1 paragraph 11.13.7 to purchase flight specific uniforms and equipment. This applies to operational and MTF assigned aviators.

Chapter 3

FORCE HEALTH AND GROUNDING MANAGEMENT

3.1. Objectives. To ensure protection and promotion of Airmen's health in garrison and when deployed. Familiarity of aircrew physical standards, deployment health requirements, and health surveillance are integral to force health and grounding management.

3.2. Aircrew Physical Standards. When making aeromedical dispositions, AFSOC flight surgeons must refer to AFI 48-123, *Medical Examinations and Standards*, the Medical Standards Directory, AF and AFSOC policy letters, and the USAF Aerospace Medicine Waiver Guide published by the Aeromedical Consultation Service on the AFMS Knowledge Exchange.

3.2.1. Disqualification Authority. Refer to AFI 48-123 for certification/disqualification authority. Local disqualification is not authorized.

3.2.2. Aeromedical Consultation Service (ACS). All ACS evaluation requests must be submitted through the Aeromedical Information Waiver Tracking System to the AFSOC Chief of Flight Medicine (SGPA) for review and subsequent forwarding to the ACS.

3.3. Diving Medical Standards. Special Warfare Airmen (SWA) require medical clearance to perform diver operations IAW DAFAM 48-123, *Medical Examinations and Standards*, and AFI 10-3504, *Dive Program*. The Special Warfare Airman (SWA) annual special duty ("flight") physical clears ST operators for operational diving and for any formal Air Force dive course of instruction. A current AF 2992 provides proof of medical clearance for diving operations unless annotated otherwise in Box 13 of the DD Form 2992. SWA will follow the appropriate sister service medical and physical standards when attending formal non-AF dive courses. Navy dive courses (eg. Dive Supervisor) require a dive physical IAW Navy MANMED. Army dive courses require a physical IAW AR 40-501. These can be accomplished by the unit flight surgeon and certified by the respective dive school UMO/DMO.

3.4. Aeromedical and Special Duty Disposition. All return to flight status or return to special operations duty status require grounding management dispositions by a licensed and credentialed Flight Surgeon (FS), Aeromedical Physician Assistant (APA), or Aeromedical Nurse Practitioner (ANP). Duties Not to Include Flying (DNIF) and Duties Not Including Controlling (DNIC) may be completed by any clinical provider or IDMT.

3.4.1. Adhere to AFMAN 48-149 on the requirements for the training and experience required for APAs and ANPs to return a flyer or special warfare airman to duty status.

3.4.1.1. IDMTs must contact a US military flight surgeon for appropriate aeromedical disposition. This contact must be documented in the aviator's or special warfare airmen's medical record and subsequently countersigned by the consulted aeromedical provider upon return from deployment.

3.4.1.2. AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log Review*. A representative from the AFSOC operational medical unit shall attend and participate in the weekly Flight and Operational Medicine Working Group at the host MTF. Operational aeromedical providers shall actively monitor and manage the aeromedical status of all DD Form 2992 holders in their assigned units.

3.5. Airmen Medical Readiness Optimization (AMRO). AFSOC embedded medical providers will participate in local AMRO Boards per DAFMAN 48-108. The AMRO Board reviews service members with duty limiting conditions that affect mobility, retention, or long-term physical fitness. A provider who is familiar with the service member's case will be present to give accurate representation.

3.6. Use of Fatigue Countermeasure Medications. Non-pharmacologic fatigue countermeasures (e.g., scheduling, aircrew augmentation, etc.) are the preferred methods of combating fatigue and making operational risk management (ORM) decisions. Fatigue countermeasure medications are an additional mitigation strategy available in consultation with a senior flight surgeon when a fatigue risk remains despite a commander's best efforts to use non-pharmacologic countermeasures. These medications are not a solution for manning shortages, suboptimal operational planning, support of a lifestyle of poor sleep habits, or inappropriate prioritization of work and play activities. Because of their addictive properties and potential for abuse, fatigue countermeasure medication use by aircrew and SWA is controlled and requires coordination and oversight by both flight medicine and line leadership.

3.6.1. Approval. AFSOC/A3 is the approval authority for operational use of Go medications for aircrew members.

3.6.1.1. The Wing representative and MTF SGP will develop a fatigue countermeasure plan for mission types in advance of deployment, based on the unit's alert or short notice requirements, and provide a copy to the MAJCOM SGP. If the unit is a tenant unit on another MAJCOM's installation, the unit's MAJCOM SGP will be consulted. For example, an AFSOC unit stationed on a PACAF Base will consult the PACAF SGP. The fatigue countermeasure plan will be reviewed annually.

3.6.2. Approved fatigue countermeasure medications. AFMRA/SG3P publishes the list of authorized stimulants ("Go Pills") and sedatives ("No-Go Pills") in the *Official Air Force Aerospace Medicine Approved Medications List.* Aeromedical clinicians must supervise the use of any fatigue countermeasure medications and exercise careful judgment before dispensing.

3.6.3. The decision to prescribe and use fatigue countermeasure medications in a specific situation is one between the Airmen and their flight surgeon. It is a voluntary decision based on anticipated levels of fatigue and alertness while participating in a mission or situation where fatigue countermeasure medications are already authorized.

3.6.4. No-Go Pills. No-Go Pills are a useful adjunct for adjusting an aircrew's or SWA's circadian rhythm to coincide with crew duty day.

3.6.4.1. AFSOC/SG delegates approval authority for operational use of No-Go pills to the FS, APA, and ANPs at the operational unit level. Authority delegation is contingent upon full compliance with all program and documentation requirements. The senior flight surgeon at the unit level is responsible for implementation of this policy.

3.6.4.2. This policy for use of No-Go pills also applies to all AFSOC operational units to include: MTF FOMC, aviation, special tactics, RPA, CAA, and GHE units.

3.6.4.3. Aircrew and Special Operations Duty personnel are verbally DNIF for 12 hours after taking Temazepam (Restoril®), 6 hours after taking Zolpidem (Ambien®), or 4 hours after taking Zaleplon (Sonata®) IAW the Official Air Force Aircrew Medications list.

3.6.4.4. No-Go pill use of Temazepam and Zolpidem is limited to a maximum duration of 7 consecutive days and no more than 20 days in a 60-day period. Zaleplon may be used for up to 10 consecutive days and no more than 28 days in a 60-day period.

3.6.4.5. No-Go pills are authorized during transition from deployment or redeployment settings to synchronize circadian rhythm for deploying or redeploying crews. Short term use of No-Go pills are also authorized to assist deployed crew members with fatigue and circadian rhythm problems.

3.6.5. Go Pills. Go Pills can improve alertness, vigilance, and ultimately safety for aircrew members during long missions or critical phases of flight, and for SWA during prolonged missions. They are used when a fatigue deficit exists during a mission despite the best efforts of leadership and aircrew or SWA to use non-pharmacologic fatigue countermeasures.

3.6.5.1. In general, Go Pills are potentially appropriate for missions that disrupt an aircrew member's or SWA's normal sleep-wake cycle, including but not limited to: multi-crewed aircraft missions greater than 12 hours or when crew duty day is expected to exceed 16 hours; fighter/single-pilot or helicopter missions greater than 8 hours duration; alert missions; combat missions for crews shifting from day to night with only 12 hour notice; and SW missions, when SWA may not return to base for a prolonged time, and do not have the benefit of fixed crew rest.

3.6.5.2. Go Pill use may be authorized for missions when there is not disruption to an aircrew member's or SWA's normal sleep-wake cycle, but use would otherwise be beneficial to the mission. The base SGP (or a flight surgeon supporting an AFSPECWAR unit) will coordinate with AFSOC/SGP for these circumstances. (For tenant units contact their MAJCOM SGP.) AFSOC/SGP should collaborate with AFSOC/A3 to identify those missions where risk may be mitigated.

3.6.5.3. For aircrew members and SWA, Go Pill use will be confined to approved medications in the most current version of the *Official Air Force Aerospace Medicine Approved Medications List*. None are authorized for routine clinical use in flyers or special duty personnel.

3.6.5.4. Remotely Piloted Aircraft aircrew members are not authorized to use Go Pills.

3.6.5.5. Go Pill use is not authorized for parachute or diving operations.

3.6.6. The use of fatigue countermeasure medications will be reviewed at Aeromedical Council and with the SOG/CC or STG/CC representative at least every six months. A copy of the usage report will be forwarded to the unit's MAJCOM SGP (home station MAJCOM if deployed). For tenant units, also send copy to their MAJCOM SGP. The review should identify groups or individuals that appear to be under- or overusing medications, and should also focus not only on medical but on the line handling of tasking and early interventions that can mitigate the need for pharmacological countermeasures (e.g., ensure schedulers are planning efficiently). Reports should include aircraft type and number of sorties (number of missions for SWA) where a fatigue countermeasure medication was prescribed, quantity and strength

prescribed, quantity used, efficacy, any untoward side effects, as well as identifying best practices. A sample format can be found on the "Go Pills" link at the Kx.

3.6.7. Ground Testing. All initial ground testing will be accomplished when new aircrew are assigned to their initial technical school, during the first few weeks of academics—i.e., when they are not actively flying. SWA will ground test at the earliest opportunity. All aircrew and SWA ground testing fatigue countermeasure medications must receive counseling regarding off label use of Go Pills as an operational countermeasure, and sign an informed consent prior to use per DoDI 6200.02, *Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs*, and AFMAN 48-149, *Flight and Operational Medicine Program*. Informed consent forms can be found on the AFMS Knowledge Exchange: **https://kx.health.mil/kj/kx4/FlightMedicine/Pages/CurentGoPillFormsNov2011.aspx**

3.6.8. Aeromedical clinicians and other healthcare clinicians transporting controlled substances on temporary duty or deployment.

3.6.8.1. Aeromedical clinicians or technicians may transport controlled substances issued by the MTF pharmacy or medical logistics specialist in the context of operational support to line units IAW AFMAN 48-149. Clinicians or technicians should only transport controlled substances on temporary duty or deployment when pharmacist or pharmacy technician is not available.

3.6.8.2. When transporting controlled substances, the clinician will:

3.6.8.2.1. Be issued an AF Form 579, *Controlled Substances Register*, by the local MTF pharmacy, MSC, or logistics technician.

3.6.8.2.2. Possess a memo signed by the MTF SGP or Wing Senior Flight Surgeon authorizing transport of controlled substances. This memo should address the rationale for transporting controlled substances; validation that controlled substances were issued and documented on the AF Form 579; any limitation on dispensing controlled substances; and a POC.

3.6.8.3. Unused medications may be collected and disposed of IAW AFI 44-102

3.7. Performance Enhancement (PE).

3.7.1. Performance Enhancement initiatives are intended to optimize performance in specific areas of function. They differ from therapeutic treatments, which are used to treat medical diagnoses, symptoms, or other identified deficiencies. PE initiatives may use biotechnology devices (e.g. biofeedback monitors or wearable devices that monitor biomarkers such as sleep cycles or heart rate variability), dietary supplements, or other biologics. New PE devices, technologies, and supplements could lead to inappropriate use if not properly vetted or approved for DoD member use. This could cause and lead to adverse actions for the provider. In order to embrace innovation and technology safely, the following criteria must be met in order to employ a PE device or technology:

3.7.1.1. The device/technology must receive approval from AFSOC/SGR for use by AFSOC personnel.

3.7.1.2. The device/technology must not be prescription controlled. If prescription controlled, it falls outside the definition of PE.

3.7.1.3. If the device/technology is part of a research study/IRB controlled, it will only be used as a part of that study.

3.7.2. Dietary Supplement Usage.

3.7.2.1. Dietary Supplement Usage is per USSOCOM Policy Memorandum 19-30, *Policy on Performance Enhancing Substance Use for Special Operations Forces (SOF) Personnel*, 17 January 2020.

3.7.2.1.1. All AFSOC personnel on flight and special operations duty status must be granted prior approval by an aeromedical provider for use of any dietary supplement. Per DAFMAN 48-123, personnel are "down" for any unauthorized use.

3.7.2.1.2. Specific supplement and rationale for use must be documented in the aircrew or operator's medical record.

3.7.2.2. Approval for use of dietary supplements does not authorize use of O&M funds to obtain approved products.

3.7.2.2.1. Operation Supplement Safety (OPSS) provides an expansive list of substances that have at one time appeared, or currently appear, as ingredients in products labeled as dietary supplements that FDA or the U.S. Armed Services have disallowed.

3.8. Blood Borne Pathogen (BBP) Exposure Risk and Control Plan.

3.8.1. AFSOC medical operational units will establish an exposure control plan for care and evaluation of AFSOC assets and those that fall under their medical responsibility in the field who may have exposure to blood or body fluids in an austere environment. The protocol should not replace the standing post exposure protocol at the in-garrison MTF for the active duty member upon their return from the austere location.

3.8.2. In accordance with *Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus (HIV) and Recommendations for Post-Exposure Prophylaxis* (PEP), medical providers who are conducting high risk training or have a high expectation of exposure to HIV must deploy with PEP. If diagnostic laboratory resources are not available to test either a source patient or medical provider prior to or following a BBP exposure, the exposure must be documented. The medical provider will complete BBP exposure testing and treatment at the next available opportunity.

3.8.2.1. Local plans should include education of deploying forces with pre-deployment briefings on HIV, Hepatitis B Virus, and Hepatitis C Virus risks in theater. Education of line members should emphasize post exposure cleanup after self-aid/buddy care, the use of personal protective equipment (PPE), and the definition of exposure.

3.8.2.1.1. Significant exposures are considered blood or body fluids on mucous membranes or non-intact skin and/or blood or body fluids injected via a needle stick from a hollow or solid needle, or other sharp objects.

3.8.2.1.2. Non-significant exposures are considered blood or body fluids on intact skin, casual contact with an HIV-infected individual, or exposure to an animal's blood or body fluids.

3.8.2.2. Education of medical forces should emphasize universal precautions and use of PPE, especially in the use of sharp instruments in a low light combat environment which places SOF medics at increased risk.

3.9. Exertional Heat Illnesses (EHI).

3.9.1. Senior unit medical provider requirements

3.9.1.1. Review AFI 48-151 and USSOCOM Policy Memo 19-13.

3.9.1.2. Conduct a post injury examination within 24 hours for all EHI casualties that receive cooling measures. If the injury occurred on a weekend of federal holiday, the appointment must be scheduled by 0900 on the first business day after the injury event.

3.9.1.3. In situations where operational and logistical constrains preclude access to rapid cooling within 10 minutes during events with moderate or high risk for EHI, a written waiver must be coordinated through OG/CC or equivalent and the AFSOC/SG as outlined in the AFSOC Guidance on Heat Illness Prevention & Treatment Protocols.

Chapter 4

AFSOC OPERATIONAL MEDICINE

4.1. AFSOC Operational Medical Personnel Responsibilities. All AFSOC operational medical personnel will work toward the successful execution of the Aerospace Medicine Enterprise as defined in AFI 48-101.

4.1.1. AFSOC operational medical personnel deliver healthcare, both in-garrison and while deployed. Flight surgeons, SOST members, APAs, ANPs, psychologists, nurses, IDMTs, physical therapists, health service management personnel, and medical technicians designated as operational medical personnel to AFSOC units have unique roles and responsibilities. When in-garrison, and when not participating in mandatory squadron functions, training, or exercises, operational medical personnel are required to maintain clinical proficiency, meet medical training and administrative requirements, and maintain clinical credentials and privileges. Meeting and sustaining the requirements contained herein qualifies AFSOC's operational medical personnel for deployment. Unit commanders shall employ their medical assets meaningfully. Therefore, operational medical personnel will not be assigned duties that normally would be performed by non-medical personnel (e.g., readiness manager).

4.1.2. AFSOC's operational medical personnel must be prepared for operational deployment. Clinical competency and proficiency are the most important and critical qualifications AFSOC operational medics bring to the fight. These skills are extraordinarily perishable. All operational medical personnel, without exception, must meet or exceed their duty clinical requirements. In order to maintain these perishable qualifications, the primary emphasis of in-garrison activities will be prioritized to the delivery of safe and effective healthcare in clinic and hospital settings. AFSOC operational medical personnel must complete the clinical exposure requirements listed in the AFSOC Medical Training Tables, as well as AFSC specific requirements.

4.1.2.1. Rules of Engagement while Deployed. AFSOC medical personnel must function within the parameters of the established mission set. No additional engagement activities will be conducted without appropriate level of approval. The chain of command will decide which medical support requests will be channeled to the embassy and/or Department of State entities in the AOR.

4.1.2.2. When in-garrison, AFSOC operational medical personnel will maximize their clinical time in the affiliated hospitals, MTF, or ACU settings while performing duties directly related to the hands-on delivery of healthcare services. MTF and clinic settings include, but are not limited to: Flight Medicine, BOMC, Family Practice, Emergency Department, Pediatrics, Radiology, and specialty clinics. Duty schedules will be developed and published, with best available information, for operational medical personnel and will be shared and coordinated with the host SGP at least 30 days prior to clinical duties. Host MTF will ensure patients, examination rooms, and operating rooms are scheduled for operational medical personnel.

4.1.2.3. Each provider's patient care time will be reported by the OSM Flight Commander or designee to the AFSOC/SGP quarterly within 15 days after the last day of the quarter. Clinic time will be reported as the number of half-days of patient care performed by the

provider for the reported quarter. The number of patients each provider sees and treats as the treating provider will be included in this report, i.e. merely signing off as a supervising provider or determining aeromedical disposition does not qualify for patient count purposes.

4.1.2.4. Clinic time for CONUS ST aeromedical providers will be reported to the 24 SOW/SG designee, who will then consolidate the information for CONUS ST providers and send to the AFSOC/SGP. For OCONUS ST aeromedical providers, the information will be reported to the senior flight surgeon, who will forward the report to the AFSOC/SGP.

4.1.3. All AFSOC operational medical personnel will comply with USAF, DHA, AFMS, AFMRA, and host MTF requirements that govern the delivery of healthcare. To remain in good standing with the host MTF, all healthcare providers, including those assigned directly to line units, must complete all training and credentialing requirements. Additionally, operational medics who are considered professional staff must attend host MTF professional staff meetings. Unit Commanders will ensure assigned operational medical personnel meet clinical exposure requirements. AFSOC medical personnel who fail to meet clinical competency and currency requirements may be subject to medical privilege abeyance and/or credentials action IAW AFI 44-119, *Medical Quality Operations*.

4.1.4. All AFSOC medical personnel will comply with AFI 44-102, *Medical Care Management*, when seeking or engaging in off-duty employment. Patients seen in off-duty employment settings will not be counted toward clinical currency requirements. Privileged AFSOC medics must obtain written permission from the credentialing/privileging MTF before any off-base employment.

4.1.4.1. In addition to obtaining permission for off-duty employment from the MTF/CC, all line assigned healthcare personnel must first obtain the written permission of the line Sq or Gp/CC. This written permission must include information outlined in AFI 44-102.

4.1.4.2. AFSOC medics on non-AFSOC bases must establish a written memorandum between the line unit and the MTF which will describe the process for completing the requirements for off-duty employment.

4.1.4.3. For line-assigned medics, the MTF/CC or the line CC may rescind permission for off-duty employment at any time.

4.1.5. When in-garrison, IDMTs will provide paraprofessional support in the aerospace medicine clinic setting as outlined in the 4N0X1 Career Field Education and Training Plan (CFETP). Aeromedical providers and IDMTs will also perform aerospace medicine administrative functions (aeromedical waiver support, shop visits, safety report reviews, 1041 log reviews, airman medical readiness optimization meetings, etc).

4.1.6. AFSOC operational medical logistics personnel and Medical Service Corps (MSC) officers will ensure medical equipment and supplies are ready for immediate deployment. Additionally, the medical logistics point of contact (POC) for each operational medical element will coordinate with the host MTF medical logistics section to ensure proper calibration, maintenance, and repair of medical equipment.

4.1.7. AFSOC MSCs assigned or attached to operational medical elements will directly participate in mission planning as the primary medical planner. Operational medical personnel will participate in mission train-up and mission rehearsal as required.

4.1.8. The host MTF retains primary responsibility for medical readiness for all total force and eligible personnel. However, operational medical personnel will assist the host MTF regarding pre-deployment preparations and individual medical readiness requirements of AFSOC flyers to include fly PHAs and DRHA 1s on a basis of OSM availability.

4.1.9. For operational medical personnel not assigned to a SOW or an installation with an AFSOC MTF, operational medical personnel will review, track, and maintain Preventive Health Assessments and Aerospace Information Management System (ASIMS) mobility requirements. Furthermore, operational medical personnel shall assist in pre- and post-deployment medical screening interviews, and coordinate with host MTF force health management regarding assigned AFSOC members. In such instances, AFSOC operational medical personnel will report Preventive Health Assessment and IMR data to appropriate AFSOC unit commander(s).

4.1.10. After completing the immunization backup technical course, operational medical personnel will assist host MTF with the administration of immunizations to deploying AFSOC forces. They will take the lead in providing immunizations for their assigned units.

4.1.11. Aeromedical providers and IDMTs attached to a flying squadron or assigned to special tactics units will have a written memorandum of attachment to an operational flying squadron. This memorandum will be updated annually and emailed to AFSOC/SGP. The intent of this attachment is to develop an ongoing relationship similar to the Squadron Medical Element in supporting the operational mission.

4.2. Operational Support Medical (OSM) Flights. OSM flight personnel are UTC-specific, trained, and equipped teams supporting both the AFSOC flying mission as well as the medical support needs of deployed SOF units. The OSM flight will focus care on operational support medicine, deployed medical support, trauma care, and CASEVAC. While in-garrison, OSM medics will support the local flight medicine mission as well as the operational planning processes. OSMs will work closely with their local MTF to support IMR, DRHA, deployment health, operational psychology, health promotion, occupational health, and preventive medicine programs.

4.2.1. OSM flights have a combination of flight surgeons, APAs, IDMTs, APTs, Public Health and BEE technicians, MSC officers, and medical logistics support. OSM flights vary depending on location, but may have several complimentary medical components. OSMs may also be augmented by appropriately trained local medical group for any personnel or capability shortfalls.

4.2.2. The OSM flights establish a comprehensive deployed medicine program to support routine care and provide a trauma response capability for deployed forces. OSM flights centrally manage medical assets assigned to their respective groups. They provide oversight of personnel management, training requirements, WRM assets, Status of Resources and Training System (SORTS), Medical Readiness Decision Support System (MRDSS), AEF Reporting Tool, Defense Readiness Reporting System (DRRS), and other reporting requirements.

4.2.3. OSM providers may practice their full scope of credentialed privileges as long as the MTF is able to provide full administrative support and medical care is performed at the MTF.

4.3. Special Operations Forces Medical Element (SOFME). SOFMEs are the deployable, operational medical units within the OSM. They provide base operational support, prolonged casualty care (PCC), initial combat trauma stabilization, Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), and CASEVAC for supported forces as mission circumstances and requirements dictate in austere locations.

4.3.1. SOFME personnel are first and foremost members of the aeromedical community and will provide full-spectrum aerospace medicine support to AFSOC aircrew members and special duty personnel, as described in AFMAN 48-149 chapter 3. SOFME flight surgeons will have a flying squadron of attachment.

4.3.1.1. The attached unit should be the unit where the SOFME providers accomplish the bulk of mission essential task list (METL) requirements, and for whom they primarily provide full-spectrum aerospace medicine support.

4.3.1.2. Each flying unit should be able to contact their assigned flight surgeon team within the OSM structure. The on-call MTF flight surgeon should not be the default response.

4.3.2. SOFME personnel perform the following functions as part of deployed operations:

4.3.2.1. Provide aeromedical clinical and operational medical support.

4.3.2.2. Provide initial trauma care and resuscitation for supported forces.

4.3.2.3. Provide PCC and CASEVAC for supported forces.

4.3.2.4. Provide base occupational and environmental assessments for supported forces.

4.3.2.5. Provide baseline and ongoing assessments and mitigation of potential environmental and occupational health hazards and water vulnerability assessments. SOFME personnel will document environmental and occupational health exposures, known or potential exposure to chemical, biological, radiological, and nuclear (CBRN) agents, or other health risk exposures.

4.3.2.6. Provide line commanders guidance on the use of pyridostigmine tablets, CBRN defensive auto-injectors, or other similar agents.

4.4. Special Operations Surgical Team (SOST). SOST personnel provide surgical support, post-surgical critical care management, and critical care transport at austere forward locations. The SOST includes a General Surgeon (45S3), Nurse Anesthetist (46M3), Critical Care Nurse (46N3), Emergency Physician (44E3A), Surgical Technician (4N1), and Cardiopulmonary technician (4H0). Suitable substitutions are Anesthesiologist (45A3) for Nurse Anesthetist (46Y3M) or Emergency Physician (44E3A) and Emergency Room Nurse (46N3J) for Critical Care Nurse (46N3E). SOST personnel provide full-spectrum SOF surgical support, post-surgical critical care management, CASEVAC, and critical care transport at austere forward locations to include the point of injury.

4.4.1. Deployment. SOSTs are configured to support enduring and alert missions. Because downrange surgical procedures may not be common, SOSTs should not be deployed for prolonged increments (i.e. 6 months). Individual Mobilization Augmentees will deploy for 30-

45 days IAW AFRC directives. Waivers for longer deployments must be approved by AFSOC/SG.

4.4.2. SOST will copy information related to daily Situation Report (SITREP) as required by AFSOC/A3 with the following information through SIPR channels to AFSOC/SGO**.**

4.4.2.1. Current location.

4.4.2.2. Number of patients treated and type: US, coalition, friendly, enemy combatant, civilian.

4.4.2.3. Number of surgeries/procedures accomplished.

4.4.2.4. Amplifying data deemed appropriate.

4.5. Medical Security Cooperation. Medical personnel assigned to 492 SOW plan and execute Irregular Warfare (IW) and Medical Stability Operations (MSO) missions, which assess, train, advise, and assist foreign military personnel.

4.5.1. AFSOC International Health Specialists (IHS). AFSOC IHS conduct medically-focused security cooperation in support of two major programs: AvFID and MedSC. Both AvFID and MedSC provide Partner Nation engagement in the areas of SOF aviation combat medicine, in line with USSOCOM objectives. Personnel must have prior operational or Flight Medicine experience, be proficient in a foreign language, complete the AFSOC UTC training pipeline, and must be proficient at combat casualty care and aerospace medical care.

4.6. Special Operations Psychologist (Ops Psych). Ops Psychs provide operational support to SOF missions and personnel. Although the provision of healthcare is not the primary support mission of ops psychs, there may be instances when it is appropriate for Ops Psychs to provide clinical support or triage in order to secure definitive care for a service member.

4.6.1. Ops Psychs advise commanders and SOF personnel on conventional and unconventional behavioral science principles affecting a variety of in-garrison and operational activities. These activities include, but are not limited to: assessment and selection of personnel, unit and individual performance optimization, stress inoculation, leadership coaching, oversight for Survival, Evasion, Resistance, and Escape (SERE) training and exercises, post-mishap consultation, combat stress control measures and return-to-duty support, reintegration of recovered personnel after isolation or capture, consultation to interrogation and detention operations, support for Influence operations and strategic communication, adversary profiling, and support to HUMINT collection activities. They can also provide human factors consultation to aircraft and incident mishap investigations and accident investigations if available, but the more appropriate/specialized consultant would be the aviation psychologist, as described below.

4.6.2. All Ops Psychs must maintain active credentials at a DOD-approved MTF and should sustain an appropriate level of operational and clinical currency to support their credentials as well as their primary duties and responsibilities as outlined above. When providing healthcare support within the MTF, all ops psychs will adhere to the requirements of the base MTF.

4.7. Aviation Psychologist. Aviation Psychologists are specially trained to perform duties in the domains of human performance, aviation assessment and selection, human factors engineering, simulation and training, and safety. They provide mission support capabilities in training, command consultation and coaching, performance enhancement, and specialized intervention

services within aerospace medicine. Aviation Psychologists require continuous exposure and familiarization of crew and individual dynamics in the aircrew environment. In order to accomplish this, they are placed on non-interference aeronautical orders, flying a minimum of four hours per month.

4.7.1. Operational Unit-Level Responsibilities: When assigned to an operational flying unit, they perform aeromedical psychological fitness and suitability evaluations, consult on the mental health portion of aeromedical waivers, consult with flight medicine and mental health providers to advise on aircrew psychological treatment, participate in operational/training flying missions to assess psychological or human factors, stressors, and demands, and employ human factors research and statistical analysis. They are the preferred psychology human factors expert to support Air Force Safety Investigation Boards (SIBs).

4.7.2. Training Unit-Level Responsibilities: When assigned to a flying training unit, aviation psychologists provide education and training in aviation psychology, consult on fatigue mitigation behavioral management, deliver and advise on proactive intervention for stress reduction, oversee airsickness management programs, and supervise other prevention services.

4.7.3. MAJCOM Safety Responsibilities: When assigned to a Safety billet, they focus on human factors and aviation/occupational safety at the organizational level. They provide direct and indirect support to SIBs, conduct organizational safety assessments, participate in human factors research, and apply psychological and human factors principals to mishap prevention.

4.7.4. All aviation psychologists must maintain active credentials at a DOD-approved MTF and should sustain an appropriate level of operational and clinical currency to support their credentials as well as their primary duties and responsibilities as outlined above. When providing healthcare support within the MTF, all aviation psychologists will adhere to the requirements of the base MTF. Although the provision of healthcare is not the primary support mission of aviation psychologists, there may be instances when it is appropriate for them to provide clinical support or triage in order to secure definitive care for an aviator.

4.7.5. Aviation psychologists are authorized to participate in aircraft flights as observers on a noninterference basis. HARM offices will publish aviation orders according to this instruction. Neither AvIP entitlement nor OFDA credit are authorized.

4.8. Special Operations Aeromedical Physician Assistants (APA) and Special Operations Aeromedical Nurse Practitioners (ANP).

4.8.1. All AFSOC APA and ANP positions must be filled by APAs and ANPs with no less than 24 months of clinical PA or NP experience and must have attained and maintained appropriate credentials on their privilege list. AFSOC APA and ANPs assigned to ACUs may support deployment missions and operations, although their main role is to provide primary care services and support, preventive healthcare services, and healthcare continuity for in-garrison AFSOC aircrews, and special duty personnel. APA and ANP assigned to an OSM flight, especially those on FFQEK and FFQE8 UTCs, will support deployment missions and operations.

4.8.2. Due to significant time and resources involved in training operational medical providers, AFSOC APAs and ANPs assigned to operational units will be assigned for a period no less than four years.

4.8.3. When APAs deploy, they function under MTF privileges and through physician consultation at all times either in person, by phone, or electronic means.

4.8.3.1. A senior flight surgeon must be identified, in writing, for each APA or ANP. This information will be placed in Section 1 of each APA or ANP's credential file.

4.8.3.2. APAs and ANPs will not deploy to an area likely to require skills outside of credentialed scope of their medical practice.

4.8.4. APA/ANP may practice appropriate aeromedical dispositions if they meet the requirements and training criteria outlined in AFMAN 48-149 and AFSOC AFSC specific training requirements in the training table located at: **https://usaf.dps.mil/sites/AFSOC-SG/SGX/SitePages/Home.aspx**.

4.9. Special Operations Independent Duty Medical Technicians (IDMT).

4.9.1. All IDMT Paramedics assigned to AFSOC will comply with AFI 44-103, and AFMAN 44-158, *The Air Force Independent Duty Medical Technician Medical and Dental Treatment Protocols*.

4.9.2. All AFSOC IDMTs will maintain National Registry of Paramedics (NRP) credentials.

4.9.3. All AFSOC IDMTs will be required to attend the Special Operations Center for Medical Integration and Development (SOCMID) Advanced Medical and Trauma Skills Sustainment Course (AMTSSC) to maintain NRP currency, and trauma skills sustainment requirements outlined *USSOCOM DIR 350-20, Special Operations Forces Baseline Interoperable Standards for Medical Training, Dated 05 JAN, 2021*.

4.10. AFSOC IDMTs without a Co-located AF Military Treatment Facility (MTF).

4.10.1. There are a number of AF IDMTs located on facilities without an AF MTF. This has resulted in challenges with oversight of the IDMT program at these locations and difficulties for the IDMTs to complete and document training requirements with appropriate preceptor oversight. AFSOC/SG provides oversight for the IDMT program at locations where there are no co-located AF MTF. AFSOC/SGP is appointed to function as the SGH for AFSOC IDMTs located on facilities without an Air Force MTF, and may delegate to 24 SOW/SG for assigned IDMTs.

4.10.2. The following guidance applies to AFSOC IDMTs on facilities without an AF MTF and fulfills the requirement, per AFI 44-103 for the MTF Operating Instructions for these IDMTs:

4.10.2.1. Preceptors and functional area representatives approved for IDMT training will be appointed by the AFSOC IDMT Certification Authority or by the AFSOC/SGP.

4.10.2.2. The AFSOC/SG 4N Functional Manager will act as the IDMT Coordinator and may delegate certain functions of the IDMT Coordinator to other AFSOC/SG staff or to IDMTs at the IDMTs' location. The 24 SOW/Senior Enlisted Medical Advisor may serve as the IDMT coordinator for 24 SOW IDMT's. All training must be reported to the AFSOC 4N Functional Manager. Any other delegation of IDMT Coordinator functions from the AFSOC/4N Functional to an IDMT at the distant site must be appointed in writing and the delegation letter will contain specific delegated tasks.

4.10.2.3. AFSOC IDMTs without an MTF may see patients independently in-garrison in local clinic settings to include ACUs with the following restrictions:

4.10.2.3.1. All care provided in-garrison by IDMTs will be reviewed by an appointed physician preceptor, and the review documented in the IDMTs training records and the medical record within 24 hours. This review will include written comments on the care provided. These comments will be on the form approved and provided by AFSOC Command 4N Functional Manager.

4.10.2.3.2. If the IDMT provides care for any DD Form 2992 holder, aeromedical disposition by a flight surgeon will occur before the patient departs from the care encounter.

4.10.2.3.3. All care by the IDMTs will be in accordance with IDMT protocols. Any deviations require advanced approval by an approved preceptor prior to deviation from protocol.

4.10.2.4. IDMTs who do not meet clinical care, training, and preceptor oversight requirements may be decertified.

4.10.2.5. For IDMTs at locations without an AF MTF, documentation of IDMT training will be forwarded for certification to the AFSOC SG IDMT Coordinator and appropriate HQ AFSOC/SG flight surgeon.

4.10.2.6. All IDMT training will be documented in the IDMT's TFTR and hardcopy training record until such time when TFTR eliminates the need for duplicate documentation in the training folder.

4.10.2.7. Any patient care or training events occurring in the deployed setting will be documented in the patient's medical record, reviewed by an in-theater IDMT preceptor or by the senior AFSOC physician in-theater, and documented in the IDMT's training records.

4.10.2.8. IDMT availability for in-garrison and deployed care will be coordinated locally by the senior IDMT in each unit with oversight by the senior flight surgeon.

4.10.2.9. All IDMTs newly assigned to units covered by this instruction will undergo initial or Permanent Change of Station (PCS) certification as outlined in AFI 44-103. On a case-by-case basis, IDMTs transitioning to units covered by this policy may be certified by AFSOC/SGP based upon experience at another AFSOC unit. Request for this certification should be made by the senior IDMT at the unit of assignment to AFSOC/SGP. Initial certification may be postponed if UTC-required training conflicts. Deferred initial IDMT training must have concurrence from the AFSOC 4N Functional Manager or the 24 SOW Senior Enlisted Medical Advisor.

4.10.2.10. Training requirements for IDMTs will be completed locally to the maximum extent practical. If training cannot reasonably be completed locally, coordinate with the AFSOC IDMT Coordinator to arrange for training options.

4.10.2.11. IDMTs covered in this policy will use the host MTF or SOMDG Pharmacy and Therapeutics Committee approved IDMT Authorized Drug List. Any changes or additions to this list will be approved by the AFSOC/SGP.

4.10.2.12. IDMTs will report all BBP exposures IAW local infection control and BBP guidance.

4.11. Special Operations Physical Therapist. Physical Therapists embedded in AFSOC operational units are neuromuscular experts who deliver care to optimize the performance of Air Force Special Warfare Airmen and Special Warfare Mission Support Airmen through direct access evaluation and treatment of neuromusculoskeletal disorders. They provide the full-scope of physical therapy services and practice independently. Physical Therapists may perform joint manipulation, dry needling, battlefield acupuncture, and use other diagnostic and treatment modalities in accordance with their privilege list. They determine equipment and supplies needed to maximize operator outcomes. Physical Therapists perform injury surveillance and collect data to inform injury prevention activities in group or individual settings. Physical Therapists consult with other medical providers and are responsible for communicating medical readiness status to unit leadership. They collaborate with other human performance professionals including Athletic Trainers and Strength and Conditioning Coaches to ensure safe exercise progression and to prevent re-injury in members who have undergone a rehabilitative program. With the exception of prevention activities, Physical Therapists must document all clinical encounters and interventions in the member's electronic health record.

4.12. AFSOC PJ Medical Program. PJs are high risk technical rescue specialists with National Registry of Paramedics (NRP) certification and Advanced Tactical Practitioner (ATP) requirements IAW USSOCOM Directive 350-29. AFSOC PJs are trained and tasked to provide emergency medical treatment and lifesaving procedures at the paramedic level. NRP currency is required for service in the PJ 1Z1 AFSC. PJs are combatants, and thus are not protected as medical personnel by the Geneva Conventions or International Law.

4.12.1. PJs are not authorized to independently provide sick call medical care in garrison. However, PJs may work directly with the medical preceptor to diagnose and treat illnesses or injuries in a training capacity in order to develop and maintain clinical proficiency. While deployed, PJs may provide limited-scope Small Unit Care per the ATP Tactical Medical Emergency Protocols (TMEPs) IAW USSOCOM Directive 350-29.

4.12.2. PJ Medical Program Management. Overarching USAF PJ medical program management is contained in AFI 10-3502, Volume 1, *Pararescue and Combat Rescue Officer Training*. PJ medical training and qualification will be documented and maintained in the member's AF Form 623, *Individual Training Record Folder*. For convenience, medical training records may be maintained geographically separated from the AF Form 623 record; refer to AFI 10-3502V1 for guidance.

4.12.3. HAF/A3S is the lead agency for Special Warfare and will appoint an Air Force PJ Medical Director IAW AFMAN 10-3509. The Air Force PJ Medical Director addresses medical qualifications, requirements, and PJ medication, and procedures handbook issues. Changes to training, protocols, medications, and equipment are coordinated through the Air Force PJ Medical Operations Advisory Board (MOAB) which meet twice yearly. AFSOC/SGP, ST medical personnel, and PJ representatives may attend annual MOABs.

4.12.4. Medical Director and Medical Control. The ST unit medical director is responsible for medical oversight of assigned PJs. The medical director will be a residency trained, board certified or board eligible credentialed physician appointed in writing by the ST unit commander. The requirement for residency trained physician may be waived by the

AFSOC/SGP. A copy of the appointment letter will be forwarded to host base MTF SGH and to the AFSOC/SGP. Additionally, a copy will be filed in each PJ's medical training record. If the ST medical director is not present during deployed operations, the senior AFSOC flight surgeon in the AOR is responsible for AFSOC PJ medical oversight. If the senior AFSOC flight surgeon in the AOR is unfamiliar with PJ protocols or scope of medical practice, they will consult the STG/SG.

4.12.4.1. DOD, Department of Transportation, and USAF directives mandate appointment of a physician medical director to oversee the medical training, qualification, and practice of NRPs to include PJs. The unit PJ medical director and deployed flight surgeons providing deployed medical oversight must have expertise in operational medicine, trauma medicine, delivery of medical care in field environments, wilderness medicine, pre-hospital medical care, and medical transport/evacuation systems and equipment.

4.12.4.2. The medical director will provide clinical supervision, oversight, and guidance to the ST unit Non-Commissioned Officer of medical training (NCOMT).

4.12.4.3. In conjunction with unit standardization and evaluation team, the medical director will review and audit PJ medical training status to ensure PJ medical currency. Additionally, the medical director will conduct unannounced medical proficiency exercises and evaluations to ensure PJs and other appropriate ST personnel meet medical and Tactical Combat Casualty Care (TCCC) proficiency standards. The medical director will assist in planning and conducting PJ Medical Situation Exercises (MEDEX) and Medical Evaluations.

4.12.5. PJs assigned above squadron level (e.g., Group, Wing, or Higher Headquarters) will fall under the medical direction of the local ST squadron medical director.

4.12.6. NCO of Medical Training (NCOMT). The NCOMT will be designated by the unit commander in writing and will manage the PJ medical program. The NCOMT will use AFI 10-3502V1 series as medical program guidance. The NCOMT must work closely with the medical director and senior team PJ to produce a robust PJ medical program.

4.12.6.1. The NCOMT should be a fully-qualified IDMT, preferably with an operational background. The NCOMT should have at least two years of experience as an IDMT and should be an experienced Basic Life Support (BLS) and TCCC instructor.

4.12.6.2. The NCOMT's secondary duties will include conducting required medical classes and training for unit operators and personnel. Additionally the medical director and NCOMT will provide emergency medical coverage for unit training.

4.12.7. Operational Medical Guidance. AFSOC PJs will follow approved published guidance for medical treatment protocols to include the Pararescue Medical Operations Handbook, USSOCOM TMEPs, and additional appropriate paramedic level pre-hospital continuum of care as defined in current paramedic textbooks.

4.12.8. Operational Medical Reporting. PJs will complete Guardian Angel (GA) Consolidated Mission Reports (CMRs) for all missions. Medical treatment information will be extracted for submission and database input.

4.12.8.1. The ST medical director or deployed AFSOC flight surgeon will submit the GA CMR to the Air Force PJ Medical Director, 24 SOW/SG, and AFSOC/SGP. Ensure

submission of the GA CMR to AFSOC/A3J, Command Personnel Recovery PJ Superintendent occurs via appropriate secure communication channels.

4.12.9. PJ Medical Qualification. The following qualifications and certifications are mandatory requirements for operational PJs assigned to AFSOC:

4.12.9.1. Current NRP certification and all associated certification requirements, including BLS, Pediatric Advanced Life Support, and ACLS.

4.12.9.2. AFSOC PJs will follow SOCOM training requirements as currently specified USSOCOM Directive 350-29.

4.12.10. Non-standard medications. Non-standard medications are defined as medications administered by PJs that are not included within the Pararescue Medical Operations Handbook or the USSOCOM TMEPs. Any administration of non-standard medications by PJs must be strictly IAW DOD, USAF and USSOCOM policy, and must be justified by mission requirements. Additionally, non-standard medication administration must be approved by the AF PJ medical director prior to use. Appropriate training must be completed and documented prior to PJ administration of non- standard medications. If non-standard medication training is completed for PJs while deployed, the training must be documented and a copy of the documentation must be forwarded to the Air Force PJ Medical Director and AFSOC/SGP, the PJ's home station medical director, and NCOMT for placement in the PJ's medical training record. If non-standard medication use is formally approved, the PJ who administers it will report this (include patient's name, age, medication, dosage and indications) to the supervising/authorizing physician, ST medical director, 24 SOW/SG, ACC/SGP, and AFSOC/SGP.

4.12.11. Experimental medical materials and equipment. Use of experimental medical materials and equipment is not authorized unless formally approved through standard DOD, USAF, USSOCOM, and AFSOC institutional research board processes.

4.13. SOF Aerospace Physiology Team (APT). The SOF APT enhances human operational performance through analyses of SOF facilities, equipment and operations, provides critical aircrew/operator training, and support mishap prevention and investigation efforts. While the Chief, AFSOC Aerospace Physiology retains oversight of all functions, Command and Control of these responsibilities are ultimately assigned to different AFSOC Directorates. AFSOC/A3T has oversight of all SOF APT training programs in accordance with AFMAN 11-403, *Aerospace Physiological Training Program*, AFSOC/SG has oversight of the SOF human performance research initiatives, and AFSOC/SE continues to oversee APT-related mishap prevention and investigation efforts in accordance with AFI 91- series instructions.

4.14. Special Operations Medical Logistics.

4.14.1. The AFSOC Medical Logistics Technician/4A1XX Functional Manager is responsible for the organization, training, and the coordination of 4A1 personnel assignments to AFSOC operational units. The 4A1XX functional will ensure compliance with AF and AFSOC instructions/policies.

4.14.1.1. All Medical Logistics Technicians assigned to an ST or OSM will attend at least 12 hours of documented Readiness Skills Verification Training annually. If training cannot

be accomplished at the local MTF, in-service training is acceptable with prior approval from the 4A1XX Functional Manager.

4.14.1.2. OSM and ST Medical Logistics Technicians require additional training and full mission profile validation above and beyond conventional force Logistics Technicians. A 3 year controlled tour is strongly recommended.

4.14.2. AFSOC/SGXL is responsible for Manning and Equipment Force Packaging (MEFPAK) related requirements. Any proposed changes to MEFPAK allowance standards will be routed to AFSOC/SGXL.

4.14.3. Medical Logistics technicians are responsible for unit WRM and associated medical logistics functions IAW AFMAN 41-209, paragraph 8.25 – Use of Medical WRM. Changes to medical logistics related policies/procedures will be coordinated with AFSOC/SGXL and approved by AFSOC/SG.

4.14.4. ST and OSM logistics may use all WRM assets for Joint Combined Exchange Training missions, Humanitarian Assistance, Disaster Relief missions, Joint Chiefs of Staff directed exercises, local sustainment training, and other approved exercises for Deployed Aircraft Ground Response Element (DAGRE), SERE, and IDMT training. The appropriate line of accounting must be established in order to perform non-routine mission support.

4.14.5. The AFSOC Medical Logistics Technician or in-garrison contractors are responsible for inventorying WRM no less than 24 months from the previous inventory. IAW AFMAN 41-209, the due date for inventory completion is the final calendar day of the anniversary month.

4.14.5.1. An inventory is not considered closed until all actions outlined in AFMAN 41-209 paragraph 8.16.3.7. are completed and documented.

4.14.5.2. A signed copy of the Inventory Summary Report will be forwarded to the 4A1XX Functional Manager.

4.15. Operational Bioenvironmental (BE) personnel Roles and Responsibilities.

4.15.1. Operational BE personnel will train OSM personnel on BEE tactics, techniques, and procedures. Training will include familiarity with the Water Protection and Industrial Hygiene Programs. BE personnel will also serve as reach-back support for deployed OSM members.

4.15.2. Operational BE personnel will maintain their skills and proficiency by annually coordinating tasks listed below with the host MTF.

4.15.2.1. One routine industrial hygiene survey including Defense Occupational and Environmental Health Readiness System (DOEHRS) entry.

4.15.2.2. One water sampling survey.

4.15.2.3. One special survey.

4.15.2.4. Participate in an emergency management exercise.

4.15.2.5. Maintain 100% currency on RSV program.

4.15.2.6. Participate in the equipment proficiency analytical testing program. If equipment is not available to complete proficiency test, submit a waiver request to AFSOC/SGPB for a suitable alternate test.

4.15.2.7. Attend host MTF's Occupational and Environmental Health Working Group meeting when AFSOC specific issues or work-centers are discussed**.**

4.15.3. Quarterly training updates for annual requirements will be documented and emailed to AFSOC/SGPB and the 4B AFSOC Functional Manager no later than 15 days after the end of each quarter.

4.15.4. Operational BE personnel will be the OPR for performing BEE support to the OSM for all elements relating to the Industrial Hygiene Program. Responsibilities and tasks will be transferred to the host Medical Group or installation BE equivalent offices when there is a conflict with AFSOC mission operations after coordination with AFSOC/SGPB.

4.15.5. Operational BE personnel will conduct Occupational and Environmental Site Assessments at deployed locations as needed IAW AFMAN 48-146, *Occupational and Environmental Health Program Management.* Information collected will be used to generate the Occupational and Environmental Health Exposure Data and/or a Periodic Occupational and Environmental Measurement Summary. Operational BE personnel will coordinate with Public Health to ensure exposure data is incorporated into personnel medical records as required.

4.16. Operational Public Health Personnel Roles and Responsibilities.

4.16.1. Act as the primary Public Health trainer for OSM personnel.

4.16.2. Maintain current medical threat and countermeasure briefs for the OSM's mission IAW DODI 6490.03, *Deployment Health*, paragraph E2, page 14 and the COCOM's reporting instructions.

4.16.3. Act as the primary liaison for unit personnel regarding the Medical Employee Health Program, BBP program, and communicable diseases. Unit is defined as any AFSOC or USSOCOM unit outside of a MTF with assigned Public Health personnel.

4.16.4. Request host MTF 4E Functional review of their TFTR on a quarterly basis. If the local 4E Functional is not available, OSM Public Health personnel will send the request to AFSOC/SGPM 4E MAJCOM Functional Manager.

4.16.5. Maintain AFSC and Comprehensive Medical Readiness Program (CMRP) proficiency by coordinating the training or tasks listed below with the host Medical Group. To the maximum extent possible, tasks, skills, or surveys should be aligned with the SOW or SOG Public Health requirements.

4.16.6. Attend host MTF Occupational and Environmental Health Working Group meetings when AFSOC specific OH issues or work-centers are discussed.

4.16.7. Maintain 100% currency for all CMRP training/tasks. Work with the host Medical Group to accomplish any training gaps.

4.16.7.1. Complete one food facility inspection every 6 months. This requirement may also be accomplished while deployed or attending an exercise.

4.16.7.2. Complete one public facility inspection every 12 months.

4.16.7.3. Complete one entomology surveillance every 12 months. This requirement may also be accomplished while deployed or attending an exercise.

4.16.7.4. Complete one ration inspection every 24 months. This requirement may also be accomplished while deployed or attending an exercise.

4.16.7.5. Complete one Category 1 or Category 2 shop inspection every 12 months.

4.16.7.6. Participate in emergency management exercises with biological scenarios.

4.16.7.7. Complete all AFSOC training, as prescribed in the Training Tables.

Chapter 5

TRAINING

5.1. Training Requirements. AFSOC Operational Medical Personnel require training to a level far exceeding their non-SOF colleagues in order to operate in the SOF environment.

5.1.1. AFSOC Medical UTC Training and Currency Requirements are organized and updated in a Training Table located at: **https://usaf.dps.mil/sites/AFSOC-SG/SGX/SitePages/Home.aspx**

5.1.2. AFSOC/SGX is the OPR for any changes to the Training Table.

5.1.3. Medical Readiness Reporting. All AFSOC medical units, as well as medical personnel assigned to non-medical units (e.g., in OSMs), must document medical readiness in MRDSS and Defense Readiness Reporting System (DRRS) IAW AFI 41-106 in order to enable accurate medical readiness reporting. Send reports to the organizational SIPR email at **afsoc.sgx@socom.smil.mil**.

5.2. Administration of Medical Training. AFSOC/SG is responsible for validating medical training requirements and clinical currency requirements. Unit commanders will ensure assigned operational medical personnel meet training requirements.

5.2.1. Medical Training Manager (MTM). All commanders of AFSOC units with medical personnel assigned will appoint a primary and alternate MTM. The MTM will serve as unit POC for medical training.

5.3. Formal Training. AFSOC/SGXT manages the medical pipeline training slots and coordinates with unit commanders and/or their MTMs in order to fill training slots with operational medical personnel, to include AFSOC ANG and AFRC medical personnel, in AFSOC UTCs who require UTC and AFSC specific training. AFSOC/SGXT will monitor MRDSS on a weekly basis.

5.3.1. AFSOC/SGXT will maintain a current training database that includes the status of all AFSOC operational medical personnel and will report, in writing, any discrepancies or noncompliance to AFSOC/SG and the appropriate unit commander.

5.3.2. Unit MTM responsibilities.

5.3.2.1. When a member is assigned to an operational medical unit, the MTM will submit the following information to AFSOC/SGXT to schedule required training: full name, grade, Social Security Number (SSN), and Report No Later Than Date. Whenever possible, required training should be accomplished en route to unit of assignment. The SSN is necessary to cross-org members into the Defense Travel System for TDY orders and travel requirements. All Personally Identifiable Information is stored in a password protected Readiness Training Oversight Committee spreadsheet.

5.3.2.2. Provide a cancellation letter for any formal training that results in the loss of a SORTS-reportable training seat. The cancellation letter must be signed by the member's flight commander and include: Course Name, Member Name, Rank, AFSC, Training date, Training location and justification found in **Attachment 5**.

5.4. Formal Training Waivers. Requirements apply to all AFSOC operational medical personnel. However, if newly assigned personnel have previously served in a similar position in

an AFSOC unit, portions of stated mission qualification requirements may be waived by AFSOC/SG on an individual basis. Waiver requests will contain the following: member's name, rank, position, unit, reason member already meets requirement(s), justification for waiver, and impact if waiver disapproved, (**Attachment 5**). Waiver requests must be endorsed by member's squadron and group commander.

5.5. AFSOC Medical Training Pipeline. All newly assigned AFSOC operational medical personnel are required to successfully complete AFSOC's medical training pipeline. The AFSOC Medical Training Pipeline is specific to each AFSC by mission, unit of assignment, and if assigned, by AFSOC UTC. Each training requirement has been placed into a phase of instruction to better identify sequential courses for unit MTMs as they prioritize training requirements. Therefore, it is recommended to follow the required phase of instruction in order.

5.5.1. Phase I: Courses related to the Introduction to Special Operations and Special Operations Medicine.

5.5.2. Phase II: Courses primarily related to combat/field skills.

5.5.3. Phase III: Courses which provide advanced AFSC or UTC training.

5.5.4. Unit commanders will ensure operational medical personnel meet all training requirements.

5.5.5. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS-ULTRA) is the single authoritative source for tracking medical readiness training completion.

5.5.6. Special Operations Command Medical Officer Special Experience Identifier (SEI). While not mandatory, all AFSOC Medical Officers are encouraged to pursue the SEI for their career field. Refer to the Training Table and the Air Force Officer Classification Directory (AFOCD) for requirements.

5.5.7. AFSOC/SGXT will manage and administer sections of all three phases of instruction. For courses administered by USAF Special Operations School (USAFSOS), unit MTMs may coordinate directly with them. Full mission qualification status will be granted, at the unit level, when personnel are clinically current and have completed all required training in the AFSOC medical training pipeline.

5.5.8. Cancellation policy for required courses. A required training pipeline course must be cancelled as follows:

5.5.8.1. 1st cancellation: Flight Commander will submit request for cancellation to AFSOC/SGXT with justification.

5.5.8.2. 2nd cancellation for same member/same course: Sq/CC will submit request for cancellation to AFSOC/SGP and/or AFSOC/SGX with justification.

5.5.8.3. 3rd cancellation for same member/same course: Gp/CC will submit request for cancellation to AFSOC/SG with justification.

5.6. Approved Training Platforms.

5.6.1. National Registry of Paramedics (NRP). The initial and biennial refresher NRP training for 4N0X1Cs are accomplished at SOCMID. Use of any other training platforms for this purpose must be approved by AFSOC/SG.

5.6.2. Trauma Training. FFQEK, FFQE3, and FFQE6 UTC personnel will complete/maintain Trauma Skills Sustainment and trauma related Continuing Medical Education (CME).

5.6.3. Trauma Skills Sustainment. In addition to aforementioned clinical competency and clinical currency requirements, FFQEK, FFQE3, and FFQE6 UTC personnel require periodic exposure to hands-on human trauma patient management in a controlled environment where current best practices in trauma care can be refreshed. AFSOC personnel who are unable to meet the American College of Surgeons' recommendation to operate and manage 35 multi-trauma patients per year must attend Center for Sustainment of Trauma and Readiness Skills (C-STARS) or a Sustained Medical and Readiness Training course at a regional currency site (SMART-RCS) every 24 months. AFSOC personnel who meet the 35 multi-trauma resuscitation requirements a year, in addition to further requirements for certain AFSCs, will follow the 24 month C-STARS exemption process as outlined in AFI 41-106, *Air Force Medical Readiness Program*. Approved methods for acquiring additional trauma patient experience include:

5.6.3.1. While deployed, appropriately documented trauma patient management may be counted for up to 50% of this trauma skills sustainment requirement. The documented trauma patient care must be subject to, and available for, the formal peer-review process and be approved by AFSOC/SGP, then filed in the individual's training folder.

5.6.3.2. Graduate Medical Education. Members reporting to AFSOC directly from residency training programs meet this trauma skills sustainment requirement if member successfully completed the program and PCSs into AFSOC within two years from the last routine exposure to significant numbers of trauma patients in the setting of trauma surgery, emergency department at a trauma center, or anesthesia at a trauma center. Members reporting to AFSOC directly from an internship-only training program must be evaluated by the OSM Flight Commander and be approved by AFSOC/SGP, to determine if they will need immediate trauma skills sustainment training at C-STARS.

5.7. Additional Training Requirements. AFSOC operational medical personnel will meet additional training requirements associated with mobility and the core training requirements indicated in AFI 41-106.

5.8. Other Training. Wing, Group, and Squadron Commanders may add additional training events based upon mission requirements. However, requirements contained herein may not be modified or deleted without AFSOC/SG written concurrence by waiver.

5.8.1. Complete CMRP Cat I, II, and III training. AFSOC operational medical personnel must complete all required Clinical Currency, Readiness Skills, and UTC training.

5.8.2. CMRP Category IV, Installation Medical All Hazard Response (IMAHR) or Medical Contingency Response Plan (MCRP) training. If assigned to support IMAHR/Medical Contingency Response Plan (MCRP) teams, AFSOC operational medical personnel will complete any required training.

5.9. Mission Qualification Training. This section establishes the minimum medical training requirements to attain initial mission qualified status for AFSOC operational medics, beyond the AFMAN 48-149 MQT requirements.

5.9.1. OSM personnel are mission qualified after completing formal AFSC awarding courses/programs, CMRP training, and the AFSOC medical training pipeline. OSM personnel also must complete the mission-ready clinical currency requirements as shown in the Training Table before their deployment. AFSOC/SG may delegate waiver authority for OSM mission-ready clinical medical requirements to AFSOC/SGP.

5.9.2. 492 SOW Medical Operations providers are mission qualified after completing applicable AFSC courses as well as CMRP training, the AFSOC medical training pipeline, and the IHS or CAA pipeline as required. Personnel must also complete the mission ready clinical currency requirements as shown in the Training Table before deployment. AFSOC/SG may delegate waiver authority for IHS or CAA related mission-ready clinical medical requirements to AFSOC/SGP.

5.9.3. Special Operations Surgical Team (SOST) personnel are mission qualified after completing formal assessment and selection, AFSC specific medical or surgical training programs, CMRP training, and AFSOC medical training pipeline. SOST personnel must be in good standing with their assigned medical institution and must be clinically competent and current in order to retain mission qualification.

5.9.3.1. SOST personnel will maintain clinical competency and clinical currency IAW requirements/guidelines set by AFMS, functional area managers, AFMS corps chiefs, AF/SG specialty consultants, applicable professional standards to include licensure, board certification, continuing medical education requirements, and those contained herein. Additionally, general surgeons, anesthesiologists, and emergency medicine specialists are expected to obtain specialty board certification. Certified registered nurse anesthetists and critical care nurses will maintain all certifications and will maintain a robust clinical schedule. Surgical technicians and RTs will also maintain all certifications and will maintain a robust clinical schedule.

5.9.3.2. SOST clinical currency requirements are listed by AFSC in the Training Table. The clinical caseload is the minimum requirement. Additional clinical experience is encouraged in order to maintain a high proficiency. Credit for clinical currency caseloads will be pro-rated when a surgeon is deployed to include approved reconstitution time.

5.9.3.3. AFSOC/SG may delegate waiver authority to the AFSOC/SGO for SOST mission-ready clinical medical requirements.

5.10. SOST UTC Training.

5.10.1. SOST initial training will be IAW this instruction and applicable Mission Capability (MISCAP).

5.10.2. SOST personnel will maintain clinical competency and clinical currency IAW requirements/guidelines set by AFMS, functional area managers, AFMS corps chiefs, AF/SG specialty consultants, applicable professional standards to include licensure, board certification, continuing medical education requirements and those contained herein.

Additionally, general surgeons, anesthesiologists, emergency medicine specialists are expected to obtain specialty board certification.

5.11. Aeromedical Physician Assistant and Aeromedical Nurse Practitioner Training.

5.11.1. AFSOC APAs and ANPs will comply with training and recertification requirements as defined by AFI 44-102 and AFMAN 48-149.

5.11.2. Operationally assigned APAs and ANPs assigned to line units must accomplish the Air Force Operational Medicine (AFOM) 101 and 102 and Aerospace Medicine Primary 201 and 202 as soon as practical upon notification of assignment, but no later than 1 year after arrival at the unit. APAs and ANPs must complete applicable courses prior to practicing aerospace medicine.

5.11.3. AFSOC APAs and ANPs assigned as operational medical personnel will receive clinical oversight by the senior flight surgeon in their respective units for six months per AFMAN 48-149 and coordinate with the host MTF SGH to update their privilege list to document the appropriate scope of practice IAW AFI 44-119.

5.12. Special Operations Independent Duty Medical Technicians Training.

5.12.1. AFSOC IDMTs will comply with training and recertification requirements as defined by AFI 44-103.

5.12.2. Additionally, AFSOC IDMTs assigned as operational medical personnel must complete training IAW 4N0X1C CFETP SEI 455, *Special Operations Command Medic*, USSOCOM Directive 350-29, and requirements contained in this instruction.

5.13. Pararescuemen Medical Training. AFSOC PJs will maintain National Registry of Paramedic certification and training as directed by USSOCOM. PJ continuing medical education and training report requirements described in AFI 10-3502V1 will be accomplished quarterly. AFSOC CROs will meet all requirements as outlined by applicable DOD, USSOCOM, USAF, and AFSOC policies, directives, and instructions.

5.13.1. The following certifications, qualifications, evaluations and training are mandatory for AFSOC PJs:

5.13.1.1. NRP certification is required during initial PJ training. This certification is obtained prior to the first phase of the 3-level PJ apprentice course.

5.13.1.2. NRP core requirement re-certification is required every two years. Completion of the Special Operations Center for Medical Integration and Development (SOCMID) or AFSOC/SG approved alternative such as Special Operations Combat Medic Skills Sustainment Course is mandatory for AFSOC PJs.

5.13.1.3. Patient encounters and trauma sustainment training are recommended every two years. The 24 SOW/SG manages the University of Alabama at Birmingham (UAB) hospital and ambulance ride-along program for PJs and IDMT/NRPs. AFSOC/SGXT provides MAJCOM concurrence for AFSOC personnel who register for the C-STARS-Baltimore course. These programs provide PJs with the opportunity to treat patients in field and trauma center settings. When performing biennial patient contact/trauma sustainment rotations, PJs will review and follow all local protocol instructions. PJs will not perform clinical duties outside their scope of practice.

5.13.1.4. Missions completed in the execution of combat, military, civil, or humanitarian operations may be used towards patient encounter and trauma sustainment currency. Documented hospital emergency department and trauma department performance may also count towards meeting currency requirements.

5.13.1.5. Refer to DoD Instruction 1322.24, *Medical Readiness Training* (MRT) for training frequency.

5.13.1.6. Medical Skills Certifications Requirements. PJs will perform MEDEX and Medical Skills Certifications Requirements in compliance with the latest AFI 10-3502V1, *Pararescue and Combat Rescue Officer Standardization and Evaluation* requirements.

5.13.2. Additional and advanced formal medical training and education courses. STG/CCs and special tactics medical directors are highly encouraged to maximize PJ participation in formalized medical training venues to enhance medical capability. For a listing of PJ MOAB-approved Advanced Medical Training and Seminars, contact the 24 SOW/SG.

5.13.3. Unit lectures and CME. Unit medical directors are encouraged to conduct routine medical classes, lectures, and seminars for unit PJs. Furthermore, unit medical directors will schedule/coordinate PJ medical training by guest physicians and specialists. Unit CME hours will be documented in PJ training records.

5.13.4. Additional medical skills instruction, validation, and continuum of practice certification will be documented and placed in the medical training records. This instruction includes topics such as dental skills, blood administration/transfusion, and packed red blood cell transfusion protocols.

5.13.5. Clinic sick call. PJs may not provide INDEPENDENT medical care in out-patient clinic or sick call settings. However, PJs are encouraged to apply ATP sick-call treatment protocols under the direct supervision of a physician in the clinic. STG/SG and unit medical directors will ensure clinical training is documented in PJ medical training records and directly supervised by a physician. Medical skills training documentation must include operating parameters, re-qualification, or currency standards, and a skill practice expiration date.

5.14. Combat Controller, Special Reconnaissance, and Tactical Air Control Party (TACP) Medical Training. Combat Controllers, Special Reconnaissance, and TACP personnel are required to maintain current SOCOM TCCC training status. Additional medical training programs for Combat Control and Special Reconnaissance personnel must be approved by the 24 SOW/SG and AFSOC/SGP.

5.15. AFSOC Casualty Evacuation (CASEVAC) Training.

5.15.1. Refer to the AFSOC Training Table for training requirements.

5.15.2. SOFME CASEVAC sustainment and currency will be maintained by completing one training or real-world inflight CASEVAC mission with an evaluation, every six months. More frequent hands-on, scenario-based training is also encouraged. In the rare instance of no aircraft availability, this training may be accomplished on a static airframe and/or a training simulator. All CASEVAC training, simulated or inflight, must be accomplished in accordance with appropriate UTC MISCAPs and TTPs. Enlisted members will document this training in the TFTR. Officers will document this training in their Competency Assessment Folder. Noncurrent members will be evaluated for proficiency regarding CASEVAC equipment and

procedures using appropriate standards of medical care, and the approved CASEVAC checklist.

5.15.3. AFSOC Medical Field Skills Training. The goal is to graduate medical personnel with the basic field skill abilities to operate in SOF environments and support USSOCOM core competencies. AFSOC/SG may grant Field Skills Training credit for alternate courses, but the course must be approved prior to attendance.

5.15.4. Operational medical personnel perform duties outside the wire and will maintain weapons qualifications, field craft, and tactical skills commensurate with UTC duties. SOFME, SOST, Med Security, and Special Tactics medical personnel may participate in live fire training exercises in order to integrate medical training requirements with aviation and special warfare operations. Weapons qualifications/training will be IAW AFI 36-2654, *Combat Arms Program,* and will be consistent with the member's Geneva Conventions status. Unit commanders are responsible for ensuring personnel sustaining these skills.

5.16. Advanced Medical Training (AMT). For guidance on AMT request and approval process, request documents at the For Official Use Only level via NIPR to the AFSOC/SGO at **AFSOC.SGO@us.af.mil**.

5.16.1. All AMT will meet the requirements prescribed in USSOCOM Directive 350-29, Special Operations Forces (SOF) Baseline Interoperable Medical Training Standards.

5.16.2. Units will make the maximum use of didactic, moulage, mannequin, simulator, and other training alternatives.

MATTHEW P. HANSON, Colonel, USAF, MC, FS
Command Surgeon, Air Force Special Operations Command

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoDI 6200.02, *Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs*

DHA PI 6490.03, *Deployment Health Procedures*, 17 December 2019

USSOCOM Directive 350-29, *Special Operations Forces Baseline Interoperable Medical Training Standards*, 5 January 2021

USSOCOM Policy Memo 19-13, *Exertional Heat Illness*

AFPD 48-1, *Aerospace & Operational Medicine Enterprise (AOME)*, 7 June 2019

AFTTP 3-42.6, *USAF Medical Support for Special Operations Forces (SOF)*, 9 January 2012

AFI 10-3501, *Dive Program*, 9 February 2009

AFI 10-3502V1, *Pararescue and Combat Rescue Officer Training*, 30 March 2017

AFI 33-322, *Records Management and Information Governance Program*, 27 July 2021

AFI 41-106, *Air Force Medical Readiness Program*, 28 July 2020

AFI 44-102, *Medical Care Management*, 22 April 2020

AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 30 August 2018

AFI 44-108, *Infection Prevention and Control Program*, 5 June 2019

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

AFI 48-101, *Aerospace Medicine Enterprise*, 22 April 2020

DAFMAN 48-123, *Medical Examination and Standards*, 8 December 2020

AFMAN 11-403_AFGM2021-01, *Aerospace Physiological Training Program*, 26 April 2021

AFMAN 48-105, *Public Health Surveillance*, 26 June 2020*Diseases*,

AFMAN 48-149, *Flight and Operational Medicine Program (FOMP)*, 13 October 2020

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

Official Air Force Aerospace Medicine Approved Medications, 10 May 2022

Updated *US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus (HIV) and Recommendations for Post-Exposure Prophylaxis*, 23 May 2018

Adopted Forms

AF Form 55, *Employee Safety and Health Record*

AF Form 623, *Individual Training Record Folder*

AF Form 765, *Medical Treatment Facility Incident Statement*

AF Form 847, *Recommendation for Change of Publication*

AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*

CDC Form 731, *International Certificate of Vaccination or Prophylaxis* (Yellow shot record)

DD Form 2766, *Adult Preventive and Chronic Care Flow Sheet*

DD Form 2795, *Pre-Deployment Health Assessment Questionnaire*

DD Form 2796, *Post-Deployment Health Assessment*

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

Abbreviations and Acronyms

AAR—After Action Report

ACC—Air Combat Command

ACLS—Advanced Cardiac Life Support

ACS—Aeromedical Consultation Service

ACU—Ambulatory Care Units

AEF—Air and Space Expeditionary Force

AF—Air Force

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFPD—Air Force Policy Directive

AFMAN—Air Force Manual

AFMRA—Air Force Medical Readiness Agency

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AFSOC—Air Force Special Operations Command

AFTTP—Air Force Tactics, Techniques, and Procedures

AHLTA-T—Armed Forces Health Longitudinal Technology Application-Theater

ANG—Air National Guard

ANP—Aeromedical Nurse Practitioner

APT—Aerospace Physiology Team

AOR—Area of Responsibility

APA—Aeromedical Physician Assistant

ARC—Air Reserve Components

ASIMS—Aerospace Information Management System

ATP—Advanced Tactical Practitioner

AvFID—Aviation Foreign Internal Defense

AvIP—Aviation Incentive Pay

BBP—Blood Borne Pathogen

BE—Bioenvironmental

BEE—Bioenvironmental Engineering

BLS—Basic Life Support

C2—Command and Control

CAA—Combat Aviation Advisor

CASEVAC—Casualty Evacuation

CBRN—Chemical, Biological, Radiological, Nuclear

CC—Commander

CDC—Centers for Disease Control and Prevention

CFETP—Career Field Education and Training Plan

CME—Continuing Medical Education

CMR—Consolidated Mission Reports

CMRP—Comprehensive Medical Readiness Program

COCOM—Combatant Commanders

CRO—Combat Rescue Officer

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

DHA—Defense Health Agency

DHP—Defense Health Program

DMIS—Defense Medical Information System

DMO—Diving Medical Officers

DNIF—Duties Not Involving Flying

DOD—Department of Defense

DODI—Department of Defense Instruction

DRHA—Deployment Readiness Health Assessment

DRRS—Defense Readiness Reporting System

EHI—Exertional Heat Illness

EHR—Electronic Health Record

FOMC—Flight and Operational Medical Clinic

FS—Flight Surgeon

GA—Guardian Angel

GHE—Global Health Engagement

HCP—Healthcare Provider

HIV—Human Immunodeficiency Virus

IAW—In Accordance With

IC—Infection Control

IDMT—Independent Duty Medical Technician

IHS—International Health Specialist

IMR—Individual Medical Readiness

IW—Irregular Warfare

Kx—Knowledge Exchange

MAJCOM—Major Command

MCRP—Medical Contingency Response Plan

MEDEX—Medical Situational Exercise

MedSC—Medical Security Cooperation

MEFPAK—Manning and Equipment Force Packaging

METL—Mission Essential Task List

MDD—Medication Dispensing Devices

MDG—Medical Group

MICT—Management Internal Control Toolset

MISCAP—Mission Capability

MOAB—Medical Operations Advisory Board

MRDSS—Medical Readiness Decision Support System

MSC—Medical Service Corps

MSO—Medical Stability Operations

MTF—Military Treatment Facility

MTM—Medical Training Manager

NCOMT—Non-Commissioned Officer of Medical Training

NRP—National Registry EMT Paramedic

OFDA—Operational Flying Duty Accumulator

OG—Operations Group

O&M—Operation and Maintenance

OPR—Office of Primary Responsibility

OSM—Operations Support Medical

PA—Physician Assistants

PEP—Post-Exposure Prophylaxis

PCC—Prolonged Casualty Care

PJ—Pararescuemen

POC—Point of Contact

PPE—Personal Protective Equipment

QA—Quality Assurance

RT—Respiratory Technician

SERE—Survival, Evasion, Resistance and Escape

SG—Surgeon General, Command Surgeon

SGH—Chief, Medical Staff

SGP—Chief, Aerospace Medicine

SGPA—Chief, Flight Medicine

SGRI—Air Force Operational Medical Information Systems Health Systems Support Specialist

SGX—Chief, Medical Readiness

SGXL—Deputy, Medical Readiness

SIB—Safety Investigation Board

SITREP—Situation Report

SOF—Special Operations Forces

SOFME—Special Operations Forces Medical Element

SOG—Special Operations Group

SOMDG—Special Operations Medical Group

SORTS—Status of Resources and Training System

SOST—Special Operations Surgical Team

SOW—Special Operations Wing

SQ—Squadron

ST—Special Tactics

STG—Special Tactics Group

STO—Special Tactics Officer

STS—Special Tactics Squadron

SW—Special Warfare

TACP—Tactical Air Control-Party

TCCC—Tactical Combat Casualty Care

TFTR—Total Force Training Record

TMEP—Tactical Medical Emergency Protocols

TMIP—Theater Medical Information Program

UAB—University of Alabama at Birmingham

UNCLASS—Unclassified

US—United States

USAF—United States Air Force

USSOCOM—United States Special Operations Command

UTC—Unit Type Code

WRM—War Reserve Materiel

Attachment 2

AFSOC GO PILL AUTHORIZATION FOR USE

Figure A2.1. Sample.

Date: 1 Jan 20XX
From (Unit/CC): XX SOW/CC

To: AFSOC/SGP

Subject: Fatigue Management Medication Use

The following personnel have been authorized the use of Dextroamphetamine/Modafinil for deployment operations:

	Last name, First name		Unit	Projected Dates of Use (6 months maximum)
1.	Doe	John	XX	1 Jan XX to 1 Mar XX
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

I have verified that each individual listed above has been ground tested, cleared for use, and all documentation is in their medical record.

Signature Block
(Validating Flight Surgeon)

Use of fatigue management medications is approved for the personnel listed above. I certify the use of these medications is appropriate, and all other fatigue management tools have been considered and will be used to the maximum extent possible. Use is approved for ground operations, not for parachute or diving operations. The use of Dextroamphetamine/Modafinil is completely voluntary.

Signature Block
(SOW/CC, SOG/CC or SOAC/CC)

Provide copy of this approval form to AFSOC/SGP, and home station Squadron.

Attachment 3

DEPLOYED QA OVERSIGHT DOCUMENTATION

Figure A3.1. Sample.

Authority: 10 U.S.C. 55, *Medical and Dental Care*, 10 U.S.C., 9013, *Secretary of the Air Force*; and E.O. 9397 Purpose: To document quality assurance reviews of chart reviews. Routine Uses: Internal review, no disclosure outside DoD. Disclosure: Voluntary, failure to provide requested information may result in delay of training requirements.										
1		2	3	4	5	6	7	8	9	10
Reviewer (Name, Unit)										
Lt Col Doe, XX SOW										
Provider (Name, Unit)	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Capt Smith XX SOW	10/22									
	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4	Pt Initials + last 4
	jdr									
Chart Documentation	Y									
Prevention Addressed	Y									
Was Pain Assessed	Y									
If yes, was pain managed	Y									
Appropriate Antibiotic Usage	Y									
List Antibiotic	N									
Appropriate use of Radiology	Y									
Consult Utilization	Y									
Appropriate Medication Rx	N									
Lab Utilization	N/A									
Grounding Management	N/A									
Y = Yes = item used or ordered and met criteria; N = No = item did not meet criteria or was indicated and not used; N/A = Not applicable = not used or ordered and was not indicated										
Documentation of Discrepancies – All items marked "N" require Explanation										
Chart #	Discrepancy – Give brief explanation of how criteria are not met. Note if Discussed with provider									

Attachment 4

OSM EXECUTIVE ACTIVITY AND CLINICAL CURRENCY QUARTERLY REPORT

Figure A4.1. Sample.

Unit Name
AFSOC Operational Medical unit Quarterly Executive Summary X Quarter CYXX

Flight Commander's/ Element OIC's Overview Completed Deployments/Exercises (UNCLASS)
List dates, supported mission/name of exercise (if not classified), UTCs

Upcoming Deployments/Exercises
(UNCLASS) Logistics
Personnel Training
Clinical: (See sections 2.3, 2.4 and 4.1 for additional information on requirements)

Accountability for pharmacologic management of Operational Fatigue Countermeasures.
(number of patients, number of doses dispensed, number of doses returned)

Not-Mission Qualified/Not Mission Ready and Mission Ready Clinical Currency in tables on following page

Current Issues

//SIGNED//
OSM/CC or Senior Flight Surgeon

Figure A4.2. Sample.

OSM CLINICAL CURRENCY OPERATIONAL MEDICAL UNIT EXECUTIVE REPORT

Not-Mission Qualified/Not Mission Ready

Name	AFSC	Reason for non-currency	Expected get well date

Mission Ready Clinical Currency

FS, IDMT/NRP, PA													
NAME	AFSC	Patient Encounters	Annual flight physical exams	Para. Flight physical exams	AF 1041 review mtgs	A/C wiaver package completions	A/C waiver package reviews	Occ health shop visits	PH sanitation inspection	AMC mtgs	ATC tower visits	Eye exams	Occ health work group meetings

45S3, 45B3, 46M3/45A3			
NAME	AFSC	# of cases	# of major cases (surgeons)	List any additional clinical activity

44E3A, 46N3E/J, 4H0X1			
NAME	AFSC	# of Clinical shifts Shift = standard time period worked by MTF peers	List any additional clinical activity

4N1X1			
NAME	AFSC	# of Clinical shifts (central sterilization, OR supply, etc)	List any additional clinical activity

Attachment 5

AFSOC OPERATIONAL MEDICAL PERSONNEL TRAINING REQUIREMENT WAIVER REQUEST

Figure A5.1. Sample.

(Unit letterhead) Date

MEMORANDUM FOR SQUADRON/CC
GROUP/CC
AFSOC/SGXT
AFSOC/SGP
AFSOC/SG
IN TURN

FROM: OSM Flight CC or Equivalent
Mailing Address

SUBJECT: AFSOCI 48-1010 Waiver Request

Waivers to AFSOCI 48-1010 must include:

Paragraph number and name defining requirement to be waived. Reason for inability to comply with requirement.

If waiver is a follow-on to a previous waiver, explain why another waiver is required.

Description of the plan to attain compliance.

Date of expected compliance.

OSM flight commander (or equivalent officer) from the originating unit must sign AFSOCI 48-1010 waiver requests and forward it to AFSOC/SG (waivers may be submitted electronically by email).

Approved waivers will expire at expected compliance date or 90 days from approval date, whichever occurs first.

Signature Block

OSM Flight Commander

Attachment 6

AFTER ACTION REPORT TEMPLATE

Figure A6.1. DEPLOYMENT, IW/MSO, EXERCISES, SITE SURVEY – AAR GUIDE.

Overall Classification (Secret, Confidential, Unclassified)
*****If something does not apply, put N/A and move on*****

MEMORANDUM FOR UNIT/GROUP CC
OTHERS (as your unit requires)

FROM: UNIT/INDIVIDUAL

SUBJECT: (CLASSIFICATION) Deployment After Action Report (AAR) for Trip Report, Exercise name/Deployment Name/Mission Name

DERIVED FROM: Single Source [Cite the Title and Date of Source Document] or Multiple Sources **DECLASSIFY ON:** List the declassify date from the single source, or the most stringent for multiple sources or add 25 years to the date the document was created.

**note: Each paragraph needs to have its own classification, S=Secret, U=Unclassified, C=Confidential

- If this is a classified report, type, update and submit in SIPR.

1. (CLASSIFICATION) **NAME AND LOCATION:** Update this information

2. (CLASSIFICATION) **INCLUSIVE DATES:** 30 Jan – 27 Feb 20XX

2.1. (CLASSIFICATION) **PREDEPLOYMENT TRAINING:** Attended T1G training from DD MMM to DD MMM, LTT at DD MMM to DD MMM, etc.

2.2. (CLASSIFICATION) **DAYS OF TRAVEL TO LOCATION:** Travel from CONUS to Location took 4 days, plane delay at LOCATION, arrived at Base X on DD MMM YY.

2.3. (CLASSIFICATION) **DAYS AT DEPLOYED LOCATION (AND OTHER TRAVEL LOCATIONS/DATES):** 45 days at deployed site, forward deployed to FOB XYZ, etc.

2.4. **(CLASSIFICATION) REDEPLOYMENT TRAVEL:** Redeployed via space-a on helicopter from place Y to place Z. Manifested on rotator from Base ZYX to CONUS. Arrived home station on DD MMM YY.

3. (CLASSIFICATION) **MISSION OBJECTIVE(S), CONOPS AND UNIT(S) SUPPORTED:** These were our mission objectives, our CONOPS were and we supported the 123 unit while they did blank missions.

3.1. (CLASSIFICATION) Expound as necessary especially for multiple mission objectives, CONOPS, etc.

3.2. (CLASSIFICATION)

3.3. (CLASSIFICATION)

4. (CLASSIFICATION) **PERSONNEL AND EQUIPMENT**

4.1. (CLASSIFICATION) **MISSION COMMANDER:** Col YYY was mission

commander, medical commander was Maj YYY.

4.2. (CLASSIFICATION) **NUMBER OF DEPLOYED PERSONNEL:** Total PAR was ## (## AD, ## Contractors, ## Local Nationals/TCNs)

4.3. (CLASSIFICATION) **PERSONNEL IN REPORTING SET:** 1 48R3, 1 4N071C

5. (CLASSIFICATION) **OPERATIONS OVERVIEW:** We performed ABC, supporting XYZ. On stand-by for CASEVAC missions.

5.1. (CLASSIFICATION) **TOTAL MISSION FLYING TIME AND SORTIES FLOWN:** 230 hours total mission flying time, 95 sorties flown.

5.2. (CLASSIFICATION) **FLYING TIME AND SORTIES FLOWN BY MEDICAL PERSONNEL:** 120 hours total mission flying time, 30 sorties flown.

5.3. (CLASSIFICATION) **PATIENTS TREATED DURING FLYING:** Summary of patients treated during flight. Reference appropriate AARs already completed do not duplicate what has already been reported via CASEVAC, AARs, etc.

6. (CLASSIFICATION) **MISSION ESSENTIAL TASK LIST (METL) EVENTS ACCOMPLISHED (TO INCLUDE AFSOCI 48-1010 REQUIREMENTS):** What METLs were completed, what was accomplished IAW AFSOCI 48-1010 requirements, you should get credit for.

7. (CLASSIFICATION) **HOST NATION SUPPORT:**

7.1. (CLASSIFICATION) **LODGING:** Lodging provided by FSS while at base XYZ. Lodging safety, sanitation, proximity, quality, etc. during forward operations was…

7.2. (CLASSIFICATION) **MEDICAL:** What type of host nation medical facilities were available, NATO/Military Treatment Facilities…

7.3. (CLASSIFICATION) **FOOD/WATER SUPPLIES:** Any specific, good to know information for someone who is going to be going to that location.

8. (CLASSIFICATION) **TRANSPORTATION:**

8.1. (CLASSIFICATION) **MEDICAL TEAM TRANSPORTATION:** What type of vehicles (if any), airframe used, local national ambulances, etc.

8.2. (CLASSIFICATION) **PATIENT TRANSPORTATION:** How did patients get to you, how did they get to definitive care whether via AE, host-nation ambulance to a hospital.

9. (CLASSIFICATION) **COMMUNICATION:** What communication challenges did you experience? What did you have available. What would have been good to have. NIPR and/or SIPR? Satellite phones, etc.

10. (CLASSIFICATION) **FACILITES:**

10.1. (CLASSIFICATION) **BILLETING:** Was lodging available, did you stay in a building of opportunity, what would have been good to know prior to leaving or what changed while you were there.

10.2. (CLASSIFICATION) **OPERATIONS FACILITY:** Where did you work out of? Was there a hardened building/facility etc.

11. (CLASSIFICATION) **MEDICAL SPECIFICS:**

11.1. (CLASSIFICATION) **WATER SUPPLY:** Bottled water supplied by a contractor? Used self-brought water purification system.

11.2. (CLASSIFICATION) **SEWER AND DISPOSAL:** Burn pits? Trailers managed by a

contractor?

11.3. (CLASSIFICATION) **LOCAL RESTAURANTS:** Safety, sanitation, proximity, quality, etc. On base and off base if applicable.

11.4. (CLASSIFICATION) **INSECTS AND ANIMALS:** What do individuals need to be aware of.

11.5. (CLASSIFICATION) **PATIENTS WORKLOAD/PAR:** what was the population at risk?

11.5.1. (CLASSIFICATION) **TOTAL PATIENT ENCOUNTERS:** Total patients treated by you/your team.

11.5.2. (CLASSIFICATION) **MINOR PROCEDURES:** How many and what kind.

11.5.3. (CLASSIFICATION) **FLYING MISSION:** What was the flying mission, how frequent?

11.5.4. (CLASSIFICATION) **OTHER MEDICAL MISSIONS:** Other medical missions, i.e. FOB build up, host-nation education, etc.

11.5.5. (CLASSIFICATION) **MEDICAL EVACUATIONS:** How many? What kind, etc.

11.5.6. (CLASSIFICATION) **PATIENTS ROTATED HOME EARLY FOR MEDICAL REASONS:** Short synopsis of why and how many.

12. (CLASSIFICATION) **SAFETY:** Safety concerns, environmental? Equipment?

13. (CLASSIFICATION) **MEDICAL MODERNIZATION OPPORTUNITIES:** Use this section to identify equipment needs, problems or shortcomings. Include ideas or observations where improved capabilities could have been improved: mission or task effectiveness, consistent delivery of patient care, safety, quality of life, time or manpower savings, risk mitigation or cost savings. Please describe as much detail as possible of the idea and potential benefits. Do not use this section to address logistical shortfalls unless they may be addressed through a research and/or developmental effort.

14. (CLASSIFICATION) **TURNOVER/END OF DEPLOYMENT:** Challenges faced while waiting on replacement. Was overlap time appropriate for familiarization to mission and coordination, etc.

15. (CLASSIFICATION) **LESSONS LEARNED.**

15.1. (CLASSIFICATION)

Observation Item:

Discussion:

Recommendation:

Is this an item for Higher HQ Action?

15.2. (CLASSIFICATION)

Observation Item:

Discussion:

Recommendation:

Is this an item for Higher HQ Action?

16. (CLASSIFICATION) **SUMMARY OF MISSION:** Overall summary of the mission, what went well, what could have been improved, changed, etc. Overall review of medical capabilities, support, etc.

Signature Block

cc: AFSOC/SGX
Others as your unit requires (Clinics)

*****if something does not apply, put N/A and move on*****