

**BY ORDER OF THE  
SUPERINTENDENT**



**HQ UNITED STATES AIR FORCE  
ACADEMY INSTRUCTION 41-202**

**8 MAY 2020**

**Health Services**

**ATHLETIC TRAINING SERVICES**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

---

**ACCESSIBILITY:** Publications and forms are available for downloading or ordering on the e-Publishing website at [www.e-publishing.af.mil](http://www.e-publishing.af.mil).

**RELEASABILITY:** There are no releasability restrictions on this publication.

---

OPR: USAFA/ADM

Certified by: USAFA/ADM  
(Lt Col Joel Dixon)

Pages: 16

---

This new instruction establishes policy for athletic training services at the United States Air Force Academy (USAFA), to include athletic training management oversight, functional control, and healthcare standards. The purpose of this instruction is to minimize injury/illness and prevent additional injuries/illness while maximizing the clinical skills of healthcare professionals at USAFA. This instruction should be used with published standards to include, but not limited to Sport Medicine, National Collegiate Athletic Association (NCAA), National Athletic Trainers' Association and other national professional organizations as appropriate. This instruction applies to all active duty Air Force, Air Force Reserve, USAFA Cadets and civilian medical components when and where USAFA events occur. This instruction supports other approved Operational Plans, Operational Orders, Medical Contingency Response Plan (MCRP), NCAA Division athletic healthcare directives or USAFA Command Surgeon (USAFA/SG) clinical judgment. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using Air Force (AF) Form 847, *Recommendation for Change of Publication*. The authorities to waive requirements in this publication are identified with a Tier (T-0, T-1, T-2, T-3) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority. The waiver authority for non-tiered requirements in this publication is USAFA/SG. Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with AF Manual (AFMAN) 33-363, *Management of Records*, and are disposed of in accordance with the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

## **1. Definition of Athletic Training.**

1.1. As defined by the National Athletic Trainers' Association, "athletic trainers (ATs) are highly qualified, multi-skilled health care professionals who collaborate with physicians to provide preventative services, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions." Athletic training services provided to cadet and cadet candidate athletes by the Athletic Departments of USAFA and the USAFA Preparatory School will be done so in collaboration with 10th Medical Group (10 MDG) and under the clinical oversight of the USAFA/SG.

## **2. Responsibilities.**

2.1. USAFA/SG is responsible for appropriate medical support for all USAFA and 10th Air Base Wing (10 ABW) sponsored events based on their risk categories. USAFA/SG appoints the USAFA Chief of Sports Medicine/Physician Supervisor and Athletic Training Program Coordinator (ATPC). USAFA/SG determines, in collaboration with the USAFA Executive Director or senior government official, the mission status of all USAFA Athletic Trainers during a government shutdown.

2.2. USAFA Executive Director, Air Force Athletics (AD-26, USAFA/AD), or the senior government official assigned to oversee inherently governmental responsibilities, ensures autonomous authority for health care providers to appropriately determine medical management and return to play of cadets.

2.2.1. USAFA Associate Athletic Director for Sports Medicine will serve as the Senior Medical Officer in the USAFA Athletic Department and will be the main liaison between the Athletic Department and the 10 MDG. In addition he/she will also serve as the administrative supervisor for all Athletic Department ATs.

2.2.2. When completing civilian performance plans, goals, and appraisals on Athletic Trainers in the performance of their medical duties, USAFA Associate Athletic Director for Sports Medicine will consult with the Physician Supervisor and ATPC.

2.3. USAFA Preparatory School Athletic Director ensures autonomous authority for health care providers to appropriately determine medical management and return to play of cadet candidates. When completing civilian performance plans, goals, and appraisals on Athletic Trainers in the performance of their medical duties, USAFA Preparatory School Athletic Director will consult with the Physician Supervisor and ATPC.

2.4. 10th Medical Group, Chief of Medical Staff (10 MDG/SGH) ensures the Physician Supervisor and ATPC are credentialed and privileged and assists them with any questions or concerns involving standard of care, quality of care oversight mechanisms, and adverse events.

2.5. 10th Medical Group, Chief of Sports Medicine/Physician Supervisor is appointed by the USAFA/SG and functions as the Physician Supervisor for all ATs at USAFA.

2.5.1. The Chief of Sports Medicine/Physician Supervisor will be selected by a hiring panel that will review applications and conduct interviews, as needed. The hiring panel will be made up of the following members:

- 2.5.1.1. USAFA/SG.
  - 2.5.1.2. Incumbent Chief of Sports Medicine/Physician Supervisor
  - 2.5.1.3. Associate Athletic Director for Sports Medicine
  - 2.5.1.4. Head Athletic Trainer (USAFA Athletic Department)
  - 2.5.1.5. Head Athletic Trainer (USAFA Preparatory School)
  - 2.5.1.6. Member at Large (Athletic Trainer)
  - 2.5.1.7. Member at Large (Athletic Trainer)
- 2.5.2. Candidates for the Chief of Sports Medicine/Physician Supervisor position will be selected based on the following prioritized criteria:
- 2.5.2.1. Fellowship training in Sports Medicine as an Orthopedic Surgeon or Family Medicine Physician.
  - 2.5.2.2. Experience providing medical coverage/care of NCAA Division 1 sports (or equivalent).
  - 2.5.2.3. Highest ranking officer amongst the Orthopedics or Family Practice physicians.
- 2.5.3. The Chief of Sports Medicine/Physician Supervisor:
- 2.5.3.1. Provides medical direction and establishes standing orders and standard operating procedures for the medical management of cadet and/or cadet candidates by ATs at USAFA.
  - 2.5.3.2. Ensures quality of care is delivered within and consistent with all applicable regulations, policies and procedures, and the AT scope of practice (**Figure 3.1.**).
  - 2.5.3.3. Assigns team physicians to specific sports teams for coverage, and provides initial/annual standard operating procedures and standing order orientations to all team physicians.
  - 2.5.3.4. Recommends an ATPC in writing to the USAFA/SG.
- 2.5.4. Working in close coordination with the ATPC, the Chief of Sports Medicine/Physician Supervisor is also responsible for ensuring:
- 2.5.4.1. All ATs receive initial orientations on standing orders and standard operating procedures.
  - 2.5.4.2. Initially, then after the first 12 months and then every 24 months thereafter, clinical competency assessments for individual ATs are completed and documented through the use of the clinical capabilities form (see **Figure 3.1.**) and written supervisory plans are established as needed.
  - 2.5.4.3. AT standing orders are reviewed and updated on an annual basis.
  - 2.5.4.4. AT patient care is documented in the electronic health record (EHR) in accordance with applicable AF and local MTF policies.

- 2.5.4.5. Quality assurance checks (peer review) are conducted on AT medical record documentation based on local policy
- 2.6. USAFA ATPC is appointed by the USAFA/SG and must be a privileged health care provider at 10 MDG. A provider who is both a physical therapist and athletic trainer is preferred. If not available, a physical therapist, athletic trainer and/or a physician with advanced sports medicine training may be the ATPC. If the ATPC is not credentialed to perform procedures for a standard AT, then the ATPC will appoint Clinical Preceptor(s) to oversee and ensure those procedures are signed off for all ATs as necessary.
- 2.6.1. The ATPC assists the Physician Supervisor with:
- 2.6.1.1. Development of standard orders and standard operating procedures for the medical management of cadet and/or cadet candidates.
  - 2.6.1.2. Initial and annual standing order orientations and clinical competency assessments.
  - 2.6.1.3. Ensuring AT patient care is documented in the EHR according to applicable policies.
- 2.6.2. Working in close coordination with the Physician Supervisor, the ATPC is additionally responsible for:
- 2.6.2.1. Ensuring AT competency folders are current and up to date and that all ATs maintain active licensure and national certifications as described in 2.7.
  - 2.6.2.2. Establishing policy and procedures for the AT peer review program and overseeing the implementation of the peer review program to make sure it is consistent with established policies and procedures.
  - 2.6.2.3. Providing counseling and/or a clinical performance improvement plan for an individual and/or for the AT staff, if needed.
- 2.6.3. In the event of absence (leave, sick, TDY, etc.), the ATPC will coordinate with the Physician Supervisor to ensure a privileged provider is assigned as the “acting” program coordinator to provide AT professional support and supervision, as necessary.
- 2.7. USAFA ATs must hold a minimum of a bachelor’s degree to practice within their core capabilities scope (**Figure 3.1**). USAFA ATs who maintain a current, active, valid and unrestricted license or other authorizing document such as certification or registration from a state; the District of Columbia, or a commonwealth, territory or possession of the United States and their national AT certification through the Board of Certification (BOC) are eligible to obtain advanced clinical capabilities (**Figure 3.1**. Diagnosis and Management and Procedures) as delineated in Chapter 3 with concurrence from the physician supervisor and ATPC.

- 2.7.1. ATs must practice under the oversight of their Physician Supervisor and any clinical preceptor or supervisor who may be appointed over them for clinical competencies. They must practice within their specific clinical competencies, as assessed by the Physician Supervisor and ATPC initially then after the first 12 months and thereafter every 24 months, and as annotated on USAFA Clinical Capabilities Form (see **Figure 3.1**).

2.7.2. ATs will complete initial and annual standing orders and standard operating procedures orientations for the medical management of cadet and/or cadet candidates.

2.7.3. ATs will complete initial, then after the first 12 months and thereafter, every 24 months clinical competency assessments. With the ATPC, ATs will establish and maintain a competency folder in accordance with local requirements and the provisions of this policy. All documents must be current.

2.7.4. ATs are responsible for providing a sports orientation to assigned team physicians.

2.7.5. ATs will document encounters involving the screening, observation, treatment or care of a medical condition in the EHR within 72 hours of the encounter as follows:

2.7.5.1. Any cadet or cadet candidate who is post-operative or has a loss of practice/competition time at the initial encounter. At a minimum, further documentation must occur on a weekly basis, at a significant milestone (e.g. protocol timeline), if a change in status occurs, and at discharge/end of care.

2.7.5.2. Any cadet or cadet candidate who is receiving ongoing care or treatment, but is not post-operative or had a loss of practice/competition time, will have the initial and discharge encounter documented. Progress notes will be documented every 2 weeks, unless the cadet or cadet candidate has a change in status, change in treatment plan, adverse reaction to treatment, or received one of the procedures outlined in [para. 2.7.5.3](#).

2.7.5.3. All of the following procedures will be documented at every encounter: skilled intervention as defined by local AT policy, dry needling or any invasive procedure, medication dispense, reduction of a dislocation, emergency care (e.g. concussion, spine stabilization), radiograph order and follow-up, manipulation, profile, and quarters.

2.7.6. ATs will conduct peer review of fellow ATs in accordance with AF guidance for privileged providers.

2.7.7. ATs will complete required hands-on and computer based training as directed by AF and USAFA/SG guidance for privileged providers.

2.8. USAFA Team Physicians will be selected in accordance with USAFAI 41-102, *Installation Emergency Medical Standby Support (EMSS)*.

2.8.1. The principal responsibility of the team physician is to provide for the safe participation and well-being of individual athletes. In support of this primary responsibility, the team physicians will:

2.8.1.1. Receive orientation to standing orders and standard operating procedures from Physician Supervisor initially and on an annual basis.

2.8.1.2. Ensure orientation to assigned sport initially and on an annual basis.

2.8.1.3. Provide sideline sports coverage and training room coverage, as needed and directed by the Physician Supervisor in coordination with the Associate Athletic Director for Sports Medicine.

- 2.8.1.4. Provide consultative services to the AT(s) assigned to their respective sport in a collegial environment.
  - 2.8.1.5. Use an integrated approach with medical specialists, athletic trainers and allied health professionals.
- 2.9. Clinical Preceptors ensure safe, efficient and effective treatment is performed according to the supervisory plan developed by the Physician Supervisor and ATPC. Clinical preceptors also ensure safe, efficient and effective documentation occurs, and co-sign the documentation in the EHR. **Note:** Co-signing is only required until an AT is fully qualified. An individual must have independent privileges to be assigned as a clinical preceptor.
- 2.10. Athletic Trainer Supervisors will consult the Physician Supervisor and ATPC when completing civilian performance plans, goals, and appraisals on Athletic Trainers in the performance of their clinical duties.

### 3. Athletic Training Core Capabilities.

- 3.1. In accordance with Department of Defense (DoD) and Air Force policy, ATs are currently credentialed non-privileged providers. While civilian state practice acts vary from state to state, in order to meet National Athletic Trainers Association policy, a supervising physician must be appointed to provide clinical oversight for each AT.
- 3.2. AT Core Capabilities consists of a standard scope of care which every AT must be able to practice at independently. Further capabilities require additional (one time, annual, or extended) training and supervision.
- 3.3. At initial assessment, then after the first 12 months and then every 24 months thereafter, the Physician Supervisor and ATPC must assess the skills of each AT through, but not limited to, peer review records review, practice patterns/trends analysis, and random direct oversight. This assessment is documented on the List of Clinical Capabilities – USAFA Athletic Training ([Figure 3.1](#)).
- 3.4. Each clinical capability beyond the core scope requires one-time, annual, or an extended period of training as listed below ([Figure 3.1](#)). All training must be clearly documented and updated as new or recurrent training occurs within each respective AT competency folder.
- 3.4.1. Order orthotics or braces. ATs will obtain this advanced capability with a one-time orientation to local policy and procedures by the Physician Supervisor or ATPC. ATs will be allowed to order orthotics or braces from 10 MDG (Physical Therapy or Orthotics clinics), or dispense from Athletic Department procured stock.

Figure 3.1. List of Clinical Capabilities – USAFA Athletic Training.

LIST OF CLINICAL CAPABILITIES – USAFA ATHLETIC TRAINING			
<p><b>PRINCIPAL PURPOSE:</b> To define the scope and limits of practice for individual athletic trainers. Capabilities are based on evaluation of the individual's credentials and performance.</p> <p><b>ROUTINE USE:</b> Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the athletic trainer is applying for staff appointments during or after separating from the Air Force.</p> <p><b>DISCLOSURE IS VOLUNTARY:</b> However, failure to provide information may result in the limitation or termination of clinical capabilities</p>			
<b>INSTRUCTIONS</b>			
<p><b>APPLICANT:</b> In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Physician Supervisor. You are practicing under the license and oversight of the appointed Physician Supervisor.</p> <p><b>PHYSICIAN SUPERVISOR:</b> In Part I, using the facility master capabilities list, enter Code 1, 2, or 4 in each VERIFIED block in answer to each requested capability. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form and forward the form to the Athletic Training Program Director.</p> <p><b>CODES:</b> 1. Fully competent within defined scope of practice.                  2. Supervision required with a written plan. (Unlicensed/uncertified or lacks current relevant clinical experience.)                  3. Not approved due to lack of facility support. (Use of this code is reserved for the Physician Supervisor and Athletic Training Program Director)                  4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.</p> <p><b>CHANGES:</b> Any change to a verified/approved capabilities list must be made only with approval from the Physician Supervisor and Athletic Training Program Director</p>			
NAME OF APPLICANT		NAME OF FACILITY	
Scope		Requested	Verified
P389690	The scope of privileges in athletic training involves the evaluation and treatment of patients recovering from injury or disease, to include concussion. Athletic trainers provide these patients with services that restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities. Services include examination, evaluation, testing. Modalities may include manual therapy techniques to include mobilization and soft tissue techniques; blister care; preventative taping; measuring strength; range of motion; balance and coordination; posture; muscle performance and motor function; therapeutic exercises; strength and conditioning training; injury prevention; and human performance optimization. Athletic trainers may provide on-site emergency care to include, but not limited to, sporting events, military training and obstacle courses in accordance with state and national regulations. Athletic trainers may see patients without a referral.		
Diagnosis and Management (D&M)		Requested	Verified
P389692	Order orthotics or braces		
P386000	Initiate, continue, and terminate temporary / limited duty profile in accordance with service policy		
P389664	Order conventional radiography of the appendicular skeleton in accordance with Military Treatment Facility (MTF) policy		
P386002	Place patients on quarters in accordance with Service policy		
P389662	Refer patients with neuromusculoskeletal conditions to other practitioners as appropriate		
P385998	Dispense medications in accordance with standing orders from the Physician Supervisor		
Procedures		Requested	Verified
P389699	Casting and bracing		
P389701	Dry needling		
P389703	Aspiration of ears, nails, blisters		
P389705	Reduce dislocations		
P389707	Provide initial emergency airway management & oxygen supplementation		
P389709	Perform suture placement and removal		
	Other (facility dependent):		
SIGNATURE OF APPLICANT		DATE	



3.4.2. Order conventional radiography of the appendicular skeleton in accordance with MTF policy. ATs will obtain this advanced capability at the supervisory level by:

3.4.2.1. Completing a radiology course approved by the Physician Supervisor or ATPC to include a post-test.

3.4.2.2. Case discussion with the appointed clinical preceptor for the first 25 cases with an emphasis on clinical reasoning before the imaging is obtained. EHR documentation must also be co-signed by the preceptor.

3.4.2.3. At the discretion of the Physician Supervisor (with ATPC consultation), the AT may be upgraded to an unsupervised level (does not require pre-approval or co-signature). The AT at the unsupervised level will be assessed through peer review by the Physician Supervisor or ATPC based on local policy.

3.4.3. Place patients on profile and/or quarters in accordance with Service policy. Shaving and uniform waivers will not be included in this policy. ATs will obtain this advanced capability with a one-time orientation to local policy and procedures by the Physician Supervisor or ATPC and the point of contact within the MTF.

3.4.4. Refer patients with neuromusculoskeletal conditions to other practitioners as appropriate. ATs will obtain this advanced capability with a one-time orientation to local policy and procedures by the Physician Supervisor or ATPC, and may refer to neuromusculoskeletal providers within the local Military Health System.

3.4.5. Dispense medications in accordance with standing orders from the Physician Supervisor. Once training requirements below have been met, ATs will be able to dispense certain medications as directed by Physician Supervisor standing orders. Refer to [Table 3.1](#) for recommended authorized medications. The 10 MDG Pharmacy and Therapeutics (P&T) Function determines the appropriate medication authorization for ATs. The 10 MDG AT Authorized Drug Formulary will be approved by the P&T Function and reviewed annually for changes, additions or substitutions.

3.4.5.1. ATs will only dispense medication after an appropriate history and physical examination are done and documented in the appropriate EHR.

3.4.5.2. ATs may dispense any medication on the approved AT Authorized Drug Formulary under standing orders from the Physician Supervisor. ATs may dispense appropriately labeled and approved over-the-counter medications as listed in [Table 3.1](#). All medications dispensed by non-pharmacy staff will follow the same procedures as if the drugs were dispensed by the pharmacy. (T-1)

3.4.5.3. Labeling prescriptions. Prescription containers for all dispensed medications must be appropriately labeled IAW federal requirements stated in the Food, Drug and Cosmetic Act, Sections 22, AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 29 AUGUST 2018; 502 and 503 or the Compounding Quality Act, Section 106A. Medications must be packaged IAW AFI 44-102, *Medical Care Management*. Containers for all medications must be appropriately labeled with the patient name, name of provider, date issued, directions for use, quantity dispensed, and number of refills allowed as well as appropriate cautionary labels to ensure safe, effective use of the medication by the patient. (T-1)

3.4.5.4. Documentation of Counseling. Documentation of patient counseling IAW the Federal Omnibus Budget Reconciliation Act (OBRA) of 1990. Documentation of such counseling must be entered on AF Form 781, *Multiple Item Prescription*, on a SF Form 600, *Medical Record - Chronological Record of Medical Care* (if applicable), and placed in the patient's medical record/EHR. Patient counseling must include, but is not limited to, the following: name and description of the medication, route of administration, dose, dosage form, and duration of drug therapy. OBRA 1990 also mandates discussion of special directions and precautions for preparation of drugs, administration and use by the patient, common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered (including their avoidance and the action required if they occur), techniques for self-monitoring drug therapy, proper storage, refill information, appropriate action in case of a missed dose, and patient specific medication allergies. If patients decline counseling, the AT must document that fact in the patient medical record or on the AF Form 781. (T-1). When the AT is away from their duty station and EHR, this documentation must be placed in the medical record within 1 duty day of returning back to USAFA.

3.4.5.5. Injections. ATs do not provide injections unless they have complete a formal suturing course (see 3.4.11.). ATs will only provide injections in conjunction with a suture procedure. Injections will be limited to 1% lidocaine and/or 0.5% ropivacaine and limited to the site of laceration. ATs will not inject joints, bursae, tendons or any other musculoskeletal condition. ATs will store syringes and hypodermic needles in a secure area. Final disposition of used, disposable hypodermic syringes and needles will be accomplished following local MTF guidelines.

3.4.5.6. Duration of Treatment. ATs will only treat musculoskeletal conditions with the appropriate dose and frequency for 30 days. (see Musculoskeletal Drugs (MDK), **Table 3.1**). For those conditions requiring non-MSK drugs, the ATs will treat their patients only for three days with the appropriate frequency and dose as annotated on the Physician Supervisor standing orders. For any patient who requires treatment for longer than these ranges, the AT will refer the patient to the assigned Team Physician.

3.4.5.7. Training Requirement. A formal training class is required for all ATs who will be given clinical capabilities to dispense medication. This class will consist of pharmacology, medication indications and contra-indications, and side effects of all medications for which ATs are allowed to dispense.

3.4.5.8. Clinical experience and supervision when dispensing medication. Upon completion of the appropriate course, the provider will submit a request for upgraded clinical capabilities to the Physician Supervisor and ATPC. This request will be for "supervised" clinical capabilities and will include the statement that a minimum of 25 supervised medication dispenses are required before the award of "unsupervised" clinical capabilities. The AT will recommend to the Physician Supervisor and ATPC a provider who is fully privileged to prescribe medication to serve as the preceptor. All of the supervised cases require oversight of prescriptions by the privileged provider.

3.4.5.8.1. Once the request for supervised clinical capabilities has been approved by the Physician Supervisor and ATPC, the AT will be granted medication dispensing capabilities with supervision. The provider will then perform at least 25 medication dispensing cases. The 25 supervised medication dispenses will consist of 15 dispenses of non-musculoskeletal medications and 10 dispenses of musculoskeletal medications. These cases do not need to have direct oversight but can be accomplished either via patient case presentation or direct oversight. A provider may require more than 25 medication dispenses to develop adequate competence. Therefore, the 25 cases are the minimum amount under supervision.

3.4.5.8.2. Upon safe and appropriate completion of 25 or more medication dispenses, the preceptor will sign via indorsement on the supervision plan and return to the Physician Supervisor and ATPC. Once the Physician Supervisor and ATPC have received the indorsed supervisory plan, the provider may apply for full unsupervised medication dispensing capabilities.

3.4.5.8.3. An AT will only have to complete this supervision process once in their career in order to dispense medications.

**Table 3.1. Recommended Athletic Training Drug Formulary.**

<b>Musculoskeletal Drugs</b>	
<i>Generic Name</i>	<i>Trade Name</i>
Acetaminophen	Tylenol
Naproxen	Naprosyn
Ibuprofen	Motrin
1% Lidocaine	1% Xylocaine
0.5% Ropivacaine	0.5% Ropivacaine
<b>Non-Musculoskeletal Drugs</b>	
<i>Generic Name</i>	<i>Trade Name</i>
Benzocaine	Cepacol
Cetirizine	Zyrtec
Diphenhydramine	Benadryl
Guaifenesin	Robitussin
Hydrocortisone, 1% topical cream	Cort-Aid
Sunscreen	Sunscreen
Aluminum-OH 200mg / Magnesium OH 200mg / Simethicone 25 mg	Maalox Plus
Docusate sodium	Colace
Loperamide	Imodium
Polymyxin B-bacitracin -neomycin ointment	Neosporin
Tolnaftate	Tinactin
Bismuth subsalicylate	Pepto Bismol

3.4.6. Casting and bracing. ATs will obtain this advanced capability with a one-time orientation to local policy and procedures by the Physician Supervisor or ATPC.

3.4.7. Dry Needling. Due to the invasive nature of dry needling, only those providers who meet the following training, experience, and supervisory criteria will be granted regular privileges to perform dry needling.

3.4.7.1. Training requirement can be met by:

3.4.7.1.1. Completion of a formal clinical and practical dry needling training program as part of an entry-level or post-graduate professional education program. The academic training program course catalogue or curriculum will be provided as proof of needling content; or,

3.4.7.1.2. Completion of a state-approved continuing medical education program; or,

3.4.7.1.3. Completion of an alternative training program approved by the Physician Supervisor and ATPC. ATs must receive prior approval from the Physician Supervisor and ATPC before engaging in an alternate training program.

3.4.7.2. Clinical experience and supervision. Upon completion of the training requirements, the AT will submit a request for upgraded clinical capabilities to the Physician Supervisor and ATPC. This request will be for “supervised” clinical capabilities and will include the statement that a minimum of 25 supervised cases are required before the award of unsupervised clinical capabilities. The Physician Supervisor and ATPC will assign a provider who has unsupervised privileges with dry needling to serve as the preceptor. All of the supervised cases require direct oversight of the procedure and each encounter in the EHR must be co-signed by the preceptor.

3.4.7.2.1. Once the request for supervised clinical capabilities has been approved by the Physician Supervisor and ATPC, the AT will be granted dry needling capabilities with supervision. The provider will then perform at least 25 separate dry needling cases (multiple encounters for the same patient will only count as one patient case), all requiring direct oversight by the preceptor. The 25 supervised cases will consist of 10 cases with insertion of a needle in an extremity, and 15 cases with insertion of a needle over the thorax, spine, or abdomen. A provider may require more than 25 cases to develop adequate competence. Therefore, the 25 cases are the minimal number for supervision. The provider may only treat areas that were covered in their initial course.

3.4.7.2.2. Upon safe and appropriate completion of 25 cases, the preceptor will sign via indorsement on the supervision plan and return to the Physician Supervisor and ATPC. Once the Physician Supervisor and ATPC have received the indorsed supervisory plan, the AT may apply for unsupervised dry needling clinical capabilities.

3.4.7.2.3. An AT who has been through this process will not have to repeat this process if they take subsequent approved courses as delineated in [paragraph 3.4.7.1](#) to expand their scope of dry needling practice.

- 3.4.7.3. Due to multiple civilian companies providing dry needling training, differences in language exist. Dry needling has been referred to as trigger point dry needling, functional dry needling, homeostatic dry needling, preventative dry needling, therapeutic dry needling and more by these companies. All are based upon the same theory and evidence, but the language has become proprietary. The scientific literature references “dry needling.” This common verbiage should be adopted by all providers who implement this treatment technique. Any other qualifier, explanation, or verbiage may confuse the patient and other healthcare providers. Additionally, dry needling can only be used for treatment of an injury or dysfunction at this time.
- 3.4.8. Aspiration of ears, nails, and blisters. ATs will obtain this advanced capability through the completion of an educational course with successful completion of a written and practical exam. The course may be locally developed by a designee of the Physician Supervisor or ATPC, or approved by the Physician Supervisor or ATPC. The AT must discuss with the appointed clinical preceptor for the first 5 cases with an emphasis on clinical reasoning before the procedure is performed. EHR documentation must be co-signed by the preceptor. At the discretion of the Physician Supervisor (with ATPC consultation), the AT may be upgraded to an unsupervised level (does not require pre-approval or co-signature). The AT will be assessed on an annual basis through peer review by the Physician Supervisor or ATPC.
- 3.4.9. Reduce dislocations. ATs will obtain this advanced capability through the completion of an educational course with successful completion of a written and practical exam. The course may be locally developed by a designee of the Physician Supervisor or ATPC, or approved by the Physician Supervisor or ATPC. An AT must discuss with the appointed clinical preceptor for the first 5 cases with an emphasis on clinical reasoning before the procedure is performed. EHR documentation must be co-signed by the preceptor. At the discretion of the Physician Supervisor (with ATPC consultation), the AT may be upgraded to an unsupervised level (does not require pre-approval or co-signature). The AT will be assessed on an annual basis through peer review by the Physician Supervisor or ATPC.
- 3.4.10. Provide initial emergency airway management & oxygen supplementation. ATs will obtain this advanced capability through the completion of an educational course with successful completion of a written and practical exam. The course may be locally developed by a designee of the Physician Supervisor or ATPC, or approved by the Physician Supervisor or ATPC. Once the initial clinical capability is granted, the Physician Supervisor or ATPC will do annual skills checks for alternate airway management and biannual skills checks for oxygen supplementation to ensure continued competence. In addition, a formal recertification of the skill is required through the completion of an educational course with successful completion of a written and practical exam as approved by the Physician Supervisor or ATPC.

3.4.11. Perform suture placement and removal. Requirements for ATs to obtain this advanced capability include:

3.4.11.1. Completion of an educational course with successful completion of a written exam. The course may be locally developed by a designee of the Physician Supervisor or ATPC, or approved by the Physician Supervisor or ATPC.

3.4.11.2. Completion of a minimum of eight hours of knot tying and suturing with surgical technicians or Physician Supervisor designee.

3.4.11.3. Under direct oversight of the Physician Supervisor or their appointed clinical preceptor, the AT will assess a simple wound for inclusion and exclusion criteria, and successfully suture a minimum of 8 wounds.

3.4.11.4. Once the initial clinical capability is granted, the AT will do an on-going self-assessment to ensure continued competency in addition to a formal biennial recertification of the skill every 24 months, including appropriate assessment and suturing of simple wounds.

#### **4. Athletic Event Coverage.**

4.1. The USAFA AD will provide an AT to cover the designated athletic home events. A 10 MDG provider may assist the AT in athletic event medical coverage upon the request of an AD representative. Guidance regarding events requiring onsite physician and AT coverage are provided in the NCAA Handbook and NATA statement "Recommendations and Guidelines for Appropriate Medical Coverage of Intercollegiate Athletics."

4.2. Complete athletic event coverage guidelines are outlined in USAFAI 41-102, *Installation Emergency Medical Standby Support (EMSS)*.

CHRIS GRUSSENDORF, Col, USAF, MC, SFS  
Command Surgeon, USAF Academy

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

AFI 33-360, *Publications and Forms Management*, 1 December 2015

AFI 44-102, *Medical Care Management*, 16 March 2015

AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 29 August 2018

AFMAN 33-363, *Management of Records*, 1 March 2008

USAFAI 41-102, *Installation Emergency Medical Standby Support (EMSS)*, 10 July 2017

***Adopted Forms***

AF 847, *Recommendation for Change of Publication*

AF 781, *Multiple Item Prescription (DD Form 2005, Privacy Act Statement Services)*

SF 600, *Chronological Record of Medical Care*

***Abbreviations and Acronyms***

**10 ABW/XP**—10th Air Base Wing/Plans/Programs

**10 MDG**—10th Medical Group

**AAFP**—American Academy of Family Physicians

**AAOS**—American Academy of Orthopedic Surgeons

**ACSM**—American College of Sports Medicine

**AD**—Athletic Department

**AF**—Air Force

**AFMAN**—Air Force Manual

**AFPD**—Air Force Policy Directive

**AFRIMS**—Armed Forces Research Institute of Medical Sciences

**AMSSM**—American Medical Society for Sports Medicine

**AOASM**—American Osteopathic Academy of Sports Medicine

**AOSSM**—American Orthopedic Society for Sports Medicine

**AT**—Athletic Trainer

**C2**—Command and Control

**CAT**—Certified Athletic Trainer

**COR**—Contracting Officer Representative

**CPR**—Cardiopulmonary Resuscitation

**DO**—Doctor of Osteopathic Medicine  
**DoD**—Department of Defense  
**DV**—Distinguished Visitor  
**EMT**—Emergency Medical Technician  
**EMT/P**—Emergency Medical Technician or Paramedic  
**EMR**—Emergency Medical Responder  
**FRT**—Field Response Team  
**MCRP**—Medical Contingency Response Plan  
**MD**—Doctor of Medicine  
**NATA**—National Athletic Trainers’ Association  
**NCAA**—National Collegiate Athletic Association  
**NonDoD**—Non Department of Defense  
**OIC**—Officer in Charge  
**OPR**—Office of Primary Responsibility  
**RDS**—Records Disposition Schedule  
**RMMM**—Rocky Mountain Mobile Medical  
**SABC**—Self Aid and Buddy Care  
**SG**—Surgeon General  
**SGH**—Chief of the Medical Staff  
**USAFA**—United States Air Force Academy  
**USAF**—United States Air Force