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Health Services Management Journeyman

Volume 3. Readiness, Patient Movement and Disability Evaluation

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Author: MSgt Antoniette D. Ruffino
MSgt Scarlett R. Woolard
382 Training Squadron
Air Force Career Development Academy Air University (AETC
382 TRS/TRR
3460 Garden Avenue
Ft. Sam Houston, Texas, 78234-7674
DSN: 420-5117
E-mail address: scarlett.r.woolard.mil@mail.mil

Instructional Systems Specialist: Todd Knowles

Editor: Evangeline K. Walmsley

Air Force Career Development Academy (AFCDA)
The Air University (AETC)
Maxwell AFB, Gunter Annex, Alabama 36114-5643

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This is the third volume of the Career Development Course (CDC) Z4A051, Health Services Management Journeyman; it consists of three units. It takes a close look at Medical Readiness, Patient Movement, and the Integrated Disability Evaluation System. The duties discussed in this volume are very important to ensuring the mission is met within each medical treatment facility. Many of the duties in this volume are accomplished on a routine basis by many 4A0s. Also, note that failure to carry out these duties properly can cause undue hardship to many personnel. Therefore, it is paramount that attention to detail is adhered to while learning these functions.

Unit 1 focuses on Medical Readiness and the many features that fall under this umbrella. You will learn how the Air Force plans for contingencies and about the different reports required to support Air Force and base plans. Next you will read on how the base, and MTF, prepare for deployment. In the last section, you will learn about the Medical Control Center mission and multiple functions required in support of the MTF and base.

Unit 2 focuses on the Patient Movement process. It reviews the terminology, describes roles of responsibility of the offices involved, and the links between the medical evacuation system and aeromedical evacuation. Finally, this unit covers the process, and documents required to prepare and process patient through the aerovacuation system.

Unit 3 describes medical disability evaluation. You will learn about fast track, fitness for duty, and how the Deployment Availability Working Group (DAWG) contributes to the monitoring of medical conditions. Next you'll read about the Integrated Disability Evaluation System (IDES), and how the Veterans Administration works together with the IDES in the process. Finally, you will learn about two programs in place to assist the seriously ill and injured patients.

A glossary is included for your use.

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NOTE:

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then complete the unit review exercises.

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IN THIS UNIT, YOU WILL LEARN HOW MEDICAL PERSONNEL PREPARE FOR CRISES and contingencies. The lesson begins with a brief look at the objectives of Air Force planning, as well as common terms and acronyms used in medical readiness, Air Expeditionary Force Construct, and some databases used to ready troops for deployment. You will then move on to deployment function and finally the Medical Control Center functions and readiness reports.

1–1. Air Force Planning

Contingencies and crises arrive with many names - natural disaster, accidents, terrorist actions, and war. Only rarely can you prevent them or control their intensity, but you can and *always should be ready to respond*. Readiness is the overall ability of the armed services to arrive where they are needed, on time, and prepared to effectively carry out their assigned missions. The chaotic environment following a disaster or an attack is not the time or place to begin thinking about how to respond. Effective post-disaster or post-attack response begins with planning well before a crisis threatens.

401. Objectives of Air Force planning, terminology, and acronyms

The Air Force Medical Service (AFMS) is responsible for planning and providing the medical support necessary to sustain maximum combat capability and effectiveness. The AFMS is part of the bigger Air Force mission, which is configured to meet the constructs of the Air and Space Expeditionary Force (AEF) concept. By definition, an expeditionary military force is one that can conduct military operations on short notice in response to crises with forces tailored to achieve limited and clearly stated objectives. Airmen from all across the Air Force contribute to expeditionary capabilities–from those who provide the stateside support, to those that deploy and those who provide reach back for support. The Air Force has deployable assets assigned to support all 10 AEFs. As you

can probably imagine, it takes a team effort to ensure all members are trained and ready to respond to any full spectrum threat response. Whether you work in readiness or not, you are a key player in ensuring a successful expeditionary force.

Joint planning overview

How does the United States prepare for unseen threats that could come from any geographic region? We plan so we are best able to meet our assigned tasks and missions. The kind of planning that takes place is not limited within the realm of the Air Force; planning happens on a bigger scale, at the National and Joint level.

Joint planning is a coordinated process used by commanders, decision-makers, and supporting staffs to determine the best method of accomplishing assigned tasks and missions. There are four major interrelated systems affecting the development of joint operational plans which will be discussed in the following few paragraphs.

National Security Council System

The National Security Council (NSC) is the principal forum for discussion on national security policy issues. The NSC system provides the framework for establishing national strategy and policy objectives, developing recommendations for the president and monitoring policy implementation.

Joint Strategic Planning System

The Joint Strategic Planning System (JSPS) is the primary formal means by which the Chairman of the Joint Chiefs of Staff (CJCS) carries out planning and policy responsibilities within the Department of Defense (DOD). The CJCS does consult with the combatant commanders and Joint Chiefs of Staff (JCS) during this process. Essentially, this provides the means to systematically review the national security environments, the US objects, risks, threats, and then propose a data based military strategy.

Planning, Programming, and Budgeting Execution System

The third major system related to the overall joint planning process is the Planning, Programming and Budgeting Execution (PPBE) system. This is an on-going process that enables senior leadership to evaluate other ways to achieve the best mix of force, requirements, and support within fiscal constraints. Essentially, this continuous process helps the commanders see what they have, where they need to be, and then enables them to decide the most effective way to get there.

Joint Operations Planning and Execution System

JOPES, or Joint Operations Planning and Execution System, is a system that provides decision makers with information to support the processes, wartime deployment, and quantify in-place requirements.

Terms and acronyms

That is the big picture view; however, before we get into how the Air Force contributes to the DOD mission, let us go over some terms and acronyms that will help you understand the material presented throughout this unit.

Administrative control

Administrative control, or ADCON, is the direction or exercise of authority over subordinate organizations in respect to administration and support. ADCON originates at the service secretary level (i.e., Secretary of the Air Force [SECAF]), but may be delegated. ADCON is the military departments' "organize, train, and equip" authority.

Air Reserve Component

The Air Reserve Component (ARC) is composed of all units, organizations, and members of the Air National Guard (ANG) of the United States and the United States Air Force Reserve (USAFR).

Assumption

An assumption is taking something for granted or supposing something without positive proof. This is necessary to enable the commander, in the process of planning, to complete an estimate of the situation and make a decision on the course of action.

Air and space expeditionary force unit task code reporting tool

The AEF unit task code (UTC) reporting tool is a web-based tool with associated databases to support the collection, collation, and report generation for UTC readiness data.

Base command post

The base command post is the facility where the installation commander and his or her staff direct actions to support the bases assigned mission. It is the focal point of the base's operations. The command post receives, analyzes, displays, and disseminates orders, information, and requests pertinent information to the assigned task.

Combatant commander

A combatant commander is the commander of one of the unified or specified combatant commands established by the president.

Communication, command, and control system

The communication, command, and control (C_3) system is a combination of people, equipment, and other resources organized to process information. Processing includes creating, collecting, protecting, analyzing, transmitting, storing, retrieving, dissemination, and disposing of information. The C_3 system encompasses areas traditionally represented by command and control systems, telecommunications, computer resources, data automation, office information systems, and communications/electronics.

Continental United States

Continental United States (CONUS) is the United States territory, including the adjacent territorial waters, located within North America between Canada and Mexico.

Contingency

Contingency is any emergency involving military forces caused by natural disasters, terrorists, subversives, or by required military operations. Contingencies require plans, rapid response, and special procedures to ensure effective response, safety, and the readiness of personnel, installations, and equipment.

Crisis planning

The physical manifestation of crisis management –with respect to the creation of a real document (digital or otherwise)–outlines a personal or organizational reaction to crisis.

Deployment

Deployment is the movement, or relocation, of forces (people, ammunition, equipment, supplies) to a desired area of operation.

Deployment requirements manning document

The Deployment Requirements Manning Document (DRMD) dictates the personnel taskings the unit must prepare for an execution deployment. It is an essential element of the personnel and manpower communities supporting total force accountability.

Designed operational capability

Designed operational capability (DOC) is the mission for which a measured unit has been equipped, organized, or designed.

Designed operational capability statement

The DOC statement is a classified document prepared by a parent major command (MAJCOM) for each of its measured units. This outlines the DOC of the unit and contains unit identification, mission tasking narrative, mission specifics, and resources to be measured.

Employment

Employment is the tactical use of aircraft or forces in a desired area of operation, and is the actual use of forces within a combat zone or an objective area. Forces may either be deployed, already in-place, or both.

Exercise

A military maneuver or simulated peacetime or wartime operation involving planning, preparation, and execution. An exercise is carried out for the purpose of practice, training, or evaluation. It may be a combined, joint, or single service exercise, depending on participating organizations.

Expeditionary medical support/Air Force medical theater hospital system

Expeditionary medical support/Air Force Medical Theater Hospital (EMEDS/AFTH) system provides individual bed-down and theater-level medical/dental services for deployed forces or select population groups within the entire spectrum of small-scale contingencies (SSC) through major theater war. EMEDS/AFTH includes the entire spectrum of Air Force health care in a theater of operations.

Fiscal year

The fiscal year is the period for the federal government, which begins on October 1 and ends on September 30. The fiscal year is designated by the calendar year in which it ends; for example, fiscal year 2016 begins on October 1, 2015 and ends on September 30, 2016.

Forced package

Force package is a predefined, standardized grouping of manpower and/or equipment to provide a specific wartime capability. It is commonly called an UTC.

Logistics Force Packaging Systems

Logistics Force Packaging Systems (LOGFOR) is a system that provides equipment and materiel requirements and summarized transportation characteristics through its Logistics Detail component.

Medical control center

A medical control center (MCC), also referred to as the unit control center (UCC), is a predetermined area designed as a central point where the military treatment facility (MTF) commander and key personnel coordinate, control, and direct actions in support of the assigned missions.

Medical contingency response plan

The medical contingency response plan (MCRP) consolidates a facility’s peacetime and wartime capabilities and plans, and outlines the general contingency medical response requirements of an MTF.

Medical Readiness Decision Support System

The Medical Readiness Decision Support System (MRDSS) is a web-based system that allows users to quickly and effectively monitor a unit’s personnel, training, and war reserve materiel (WRM) and deployment status.

Manpower Force Packaging System

Manpower Force Packaging System (MANFOR) is a system that provides the title of the unit or force element, the mission capability statement and the manpower detail by function, grade, and Air Force specialty code required to meet the defined capability.

Mission capability statements

The MISCAP, or mission capability statement, is a short paragraph describing the mission capabilities that higher headquarters planners expect of a specific UTC at execution. The statement usually contains pertinent information such as the type of base where commanders will deploy the unit, the unit's functional activities, and other augmentation requirements necessary to conduct specific missions.

Mission essential task

Tasks deemed essential to mission accomplishment and defined in terms of tasks, conditions, and standards is considered a mission essential task (MET).

Mobility

Mobility is the quality or capability of military forces that permits them to move from place to place while retaining the ability to fulfill their primary mission.

Operational control

Operational control (OPCON) is the command authority that a commander uses at any echelon at or below the level of combatant command. OPCON is the authority to perform those functions of command over *subordinate forces* involving organizing and employing forces, assigning tasks, designating objectives, and giving authoritative direction necessary to accomplish the mission.

Operation plan

An operation plan (OPLAN) is for the conduct of joint operations that can be used for the basis development of an operation order. An OPLAN identifies the forces and supplies required to execute the Commander-in-Chief's strategic concept. Often it will include a movement schedule of these resources to the theater of operations. The time phased force deployment data (TPFDD) files identify the forces and supplies. OPLANs include all phases of the tasked operation.

Plan

A plan is the scheme or proposed method for accomplishing a mission or reaching an objective. It implies a scheme or proposed method or design or formulation of ideas for the accomplishment of a mission, which suggests use of imaginative scope and vision.

Planning

Planning is the procedure by which a commander identifies those forces required to carry out an assigned task within a prescribed area of responsibility.

Simulation

Simulation is a tool or procedure used to closely mimic or represent a process or action. It is a representation of reality.

Status of Resources and Training System

The Status of Resources and Training System (SORTS) is a JCS controlled, automated data system primarily created to provide the National Command Authority (NCA) and the JCS with authoritative identification, location, and resource information for crisis actions. It is used throughout the chain of command to measure the daily resource status of operating forces.

Tactical control

Tactical control (TACON) is limited to the detailed and local direction and control of movements or maneuvers necessary to accomplish missions or assigned tasks. It includes sufficient authority for controlling and directing the application of force or tactical use of supporting forces. TACON is inherent in OPCON; however, it is normally delegated or transferred to functional component commanders.

Triage

The process of classifying or reclassifying the sick and injured according to the urgency of treatment required and types of conditions presented is called triage. Triage begins when medical personnel first evaluate casualties and continues through all levels of medical care.

Unit task code

A UTC is a five-character alphanumeric code that uniquely identifies each force package.

Vulnerability period

This is the period of time the forces aligned in a specific AEF block are susceptible to initial deployment.

War reserve material

War reserve material (WRM) is the portion of material, above and beyond peacetime operating stocks, required to support the increased activity of forces during wartime. WRM is necessary to assure the timely response and sustainability of weapon systems to support forces, activities, and mission objectives for wartime scenarios consistent with defense guidance.

402. Air and Space Expeditionary Force overview

Have you ever wondered why you cannot deploy when you want to? This lesson describes how the Air Force is configured to meet the deployments. We review the Air Force construct, composition, schedule, battle rhythm, and vulnerability period.

Air and space expeditionary force construct

The AEF is a force generation configuration used to manage the battle rhythm of forces in order to meet global requirements while maintaining the highest possible level of overall readiness. Through the AEF, the Air Force establishes a predictable, standardized battle rhythm ensuring rotational forces are properly organized, trained, equipped, and ready to sustain capabilities while rapidly responding to emerging crises. There are four major elements of the AEF structure: readily available force, enabler force, in-place support, and institutional force.

Readily available force

The readily available force is the primary pool from which the Air Force fulfills requirements. To meet these requirements, the Air Force aligns its war fighting capabilities (i.e., forces from combat, combat support, and combat service support organizations) into five AEF blocks, each intended to contain an equivalent capability from which to provide forces. Currently, the baseline AEF (Band-B) is organized to support a one-to-four deploy-to-dwell ratio. This means service members deploy for one cycle, and then come back for four cycles. However, if a commander's requirements increase, then capability can be moved between the blocks. This movement allows for a higher deploy-to-dwell rate, and permits a greater pool within each block to pull from. This is shown in other bands:

Tempo Bands	Ratio
A	one-to-four*
B	one-to-four
C	one-to-three
D (P)	one-to-two
E (T)	one-to-one ratio

* Different vulnerability window then the other tempo bands

Each band listed above has a six-month AEF vulnerability window. The only difference is Band A, which supports a one-to-four ratio, but with a four month vulnerability period. This band is typically for the functional areas that deploy for four months.

Enabler force

The enabler force includes common user assets, such as global mobility forces, special recovery forces, space forces, and other uniquely categorized forces that provide support to the Department of Defense. Due to their unique nature, these forces are not easily aligned in one of the tempo bands; however, every effort is made to develop a sustained plan.

In-place support

There are two types of in-place support: forces that almost exclusively employ in direct support of a combatant commander mission, and then those that support critical home station operations. In-place support forces are also included in the AEF tempo bands.

Intuitional force

The institutional force consists of those forces assigned to organizations responsible to carry Air Force level functions such as (i.e., organize, train, equip, recruit, supply, etc.). These organizations will not posture UTCs in the AEF Capability Library. Although these organizations as a whole do not represent a war fighting capability, the individuals assigned to these organizations are inherently deployable.

The Air and space expeditionary force capability library

The blocks within the five primary and two ARC tempo bands, plus the enabler force make up the AEF Capability Library as shown in figure 1–1. The AEF Capability Library consists of 100 percent of the USAF's postured capability and encompasses "one iteration" of each of the 41 AEF blocks plus the enabler force. The AEF Capability Library contains a finite capability that at any given time identifies forces that constitute the total force that has been made available or allocated for scheduling and provides a composite of capabilities from which AETFs are task organized to meet mission requirements.

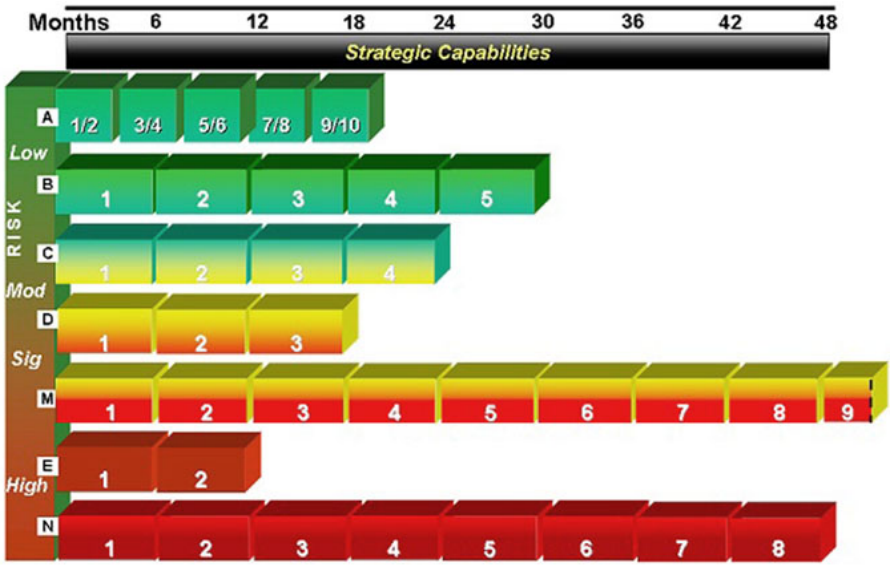


Figure 1–1. AEF Capability Library.

Schedule

The AEF Capability Library is the basis for the AEF schedule (fig. 1–2). The AEF schedule operates on two 12-month life cycles that align with global planning and requirements, and coincides with fiscal years. Prior to the beginning of every AEF cycle, functional areas revalidate the tempo band alignment of their respective capability areas and realign forces if necessary. It is the Air Force goal that functional areas align to the least strenuous band to minimize risk to the force and to effectively support the AEF. Every 12 months, a new 24-month AEF schedule is established.

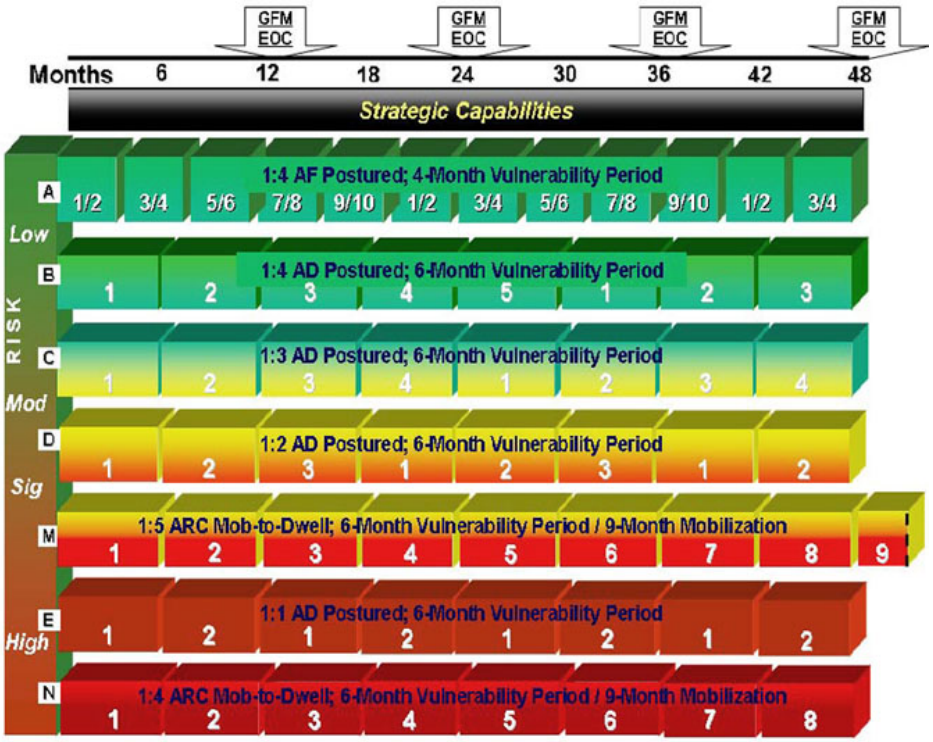


Figure 1–2. AEF schedule.

Battle rhythm

The AEF timeframe operates on a 24-month life cycle. This cycle includes periods of normal training, preparation, and deployment vulnerability. However, each tempo band within the AEF construct operates under a different battle rhythm.

For most forces, the AEF battle rhythm is spent in normal training during which forces concentrate on unit missions and basic proficiency events. This may include AFSC specific, joint, Air Force, or MAJCOM exercise training. Most contingency and deployment training takes place during this period and are typically less than 60 days.

Post-deployment reconstitution is included in this period. The month immediately after deployment is focused on recovery. Permanent change of station (PCS) and permanent change of assignment (PCA) moves into and out of the unit are de-conflicted to the maximum extent possible. This should not take place until a three-month period immediately after the vulnerability period.

Also built into the schedule is a two to three month deployment preparation period. This time focuses unit activities on specific deployment preparation activities.

The four-month (Band-A) or six-month (Bands -B through -E) vulnerability period is the period of time the forces aligned in a specific AEF block are susceptible to initial deployment. Figures 1–3, 1–4, and 1–5 will help you visualize the difference between the bands. Forces will not initially deploy outside of the vulnerability period except in cases of reach forward. Only one AEF block from each tempo band will be vulnerable at a time. Individuals and equipment must not participate in any activity that directly impacts their availability to deploy during their AEF vulnerability period unless specifically approved by the wing commander or their equivalent. Exercise estimated tour lengths (ETL) of 30 days or more are sourced from forces in their AEF vulnerability period.

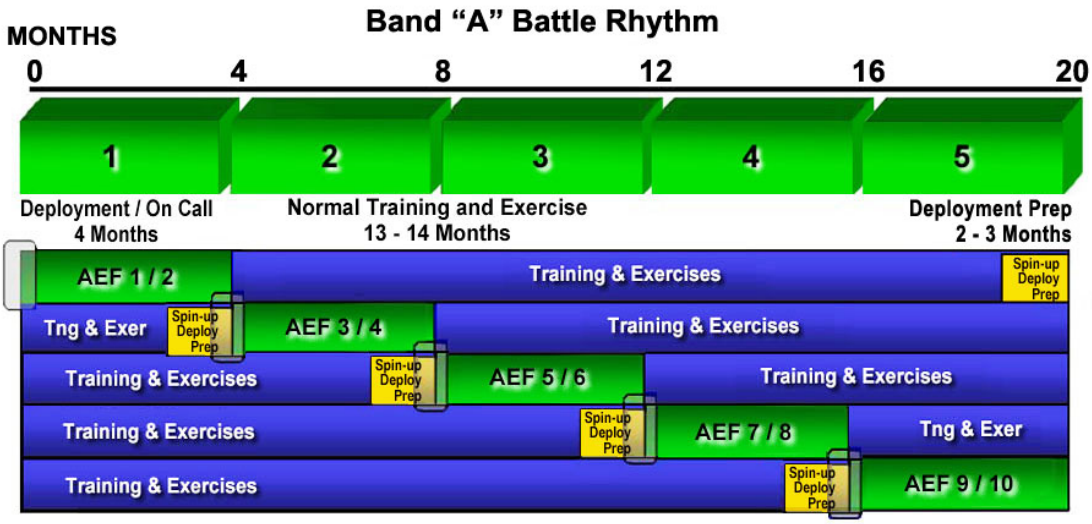


Figure 1–3. Tempo Band "A" Battle Rhythm.

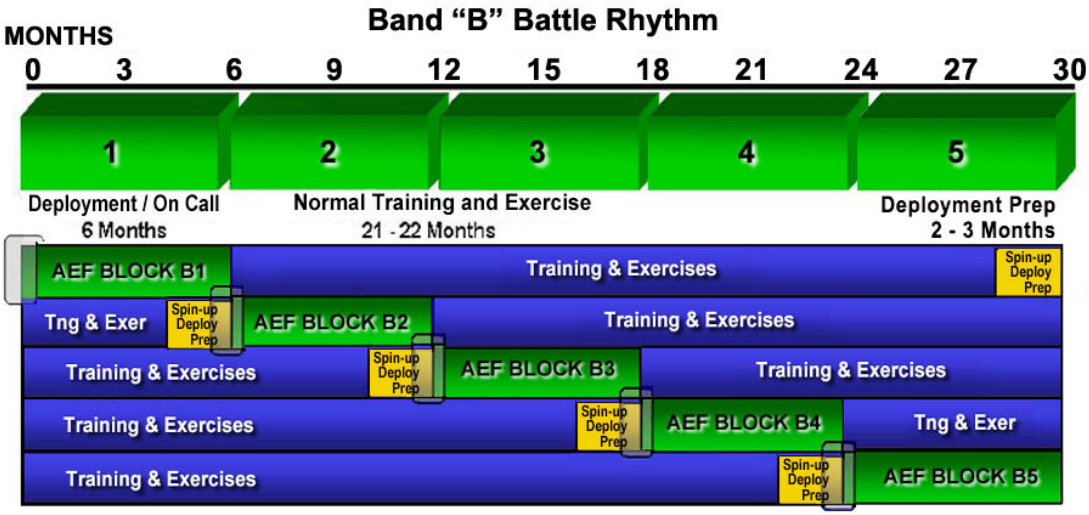


Figure 1–4. Tempo Band "B" Battle Rhythm.

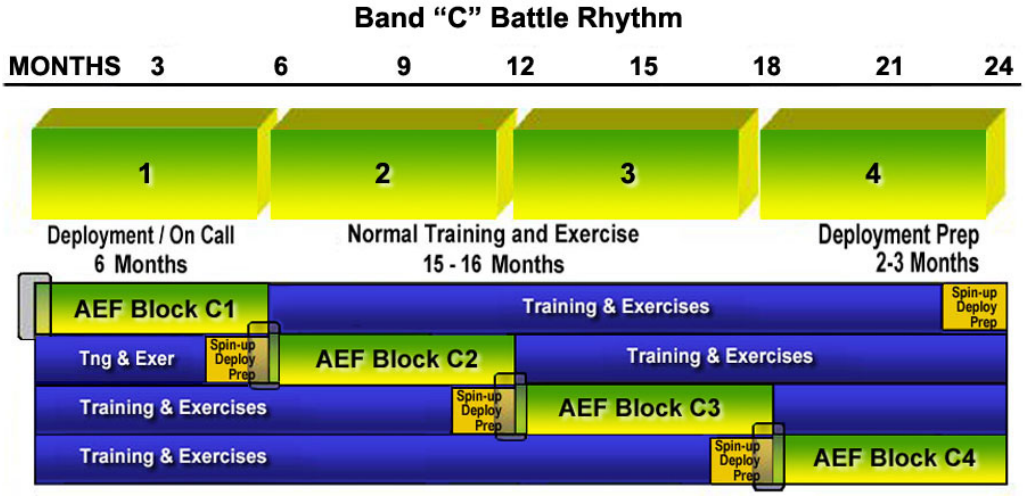


Figure 1–5. Tempo Band "C" Battle Rhythm.

Vulnerability period

At any given time, one AEF block from each tempo band is in the AEF vulnerability period. Available forces postured in these AEF blocks meet known rotational expeditionary requirements and home station requirements. Forces aligned to the AEFs in the vulnerability period and not tasked to deploy remain in an on-call status to reinforce forward-deployed forces or provide additional capability. If tasked, their deployment commitments may extend outside their vulnerability period. Additionally, all AEF forces, including those recently returned from deployment, are vulnerable for OPLAN tasking.

NOTE: Members are vulnerable to be tasked until the last day of their tempo band cycle.

Air and space expeditionary force composition

The AEF composition includes everything that is required to accomplish the team's deployed mission. This is available in all vulnerability periods. Those capabilities include aircraft-oriented and non-aircraft-oriented forces. A numbered expeditionary Air Force consists of multiple air expeditionary wings (AEW), with subordinate air expeditionary groups (AEG), and air expeditionary squadrons (AES). An AEW structure is in accordance with the Air Force combat wing structure. It is capable of establishing and operating an expeditionary base as well as exercising command and control (C2) of subordinate units at geographically separated locations. Normally, only one AEW are at a single location. Subordinate units, regardless of size, will be organized as an AEG or AES. When an Air & Space Expeditionary Task Force (AETF) is comprised of AEGs at multiple operating locations, each AEG will normally be attached to the nearest AEW in the same AETF. An AEG does not normally possess the capability to establish and operate a base; therefore, AEGs are typically tenant units at a deployed location.

403. Deliberate and Crisis Action Planning and Execution Segments overview

Thinking about the AEF formation seems a little overwhelming, but you can see some order in it and there is still a lot of information on how the Air Force structure supports the DOD deployed mission. You are probably starting to wonder how all of this information condenses into a way where it is easy for decision makers to interpret and make effective choices. As you may have expected, there is a tool that makes this possible. Deliberate and Crisis Action Planning and Execution Segment (DCAPES) is the database the Air Force uses to manage forces.

DCAPES is the Air Force's war planning system. It provides the AF with the ability to perform operational planning and execution at an increased level of detail that complements joint planning. It supports the AF planning and execution community in deliberate planning, crisis planning, and crisis execution. DCAPES provides standard data files, formats, application programs, and management procedures that are Air Force unique and used primarily for force planning, sourcing equipment and personnel requirements, and medical planning. DCAPES incorporates and extends the capabilities with many other Air Force systems.

DCAPES is a planner's tool that supports all phases of operations planning and execution at the Headquarters Air Force (HAF), MAJCOM, component, and wing level. It provides data manipulation capability to Air Force planners to perform rapid OPLAN development, conduct feasibility and capability analyses, and support mobilization, deployment, sustainment, redeployment, demobilization, reconstitution, and personnel accounting of forces. Its objective is to enable improved and streamlined operations planning and execution processes. This includes associated policy and procedures, with organizational and technology improvements.

DCAPES provides real-time command, control, planning, and execution information for Air Force functional users in the four main Air Force disciplines: operations, logistics, manpower, and personnel.

404. Air and Space Expeditionary Force reporting tool

The AEF reporting tool (ART) allows units the ability to report UTC level readiness data. It provides one central location to archive reported data. It allows for immediate updates and access to the status

of UTCs for all levels of command. This information allows the Air Force to make informed decisions on the employment of forces for AEF operations.

Operationally, ART collects and collates unit-reported data to answer, in whole or in part, the following questions:

- Are UTCs able to accomplish their mission capability?
- Are UTCs able to accomplish their deployment tasking?
- Are adequate resources and training available in order to accomplish and sustain the AEF mission(s)?

When unit commanders present the readiness of each UTC in ART, they provide higher levels of command the necessary information to make force and resource allocation decisions to effectively support theater commanders. For this reason, integrity in reporting an accurate status is paramount. *ART is not a report card*, but identifies a UTC's ability to perform its MISCAP and identify shortages of resources. As you can see, this is an important database with a lot of important and essential information. With great power comes great responsibility.

Unit task code readiness assessments

You may ask yourself, what is a unit task code? You know what the definition is from the terms section, but what is this "identification (ID) code" for and what does it do? According to the DOD, a UTC is a JCS-developed assigned code, consisting of five characters that uniquely identify a type "unit" or force package. These "type units" can be made up of personnel, equipment, or personnel and equipment. Personnel UTCs may have any number or mix of Air Force specialty codes (AFSC) assigned that best fulfill that UTC's mission. To help determine what AFSCs make up a UTC, a listing specifically spells out what is needed. This listing is the Manpower Force Element Listing (MFEL). The MFEL is a standard manpower listing published to identify the manpower tasked to deploy in support of a specific UTC.

Reporting

Commanders rate each UTC against the unit's current ability to deploy and employ the UTC. Areas considered include personnel, training equipment or supply, and equipment condition. Personnel must be fully qualified without deployment limitations and have all required mission and skill level training. Equipment must be serviceable and available for deployment.

Commanders determine the readiness status based on the availability of mission required equipment and supplies. Items are available if they are assigned to the unit, physically present at the unit or have been deployed by the unit with an expectation of return.

Equipment

The equipment condition area is used to determine the combat essential and support equipment that can be made ready within the UTC's response time to undertake the mission. Units assess the condition of equipment based on whether the available UTC required equipment is in working order and mission ready.

Personnel

The training assessment area indicates the status of training needed to support the mission for which a UTC is designed as described in the UTC MISCAP. All personnel assigned to a UTC must have all required UTC and skill level training completed at the time of assessment. Individual training not required by the UTC (MISCAP or manpower detail), will not affect the UTC readiness assessment, but it will be captured for deployment readiness tracking.

Rating status

The three rating assessments are green, yellow, and red.

Green

All required deployment training for the UTC can be accomplished within 72 hours of notification or sooner if subject to more stringent criteria.

Yellow

The UTC has a missing requirement, but that missing or deficient capability does not prevent the UTC from tasking and accomplishing its mission in a contingency and/or AEF rotation. A detailed description is required in the remarks section. The description should include the condition, the corrective action and a projected get-well date.

Red

The UTC has a missing or deficient capability that prevents the entire UTC from being tasked and accomplishing its mission in a contingency and/or AEF rotation. Provide detailed explanation of the shortfall in remarks. Describe the shortfall, the corrective action, and provide a get-well date.

Remarks

Remarks are required if a unit is less than fully capable in any reportable area and are mandatory for the UTCs assessed in yellow and red. This is used to identify trends and to redirect resources if necessary. Commanders use the remarks and associated get-well-dates (GWD) to explain and amplify data contained in ART reports.

When to update

There are three times that a commander needs to update ART: (1) monthly, (2) onset of significant changes, or (3) when one of the UTCs is tasked to deploy.

Once a month

All units submit and update UTC assessments at least every 31-calendar days. The Air Force goal for on-time reporting is 97 percent.

Significant unit task code change

The unit commander submits an out-of-cycle report within 24 hours of the change. This includes notification of a UTC change or addition.

Unit task code tasked to deploy

Through ART, commanders submit an assessment of their ability to support the tasking, including theater-specific requirements, within five days of receipt of a deployment notification.

Data classification

ART is an online database that supports collections, collation and report generation of unit and UTC readiness data. ART contains real world deployment and personnel data. The information in ART has a derivative classification. This means it incorporates, paraphrases, restates, and/or generates in a new form, information that is already classified, and marking the newly developed material consistent with the classification markings that apply on the source information. ART resides on the Secret Internet Protocol Router Network (SIPRNET).

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

401. Objectives of Air Force planning, terminology, and acronyms

1. What concept is the Air Force mission configured to meet?

2. What by definition, can conduct military operations on short notice in response to crises with forces tailored to achieve limited and clearly stated objectives?

3. What is the principal forum for discussion on national security policy issues?

4. What is a continuous process that helps the commanders see what they have, where they need it to be, and then enables them to decide the most effective way to get there?

5. Of what is the ARC composed?

6. Match the terms in column B with definitions in column A. Items in column B may be used once, more than once, or not at all.

Column A	*Column B*
____ (1) The scheme or proposed method for accomplishing a mission or reaching an objective.	a. Assumption.
____ (2) The relocation of forces to a desired area of operation.	b. Contingency.
____ (3) A predetermined area in the MTF.	c. Planning.
____ (4) Supposing something without positive proof.	d. Deployment.
____ (5) An emergency involving military force.	e. DOC.
____ (6) A quality or capability of military force which permits movement from place to place while retaining the ability to fulfill the primary mission.	f. MCC.
____ (7) Consolidates a facility's peacetime and wartime capabilities and plans.	g. Mobility.
____ (8) The mission for which a measured unit has been equipped, organized, or designed.	h. Plan.
____ (9) The area where the MTF commander coordinates actions in support of the assigned mission.	i. Triage.
____ (10) Classifying or reclassifying the sick and injured according to urgency of treatment required.	j. MCRP.

402. Air and Space Expeditionary Force overview

1. Through what does the Air Force establish a predictable, standardized battle rhythm ensuring rotational forces are properly organized, trained, equipped, and ready to sustain capabilities while rabidly responding to emerging crises?

2. Match the terms in column B with definitions in column A. Items in column B may be used only once.

Column A	*Column B*
____ (1) Supports critical home station operations.	a. Enabler-force.
____ (2) Primary pool from which the Air Force fulfills requirements.	b. In-place support.
____ (3) Consists of those forces assigned to organizations responsible to carry Air Force level functions.	c. Intuitional force.
____ (4) Includes common user assets, such as global mobility forces, special recovery forces, space forces, and other uniquely categorized forces that provide support to the DOD.	d. Readily available force.

3. The AEF library contains blocks of time within how many *primary tempo bands* that represent 100 percent of the AF-postured capabilities?

4. What is the AEF life cycle schedule?

5. For most of the forces, how is the AEF battle rhythm spent?

6. What band has a four-month vulnerability period?

7. What band has a six-month vulnerability period?

8. What do Airmen do if they are not tasked to deploy?

9. What does a numbered expeditionary Air Force consist of?

403. Deliberate and Crisis Action Planning and Execution Segments overview

1. What provides the USAF with the ability to perform operational planning and execution at an increased level of detail that complements joint planning?

2. What AF discipline does DCAPES provide real-time command, control, planning, and execution information for Air Force functional users?

404. Aerospace and Space Expeditionary Force reporting tool

1. What does the AEF reporting tool allow units the ability to report?

2. According to the DOD, what is a unit task code?

3. What makes up unit task codes?

4. Who rates each UTC against the unit's current ability to deploy and employs the unit task codes?

5. In the ART report, what does the yellow rating mean?

6. What does derivative classification mean?

1–2. Medical Readiness Office Reports

As a Health Service manager (HSM), you may have the opportunity of working in a medical readiness office and this position comes with a lot of responsibility. One of those responsibilities is planning for base response to crisis or deployment response. Planning does not just happen at the Air Force level, it also happens at base level. Each installation is charged with discussing, planning and determining how the base should respond to incidents as one cohesive unit. This supports mission execution and ensures the safety of those on and around the installation.

Why does a base have to plan? Imagine if a unit is tasked to deploy and the supporting base did not plan or prepare their people. Airmen could easily be "lost in the system" and may not be ready to deploy on time. The same thought process can be applied to natural disasters. If there is an earthquake or tornado at your base, but the base did not prepare, what do you think would happen? There could be no electricity, running water, and people would be hurt without medical care available to them. However, with appropriate planning, we can accomplish the mission with little or no impact to the mission.

Just as DOD and the Air Force have systems to assist their planning, bases have systems and plans to support their preparation. Some of the systems and plans include Defense Readiness Reporting System (DRRS), SORTS, MRDSS Unit Level Tracking and Reporting Application (ULTRA) MCRP, Disease Containment Plan (DCP), Comprehensive Emergency Management Plan (CEMP), Installation Deployment Plan (IDP), and the In-Garrison Expeditionary Site Planning (IGESP).

405. Defense Readiness Reporting System

You just read about ART, which provides assessment on how a unit meets their deployment mission. Now you will read about how commanders assess the readiness of meeting their home station mission requirement. The DRRS is a capabilities-based reporting system that measures an organization's ability to execute mission essential tasks at the unit level. METs are the minimum required tasks required to be met in order to accomplish the unit specific mission. METs will vary from unit to unit.

The unit commander is responsible for assessing the "mission ready" status of their unit and its assigned UTCs and personnel. This is done through readiness practice or computer-based training (CBT). The commander's assessment is a combination of objective and subjective data.

Objective

DRRS establishes a capabilities-based real-time readiness reporting system for the DOD to measure the readiness of military units to meet missions and goals assigned by the Secretary of Defense (SECDEF).

As a capabilities-based system, DRRS indicates what tasks a unit can accomplish based upon the mission(s) for which a unit was organized or designed. DRRS provides this information on measured units at a specific point in time.

This information supports the following:

- Crisis planning.
- Deliberate planning.
- Management responsibilities to organize, train, and equip combat-ready forces.

DRRS data is used as part of the Global Force Management and Adaptive Planning and Execution processes. DRRS provides the CJCS and the Chief of Staff of the Air Force (CSAF) an assessment of unit information to achieve adequate and feasible military responses to crises. The AF uses DRRS information in assessing readiness, determining budgetary allocation and management action impacts on unit level readiness, answering congressional inquiries, analyzing readiness trends, and supporting readiness decisions.

Measured units

Measured units, or reporting units, are established units, stateside and overseas. At a minimum, AF units that report SORTS will assess a DRRS. The system measures the METs and the Mission Essential Task Listing (METL) capabilities. Standard measurement criteria are necessary to provide similarly trained units globally.

When units either exceed or fall below established capabilities, MAJCOMs can adjust the units METL with adding or subtracting METs. Since the MAJCOM has this authority, it is essential that the units provide accurate data, and not view this as a “report card” or evaluation tool. Effective management of unit resources requires accurate information at all levels.

Data classification

Just like ART, you will access DRRS through the SIPERNET and have a derivative classification. It incorporates, paraphrases, restates, and/or generates in a new form, information that is already classified, and marking the newly developed material consistent with the classification markings that apply on the source information. Assessment levels, mission assessment levels, and limiting factors are classified SECRET. The association of the unit with its OPLAN tasking has the same classification of the OPLAN. Classified material exceeding the classification of the DRRS database (SECRET) will not be entered into DRRS.

Worksheets/briefing materials reflecting measured unit data have the same classification level as the material from which it came from. Although sources used to compile a unit’s DRRS report may be unclassified, once compiled and associated with DRRS ratings, it becomes classified at the highest level associated with the data.

Unit users

Unit user (UU) role can view and edit information in SORTS. A UU has privileges to assess the specific tasks assigned by their office of primary responsibility. Their responsibilities include the following:

- UUs complete HAF-approved DRRS training within 90 days of appointment.
- Make MET assessments monthly, no later than the 15th of each month or within 24 hours of a change that affects the units MET readiness assessment.

406. Status of Resources and Training System Report

The SORTS is an internal management tool, used by the CJCS, unified commands, and combat support agencies. It is the single automated reporting system within the DOD functioning as the central registry of all operational units of the US Armed Forces. SORTS has a threefold purpose, it provides data critical to crisis planning, provides for deliberate or peacetime planning, and is used by the CSAF and subordinate commanders in assessing their effectiveness responsibilities to organize, train, and equip forces for combatant commands.

SORTS is not designed to be used as input for the performance appraisal of a unit or a unit commander. It indicates a unit's ability to undertake its full mission or particular missions. The DOC statement, received from the MAJCOM, defines the unit's mission. SORTS may also provide indications of the efficacy of resource allocation decisions and the impacts of budgetary constraints on resourcing unit requirements.

Designed operational capability statement

The purpose of an AF SORTS DOC statement is to summarize the unit's mission(s).Often combined with the DRRS Core METL, it and provides units with a convenient single document referencing all medical readiness data systems that determine the pool of resources and training to measure and report in SORTS.

The DOC statement, itself, is not a source document. It does not establish, organize, design, equip, or task a unit. The DOC statement is a centralization of references from several systems that do establish, organize, man/equip, or task a unit. Each measured unit is required to have a single, all-encompassing DOC statement.

The DOC statement not only addresses a single set of resources, it is limited to only resources authorized to that unit. No two medical units will report on the same resources. The forwarding operating agency's readiness office manages, coordinates, publishes and approves the SORTS DOC statements.

Category levels

Unit SORTS reports are reflected in Category-Levels known as C-levels. C-levels reflect the degree to which a unit's resources meet prescribed levels of personnel, equipment, and training. There are six different C-levels.

C–1

The unit possesses the required resources and is trained to undertake the full wartime mission for which it is organized or designed.

C–2

The unit possesses the required resources and is trained to undertake ***most*** of the wartime missions for which it is organized or designed.

C–3

The unit possesses the required resources and is trained to undertake ***many***, but not all, portions of the wartime missions for which it is organized or designed.

C–4

The unit requires additional resources or training to undertake its wartime missions.

C–5

The unit is undergoing a service-directed resource action and is not prepared, at this time, to undertake the mission.

Overall C-level

Only the commander, or officially designated representative, of the measured unit can assign an Overall C-level. Commanders may not modify calculated resource area category levels, but they can use judgment in the commander's assessment and to raise and lower the Overall C-level when appropriate.

Medical units are required to report their C-levels in the following three major areas:

1. Training—known as the T-level.
2. Equipment and supplies—known as the S-level.
3. Personnel—known as the P-level.

Data classification

Unauthorized disclosure of AF SORTS data could cause serious damage to the national security. Classification level, at a minimum, should be SECRET.

Frequency of reports

As with any report, there are requirements for reporting. This includes the following:

- Monthly, no later than (NLT) the 15th of each month.
- When there is a change in category-levels (C-levels).
- Within 24 hours of a change (changes in the overall C-level, overall reason code, measured area levels, measured area reason codes, GWD, etc.).

Finally, you should always verify the receiving unit accepted the report.

407. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application

MRDSS ULTRA is the official system of record for management of expeditionary medical personnel and resources for the AFMS. It is also the single source of readiness training data for medical personnel and UTC apportionment. Upon arrival at a new duty station, each member will visit the medical readiness (MR) office. The MR office in-processes each newly assigned member into MRDSS ULTRA.

Once all of the data is current in MRDSS ULTRA, you will have the ability to run reports that will allow you to give an accurate look at your unit's readiness status to your commanders. This allows them to make educated decisions on items such as deployment tasking, unit training events, and coordinating upcoming exercises. The data from MRDSS ULTRA is for reporting the capabilities of your unit in systems such as SORTS, ART, and DRRS. In addition, many of the statistics from these reports are reported in your medical readiness committee (MRC) meeting.

Access

Only authorized medical personnel and units may have access to MRDSS ULTRA. Other unit personnel such as education and training (E&T) and MCRP team chiefs may have access, but must contact the MRDSS ULTRA unit system administrator to obtain accounts.

NOTE: The MRDSS Help Desk does not establish user accounts without authorization from MAJCOM or higher headquarters.

Data currency

The MR office ensures the currency of MRDSS ULTRA data at all times, and updates it as events or changes occur. Updates include the following, at a minimum:

- Annotating training events.
- UTC assignments.
- MCRP team assignments.
- Deployment availability codes.
- Unit information such as contact information (phone numbers, e-mail addresses, etc.).

Data back up

Save back-up copies of MRDSS ULTRA data in the form of reports every 30 days, at a minimum.

The following table shows the suggested back-up reports:

Suggested Back-up Reports	
Reportable Statistics	**Each Report Applicable to the Unit**
Personnel	Unit Roster by Alpha
	AFSC Substitutions Report
	Appointed Positions
	Expired Deployment Availability (DAV) Codes
Readiness Skills Verification Program (RSVP)	RSVP Unit Summary
	RSVP Roster - Individual Summary
Training	MCRP Team Unit Personnel Training Detail by Team
	Medical Readiness Training Completion by Category
	Training Accomplished by Training Event

Medical resource letter

The medical resource letter (MRL), maintained within MRDSS, is the tool designed to manage AFMS readiness resources. Information provided in the MRL for a specific unit includes, but is not limited to the following:

- UTCs currently appointed to the unit.
- UTCs the unit is projected to gain or lose over the next five years.
- Whether assigned UTCs are manpower or equipment.
- AEF assignments (past, present and projected) for each UTC.
- UTC availability codes.
- Additional information for equipment UTCs.

408. Medical readiness office plans

While in the medical readiness office, you may come in contact and work with multiple plans. Each plan has an established office of primary responsibility (OPR) assigned to it. The OPR is responsible for coordinating input from supporting agencies (e.g., the medical unit). An Air Force instruction (AFI) governs each plan. The AFI outlines the intent of the plan, the contingencies in which the plan executes, and the required response procedures. In addition, the AFI dictates how often the MTF reviews and rewrites each plan. Some plans you may work on include the IDP, CEMP, DCP, IGESP, and the MCRP.

Installation Deployment Plan

The IDP outlines local deployment processes, procedures, planning, and execution guidance used to deploy whole units or a single Airman. It is different for each installation and its specific mission. This plan serves as a complete, single source document establishing standardized deployment procedures for units, personnel, and equipment in response to valid “taskings.” It must describe who, what, when, where, and how the base meets the deployment requirement.

In-garrison Expeditionary Site Planning

The objective of the IGESP is to identify resources and capabilities of an installation by functional area and is the focus of the expeditionary site survey process (ESSP). The ESSP identifies potential operational locations in support of the war fighter decision-making process.

In simple terms, the IGESP lists the resources and capabilities of the base. Strategic planners use this information to identify installations that could use support employment, reception and bed down, and sustainment of forces. Here’s an example of this scenario: planners need to support operations in

Country X; however, we do not have permanent resources in Country X. Planners use the IGESP to identify an installation nearest to Country X that can support the contingency. With the information collected in the IGESP, planners can determine where to place our forces.

Comprehensive Emergency Management Plan

CEMP is a base-level plan that aligns AF planning with the National Response Framework (NRF). The NRF provides the structure and mechanisms for coordinating federal support to the state and local governments.

The CEMP identifies procedures to prevent, protect against, respond to, recover from, and how to mitigate the effects of major accidents, natural disasters, attacks, and terrorist use of chemical, biological, radiological, nuclear and high- yield explosives (CBRNE). On some level, the same basic response actions may apply to multiple events; however, some contingencies require consideration of additional issues. The CEMP identifies these differences and describes unique actions tailored for specific events or contingencies that would negatively impact the base. Additionally, it includes functional area checklists required to implement response procedures and minimize operational capability impacts on Air Force units. Each installation develops a CEMP to address the physical threats and vulnerabilities unique to their base.

Disease Containment Plan

The DCP addresses roles and procedures for responding to a disease outbreak. This plan prepares Air Force units to respond to and mitigate biological events, whether naturally occurring or the result of an attack, while ensuring mission sustainment. It will describe local procedures used in the planning and tasking of units or personnel. It applies to the protection of military personnel, resources, to other individuals on the installation.

The DCP identifies the biological threats applicable to the installation, considering the enemy or terrorist use of biological agents, and describe the probable conditions for plan implementation. In addition, it outlines the equipment and supplies required for plan execution, sustainment, and if applicable, the sustainment of mission operations during disease outbreaks. Included in the DCP are disease specific annexes that identify specific requirements based on disease characteristics, such as contagiousness and infectivity.

Medical Contingency Response Plan

The MCRP is the medical unit commander’s plan, establishing procedures for the unit’s expeditionary missions identified in the DOC statement and emergency response missions identified in the CEMP.

The MCRP establishes procedures for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies; as well as provides medical policy and local procedures for the Base Support Plan (BSP). The MCRP consists of a basic plan and annexes. The basic plan provides general policy and the annexes provide information that is more specific. Medical personnel are required to review the basic part of the plan and all annexes that affect them. Key medical personnel must be familiar with the entire plan.

The body of the plan consists of the following:

- Basic plan.
- Supporting plans and agencies.
- References.
- Unit’s mission.
- Contributing organizations.
- Execution.
- Threat assessment.
- MCRP annexes.

Annex overview

Each annex specifically addresses all environments in which the team may be required to respond and operate, including accidents, natural disasters, terrorist incidents, and CBRNE capabilities.

The annexes will provide definitive information as to how, where, when, and who performs specific functions in support of the contingency (wartime or peacetime).

The annex of general instructions includes information applicable to all medical personnel regardless of team assignment. This annex discusses recall procedures, space allocation, and triage categories.

The triage officer examines all casualties and categories according to a color-coded system. Colored clothespins or other markers are placed on litters or on the patients clothing. Peacetime triage category identification methods are coordinated with the local emergency response agencies to prevent confusion during actual emergencies or joint civilian/military exercise. The following table provides categories and colors that are generally used for standardization.

Category Color Explanation of Injuries			
Category	**Color**	**Explanation of Injuries**	**Examples**
Minimal	Green	Minor injuries requiring some attention, but so slight that a physician may not be needed.	Minor abrasions, lacerations, mild anxiety states, simple fractures of small bones, superficial burns.
Immediate	Red	Injuries needing immediate medical or surgical attention to save a life. Immediate attention is imperative as long as the life threat can be quickly removed without great expenditure of time, personnel, or supplies.	Arterial bleeding, sucking chest wound.
Delayed	Yellow	Injuries are not life-threatening, so definitive treatment may not be required, although recovery may take longer. Usually require extensive surgery or extensive medical care, but immediate transportation to an MTF is not imperative.	Closed fractures of long bones and moderate lacerations with hemorrhage.
Expectant **NOTE:** Civilian agencies do not recognize EXPECANT as a peacetime triage category	Blue	Mortal injuries or injuries requiring inordinate medical treatment to the detriment or neglect of other patients.	Extensive head injury with brain involvement, or very extensive burns.

Annexes

The following are the *15 minimum annexes* in the MCRP:

- Annex A – Annex general instructions.
- Annex B – Medical treatment facility commander/medical control center.
- Annex C – Field response team.
- Annex D – Patient support and casualty management.
- Annex E – Triage team.
- Annex F – Laboratory team and laboratory biological defense team (LBDT).
- Annex G – Pharmacy team.
- Annex H – In-place patient decontamination team (IPPD).

- Annex I – Patient administration team.
- Annex J – Disaster mental health (DMH) team.
- Annex K – Public health.
- Annex L – Bioenvironmental engineering (BE) team.
- Annex M – Medical logistics team.
- Annex N – Manpower and security team.
- Annex O – Facility management team.

409. Medical readiness committee

You have already learned some of the reports maintained, but maintaining those, reports are only a portion of what the medical readiness office responsibility. One of the major functions of the readiness office is facilitating the medical readiness committee meeting. The medical readiness committee provides executive oversight for all medical readiness activities, to include the organizing, training, and equipping of all assigned personnel, and to ensure the unit is able to meet its assigned expeditionary and installation response missions. Meetings are held in-person, chaired by and minutes approved by the MTF commander.

In consultation with the unit commander, the medical readiness office (MRO) schedules the MRC meetings, develops the agenda and provides it to the members in advance. They also ensure the MCRP team chiefs and AFSC functional training managers, and others as appointed by commander, are prepared to provide data, briefings, or updates as requested. Finally, the MRO prepares the MRC meeting minutes following the meeting.

Chair/membership

As with most reoccurring meetings, there are individuals that are required to attend the meeting. AFI 41–106, *Medical Readiness Program Management*, sets the minimum required membership to attend each meeting. The following individuals must be accounted for via meeting minutes:

- Medical group commander (Chair).
- MRO, medical readiness noncomissionned officer or medical readiness model.
- Medical group executive committee (hospital administrator, squadron commanders and superintendents, etc.).
- Bioenvironmental engineer.
- Public health emergency officer.
- Public health officer.
- Medical logistics officer.
- Medical exercise evaluation team chief.
- Education and training officer.
- Other individuals designated by the committee chair. This could include RMO, unit deployment manager, AFSC functional training managers, etc.

Standard agenda and organization

The commander chairs the MRC and it meets at least every other month. The MRC chair can designate the meeting to be held more often and the duration will vary based on the needs of each unit. There are standard agenda items that the members must address in each meeting. The meetings will include approval of past minutes, discussion of any open items, new business items and standard agenda items. Standard agenda items are included in the following paragraphs.

Unit plans review

This is a status update of required plan reviews, including the MCRP, wing/base plans, and applicable emergency management and contingency memorandum of understanding/memorandum of agreements/memorandum and articles of association.

Medical readiness training update

The comprehensive training update should include training statistics briefed by designated points of contact (POC).

Medical contingency response plan team chief update

MCRP team chiefs brief on their team staffing and overall team training status to include make-up training. Team chiefs may provide updates on a rotating basis, as long as they all report at least once during the year.

Response capability

Response capability analysis is also briefed during the MRC meeting. The MRC evaluates the risks and recommendations, identifies appropriate OPRs, actions, and advises the MRO on response readiness information to be presented to installation level meetings that enable an integrated installation response capabilities assessment.

Unit task code team chief and family group leader update

The team chiefs and family group leaders, brief on team staffing and overall training status. Team chiefs and family group leaders may provide personnel and training updates on a rotating basis, as long as all team chiefs provide an update at least once during the year.

Exercise update

The medical exercise evaluation team (EET) chief presents all new post-incident/exercise summary and base exercise reports, to include exercise findings, discrepancies, deficiencies, and DRRS METs evaluated, to the MRC for review and discussion. The MRC tracks the corrective actions until they are tested (via subsequent exercise), re-evaluated, and closed.

Unit deployment manager update

The unit deployment manager (UDM) addresses UTC personnel assignments, highlighting any shortages, vacancies, and hard-to-fill positions. The UDM also briefs on MRL changes, changes to the status of deployed personnel and any upcoming deployments, if applicable.

Deployment after action report update

The deployed commander or team leader briefs on deployment after action report (AAR) contents. At this time, the MRC identifies any lessons learned appropriate for Air Force-Joint Lessons Learned Information System input and tracking.

Logistics update

Logistics personnel provide a review of the inventory schedule, deferred procurement program exercise results, and a status update on biological warfare/chemical warfare (BW/CW). For units with assigned WRM UTC assemblages, brief materiel status at every MRC meeting as long as percentages are less than 100 percent. Finally, they include critical item shortages, open items/lessons learned from the most recent inventory, get-well plan, and projected get-well dates.

Unit reports update

The MRO provides an overview of unit SORTS and ART status. Keep in mind that these discussions may be classified. Do not include classified material in the MRC agenda or minutes. Instead, include this statement, or a similar phrase, in the minutes: “Classified report provided and understood by members.”

Inspection results update

Include status of any open items from self-inspections and the most recent Health Service Inspection, Operational Readiness Inspection, staff assistance visits, etc.

Minutes

Like many other meetings, the MRC is required to maintain meeting minutes. It is the responsibility of the medical readiness office to ensure the MRC meeting minutes are clear, concise and complete. The readiness staff should maintain the current year plus two previous years for inspection and historical reference. Once the commander approves the minutes, they are submitted to MAJCOM Readiness Office (SGX) as required.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

405. Defense Readiness Reporting System

1. What is DRRS?

2. What type of information does the unit commander use to assess the unit “mission ready” status?

3. To whom does the DRRS provide an assessment of unit information to achieve adequate and feasible military response to crises?

4. What is a measured unit?

406. Status of Resources and Training System Report

1. What is the SORTS report?

2. What does the SORTS report indicate?

3. What is the purpose of the DOC statement?

4. How many category levels are there, and what are they?

5. What are the three major areas that medical units are required to report their C-levels?

6. How often should the SORTS report be completed and submitted?

407. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application

1. What is the single source of readiness training data for medical personnel and UTC appointment?

2. How often should you back up your data?

3. What suggested back up item(s) fall under Reportable Statistics?

4. What information is provided in the Medical Resource Letter?

408. Medical readiness office plans

1. What plan outlines local deployment processes, procedures, planning and execution guidance used to deploy whole units or a single Airman?

2. What is the objective of the IGESP?

3. What plan identifies procedures to prevent, protect against, respond to, recover from, and how to mitigate the effects of major accidents, natural disasters, attacks, and terrorist use of CBRNE?

4. What do the disease specific annexes in the disease containment plan identify?

5. What does the medical contingency response plan establish procedures for?

6. What does the body of the medical contingency response plan consist of?

7. What are the four TRIAGE categories?

8. What category do the civilian agencies *not* recognize as a peacetime triage category?

9. What are the minimum annexes covered in the MCRP?

409. Medical readiness committee

1. Who chairs the medical readiness committee and approves the minutes?

2. Name three individuals that must be accounted for in the medical readiness committee meeting minutes.

3. How often should the medical readiness committee meet?

4. What does the unit deployment manager brief during the meeting?

5. Who provides an overview of the SORTS and ART status?

6. How long should the MRO keep meeting minutes for inspection and historical purposes?

1–3. Deployment Functions

As you know, the medical readiness office is the focal point for deployment functions. So, how does a base spin up their planning machine for deployments that are levied upon it? Where is that function located and who is responsible for such a vast amount of execution responsibility? In this section, you will take a look at the base deployment functions and how it fulfills its obligations to ensure the base meets its deployment and execution operations requirements.

410. Installation and facility deployment function

When the deployment actually begins, all work centers and deploying units have to work together as a team to meet deployment timelines. The purpose of the installation deployment function, commonly referred to as the personnel deployment function (PDF), is to ensure command and control by pulling

units together to accomplish the mission and deploy the UTCs (fig. 1–6). The installation considers the “big picture” of *who*, *what*, *where*, and *when* of the tasked UTCs.

Figure 1–6. Deploying UTCs.

Installation deployment function

Each unit pre-identifies a personnel assembly area where deploying personnel are checked before reporting to the PDF for processing. During unit assembly, the unit verifies personnel eligibility, and then confirms baggage and documentation as ready to go. Force health supports the line by completing PHAs and providing unique immunization and disease prevention requirements identified by the base medical facility

From the time unit personnel arrive at the PDF for processing until they are physically turned over to the passenger terminal function, the PDF maintains responsibility for personnel accountability. The PDF processes all the personnel requirements contained in the DRMD. The functions of the PDF include the following:

- Advising commanders when their personnel are ineligible for deployment.
- Preparing new DD Forms 93, Record of Emergency Data; ID cards; and dog tags.
- Providing counseling for legal and spiritual concerns.

In most cases, the PDF processes Airmen by exception. Processing by exception means that with the exception of eligibility, orders, and immunizations, all other stations are as needed. If deploying personnel have no need to stop at particular stations, they by-pass them and go on to the passenger holding area. It is easier to keep on track with the schedule when not everyone has to stop at every station. After personnel are in-checked and their eligibility verified, the PDF orders section is notified of any shortages or personnel who are deemed ineligible for deployment.

Each facility must know what is required of them as part of the facility deployment processing function. As part of a medical unit, you will have many opportunities to be part of the deployment process. You may be called upon throughout your career to fill one of these highly visible roles. How you and others complete these taskings will likely determine just how successful a given deployment process could be for your wing. There are key individuals who ensure the medical portion of deployment processing is flawless.

Military treatment facility deployment function

When there is a requirement for your unit to be involved in deployment processing, there are certain procedures that your facility will execute to ensure that the process runs smoothly and correctly. Here is an example of actions taken when responding and preparing to process individuals for deployment:

- Notify the MTF/CC immediately upon receipt of the deployment order (DEPORD).
- The MTF/CC activates the MCC, if needed.
- The UDM attends the deployment order briefing. The group commander attends if necessary.
- Immediately following the deployment order briefing, the UDM briefs the MDG/CC, squadron commanders, and mobility personnel on (as necessary): personnel placed on alert status, leave restriction guidance, and recall of personnel.
- The UDM, squadron, and group commanders attend the concept briefing.
- The medical readiness staff reviews the mobility folders, conducts a location specific "bag drag," gives OPSEC briefing, and provides rules of engagement in the deployed location.
- The UDM briefs the MDG/CC, squadron commanders and mobility personnel on pertinent action items discussed during the concept briefing.

NOTE: These briefs include specific planning guidance and constraints on the conduct of operations, tasked UTCs and identified shortfall positions (positions that cannot be filled due to lack of assigned/trained/qualified personnel in a given AFSC), personnel with discrepancies in mobility folders/mobility bas as noted during the "bag drag" to the UTC team chiefs for corrective actions, and estimated duration of operation, classification and anticipated constraints on deployments, including factors that affect granting rights and facilities access.

- The MCC, if activated, will schedule MCC team members to ensure manning of the MCC for the duration of the contingency, activate the deployment recall roster when directed by the MTF commander, and prepare and transmit reports as required (AEF reporting tool, MRDSS, etc.). (**NOTE:** If the MCC is not activated, the medical readiness staff will accomplish the MCC tasks.)
- The Medical Readiness flight commander or noncommissioned officer-in-charge (NCOIC) will immediately notify the MAJCOM of any/all shortfalls.

411. Unit deployment manager responsibilities

You have already read a little bit about the unit deployment manager, and you will work closely with him or her if assigned to the medical readiness office. The UDM matches personnel to the UTC position and ensures the personnel are trained and equipped appropriately to accomplish the mission of their respective UTC team. The types of UTCs assigned to each facility depend on the capability to fulfill UTC assignment. The following lists the UDM duties.

- Primary liaison to the unit training manager (UTM), flight/squadron leadership, and wing training functions regarding deployment related issues.
- Applies Joint, Air Force, MAJCOM, or component command operational/exercise planning and execution policies, as required.
- Have working knowledge of Air Force planning policy and guidance.
- Performs UTC development duties, in order to perform UTC management and maintenance activities.
- Assigns and maintains functional UTCs (in coordination with their respective commanders) as postured by MAJCOM FAMs using available unit assets. UDMs also notify their respective installation/wing installation deployment offices (IDO) for remedial action(s) when UTCs cannot be supported due to changes in manpower or equipment.
- Conducts squadron deployment briefings that encompass readiness reporting and monitoring.

- Performs execution activities.
- Performs analysis activities and assist MAJCOM functional area managers (FAM) in conducting analysis to determine the wartime readiness of their functional area.
- Contacts deploying/redeploying personnel to inform them of DHA completion requirements.
- Maintains UDM continuity binder.

The items within the UDM continuity binder can be printed and kept in a binder, it may be electronic and kept on the computer, or it can be a combination of both printed and electronic. Whatever format the continuity binder is kept in, it should include the following items:

- Copies of appointment letters (i.e., UDM and unit cargo increment monitor).
- UDM training certificates.
- UDM meeting minutes.
- UTC MISCAPs, MANFORs and Logistics detail (LOGDETs) for UTA (unit type code availability)-postured UTCs.
- Unit manpower document (UMD)/unit manpower personnel roster (UMPR).
- IDP.
- UDM checklists.
- Installation/wing specific deployment operating instructions.
- Applicable inspection and self-assessment checklist (SAC) finding.
- Lessons learned.
- Training slides.
- Recall rosters.
- Signed/approved shortfalls and waivers.

412. Update training

One of the tasks you will have to complete while working in the MRO is updating the training dates for individuals. You have already learned that information put into all medical readiness systems is compiled and provided to higher headquarters to make decisions. This includes information you put into MRDSS ULTRA. For this reason, it is imperative that you ensure training dates are accurate. In order to update training, you need to know the appropriate steps to take.

Title bar

When you log into MRDSS ULTRA, you will see the home screen where you can select what you want to do. From the title bar select your unit from the drop down box; then click the TRAINING button in the header (fig. 1–7).

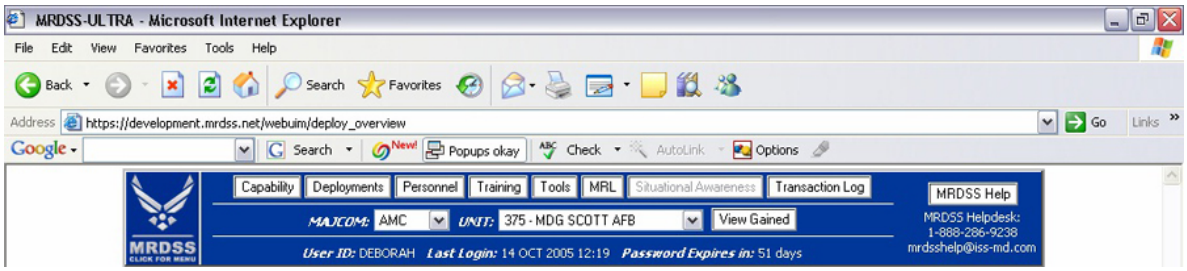


Figure 1–7. MRDSS ULTRA title bar.

Training overview page

The training overview page appears with unit statistics, unit graph, and buttons (fig. 1–8). The radio buttons enables you to navigate to sections of the application related to updating and tracking of training of unit personnel.

- Find Individual Training Record—Activates the *Find Individual Record* page.
- Update Training for Multiple Individuals—Activates the *Assign Training to Multiple Individuals* page.
- Record Training Course Attendance—Activates the *Training Courses* page.

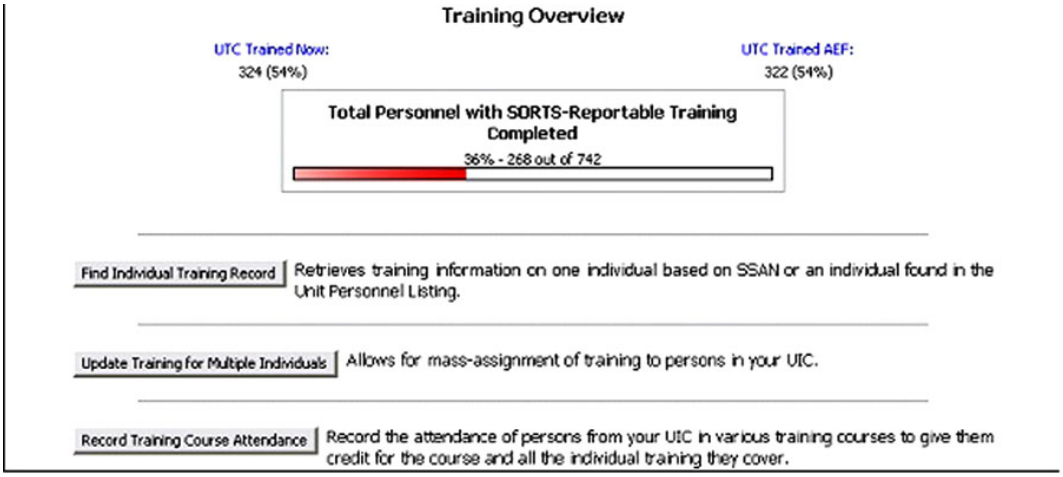


Figure 1–8. Training overview.

Search for individual

From the training page, selecting the 'Find Individual Record' screen enables the user to use different methods to locate an individual record, either via a filtered search or by the individual's Social Security Account Number (SSAN) (fig. 1–9). The page appears displaying the (activated) Unit Personnel Listing tab. Under the Unit Personnel Listing tab, select the Filter Type arrow. The Filter Type pick list allows you to choose many filters for sorting (all by Alpha, All by AFSC, All by Assigned UTC, etc.). In order to update training, select the first selection from the drop down box "All by Alpha."

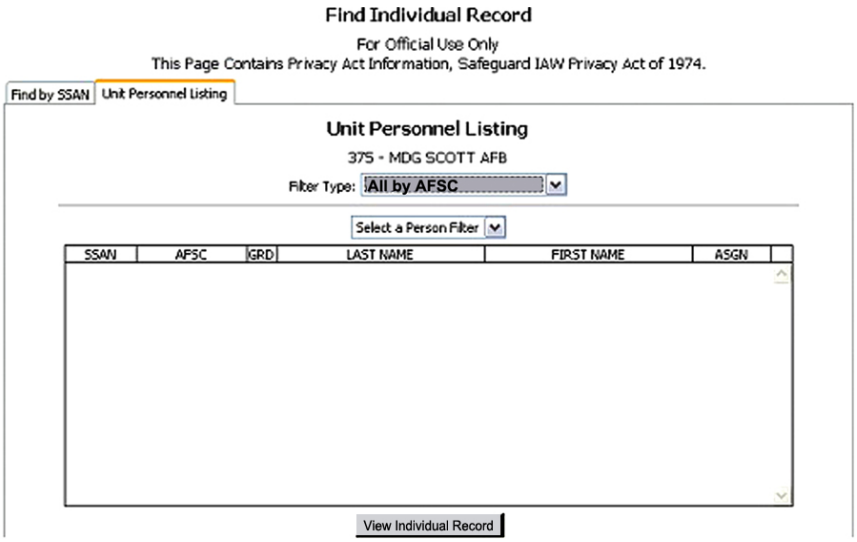


Figure 1–9. Search for individual.

When the refreshed listing comes up, scroll until you see the record you need to update (fig. 1–10). Click on the name to highlight the record, and then click on View Individual Record.

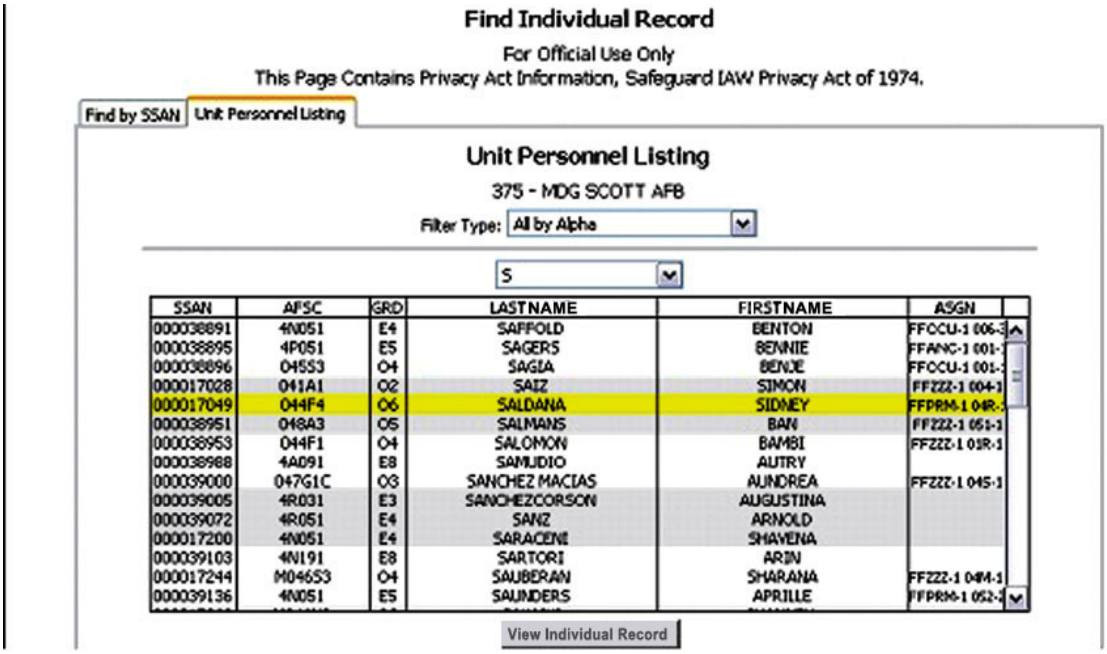


Figure 1–10. Find and select individual.

Once the screen refreshes, a list of training and dates training was completed will display as shown in figure 1–11. Update training elements as desired either by entering a date or by selecting a date via the calendar icon. The dates of training and due dates are updated according to the date selected. Make sure to select the save button on the bottom of the page. Once you do, the changes are saved to the database and the Training Requirements for page refreshes with the updated changes.

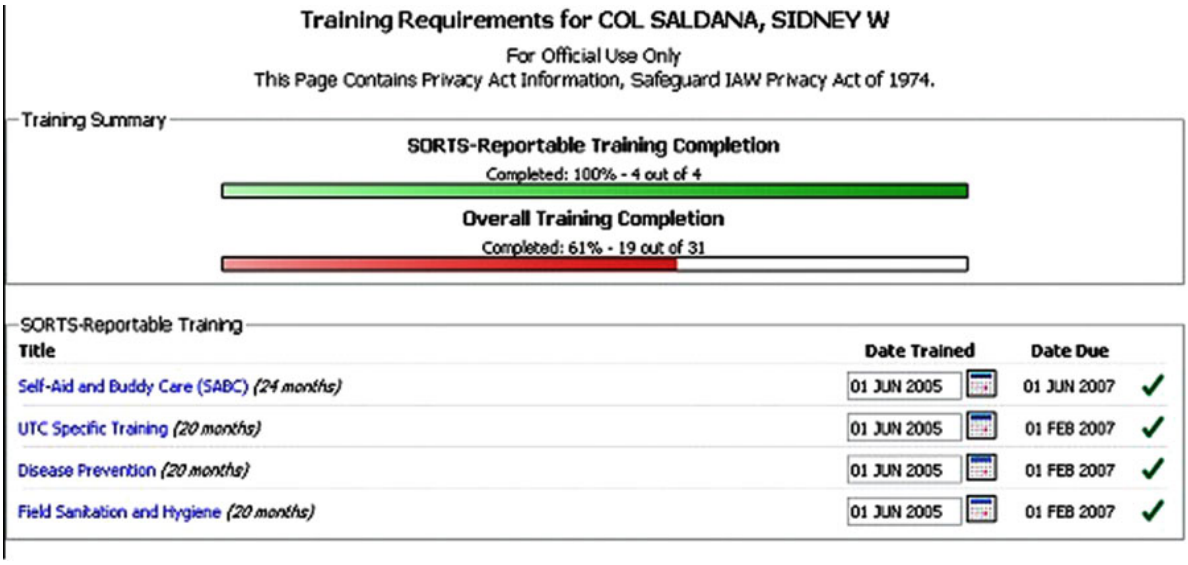


Figure 1–11. Update individual training dates.

NOTE: Training elements displayed will vary based on requirements generated by the AFSC, officer or enlisted, UTC, disaster team, and appointed positions to which an individual is assigned.

413. Maintain personnel readiness folders

To prepare Airmen for deployment, AFI 10–403, *Deployment Planning and Execution* directs the use of standardized readiness folders. These folders contain all required information for members to deploy. As a HSMs working in the medical readiness office, it is your responsibility to verify the information in the folder is appropriate and current as required by guidance. Folders are typically created when members in-process a base; however MAJCOM and local guidance describe how records are created, maintained and reviewed. The following table provides items required to be in the folder.

Personnel Readiness Folder	
Part	**Description**
1. Table of Contents	Deployment folder table of contents -This lists what is mandatory in the folder.
	Squadron commander letter of selection for a deployment position (one of the following letters within this table) includes the member's AEF and UTC position (figs. 1–12 and 1–13).
2. Readiness requirements	AF Form 4005, Individual Deployment Requirements Checklist.
	Individual expeditionary skills training (EST) documentation, Advanced Distributed Learning System (ADLS) transcript, or other HQ USAF approved training system documentation is recommended.
	Quantitative fit testing (QNFT). Documentation of annual QFNT instruction and retraining (as required).
	Deployed equipment custodian appointment letter and training documentation (if applicable).
	Weapons courier appointment letter and training documentation (if applicable)
	Ammunition courier appointment letter and training documentation (if applicable).
	Cargo increments monitor appointment letter and training documentation (if applicable).
	Classified courier appointment letter and training documentation (if applicable).
3. Deployment information	Identification (dog/ID) tags – these are not required to be stored by MR; however it is recommended that MR store them in a plastic bag to avoid loss and/or damage prior to deployment.
	AF Form 245, Employment Locator and Processing Checklist.
	Mobility Inventory Control and Accountability System (MICAS)-generated AF Form 1297 (upon receipt of mobility bags/weapons).
	DD Form 93.
	Fitness documentation.
	AF Form 94, Air Baggage Claim Check (four tags).
	AF Form 522, USAF Ground Weapons Training Data.
	DD Form 2760, Qualification to Possess Firearms or Ammunition (fig. 1–14).
4. Deployment checklists	Area of responsibility (AOR) specific or installation deployment out-processing checklist.
	Medical deployment out-processing checklist.
5. Major command/installation/ wing/unit requirements	This paperwork requirement is specific to the applicable level of authority and will be provided to you by the respective authority.
6. Air Forces command and control/combatant commander requirements	This paperwork requirement is specific to the deployment location and will be provided to you upon tasking notification.

DEPARTMENT OF THE AIR FORCE
AIR EDUCATION AND TRAINING COMMAND

Date: 2-Jul-15

MEMORANDUM FOR: SSgt Liz Heckman

FROM: 11 MDSS/SGSX

SUBJECT: Unit Type Code (UTC) Letter of Selection to a Deployment Position

1. This letter is to advise you that you have been selected to fill a UTC deployment position.

2. Your Unit Type Code is: FFZZZ

3. Your AEF Indicator (AEFI) is: C1. All Airmen need to be ready to deploy throughout their entire vulnerability period, because their capabilities could be required any time during the vulnerability period.

4. Except in cases of reaching forward to support emerging requirements, individuals will deploy during their associated AEF vulnerability period. Changing an individual's AEFI (via MilPDS) will only be done under extenuating circumstances, and as outlined in AFI 10-401, *Air Force Operations Planning and Execution*.

5. All Airmen are required to maintain the highest state of readiness at all times. Contact your Unit Deployment Managers (UDM), who will assist you in your pre-deployment actions.

6. Your appointment to an AEF Tempo Band and Block requires you to complete all required Tier 2A Expeditionary Skills (ES) Proficiency Training as outlined in AFI 36-2201 attend mandatory briefings, participate in deployment exercises, and deploy if necessary. These are mandatory requirements.

7. Your AEF vulnerability period is for a minimum of 179 days, which does not account for any Combat Skills Training (CST), which may be required as a part of an actual deployment tasking notification.

8. Keep your UDMs informed of potential changes in duty status (i.e. approved retirement, separations, PCS or PCA). Additionally, if not medically, dentally, or legally cleared to deploy, notify your supervisor and UDMs immediately.

Figure 1–12. UTC appointment letter, page 1.

9. Brief dependents and Emergency Points of Contact (EPC) on your potential deployment status and ensure they will be secure in your absence. Keep your virtual Record of Emergency Data (vRED), a.k.a., DD Form 93, Record of Emergency Data, up to date at all times and establish a will, power-of-attorney, or special power of attorney (for financial purposes) and other items that could help preclude extreme family hardships. Single personnel with dependents and military personnel married to another military person must ensure they have an AF Form 357, Dependent Care Annual Certification, on file with their First Sergeants.

10. Ensure your name, address and phone numbers are current on recall rosters at all times.

11. Finally, this posturing does not align with AFPC 365-day TDY taskings. Those are managed by your AFPC functional counterparts based on short/long tours, assignments, etc. It is in your best interest to contact your AFPC representative to find out where your rack and stack in order to prepare for that type of deployment as well.

12. In cases where the commander deems it beneficial for mission accomplishment, Airmen may be allowed to voluntarily deploy outside their associated AEF deployment period as long as they understand they are still eligible to deploy during their AEF deployment period. Specific policy and guidance regarding volunteerism is outlined in AFI 10-401, *Air Force Operations Planning and Execution.*

13. Please direct questions to the Medical Readiness Office at (222) 333-5555 .

MICHELLE N. WEAVER, MSgt, USAF
Lead Unit Deployment Manager

1st Ind to Letter of Selection to a Deployment Position: Tempo Band: ____

MEMORANDUM FOR 11 MDG/SGSX

I understand and acknowledge receipt of above guidance.

Supervisor's Printed Name	Individual's Printed Name
Supervisor's Signature/Date	Individual's Signature/Date

Figure 1–13. UTC appointment letter, page 2.

QUALIFICATION TO POSSESS FIREARMS OR AMMUNITION

PRIVACY ACT STATEMENT

AUTHORITY: 18 U.S.C. 922(g)(9); E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain information to determine if you have been convicted of a crime of domestic violence which would disqualify you from shipping, transporting, possessing or receiving either Government-issued or private firearms or ammunition and to determine if reassignment, reclassification, detail or other administrative action is warranted. Your Social Security Number is solicited solely for purposes of verifying your identity.

ROUTINE USE(S): To the Department of Justice so that such information can be included in the National Instant Criminal Background Check System which may be used by firearm licensees (importers, manufacturers or dealers) to determine whether individuals are qualified to receive or possess firearms and ammunition.

DISCLOSURE: Mandatory for all personnel who are required to certify. Failure to provide the information may result in (1) (military only) the imposition of criminal or administrative penalties for failing to obey a lawful order, and (2) (civilian only) the imposition of administrative penalties, to include removal from Federal service. However, neither your answers nor information or evidence gained by reason of your answers can be used against you in any criminal prosecution for a violation of Title 18, United States Code, Section 922(g)(9), including (military only) prosecutions under the Uniform Code of Military Justice, based on a violation of Section 922(g)(9), for conduct which occurred prior to the completion of this form. The answers you furnish and any information resulting therefrom, however, may be used against you in a criminal or administrative proceedings if you knowingly and willfully provide false statements or information.

SECTION I - INSTRUCTIONS

An amendment to the Gun Control Act of 1968 (18 U.S.C. 922) makes it a felony for anyone who has been convicted of a misdemeanor crime of domestic violence to ship, transport, possess, or receive firearms or ammunition. It is also a felony for any person to sell or otherwise dispose of a firearm to any person so convicted.

The Department of Defense has, by policy, expanded the prohibitions contained in Title 18 Section 922(g)(9) to those military or civilian personnel who have felony convictions for crimes of domestic violence. Convictions of crimes of domestic violence do not include summary court-martial convictions, the imposition of nonjudicial punishment (Article 15, UCMJ), or deferred prosecutions (or similar alternative dispositions) in civilian courts. Furthermore, a person shall not be considered as having committed a "crime of domestic violence" for purposes of the firearms restriction of the Gun Control Act unless all of the following elements are present:

(1) the person was convicted of a crime;

(2) the offense has as its factual basis the use or attempted use of physical force, or threatened use of a deadly weapon;

(3) the convicted offender was at the time of the offense:
- (a) a current or former spouse, parent or guardian of the victim,
- (b) a person with whom the victim shared a child in common,
- (c) a person who was cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or
- (d) a person who was similarly situated to a spouse, parent, or guardian of the victim;

(4) the convicted offender was represented by counsel, or knowingly and intelligently waived the right to counsel;

(5) if entitled to have the case tried by jury, the case was actually tried by jury or the person knowingly and intelligently waived the right to have the case tried by jury;

(6) the conviction has not been expunged or set aside, or the convicted offender has not been pardoned for the offense or had civil rights restored, unless the pardon, expungement, or restoration of civil rights provides that the person may not ship, transport, possess or receive firearms.

If you have ever received a domestic violence conviction: (1) you may not possess any firearm or ammunition; and (2) you must return any Government-issued firearm or ammunition to your commander or immediate supervisor; and (3) you must take steps to relinquish possession of any privately owned firearms or ammunition. Furthermore, any previously issued authorization to possess a firearm or ammunition is revoked.

If you have any questions, or you are uncertain if you have such a conviction, you may wish to contact a legal assistance attorney, if eligible, or a private attorney, at your own expense.

SECTION II - QUALIFICATION INQUIRY *(Complete and return to your commander or immediate supervisor within 10 days of receipt)*

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME OF DOMESTIC VIOLENCE AS DESCRIBED ABOVE: *(Initial and date)*

YES	NO JND	I DON'T KNOW *(Provide explanation on reverse)*

2. IF YOU ANSWERED "YES" TO THE FIRST QUESTION, PROVIDE THE FOLLOWING INFORMATION WITH RESPECT TO THE CONVICTION:

a. COURT/JURISDICTION	b. DOCKET/CASE NUMBER
c. STATUTE/CHARGE	d. DATE SENTENCED *(YYYYMMDD)*

3. CERTIFICATION. I hereby certify that, to the best of my information and belief, all of the information provided by me is true, correct, complete, and made in good faith. I understand that false or fraudulent information provided herein may be grounds for criminal and/or administrative proceedings, to include (if civilian) adverse action, up to and including removal, and (if military) disciplinary action under the Uniform Code of Military Justice. I further understand that I have a continuing obligation to inform my Commander or Supervisor should I be convicted of a crime of domestic violence in the future.

a. NAME *(Last, First, Middle Initial)*	b. RANK/GRADE	c. SOCIAL SECURITY NUMBER
DOE, JOHN N.	SRA/E-4	123-45-6789

d. ORGANIZATION	e. SIGNATURE	f. DATE SIGNED *(YYYYMMDD)*
81st MDSS/SGSX		20140613

DD FORM 2760, DEC 2002 PREVIOUS EDITION IS OBSOLETE. Reset Adobe Professional 7.0

Figure 1–14. DD Form 2760, Qualification to possess firearms or ammunition.

414. Procedures for medical readiness in- and out-processing

Another responsibility you will have while working in the MRO is in and out-processing individuals to within the medical readiness system.

In-processing checklists

In-processing requirements will vary depending on your MTF, installation and MAJCOM directions provided. Requirements vary by location; however, the steps may include the following items.

- Create personnel readiness folder (as required).
- Mark member as assigned to the UNIT.
- Document training in MRDSS.
- Assign the member to a UTC.
- Assign the member to a MCRP Team.
- Review training requirements in MRDSS, and notify member of training due.
- Have member review the MCRP.

Out-processing checklist

Out-processing a member typically does not require as many steps, but it is just as important. Just like in-processing, requirements vary on location. Some of the steps you may see on the out-processing checklist include:

- Remove member from MRDSS.
- Give the member their mobility folder so he or she can give it to their new readiness office.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

410. Installation and facility deployment function

1. What is the purpose of the installation deployment function?

2. What does processing by exception mean?

3. When required, who activates the MCC?

4. Who attends the concept briefing?

5. If the MCC is activated, what do they need to do?

411. Unit deployment manager responsibilities

1. Who matches personnel to the UTC position and ensures those personnel are trained and equipped appropriately to accomplish the mission of their respective UTC team?

2. Whom is the UDM primary liaison to?

3. Who does the UDM work with to conduct analysis to determine the wartime readiness of functional areas?

4. Where should the UDM appointment letter be maintained?

412. Update training

1. When updating training, you go to MRDSS ULTRA home screen and then what do you do next?

2. From the training page, what button do you want to select to update an individual record?

3. What training elements are displayed?

413. Maintain personnel readiness folders

1. What guidance directs the use of standardized readiness folders?

2. What part of the personnel readiness folder is the commander letter of selection for a deployment position filed?

3. Where should you file the Identification (Dog) Tags?

4. What three AF Forms should be filed in part three?

5. What paperwork is filed in Part 5 and Part 6?

414. Procedures for medical readiness in- and out-processing

1. What should you document in MRDSS when members are in-processing?

2. What document should the medical readiness office have the member review during in-processing?

3. What are two steps you may see on the out-processing checklist?

1–4. Medical Control Center

Picture it, you have been at your first base for the last few months, and now are finally getting in the swing of things. You completed the first three volumes of your career development course (CDC) for up-grade training and have recently moved from the patient administration team to the MCC. One day, you are working in your duty section, and you hear a page over the public address system, "Attention in the facility, all MCC team members please report to the MCC." You jump up and rush to the MCC, which is right next to your duty section. You walk in the MCC and are the first one there, so what do you do? What is expected of you now that you are a MCC team member, and what should you anticipate?

The MCC is the commander's communications conduit to individuals assigned to the organization. It directs, monitors, reports mitigation and preparedness activities, and maintains unit continuity for command and control.

When working in the MCC, it is critical that you understand the procedures within the MCC so you can effectively support not only the MCC, but the incident response as well. This section covers the responsibilities you need to be familiar with such as communication, maintaining an events log and status board, and mapping coordinates. These are key duties in supporting an effective MCC.

415. Medical control center mission and functions

The medical control center, also known as the UCC, is a predetermined area designed as a central point where the MTF commander and key personnel coordinate, control, and direct medical response actions during crises or contingencies. It serves as the nerve center for the MTF during all disaster operations. MCCs support the base by providing technical subject matter experts (SME) and support. MCCs vary depending on the resources, capabilities, and mission of a respective group or squadron on the installation. A typical MCC provides the following capabilities:

- Acts as a focal point within an organization to monitor unit resources and mission capability and coordinates activities during major accidents, natural disasters, and enemy attack response operations.
- Maintains unit checklists for response to major accidents, natural disasters, and enemy attacks, maps, communications equipment, alternate control centers, and recall rosters for assigned disaster response force (DRF) elements.
- Operates continuously during contingency response operations.
- Alerts, recalls, deploys, and supervises organizational DRF elements.
- Disseminates threat and emergency action information, incident cordon evacuation instructions, protective measures and other emergency information to all organizational elements.
- Evaluates and reports damage, casualties, and mission capability.
- Maintains a log of events to document incident/contingency support activities.

Medical control center mission

Medical control centers are the essential focal point within an organization during a major accident or natural disaster. Its primary focus is to relay information to and from unit personnel, provide expertise to the base emergency response, and leverage unit resources to respond to and mitigate the incident. MCCs are responsible for coordinating activities for incident response with the respective emergency support functions. They are also responsible for personnel accountability, emergency notification, accomplishing unit-level preparation and recovery actions, and providing additional required support. All responders report in accordance with procedures to receive mission assignments. To properly support the MCC and the base, you need to have a general idea of whom the MCC supports and interacts.

Functions within the medical control center

As with any duty section, many activities occur within the MCC. The following paragraphs cover some of these.

Recall

Because unit personnel must respond immediately during crises and contingencies, the MTF commander ensures an effective alert notification and recall system is established for the unit. The alert notification and recall system used throughout the Air Force is the pyramid alerting system. The following is how it works:

1. The base alerting system is activated.
2. The installation commander and key staff (group/unit commanders) are notified.
3. The key staff notifies three or four individuals in their units.
4. Each of these, in turn, notifies three or four individuals.
5. The notification spreads until all personnel are notified.

After a recall is initiated, the MCC team members monitor sign-in logs. The MCC team members place sign-in logs in designated areas. Use separate sign-in logs for each prescribed reporting period, known as H or hour. H is the time a Manning Status Report (MSR) is due to the base personnel readiness unit. Reports are made by telephone (when possible) on (1) the number of military personnel *assigned* to the unit, (2) the number of military personnel who are *not available for duty*, (3) the number of military personnel who are *currently available for duty*, and (4) the total *percentage of military personnel available* for duty. MCC team members must be careful not to divulge classified unit information when transferring the MSR through unsecure modes of communication. To aid reminding personnel to sign-in, the MCC will makes frequent announcements over the public address system (or other means) requesting all personnel arriving for duty report immediately to their designated sign-in area.

Finally, the MCC monitors the personnel status board. An MCC team member obtains the number of military personnel authorized and assigned from the medical resource management office and the number of personnel not available, due to leave, TDY, quarters, and so forth, from the commander's support staff (CSS). With this information and the numbers taken from the sign-in sheets, the MSR is accomplished.

Communication

As you have read, the primary focus of the MCC is communication. Members are required to maintain liaison with medical and other non-MTF agencies.

Understanding the different agencies or offices that MCC members interact with is crucial to effective communication within the MCC. A "request from the incident commander (IC)" is different from a "request from emergency responders." As a HSM, you should know who you are talking to, and appropriately notify others within the MCC. Some of the key members in the incident command structure (ICS) you will communicate with while in the MCC include the emergency operations

center (EOC), crisis action team (CAT), incident commander, first responders, contamination control teams, emergency responders, and emergency support functions.

Emergency operations center

The EOC is the C2 support element that coordinates information and resources to support the installation's actions before, during, and after an incident. The EOC has the capability to determine the nature of the incident, mitigate its effects, assess damage, and support recovery operations. The EOC director provides oversight for the installation commander to support and control emergency response to incidents. The EOC director can support multiple ICs simultaneously while providing senior officer level C2 for sustained response and recovery operations.

Crisis action team

The crisis action team is a C2 function activated to oversee the mission operation of the installation. Activation could happen for any reason such as an airplane incident, severe weather and so on. When activated for an incident, the CAT devotes full-time attention to how the crisis affects mission execution. The CAT develops courses of action and executes the commander's and higher head quarters' directives. The composition and function of the CAT is largely mission driven and therefore a MAJCOM or installation commander prerogative. The EOC provides the CAT continuous status updates, and requests support through the CAT when on-scene requirements surpass the installation's capabilities.

Incident commander

The IC has overall authority and responsibility for conducting all incident activities including development of strategies and tactics and distribution of resources at the incident site. The senior Fire and Emergency Services (FES) is incident commander for all incidents involving two or more response agencies. On scene, the IC maintains legal authority and tactical control.

First responders

First responders are members of the DRF elements that deploy immediately to the disaster scene to provide initial C2, save lives, and suppress and control hazards. This could include firefighters, law enforcement, security personnel, key emergency medical personnel, and explosive ordnance disposal (EOD). All first responders are emergency responders, but not all emergency responders are first responders. First responder duties have priority over other assigned duties.

Contamination control teams

Contamination control teams (CCT) are comprised of unit personnel that perform contamination control measures specific to an incident. CCTs include the logistics readiness squadron (LRS), maintenance, munitions, medical, and civil engineers. CCTs are required to perform decontamination on assets under the control of their functional area for both peacetime incidents and wartime operations. The IC decides whether contamination control teams are established. Emergency management personnel train CCTs, and each functional area develops a CCT checklist for decontaminating specific objects under their control.

Emergency responders

These individuals respond to the accident scene after the first responders to expand C2 and perform support functions. Emergency responders include follow-on elements such as firefighters, law enforcement personnel, security personnel, and emergency medical technicians, as well as emergency management personnel, EOD personnel, physicians, nurses, medical treatment providers at MTFs, public health officers, BE personnel, and mortuary affairs personnel. Not all emergency responders are first responders, but all first responders are emergency responders.

Emergency support functions

Emergency support functions (ESF) provide the structure for coordinating installation strategic interagency support during all phases of incident management. The ESF structure includes

mechanisms used to provide support to the installation. The type and scope of the event will determine the type, magnitude, and timing of the support provided by each of the 15 ESFs.

Communication devices

Of the various types of communications systems used in the MCC, the telephones, radios and Defense Connect Online (DCO) are the one most often used. Each of these is described in the following table.

Communication System Devices	
Communication Type	**Explanation**
Administrative	Administrative telephones are much the same as those in your office; use the dial portion of the telephone to complete the contact with the individual or office you are calling. In most MCCs, these telephones have the capability to access the off-base and Defense Switched Network (DSN) telephone systems.
Primary crash alarm circuit	The primary crash alarm circuit, also known as a primary crash phone, is a direct-line telephone net designed to save lives and prevent the destruction of property through rapid relay of emergency, disaster, and crash information to specific base agencies. The agencies on this circuit take specific actions to save lives and protect property. Usually, there are four principal agencies on the primary crash alarm circuit: the command post, the MTF emergency room, the crash station, and base operations. The command post is usually the first to learn of a problem, which requires an immediate response. Consequently, the command post operator is responsible for activating the primary crash alarm circuit (primary crash phone).
Secondary crash alarm circuit	The secondary circuit is very similar to the primary circuit except that it is activated by the base operations dispatcher and designed to alert support activities of emergencies. Some of the support activities that are included on the circuit are: base operations, fire department, MTF, weather station, disaster preparedness, base commander, command post, security forces, chaplain, and public affairs. Agencies included on the secondary crash net may vary from base to base. In addition, primary and secondary crash alarm circuit procedures may differ from those described, depending on the mission.
Defense Switched Network	The DSN system is, in simple terms, a long-distance telephone system. It provides direct dialing access to most military installations and DOD facilities around the world.
Radio operations	Radios rely on radio waves instead of telephone lines to communicate with field personnel or other control centers. Most control centers have ultra-high frequency (UHF) and very high frequency (VHF) radios. These systems can be categorized as either tactical or nontactical. Tactical UHF and VHF systems are most often used by commanders directly involved in controlling or coordinating air operations. These systems may also be used for short-range operations. Nontactical UHF and VHF radio systems are land mobile radios (LMR) (or intrabase radios) used to provide commanders access to local nontactical radio nets such as the commander's net, disaster control net, and security police net. The MCC must have ready access to the commander and disaster teams. The LMR, consisting of a base station and portable hand-held or vehicle mounted radios, allows MCC team members to maintain contact with personnel in the field.
Defense Connect Online	The DCO service is the designated enterprise tool for world-wide synchronous and asynchronous collaboration for both the Unclassified but Nonsecure Internet Protocol Router Network (NIPRNet) and SIPRNet. DCO is available to all DOD partners, allowing users to communicate and share information in a secure forum through the use of instant messaging, low-bandwidth text chat, and audio/video web conferencing.

416. Utilizing maps, events log, and status boards

In addition to recalls and communication, you also need to identify on a map where the incident is. One of the most important tasks you need to do within the MCC is to identify where, on a map, the incident is, and mark the safest route there. This is important because you will provide this information to your first and emergency responders. If you do not know how to plot the course, or verify the safe route, you could be putting your teammates in harm's way. Before we start to plot coordinates, you need to understand the different types of maps with which you may work.

Maps

As a MCC team member, you should know the different types of maps you could use. Different maps show different things, which could affect the way you not only plot coordinates, but also mark the safe route.

Type of maps

The three types of maps that you should be familiar with include the topographical maps, city maps, and highway maps.

Topographical map

A military map, also known as a topographical map, is a graphic representation of the earth's surface to include man-made features as well as natural features through the use of symbols, lines, colors, and forms. These maps are drawn to scale, such as 1-inch on a map, that has a 1:25,000 scale ratio, equals 25,000 inches on the ground.

City map

A city map is a topographic map usually drawn on the scale of 1:10,000 to 1:25,000. Densely-settled downtown areas will sometimes be partly drawn on a separate larger scale map. The purpose of a city map is to show the details of streets and street names, important buildings, and other elements of the urban landscape important to navigation. Most commercial city maps are available locally, but you can find a city map for almost every city by searching the Internet.

Highway maps

The purpose of a highway map is to display the mileage between towns and major landmarks. They also show the names and numbers of routes along with exit numbers on interstate routes. Each state distributes most highway maps; there are also nationwide maps known as atlases. Almost all of these maps are available online. You can also find them at most service stations, state highway departments, and automobile clubs. Most highway maps include a legend.

Map legend

A map legend identifies the symbols used to show how the map presents the terrain's natural and man-made features (fig. 1–15). These symbols are not the same on every map, so you should always check the legend to avoid making mistakes.

Topographic symbols

The topographic symbols on the map represent natural or man-made features. Figure 1–16 shows common topographical symbols used on military maps. Not all maps use the same topographical symbols, so always check the legend.

Military symbols

In addition to the topographic symbols used to represent the natural and man-made features of the earth, military maps also display military symbols. These features show the identity, size, location, or movement of personnel, military activities, and installations. These symbols are not normally printed on maps because the features and units they represent are constantly moving or changing; military security is also a consideration. Military symbols do appear in special maps and overlays. This information is available on a need-to-know basis.

Military map colors

To make the identification of features on the map simpler, mapmakers use specific symbols and colors to provide a more natural appearance and better contrast. Topographical symbols are normally exaggerated for clarity and printed in different colors to identify a class of features. Common colors used on a military map discussed are in the following table labeled "Military Map Colors."

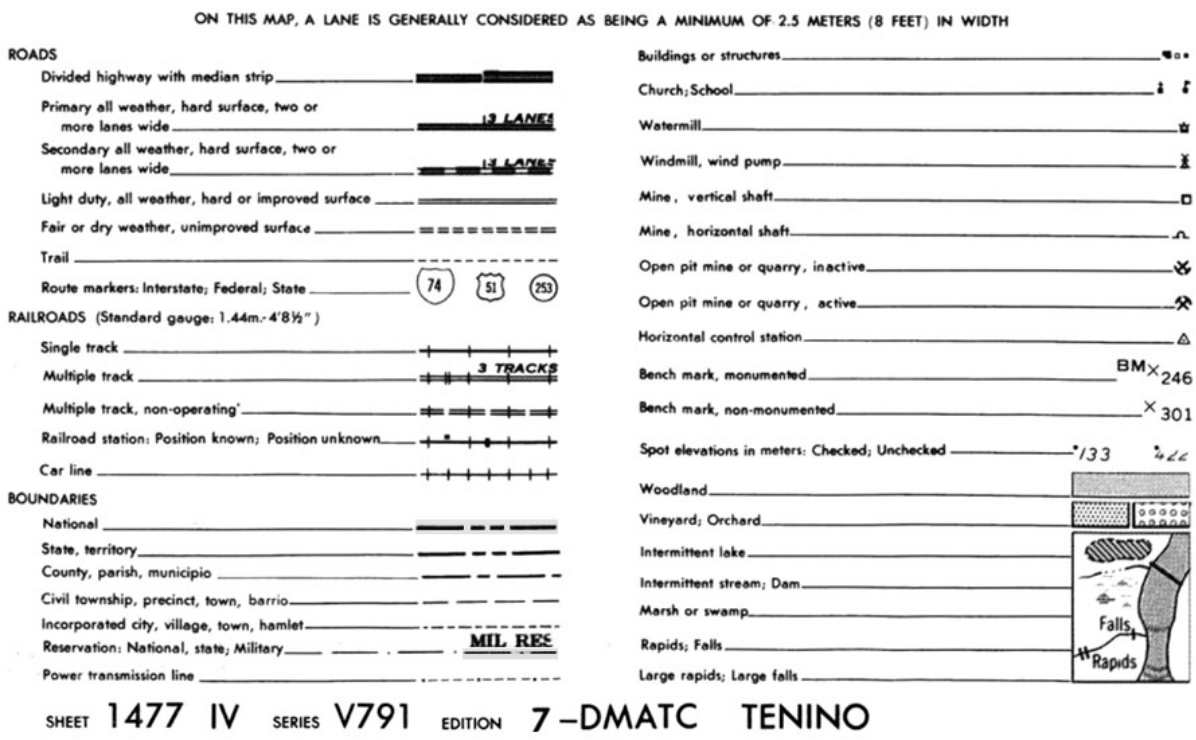


Figure 1–15. Map legend.

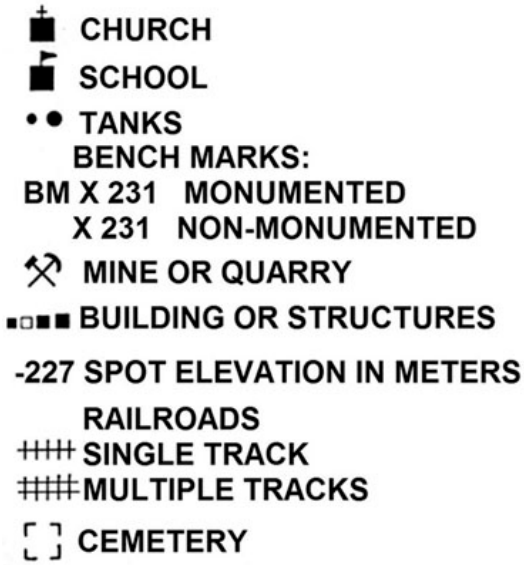


Figure 1–16. Topographic symbols.

Military Map Colors	
Color	**Meaning**
Black	Symbols in black represent cultural and man-made features. These symbols resemble the features they represent as viewed from above. The symbols are not standard on all maps; however, those used are explained in the marginal information.
Blue	Blue represents water, such as lakes or rivers. The actual shape of the diagram shows the shape of the water. Lakes, ponds, and pools are solid blue. Solid blue lines, typically with thin black lines as the banks, are symbols for rivers. The size of the river is proportional to the line's width.
Green	Green shows vegetation, such as forests and orchards. Green shadings show wooded areas. The darkness of the shading represents the density of the woods.
Brown	Brown illustrates the relief features, such as contours. A contour line shows the vertical elevation of the terrain on a map as seen from above. Each line forms a ring, not always circular, around a higher piece of ground. The distance between each line is defined as the contour interval located in the lower center map margin. Contour intervals are typically shown in meters above sea level; some older maps use foot measurements. The distance between each line, NOT the interval each line measures, indicates the slope of the land. If the contour lines are spread out, the terrain is gently sloping. If the contour lines on the opposite side of the same hill are so close, they appear as a single line, indicating a vertical cliff.
Red	Red is also used for main roads, built-up areas, and special features. The amount of red displayed tells you the state of the road. A paved, heavy-duty (improved) road is solid red; a paved, secondary medium-duty (improved) road is a dashed red. Red-pink shading shows built up areas of cities and towns. Red-pink shading also covers the areas containing buildings. When the red-pink shading deepens to purple, it shows the areas that have been built up since the original version of the map was printed.

Base grid map

Your base grid map should be displayed where it is accessible to all personnel who need to consult it. It must be as large as practical, allowing for greater detail. Use this map to show locations on the base.

Grid reference system

Maps provide a graphic representation depicting a portion of the earth's surface to include major man-made features as well as natural features using symbols, lines, colors, and forms. We use maps to find our location, move from one point to another, and locate destinations. In order to do these things we must have a method for determining exact locations on a map. This is plotting a position, and it requires a logical system of measurement.

Plotting base grid map coordinates

There is only one rule of thumb to remember when reading or reporting grid coordinates, always read left to right and then bottom to top.

The first half of the reported set of coordinate digits represents the left-to-right (easting) grid label, and the second half represents the label as read vertically, from the bottom to top (northing). The grid coordinates may represent the location to the nearest 10-, 100-, or 1,000-meter increment.

The map displays a network of straight parallel lines running bottom to top (vertical), then from left to right (horizontal). These are grids lines which form squares that are all the same size on a base map. Since each line has a letter or number, you can identify any position on a map with a grid on it. Every grid line on a map is identified by a number or letter printed just outside the border of the map. The vertical grid lines are numbered and increase sequentially to the right. The horizontal lines are lettered and increase alphabetically bottom to top.

Rough coordinates

An example of a rough grid coordinate is 7/D. To find a rough grid coordinate, remember, you read to the right and then up. Start at the bottom of the map in figure 1–14 and read to the right until you find the correct grid line, in this case 7. Once you find the corresponding grid line, follow it up to the point where the appropriate grid line letter, in this case D, intersects the grid line number. The area to the right of grid line 7 and the area above grid line D represent the grid square 7/D (fig. 1–17).

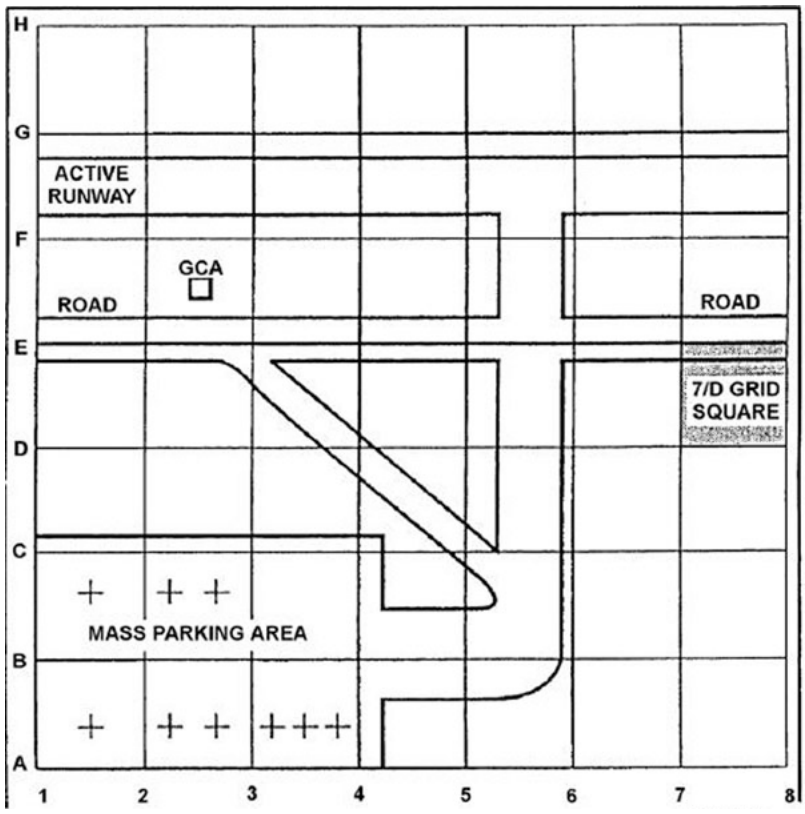


Figure 1–17. Grid coordinates.

Refined coordinates

Each grid square is subdivided into tenths (1/10) and identified by a numerical designation of 1 through 9. An example of a refined grid coordinate is 2.5/E.4. The 2 represents the vertical grid line and the 5 represents the subdivided area of that grid line. The E represents the horizontal grid line and the 4 represents the subdivided area of that grid line. To locate a refined grid coordinate, find the rough grid first, 2/E. Once you have found the rough grid, simply locate the subdivided section, .5/.4. The point where the two lines intersect is your refined grid coordinate. On the illustrated grid map (fig. 1–17), the refined coordinate 2.5/E.4 shows the GCA building.

Safe route

The *hot zone* is the area *where the actual incident occurred and contamination exists*. Individuals entering the hot zone must wear the prescribed levels of personal protective equipment (PPE) and be decontaminated before leaving the hot zone. Entry and exit checkpoints will be established at the outer boundary of the hot zone to regulate ingress and egress of personnel and equipment.

The *warm zone* is the *transitional area between the hot zone and the cold zone*. This zone contains the decontamination area and access control points through which personnel and equipment ingress and egress. Since this zone is less hazardous, personnel can wear lower levels of PPE.

The *cold zone* is the *outermost part of the site and is considered non-contaminated*. This is where the incident command post (ICP) and support equipment are located. Normal work clothes are acceptable in this area. The ICP is situated upwind and upstream of the hot zone and is easily accessible to highways or other transportation routes. These roads are safe from the contamination and used when the responders approach the entry control point. When you tell your response team where the ICP is, you need to make sure they know the safe roadways, or the safe route. The EOC provides the safe route; however, you should double check the route provided. Compare it to the hot spot and notify responding teams accordingly.

Events log

The events log is one of the most important documents kept in the MCC. All MCCs must maintain a log, which will serve as an official record of events affecting the facility. Event logs vary from MCC to MCC, and may be a handwritten or computer-generated form. The events log covers a 24-hour period. However, you may need more than one form to cover the entire period.

You are probably thinking, "What should I enter in the events log?" Enter anything that occurs during your tour of duty that is of importance now or could be at some time in the future (fig. 1–18). There will be times that require the MRO or medical readiness noncommissioned officer (MRNCO) to go back through the logs of the past several months to clarify a question. Remember to make log entries as soon as possible following the event and to include the time of occurrence. Prior to signing in on the events log, all MCC team members receive a thorough briefing from the previous shift's supervisor. The briefing covers all log entries and other items such as the location of key personnel, disaster teams, and emergency response vehicles. Give special emphasis to those entries requiring further actions. Entries in the log should include, but not be limited to the following:

- Personnel on duty.
- Summary of unusual events.
- Results of tests or exercises.
- Changes to unit posture/preparedness.
- Emergency conditions or equipment failure.
- Weapons control and transfer.

Status board

Status boards are displays, charts, slides, maps, or computer shows that present important unit information. The status of emergency response teams, incident location, and weather are only a few of the displays used to monitor emergency response operations.

The *weather section* gives you the information to be posted on the weather display; *emergency response teams* provide status and location of all emergency response personnel; *incident location* shows the coordinates of the incident and special notes that MCC personnel need to know.

Any time this information changes, you must update the displays and relay the new information to all interested parties. Every day, more displays are being computerized. Although the appearance may be slightly different, the purpose and use of these displays remains the same. One of the greatest advantages of using computer displays is that one agency can update these rather than each agency updating their own display. Computer-generated displays are preferred in lieu of manually updated displays.

EVENTS LOG

DATE (YYYYMMDD): 20150725 | PAGE 1 OF 1 PAGES

FACILITY: 91 MDG/MCC | REVIEWED BY:

NAME	INITIALS	TIME ON	TIME OFF	NAME	INITIALS	TIME ON	TIME OFF
SrA Harvey	CH	0001	0700				

TIME	CLASS	RECORD OF EVENTS
0001		Log opened SrA Harvey con duty
0030		Zulu change over complete
0608		Wx warning for lightening recieved. All notifications complete

AF FORM 4377, 20080404 REPLACES AFSPC IMT 1924, APR 94, WHICH IS OBSOLETE.

Figure 1–18. Events log.

417. Utilizing medical control center checklists

Some of the important documents you will use in a MCC are checklists. These documents are important because they ensure you complete essential steps during a chaotic time. They are like a roadmap, and if used properly, keep the MCC and medical group on track. Checklists outline actions in response to emergencies, abnormal or recurring circumstances, or implement force protection conditions (FPCON). They are brief and concise and lead team members through an orderly and prioritized sequence from initiation to completion.

The MCC chief ensures development, maintenance, and semi-annual review of the checklist; or immediately after making a procedural change to the checklist. There are many types of checklists, and the first step in completing a checklist is to evaluate the scenario and then choose the correct checklist. In order to choose the correct checklist, you need to know some facts about the checklists from which you can choose.

Types of checklists

There are many types of checklist used in the MCC, and contents will vary depending on mission requirements. Although content may differ, there are some checklists that a MCC must have such as activation, major accident response, and force protection condition.

Activation

Use this checklist when the MCC is stood up or activated. The MCC activates by notification of the base or hospital commander. Figure 1–19 is an example of an activation checklist.

ALL PURPOSE CHECKLIST — Page 1 of 2 Pages

TITLE/ SUBJECT/ACTIVITY/FUNCTIONAL AREA: Medical Control Center (MCC) Activation Checklist

OPR:

DATE: 2-2-15

NO.	ITEM (Assign a paragraph number to each item. Draw a horizontal line between each major paragraph)	YES	NO	N/A
1.	Scan MCC and immediate area for suspicious or unfamiliar objects or packages	✓		
2.	a. Are two MCC members present (radio operator and recorder/telephone operator)? ****If two members are not present continue to run the checklist but do not activate MCC until second arrives. ER maintains control until MCC has two members present****	✓		
3.	a. Has a Log of Events (LOE) been requested from Medical Readiness or ER? **Obtain a copy of the LOE from Medical Readiness or ER	✓		
	b. Has the MCC established a log of events?	✓		
4.	a. Turn on radios, monitor HOSP/Fire Net, and perform a radio check with ER.	✓		
	b. Test Telephones to ensure they are operational	✓		
5.	a. Remove/Review all required plans, reference material pertaining to situation	✓		
	b. Obtain classified OPLANS and STE keys from MCC safe if required by situation	✓		
	c. Activate Unit Level Unit Control Center (ULUC2) NIPR or SIPR as required by situation	✓		
6.	a. Notify ER (555-5555) when MCC has been activated and is taking command and control of the situation	✓		
	b. Notify EOC and CAT that the MCC is operational (555-5555)	✓		
7.	a. Obtain current weather (555-5555) i.e. wind speed and direction, temperature	✓		
	b. Obtain Vehicle Status from the Vehicle Control NCO/Officer (555-5555)	✓		
	c. Obtain Blood Status from the Laboratory (555-5555)	✓		
	d. Obtain Bed Status from Nurse Director 555-5555) or individual wards	✓		
	e. Obtain Bed Status/OR Availability from area hospitals	✓		
	f. (If major accident) Obtain current ambulance availability from AFD (555-5555) - Anchorage divert status located at www.muni.org – depts > fire dept - Current traffic information located at www.localconditions.com	✓		
	g. Obtain incident/disaster site grid coordinates ( ) plot coordinates on grid map	✓		
	h. Obtain Entry Control Point (ECP)/provide to responding medical asset	✓		
	i. Update information on Status Boards and in ULUC2	✓		
8.	a. Alert hospital personnel of current situation via public address system and/or email	✓		
	b. Alert Sections not on the PA system via telephone or runner 1) Bioenvironmental Engineering (555-5555) bldg # 604 2) VA 555-5555 123) Group Education and Training (555-5555) 4) WRM Warehouse (555-5555 5) Chaplain (555-5555) (Pager: 580-PAGE #0692) 6) HAWC (555-5555)	✓		

AF FORM 2519, NOV 91 (EF) PREVIOUS EDITION WILL BE USED.

Figure 1–19. Activation checklist example.

Disaster response

Disasters can create emergency conditions that vary widely in scope, urgency and degree of damage and destruction. Specific disasters will differ in scope and effects. Therefore, response, recovery and mitigation actions will vary. Disasters include earthquakes, extreme heat or cold, floods and flash floods, hurricanes or typhoons, landslides and mudflows, thunderstorms and lightning, tornadoes, cyclones, tsunamis, volcanoes, wild land fires, avalanches, winter storms, and natural outbreaks of disease.

Some of the checklists can cover multiple events as shown in figures 1–20, and 1–21, or they can be as specific as the earthquake response as shown in fig 1–22.

ALL PURPOSE CHECKLIST		Page 1 of 3 Pages		
TITLE/ SUBJECT/ACTIVITY/FUNCTIONAL AREA		OPR	DATE	
DISASTER RESPONSE AND RECOVERY				
NO.	ITEM (Assign a paragraph number to each item. Draw a horizontal line between each major paragraph)	YES	NO	N/A
	UNDER THE DAMAGE ASSESSMENT PHASE: If after duty hours, initiate a personnel recall/accountability per the 123 MDG Commander. Comm-out recall procedures: - Utilize local radio/TV stations			
	Ensure damage survey and assessment operations and report results to the EOC			
	If Facility Management determines facility is un-usable, refer to Annex P			
	Request/Prepare Reports. (MEDRED-C/SITREP, etc.)			
	Ensure damage assessment reports are completed per 123 WG guidance.			
	Respond to calls for casualty treatment (Ref: Annex A; General Instruction, Annex C; Patient Redistribution, Annex D; Casualty Management)			
	Contact all Disaster Team Chiefs and place teams on stand-by			
	Ensure ambulances are dispersed/secured, depending on the type and severity of the situation.			
	Assess damage of medical supplies and equipment, to include War Reserve Material (WRM) assets.			
	Contact the Chaplain			
	Ensure all available laptops, radios, cell phones, bricks are gathered			
	Monitor weather reports and follow the instructions of the local authorities. If you are advised to evacuate, do so promptly. If you are instructed to move to a certain location, go there; do not go anywhere else.			
	UNDER THE RECOVERY PHASE:			
	Contact medical response team. Contact the ER to accomplish ambulance checklist. Ensure route is safe.			
	Provide manpower for the Manpower Team, Facilities Management, Patient Administration, and any other team as needed.			
	Ensure the Facilities Management Team has coordinated with 123 CES and has the support necessary to accomplish recovery.			
	De-activate teams as contingency dictates.			
	After facility assessment is complete and deemed safe, clinics should prepare to treat patients and strive to achieve normal operations tempo as soon as possible.			
	Request report of personnel and or operational LIMFACS as soon as possible.			
	Ensure patient care activities are coordinated with TRICARE/Patient Administration personnel to ensure beneficiary needs are addressed as soon as possible.			
	De-activate teams as contingency dictates.			
	Facility Management will:			
	Work with 123 CES regarding the restoration and recovery of the 3 MDG main building and any other medical group buildings if damaged/destroyed. 3 CES will assist with the following:			
	- Assess and prevent additional damage to facilities.			
	- Isolate water, gas, electric, and fuel lines.			

Figure 1–20. Disaster response checklist example, page 1.

	- Coordinate all outages with the Fire Protection Flight.			
	- Clear roadways and debris for search/rescue operations.			
	Contain or divert dangerous spilled materials/fluids			
	MCC will monitor clean-up operations the following will apply:			
	Approximately 300,000 pieces of linen in inventory. Inventory is sufficient to needs of 350 patients per day. There is an inter-service agreement with Ft Richardson to launder linen during contingencies.			
	Contact WRM assets: (4-25 bed increments) sufficient linen/bed expansion.			
	Facility Management will:			
	Manage facility fuel and power supply.			
	Generators are supported by 75,000 gallons of diesel fuel. Base and local contract support refueling as only 50 percent of total capacity for 10-day period.			
	A 1,500-gallon liquid oxygen tank supports our facility. At full contingency operations, we would consume 100 gallons per day.			
	Determine from Medical Logistics if adequate levels of PPE are available for patients and staff (i.e. N95 masks due to volcanic ash fall out).			
	Medical Logistics is responsible for procurement and distribution of medical supplies/equipment. Verbal orders may be used when maintaining records of issues and reconstructing order and issue records, when time permits.			
	Coordinate with the 123 MDG/CC to consider the need to utilize WRM assets by erecting EMEDS or Air Transportable Clinic(s) to provide care and treatment to eligible beneficiaries following coordination with HQ PACAF.			
	Coordinate supplies and equipment as required for cleanup and recovery. Ensure availability of items such as masking tape, flashlights, batteries, rags, mops, buckets, and chemicals for toilets.			
	Monitor/coordinate Aeromedical Evacuation as required.			
	The 123 MDG will activate and operate an EBTC and a Blood Product Depot (BPD) upon direction from the USPACOM Joint Blood Program Office or ALCOM/SG. (See Annex U)..			
	For volcanic ash fall, determine supplies of N95 or similar masks for breathing protection as well as wear eye protection			
	Determine critical personnel from 673MDG or designate to be on duty in the MTF.			
	For Flooding Conditions:			
	KEY TELEPHONE NUMBERS AND CONTACTS FOR COORDINATING AND EXECUTING DISASTER RESPONSE:			
	123 MDG Medical Control Center: DSN 552-5555			
	123 CES Readiness Flight: DSN 552-5555			
	123 CES Fire Protection Flight: DSN 552-5555			
	123 MDG Medical Readiness Office: DSN 552-5555			
	123 MDG Emergency Department: DSN 552-5555			
	123 WG Emergency operations Center: DSN 552-5555			
	ALCOM/J07 Office: DSN 552-5555			
	Consider using public television/radio for staff announcements during comm. Outages.			

Figure 1–21. Disaster response checklist example, page 2.

ALL PURPOSE CHECKLIST	Page 1 of 1 Pages		
TITLE/ SUBJECT/ACTIVITY/FUNCTIONAL AREA Earthquake Checklist (Refer to YOUR BASE CEMP 10-2)	OPR	DATE	

NO.	ITEM (Assign a paragraph number to each item. Draw a horizontal line between each major paragraph)	YES	NO	N/A
	Purpose: To outline procedures for and effective response by the 123 MDG to protect resources, maintain operational capability (manage casualties) in the event of an earthquake.			
1.	Execution: The following actions may not always be required, but must be considered in the event of an earthquake and are not listed in order of response.			
2.	Tasks/Actions a. Notification phase (1) Activate MCC and maintain Log of Events, if required initiate MDG recall (2) Run the Disaster Checklist Tab 21 (3) Activate the following disaster teams: _____Logistics _____Facility Management _____Security _____Manpower _____Chief Nurse _____Chief Hospital Services _____Sq Commanders _____ Shelter Team _____ Bioenvironmental _____Chaplain/Casualty Assistance Office (4) Identify/inventory required supplies (food, fuel reserves, shovels, flashlights, plastic, emergency medical supplies, emergency vehicles, and treatment facilities) (5) Consider protection of personnel, equipment and facilities. (6) Consider limiting entry (7) Distribute earthquake information throughout MDG (8) Initiate MEDRED-C as required b. Sustained Emergency Phase (1) Nutritional Medicine salvage, protect, and distribute food as required (2) Implement sanitation control (3) Establish more definitive medical treatment (4) Initiate damage assessment/ monitor shelter activation and operations (5) Provide casualty updates to Chaplains/Casualty Assistance Office c. Recovery Phase (1) Establish on-going manpower team for necessary cleanup; per 123 CES/CC instruction (2) Manage clean-up supplies (3) On-going water sampling/health hazard and personal protection actions (4) Daily Sitreps (5) Establish log of expenditures provide information to resource management (6) Consider establishing an ATC, SPEAR			

Figure 1–22. Earthquake response checklist example.

ALL PURPOSE CHECKLIST	Page 1 of 1 Pages		
TITLE/ SUBJECT/ACTIVITY/FUNCTIONAL AREA FPCON CHECKLIST (MCC)	OPR	DATE	

NO.	ITEM (Assign a paragraph number to each item. Draw a horizontal line between each major paragraph)	YES	NO	N/A
	PURPOSE; If a FPCON is declared, either initially or as an update, the following items should be accomplished by the Medical Control Center:			
1.	RUN MCC ACTIVATION CHECKLIST AND MAINTAIN LOG OF EVENTS			
2.	Has notification of a FPCON declaration been received? (Has the BSD been reviewed for any medical group actions?) see appendix 3 to annex N to 123 MDG MCRP (attach. 1)			
3.	If yes, review appendix 3 to annex N to 123 MDG MCRP (attach. 1) and PACAF instruction 10-205 which is located in the top drawer of the safe then complete the following information:			
4.	The declared FPCON is (circle appropriate FPCON) Alpha / Bravo / Charlie / Delta			
5.	The time is _____			
6.	The reason for the FPCON declaration: _____ _____			
7.	Has the Security Team been notified? (reference the team chief recall roster)			
8.	Was an announcement made to clinic personnel concerning the FPCON status? If no, make overhead announcement using the paging system/555-5555 (use the messages listed in this checklist for the respective FPCON) and send a Medical Group ALL e-mail if unclassified.			
9.	Have outlying facilities been notified (See Activation Checklist)?			
10.	Has all information been posted to the log and status board?			
11.	Follow appropriate FPCON Checklist.			
12.	Call Medical Logistics (555-5555) to report to MCC for FPCON status.			
13.	Call Security Team Chief (Look at Team Chief Recall Roster) to report to MCC for FPCON status.			
14.	Call Safety Officer (555-5555) to report to MCC for FPCON status.			
15.	Call Facility Management (555-5555) to report to MCC for FPCON status.			

Figure 1–23. Force protection condition checklist example.

Force protection condition

Force protection condition, or FPCON, is a DOD-approved system standardizing the department's identification, recommended preventive actions and response to terrorists' threats against US personnel and families. This system is the principal means for a commander to apply an operation decision on how to protect against terrorism. There are five categories under force protection conditions and each category has its own requirements, and these requirements are referred to as measures (fig. 1–23).

Normal

Normal condition applies when a general global threat of possible terrorist activity exists and warrants a routine security posture. Some measures under this category include secure and randomly inspect buildings, rooms, and storage areas not in regular use, conduct random security checks of vehicles and persons entering facilities, and limit access points for vehicles and personnel commensurate with a reasonable flow of traffic.

Alpha

An alpha condition applies when there is an *increased general threat* of possible terrorist activity against personnel or facilities, the nature and extent of which are unpredictable, and circumstances do not justify full implementation of FPCON BRAVO measures. Some measures under this category include informing personnel and family members of the general situation at regular intervals, increase of random security checks of vehicles and persons entering installations or facilities, and review all higher FPCON measures.

Bravo

A bravo condition applies when an *increased or more predictable* threat of terrorist activity exists. Some measures under this category include, increase frequency of daily random antiterrorism measures (RAM), keep cars and objects away from buildings to reduce vulnerability to bomb attacks, and secure and periodically inspect all buildings, rooms, and storage areas not in regular use.

Charlie

Charlie condition applies when an *incident occurs* or intelligence indicates that some form of terrorist action or targeting against personnel or facilities is likely. Some measures under this category include conducting 100 percent identification checks of all personnel entering, recall additional required personnel, and limit access points in order to enforce entry control.

Delta

Delta condition applies in the *immediate area where a terrorist attack has occurred* or when intelligence shows terrorist action against a specific location or person is imminent. Some measures under this category include control facility access and implement positive identification of all personnel with no exceptions, make frequent checks of the exterior of buildings and of parking areas, and restrict all non-essential movement.

What is special with this checklist is that it can be modified to meet mission requirements. For example, the base can be in FPCON Alpha; however, only enact three or four of the measures.

Complete the checklist

Once you identify the appropriate checklist, start at the top of the list, and complete each item in order; in other words, from top to bottom. Some checklists require initials, date and time, while others checklist require other types of markings.

Markings

Use standard checklist markings to identify actions taken for each checklist step.

The following is a list of the markings and their meanings:

- (✓) Check mark—Action was accomplished.
- (O) Circle—Action was noted or initiated but not completed (opening a step prior to reading/acting on the step is **not** required).
- (N) Letter "N"—Does not apply.
- (P) Letter "P"—Item was previously accomplished.
- (S) Letter "S"—Item is to be simulated (only used during exercises).

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

415. Medical control center mission and functions

1. What is the medical control center?

2. What is the MCC primary focus?

3. Who ensures there is an effective alert notification and recall system for the unit?

4. Who are some of the incident command system members you will communicate with while working in the MCC?

5. Who has the capability to determine the nature of the incident, mitigate its effects, assess damages and support recovery operations?

6. When activated for an incident, what team devotes full-time attention to how the crisis affects mission execution?

7. What is the purpose of first responders?

8. Who is included in the CCTs?

9. What do the emergency responders carry out?

10. What do ESFs provide?

11. What are the most often used forms of communication?

12. What is the primary crash alarm circuit?

416. Utilizing maps, events log, and status boards

1. What are the types of maps you could work with in the MCC?

2. What is a topographical map?

3. What is the purpose of the city map?

4. What identifies the symbols used to show how the map presents the terrain's natural and man-made features?

5. What do military symbols show?

6. What map color shows vegetation, such as forests and orchards?

7. What is it called when you are determining an exact location on a map?

8. What is the first half of plotting that represents the label as read from left to right called?

9. What is the second half of plotting that represents the label as read from the bottom to top called?

10. What are grid lines?

11. 7/D is an example of what type of grid coordinate?

12. 2.5/E.4 is an example of what type of grid coordinate?

13. What is the hot zone?

14. What type of events should be put on the events log?

15. What is a status board?

417. Utilizing medical control center checklists

1. Who ensures checklists are developed, maintained, and reviewed?

2. What checklist(s) must a MCC have?

3. How many FPCON categories are there?

4. What are the FPCON checklist lines referred to?

5. What FPCON requires an increase of random security checks of vehicles and person entering the installations or facilities?

6. What are the measures included in FPCON Charlie?

7. In what order do you complete a checklist?

8. What does the ‘N’ marking on a checklist mean?

Answers to Self-Test Questions

401

1. Expeditionary Military Force.
2. The Air and Space Expeditionary Force.
3. The National Security Council System.
4. The Planning, Programming, Budgeting and Execution System.
5. All units, organizations, and members of the ANG of the United States and USAFR.
6. (1) h.
   (2) d.
   (3) f.
   (4) a.
   (5) b.
   (6) g.
   (7) j.
   (8) e.
   (9) f.
   (10) i.

402

1. Through the Air and Space Expeditionary Force.
2. (1) b.
   (2) d.
   (3) c.
   (4) a.
3. Five tempo bands.
4. Two, 12 month life cycles.
5. In normal training during which forces concentrate on unit missions and basic proficiency events.
6. Band “A”.
7. Band “B” through “E”.
8. They will remain in an on-call status to reinforce forward-deployed forces or provide additional capability.
9. Multiple AEWs, with subordinate AEGs, and AESs.

403

1. DCAPES.
2. Operations, logistics, manpower, and personnel.

404

1. UTC level readiness data.
2. A JCS developed assigned code, consisting of five characters that uniquely identify a type “unit” or force package.
3. Personnel, equipment or personnel and equipment.
4. Commanders.
5. The UTC has a missing requirement, but that missing or deficient capability does not prevent the UTC from being tasked and accomplishing its mission in a contingency and/or AEF rotation.
6. This means it incorporates, paraphrases, restates, and/or generates in a new form, information that is already classified, and marking the newly developed material consistent with the classification markings that apply on the source information.

405

1. A capabilities-based reporting system that measures an organization's ability to execute Mission Essential Tasks at the unit level.
2. A combination of objective and subjective data.
3. CJCS and the CSAF.
4. An established unit, stateside and overseas.

406

1. It is the single automated reporting system within the DOD functioning as the central registry of all operational units of the US Armed Forces.
2. The unit's ability to undertake its full mission or particular missions.
3. It summarizes the unit's mission.
4. Six; C–1, C–2, C–3, C–4, C–5, Overall C–level.
5. Training, equipment and supplies, and personnel.
6. Monthly, and NLT the 15th of each month; when there are changes to the category levels; within 24 hours of a change.

407

1. MRDSS-ULTRA.
2. Every 30 days at a minimum.
3. Each report applicable to the unit.
4. UTCs currently appointed to the unit, UTCs the unit is projected to gain or lose over the next five years, whether assigned UTCs are manpower or equipment, AEF assignments for each UTC, UTC availability codes and additional information for equipment UTCs.

408

1. The Installation Deployment Plan.
2. The IGESP identifies resources and capabilities of an installation by functional area, and is the focus of the ESSP.
3. The Comprehensive Emergency Management Plan.
4. Specific requirements based on disease characteristics, such as contagiousness and infectivity.
5. Wartime, humanitarian assistance, homeland security/defense, and disaster responsive contingencies.
6. Basic plan, supporting plans and agencies, references, unit's mission, contributing organizations, execution, threat assessment, and MCRP annexes.
7. Minimal, immediate, delayed and expectant.
8. Expectant.
9. Annex A – Annex General Instructions, Annex B—Medical treatment facility commander/medical control center, Annex C—Field response team, Annex D—Patient support and casualty management, Annex E – Triage team, Annex F – Laboratory team and laboratory biological defense team, Annex G – Pharmacy team, Annex H—Patient decontamination team, Annex I – Patient administration team, Annex J—Disaster mental health team, Annex K – Public health, Annex L—Bioenvironmental engineering team, Annex M—Medical logistics team, Annex N—Manpower and security team, Annex O—Facility management team.

409

1. The MTF commander.
2. Any of the following three: medical group commander (Chair), MRO, MRNCO or MRM, medical group executive committee (hospital administrator, squadron commanders and superintendents), bioenvironmental engineer, public health emergency officer, public health officer, medical logistics officer, medical exercise evaluation team chief, education and training officer, other individuals designated by the committee chair.
3. At least every other month.
4. UTC personnel assigned, highlights any shortages, vacancies, and hard to fill positions.
5. The medical readiness office.

6. Current year plus two previous years.

410

1. Ensure command and control by pulling units together to accomplish the mission and deploy the UTCs.
2. With the exception of eligibility, orders, and immunizations, all other stations are as needed.
3. The MTF commander.
4. The UDM, group commander, and squadron commanders.
5. Schedule MCC team members to ensure manning of the MCC for the duration of the contingency. Activate the deployment recall roster when directed by the MTF commander. Prepare and transmit reports as required (AEF reporting tool, MRDSS, etc.).

411

1. Unit deployment manager.
2. Unit training manager, flight and squadron leadership and wing training functions regarding deployment related issues.
3. MAJCOM FAMs.
4. In the UDM continuity binder.

412

1. Select the unit from the drop down box, then click the ‘Training’ button in the header.
2. Select the ‘Find Individual Training Record’ button.
3. They are based on requirements generated by the AFSC, officer or enlisted, UTC, Disaster Team, and appointed positions to which an individual is assigned.

413

1. AFI 10–403, Deployment Planning and Execution.
2. Part 1, Table of Contents.
3. Within a plastic bag in Part 3, Deployment information.
4. AF Form 245, Employment Locator and Processing Checklist; AF Form 94, Air Baggage Claim Check; and AF Form 522, USAF Ground Weapons Training Data.
5. In Part 5, the paperwork requirements are specific to the applicable level of authority and are provided by the respective authority. In Part 6, the paperwork requirements are specific to the deployment location.

414

1. Training.
2. The medical contingency response plan.
3. Remove the member from MRDSS and give the member their mobility folder to take to their new readiness office.

415

1. It is a predetermined area designed as a central point where the MTF commander and key personnel coordinate, control, and direct medical response actions during crises or contingencies.
2. To relay information to and from unit personnel, provide expertise to the base emergency response, and leverage unit resources to respond to and mitigate the incident.
3. The MTF commander.
4. The emergency operations center, crisis action team, incident commander, first responders, contamination control teams, emergency responders and emergency support functions.
5. The emergency operations center.
6. Crisis action team.
7. They provide initial C2 to save lives, and suppress and control hazards.
8. Logistics readiness squadron, maintenance, munitions, medical and civil engineers.
9. They expand C2 and perform support functions.

10. The structure for coordinating installation strategic interagency support during all phases of incident management.
11. Telephones, radios and DCO.
12. It is a direct-line telephone net designed to save lives and prevent the destruction of property through rapid relay of emergency, disaster, and crash information to specific base agencies.

416

1. Topographical map, city map and highway maps.
2. It is a graphic representation of the earth's surface to include man-made features as well as natural features through the use of symbols, lines, colors and forms.
3. To show the details of streets and street names, important building and other elements of urban landscape important to navigation.
4. The map legend.
5. The identity, size, location or movement of personnel, military activities and installations.
6. Green.
7. Plotting a position.
8. Easting.
9. Northing.
10. A network of straight parallel lines running bottom to top (vertical), then from left to right (horizontal).
11. Rough grid coordinate.
12. Refined grid coordinate.
13. The area where the actual incident occurred and contamination exists.
14. Enter anything that occurs during your tour of duty that is of importance now or could be at some time in the future.
15. Status boards are displays, charts, slides, maps or computer shows that present important unit information.

417

1. The MCC Chief.
2. Activation, major accident response and force protection condition.
3. Five.
4. Measures.
5. Alpha.
6. Conduct 100 percent identification checks of all personnel entering, recall additional required personnel, and limit access points in order to enforce entry control.
7. Start at the top of the checklist, and complete each item in order.
8. Does not apply.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field Scoring Answer Sheet.

Do not return your answer sheet to Air Force Career Development Academy (AFCDA).

1. (401) The four major interrelated systems affecting the development of joint operational plans include the National Security Council System;
   a. Communication, Command, and Control System; Planning, Programming, Budgeting and Execution System; and Joint Operations Planning and Execution System.
   b. Joint Strategic Planning System, Planning, Programming, Budgeting and Execution System, and Joint Operations Planning and Execution System.
   c. Communication, Command, and Control System; Joint Strategic Planning System, Planning, Programming; and Budgeting and Execution System.
   d. Joint Strategic Planning System, Communication, Command, and Control System, and Joint Operations Planning and Execution System.

2. (401) What is an on-going process that enables senior leadership to evaluate other ways to achieve the best mix of force, requirements, and support within fiscal constraints?
   a. Joint Strategic Planning System.
   b. National Security Council System.
   c. Joint Operations Planning and Execution System.
   d. Planning, Programming and Budgeting Execution (PPBE) System.

3. (401) What is the tactical use of aircraft or forces in a desired area of operation, and is the actual use of forces within a combat zone or an objective area?
   a. Deployment.
   b. Employment.
   c. Force package.
   d. Mission essential task.

4. (401) What is the command authority that may be exercised by commanders at any echelon at or below the level of combatant command?
   a. Plan.
   b. Mobility.
   c. Tactical control.
   d. Operational control.

5. (402) In order to effectively support the Air and Space Expeditionary Force (AEF), when do functional areas revalidate the tempo band alignment of their respective capability areas and realign forces, if necessary?
   a. Quarterly.
   b. Every other AEF cycle.
   c. In the middle of each AEF cycle.
   d. Prior to the beginning of every AEF cycle.

6. (402) What is the timeframe of the Air and Space Expeditionary Force (AEF) life cycle?
   a. 6 months.
   b. 12 months.
   c. 24 months.
   d. 36 months.

7. (403) What is the Air Force's war planning system?
   a. DCAPES.
   b. MRDSS.
   c. DRRS.
   d. ART.

8. (403) What system's objective is to enable improved and streamlined operations planning and execution process?
   a. ART.
   b. DRRS.
   c. MRDSS.
   d. DCAPES.

9. (404) According to the Department of Defense (DOD), a unit task code is developed and assigned by the
   a. Chief of Staff of the Air Force.
   b. Joint Chiefs of Staff.
   c. wing commander.
   d. major command.

10. (404) What is a standard manpower listing published to identify the manpower tasked to deploy in support of specific unit task codes (UTC)?
   a. Manpower Force Element Listing (MFEL).
   b. Unit Personnel Management Roster.
   c. Manpower Deployment Roster.
   d. Unit Manpower Listing.

11. (404) What is the three tier rating system in the Air and Space Expedition Force reporting tool (ART)?
   a. One, two, three.
   b. Red, yellow, green.
   c. On target, satisfactory, delinquent.
   d. Met objective, close to objective, fail objective.

12. (404) Which of the following is *not* a minimum requirement to update the Air and Space Expedition Force reporting tool (ART)?
   a. Unit task code (UTC) tasked to deploy.
   b. Significant UTC change.
   c. Once a month.
   d. Daily.

13. (405) Who is responsible for assessing the "mission ready" status of their unit, assigned unit type codes (UTC), and assigned personnel?
   a. Unit deployment manager.
   b. Medical readiness manager.
   c. Unit commander.
   d. Base commander.

14. (405) Who assigns the unit's missions and goals in the Defense Readiness Reporting System (DRRS)?
   a. Major command commander (MAJCOM/CC).
   b. Secretary of the Air Force (SAF).
   c. Secretary of Defense (SECDEF).
   d. Wing commander (Wing/CC).

15. (406) What is an internal management tool used by the Chairman of the Joint Chiefs of Staff, Unified Commands, and Combat Support Agencies?
    a. Military Personnel Data System (MilPDS).
    b. Defense Readiness Reporting System (DRRS).
    c. Medical Readiness Decision Support System (MRDSS).
    d. Status of Resources and Training System report (SORTS).

16. (406) What C-level states the unit possesses the required resources and is trained to undertake the full wartime mission for which it is organized or designed?
    a. C–1.
    b. C–2.
    c. C–3.
    d. C–4.

17. (406) Units must update the Status of Resources and Training System (SORTS) monthly, no later then what day of the month?
    a. 1st.
    b. 5th.
    c. 10th.
    d. 15th.

18. (407) What is the official system of record for management of expeditionary medical personnel and resources for the Air Force Medical Service (AFMS)?
    a. MRDSS-ULTRA.
    b. MEDRED-C.
    c. SITREP.
    d. SORTS.

19. (407) Who must approve user accounts before the Medical Readiness Decision Support System (MRDSS) Help Desk creates accounts?
    a. Major command (MAJCOM) or higher headquarters.
    b. Military treatment facility (MTF) commander.
    c. Medical readiness office.
    d. Base commander.

20. (407) In the Medical Readiness Decision Support System (MRDSS), what tool is designed to manage the Air Force Medical Service (AFMS) readiness resources?
    a. Mission Essential Task.
    b. Medical Resource Letter.
    c. Manpower Force Element Listing.
    d. Designed Operational Capability Statement.

21. (408) What plan is the medical unit commander’s plan, establishing procedures for the unit’s expeditionary missions identified in the designed operational capability (DOC) statement and emergency response missions identified in the Comprehensive Emergency Management Plan (CEMP)?
    a. MCRP.
    b. IGESP.
    c. DCP.
    d. IDP.

22. (408) What triage category would include injuries that need immediate medical or surgical attention to save a life?
    a. Delayed.
    b. Minimal.
    c. Expectant.
    d. Immediate.

23. (409) Once the minutes are approved, who should they be submitted to?
    a. Major command (MAJCOM) commander.
    b. MAJCOM readiness office.
    c. Base readiness office.
    d. Base commander.

24. (410) When unit personnel are processed through the personnel deployment function (PDF), who is responsible for their accountability?
    a. Unit commander
    b. Base commander.
    c. Unit deployment manager.
    d. Personnel deployment function.

25. (410) At minimum, who attends the deployment order briefing?
    a. The military treatment facility commander (MTF/CC).
    b. The unit deployment manager (UDM).
    c. Medical control center chief (MCC).
    d. Medical readiness office (MRO).

26. (411) Who does the unit deployment manager (UDM) notify for remedial actions when unit task codes (UTC) cannot be supported due to changes in manpower or equipment?
    a. Military treatment facility commander (MTF/CC).
    b. Support squadron commander (MDSS/CC).
    c. Installation deployment office (IDO).
    d. Medical readiness office (MRO).

27. (412) Once you have navigated to the *Training Overview Page*, what do you select to update an individual's training information?
    a. The individual's name.
    b. Find individual's record.
    c. Record training course attendance.
    d. Update training for multiple individuals.

28. (413) What part of the deployment folder is for major command (MAJCOM)/installation/wing/unit requirements?
    a. Part 2.
    b. Part 3.
    c. Part 4.
    d. Part 5.

29. (414) All of the following should be on the in-processing checklist, *except*
    a. document training in Medical Readiness Decision Support System (MRDSS).
    b. assign the member to a medical contingency response plan (MCRP) team.
    c. assign the member to a unit task code (UTC).
    d. give the member their mobility folder.

30. (415) The medical control center is also known as the
    a. unit control center.
    b. mission control center.
    c. readiness control center.
    d. commander control center.

31. (415) The alert notification and recall system used through the Air Force is referred to as what kind of system?
    a. Mass notification.
    b. Pyramid alerting system.
    c. Enterprise notification system.
    d. Mission essential alerting system.

32. (415) Who’s function is it to oversee the mission operation of the installation?
    a. First responders (FR).
    b. Crisis action team (CAT).
    c. Incident commander (IC).
    d. Emergency operations center (EOC).

33. (415) Who has overall authority and responsibility for conducting all incident activities including development of strategies and tactics and distribution of resources at the incident site?
    a. First responders (FR).
    b. Crisis action team (CAT).
    c. Incident commander (IC).
    d. Emergency operations center (EOC).

34. (416) On a military map, what color illustrates the relief features, such as the vertical elevation of the terrain on a map as seen from above?
    a. Red.
    b. Black.
    c. Green.
    d. Brown.

35. (416) On a military map, what color represents main roads, built-up areas, and special features?
    a. Red.
    b. Black.
    c. Green.
    d. Brown.

36. (416) On a grid coordinate of 2.5/E.4, the 2 represents the
    a. horizontal grid line.
    b. grid line number.
    c. vertical grid line.
    d. grid square.

37. (416) What time frame should an event log cover?
    a. 6-hour period.
    b. 12-hour period.
    c. 24-hour period.
    d. 48-hour period.

38. (417) What is the first step in completing a checklist?
    a. Initial the checklist.
    b. Evaluate the scenario.
    c. Enter the date on the checklist.
    d. Write your name on the checklist.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Patient Movement

2–1. Aeromedical Evacuation Overview 2–2
418. General aeromedical evacuation information 2–2
419. Patient movement requirement centers' roles and responsibilities 2–5
2–2. Medical Evacuation 2–8
420. Medical evacuation 2–8
421. Overview Theater Medical Information Program-Joint 2–11
2–3. Patient Movement Process 2–13
422. Patient classification and precedence 2–13
423. Initiate patient movement request 2–16
424. Preparing for the mission 2–25
425. Flight arrival 2–37

AN AIRMAN HAS BEEN ADMITTED TO THE 212TH AEW UNIT, CAMP BEDROCK, IRAQ. The scarce medical resources on-hand cannot adequately support his life and death condition. The nearest medical facility with the appropriate medical care is Landstuhl Regional Medical Center (LRMC), Germany (GE).

A two-day-old infant was born at Fort Wainwright, Alaska. The child was born two-months premature with severe respiratory complications. The best-equipped treatment facility with a neonatal intensive care unit is located at the San Antonio Military Medical Center (SAMMC), Lackland Air Force Base (AFB), Texas.

How do we get the patients mentioned above to the appropriate military treatment facility for care? Who coordinates the patients' movements?

These questions and more will be discussed as we enter the exciting world of patient movement! Patient movement is literally and figuratively where the rubber meets the road. Our real world peacetime process helps prepare us for contingency operations. This process also ensures that all of our beneficiaries receive quality medical care regardless of where they may be stationed around the globe.

Patient movement is composed of two sequential steps: regulating and moving. Before regulating a patient, an MTF must report the patient for movement. Once reported, the patient is regulated (meaning his or her medical needs are matched against available medical capabilities) with the assistance of the Theater Patient Movement Requirements Centers-Americas (TPMRC-A) located at Scott AFB, IL or by one of the two other theater patient movement requirements centers (TPMRC) located at Ramstein Air Base (AB), Germany or Kadena AB, Japan. During the aeromedical evacuation (AE), a patient may have to remain overnight (RON) at an en route stop, prior to arriving at their final destination. Normally a RON occurs at facilities equipped with aeromedical staging facility (ASF) or in En Route Patient Staging Systems (ERPSS). For instance, a patient's travel itinerary for an aeromedical evacuation flight from Bagram AB, Afghanistan destined for Walter Reed Army Medical Center, DC (WRAMC) may look something like the following table:

Aeromedical Flight Itinerary				
Flight	**Day**	**Depart**	**Arrive**	**Notes**
10T1	Thursday	Bagram AB, AF	Ramstein AB, GE	Ground transport patient to LRMC
4R2	Saturday	Ramstein AB, GE	Andrews AFB, DC	Ground transport patient to WRAMC

As you can see, the patient arrived at LRMC on Thursday, yet their scheduled 4R2 flight to WRAMC does not depart Germany until Saturday. Therefore, the patient will RON at the ASF located at LRMC Thursday and Friday and then depart for CONUS on Saturday.

Believe it or not, this is a quick synopsis of the inner workings of the patient movement system. The patient movement process has many facets. It starts when the patient is identified to be moved, and ends when the patient arrives at his or her final destination. The major features that contribute to patient movement include medical evacuation (MEDEVAC) and AE. Let us look at some terminology and definitions that will be helpful as you continue throughout this unit.

2–1. Aeromedical Evacuation Overview

The AE mission is based on our ability to successfully evacuate casualties from the forward areas to definitive care facilities, thus relieving combat commanders of the responsibility for patient care and protection. The AE system exists primarily for the wartime evacuation of patients from the battle zone.

In the field, medical technicians or physicians give on-the-spot emergency medical care. A helicopter or ambulance, called to the site by radio, transports patients to a forward MTF. At the forward MTF, wounds are debrided, casts applied, and blood given, when necessary. Once the patients are stable, their travel continues. Patients who cannot be returned to duty and need definitive or long-term care are evacuated to a rear area medical facility. Patients who need AE enter into the AE system by the order provided by the attending physician.

418. General aeromedical evacuation information

Before you learn how to get a patient ready for the aeromedical evacuation system, you need to be familiar with the terminology used in this functional area. The following terms associated with AE will help you understand the AE portion of the patient movement process.

Aeromedical evacuation

AE is the movement of patients under medical supervision to and between MTFs by air transportation. There are four types of AE, including forward, theater, strategic and domestic.

Forward

The forward phase of AE provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and then to subsequent points of treatment within the combat zone.

Theater (intratheater)

The theater phase of AE provides airlift for patients between points of treatment outside the combat zone, within a theater of operations.

Strategic (intertheater)

The strategic phase of AE provides airlift for patients from overseas areas or from theaters of active operations to the CONUS or patient movements between theaters (i.e., a patient movement from CENTCOM [US Central Command] to EUCOM [European Command]).

Domestic

The domestic phase of AE provides airlift for patients between points within the CONUS, and from near offshore installations.

Aeromedical evacuation system

The aeromedical evacuation system (AES) provides control of patient movement by air transport, and specialized medical attendants (MA) and equipment for in flight medical care. It also encompasses

facilities on or in the vicinity of flight lines and air bases for the limited medical care of in transit patients entering, en route, or leaving the system. The system includes communication with originating, en route, and destination MTFs concerning patient requirements.

Aeromedical staging facility

The ASF is vital in the successful flow of patients and attendants in the AE system. It provides significant support and suitable accommodations for patients required to remain at installations while awaiting aeromedical transportation. The ASF mission is to receive, shelter, process, and provide medical and nursing care to patients who enter, travel in, or leave the AE system. ASFs are located where aeromedical routes originate, terminate or interface, or where other suitable accommodations are provided for patients that are required to remain at installations while awaiting AE. ASFs either are a series of large tents or fixed facilities, usually collocated with an MTF. They function as holding units in both peacetime and wartime for patients awaiting further transportation while en route in the AE system. The patient capacity ranges from 50 to 250 beds, and turnover is rapid. The Air Force Chief of Staff must approve the activation or inactivation of a designated ASF or the partial curtailment of the mission assigned to an ASF. The mobile aeromedical staging facility (MASF) is a 25-bed tent-type facility used during wartime or contingencies as a collecting point or holding ward. MASFs are usually strategically positioned near active flight lines to provide quick access to enplaning/deplaning patients involved with AE.

Aeromedical evacuation aircraft

The primary USAF aircrafts supporting intratheater AE are the C–130 Hercules, C–17 Globemaster, C–21 and the KC–135 Stratotanker. Overseas theater commanders have operational control of theater-assigned or attached aircraft through the airlift operations center (AOC), who allocates those airframes as required to meet operational mission requirements. Primary intertheater aircraft are KC–135 Stratotanker, and C–17 Globemaster. The UH 60 Q Medevac Black Hawk Helicopter or "*dustoff*" assists with the AE process by providing forward AE. In peacetime it can also be used in mass casualty situations and for providing transportation for patients when ground transport would not suffice (such as with immediate and urgent patients). Aircraft of opportunity is preferred to launching a special airlift aircraft. Use of an opportune airlift is considered an unscheduled AE mission, and managed/reported in the same manner as any other AE mission, to include the change of the mission number when patient(s) is/are onboard.

Continental United States patient

A CONUS patient is a member of a uniformed service or other eligible beneficiary hospitalized in a CONUS MTF.

Destination medical facility

The destination medical facility is the MTF the patient is en route to for specific medical care.

Expeditionary medical support

EMEDS allows the AF to deploy capabilities from small teams that can provide highly skilled medical care for a limited number of casualties, to a medical system as large as an AFTH that can provide specialized medical care to several thousand.

Theater Patient Movement Requirement Center-Americas

The TPMRC-A is responsible for coordinating all patient movement once the mission arrives at the CONUS reception aerial port, ensuring the patients are continued to final destinations as appropriate. The lessons learned from combat airlift of war casualties also apply in civilian disaster situations. Our system of air transportation of sick or injured from all parts of the world to MTFs offer the finest diagnostic and definitive care, and has improved health care delivery in the US.

Originating military treatment facility

The MTF that initiates the transfer of a patient to another MTF is the originating MTF. Your MTF becomes the originating MTF when you, as the patient movement technician (PMT), initiate the action to transfer a patient from your MTF to another MTF using the AE system.

Transportation Command Regulating and Command & Control Evacuation System

Transportation Command (TRANSCOM) Regulating and Command & Control Evacuation System (TRAC2ES) is the automated information system responsible for combining transportation, logistics and clinical decision support elements into a seamless patient movement information management system. This system is capable of visualizing, assessing, and prioritizing patient movement requirements, assigning proper resources and distributing relevant data to efficiently deliver patients.TRAC2ES replaced the antiquated Defense Medical Regulating Information System (DMRIS).

Theater patient movement requirements centers

TPMRCs are directly responsible for managing patient movement within their respective theater or AOR or *intratheater* AE. The primary role of the TPMRC is to coordinate and communicate patient movement requirements and proposed lift-bed plans to the service transportation components, which execute the patient movement decisions, and then monitor their execution in concert with the TPMRC-A.

In summary - a typical aeromedical evacuation scenario

Do some of the terms and phrases sound like Greek? Do you think you will ever be able to fully understand them? The following illustration will help put everything in perspective (fig. 2–1): Specialist (SPC) Ford was driving a Humvee in downtown Baghdad, Iraq. She ran over a land mine, which pierced through the undercarriage of the Humvee and lodged shrapnel into her Achilles tendon. The vehicle directly behind her in the convoy made radio contact with their unit who immediately requested a dustoff.

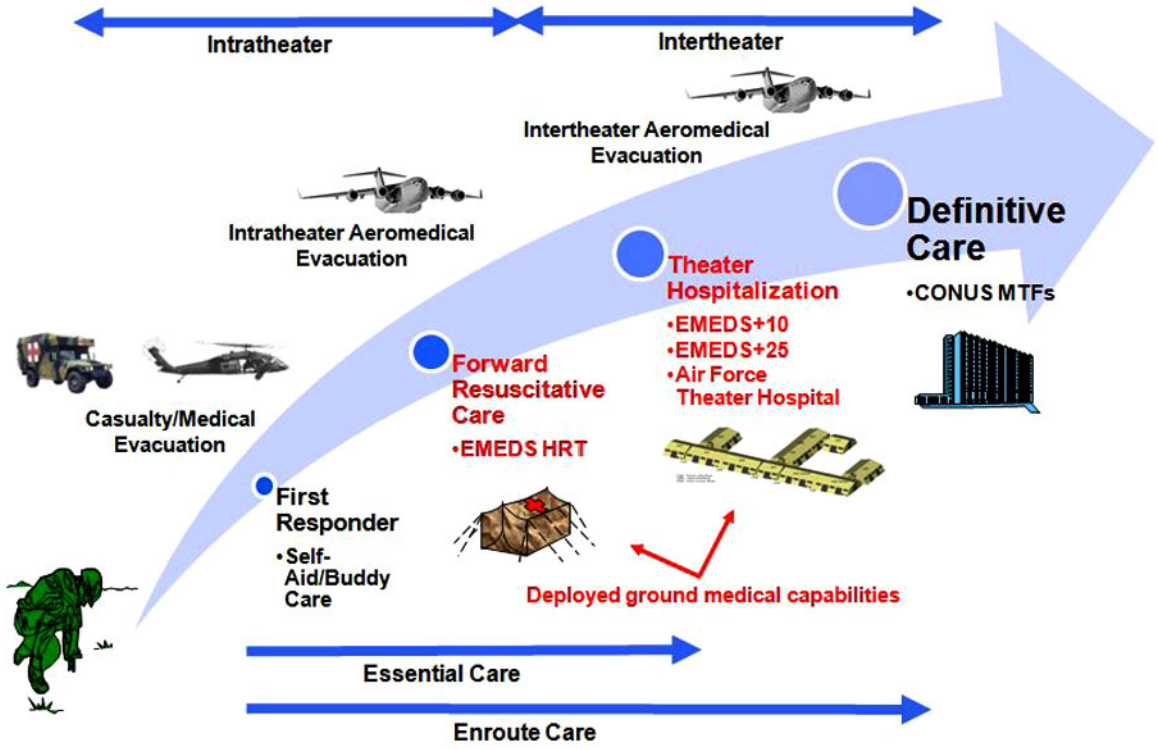


Figure 2–1. Summary patient movement.

The UH 60 Q Medevac Black Hawk Helicopter arrived at the scene and provided forward AE to the 212th Air Force Theater Hospital located at Camp Bedrock, Iraq. After evaluating the battle injury, the attending orthopedic physician at the 212th AFTH quickly realized that the extent of the injury was beyond the scope of care that is available at the AFTH unit. He ordered evacuation for SPC Ford to Landstuhl, Germany for further treatment. The joint patient movement requirement center (JPMRC) received the request from the AE technician assigned to the AFTH unit and coordinated an intratheater AE using a C–130, Hercules. SPC Ford was ground transported from the AFTH unit to the MASF which was located near the flightline at Eagle Base, Baghdad, Iraq. From the MASF the patient was transported to the C–130 where she enplaned the aircraft with the assistance of the medical crew. The C–130 departed Eagle Base bound for Ramstein Germany. ASF personnel were awaiting their arrival and ground transported SPC Ford to Landstuhl Regional Medical Center. Once at Landstuhl she received further care for her battle injury. The attending physician (Dr. Wood) at Landstuhl decided that SPC Ford would not be able redeploy with her unit due to the extent of her injuries. She still needed further care so Dr. Smith ordered the patient to proceed via AE back to her duty station located at Fort Sill, Oklahoma.

After the TPMRC in Europe (TPMRC-E) received the request from the patient movement technician at Landstuhl via TRAC2ES, they validated the patient movement and then coordinated an intertheater airlift utilizing a KC–135 Stratotanker. The TPMRC-A, seeing the patient movement request via TRAC2ES coordinated the transportation for the patient to arrive at her final domestic destination. The C–17 Globemaster aircraft transported SPC Ford from Ramstein, GE to Andrews AFB, DC. SPC Ford was then ground transported from the flightline at Andrews to the ASF where she would have to RON until the following day. At that time, she enplaned the scheduled C–130 Hercules and departed Andrews AFB bound for Ft Sill, Oklahoma. After landing at Ft Sill (the destination facility), she deplaned with the help of the medical crew and was ground transported to the MTF where SPC Ford's AE experience had finally come to a conclusion! Wow, does this sound far-fetched? Trust me, it is not. This represents a very typical scenario of how a patient with a battle injury may proceed from the point of injury to his or her final destination!

419. Patient movement requirement centers' roles and responsibilities

Now that you are familiar with the general process, it should be easier to understand the different patient movement requirement centers (PMRC). You should know that there are four major PMRCs: the global patient movement requirement center, theater patient movement requirement center-Pacific, patient movement requirement center-Europe, and the joint patient movement requirement center.

Theater patient movement requirement center-A

Global Patient Movement Requirements Center (GPMRC), referred to as TPMRC-A, is located at Scott AFB, Illinois and is a joint activity that reports directly to USTRANSCOM. TPMRC-A provides medical regulating services, including clinical validation, limited patient in transit visibility, and evacuation requirements planning for intertheater patient movement and intratheater patient movement for CONUS. The TPMRC-A coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to service components, or other agencies, to execute the mission.

- Coordinate AE requirements with airlift operations.
- Receive, consolidate, and process requests for patient movement, and where appropriate, transmit these requests to other AE operating elements within the system.
- Monitor in transit patient handling, including the administrative processing of patients at RON stops.
- Monitor appropriate records and submit reports relating to AE activities.

- Coordinate the timely and orderly movement of patients and establishing necessary records to make certain that patients move consistent with their date of travel readiness and operating schedules.
- Consolidate patient movement requests and furnishing necessary assistance to using agencies, including AE liaison functions.
- Prepare reports to reflect patient movement and backlog for the aeromedical evacuation control center (AECC).
- Provide AE operations officers (AEOO) for specific geographical areas.
- Advise the destination hospital when a patient is removed from the AE system because of death, medical deterioration, etc.
- Order a quantity of in-flight meals, by type (breakfast, dinner, or supper), and have beverages for flights departing or transiting their stations.
- Coordinate the arrival of the AE aircraft with that of the civilian ambulance agency.

Theater Patient Movement Requirement Center – Pacific

Located at Joint Base Hickam Pearl Harbor, the Pacific TPMRC (TPMRC-P) is also a unified operating agency for the Pacific Command (PACAF). Headquarters (HQ) PACAF has been designated executive agent responsible for the TPMRC and has aligned the organization under the PACAF Air Mobility Operations Control Center. The TPMRC is responsible for patient eligibility, requirements determination and overall patient movement systems management. The TPMRC regulates medical patients by assigning movement of these patients by the most appropriate means of transportation.

Theater Patient Movement Requirement Center –Europe

Located at Ramstein AB, Germany, the European TPMRC is a unified operating agency for the European Command. HQ US AF Europe (USAFE) has been designated executive agent responsible for the TPMRC and has aligned the organization under the USAFE Surgeon General's Office as a field operating agency. The TPMRC is responsible for patient eligibility, requirements determination and overall patient movement systems management. The TPMRC regulates medical patients by assigning movement of these patients by the most appropriate means of transportation.

Joint Patient Movement Requirement Center Responsibilities

A deployable JPMRC serves as the patient movement decision authority in a specific joint task force (JTF) commander's AOR. The commander will establish joint patient movement systems that are commensurate with JTF operations. A JPMRC will provide patient movement for individual patients as well as mass casualties, in peacetime as well as in war or in contingency and from fixed as well as deployable environments, thus providing the JTF commander TPMRC (like) capabilities for his or her operations. The JPMRC will support the movement of patients as far forward as the "communication and transportation" infrastructure permits.

The team

Do you think you understand it yet? Let me explain a little further. The European TPMRC is collocated with the 86 AES at Ramstein AB, Germany. The Pacific TPMRC is collocated with the Joint Base Pearl Harbor Hickam, Hi. The TPMRC-A is collocated with the 375th AES at Scott AFB, Illinois. The TPMRCs with their respective AES' work together as teams to ensure each AE mission within their AOR is successfully launched. The TPMRC is responsible for the following:

- Accepting patient movement taskings.
- Scheduling AE missions to meet patient movement requirements.
- Regulation and validation of the patients.

A TPMRC is comprised of personnel who work as mission controllers (4N0s and their Army and Navy equivalents), mission controllers (4A0) patient movement clinical coordinators (nurses), and operations officers. Aeromedical evacuation squadrons are responsible for providing in-flight medical care to patients moving within the AE system. The AES is comprised *mostly* of 4N0s, and flight nurses who are on flying status and make-up the medical crews who fly on the AE missions. To understand it better, you can look at the TPMRC/AES relationship like this: *TPMRC generally focuses on the overall management of the patient movement prior to, during and immediately following the movement, while the AES is generally focused on care in the air.*

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

418. General aeromedical evacuation information

1. What are the four types of AE?

2. What provides support and accommodations for patients required to remain at installations while awaiting AE?

3. What type of facility is generally located near active flight lines?

4. What is the primary aircraft used for supporting intratheater AE?

5. What allows the AF to deploy capabilities from small teams that can provide highly skilled medical care for a limited number of casualties?

6. What system is responsible for combining transportation, logistics and clinical decision support elements into a seamless patient movement information management system, which is capable of visualizing, assessing and prioritizing patient movement requirements?

7. Who is responsible for managing patient movement within their respective area of responsibility?

419. Patient movement requirement centers' roles and responsibilities

1. What regulating services are provided by TPMRC-A?

2. What PMRC is located in Joint Base Hickam Pearl Harbor?

3. What PMRC is located at Ramstein AB, Germany?

4. What serves as the patient movement decision authority in a specific JTF commanders' AOR?

2–2. Medical Evacuation

Did you catch the difference between aeromedical evacuation and medical evacuation? Aeromedical evacuation specifically refers to USAF provided fixed-wing movement of regulated casualties using organic and/or contracted mobility airframes with AE aircrew trained explicitly for this mission. The AE system can operate as far forward as fixed-wing aircraft are able to conduct air/land operations. Medical evacuation traditionally refers to US Army (USA), US Navy (USN), US Marine Corps (USMC), and US Coast Guard (USCG) patient movement using predestinated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with medical personnel for en route care.

420. Medical evacuation

Medical evacuation is the timely, efficient movement and en route care by medical personnel of the wounded, injured, or ill persons from the battlefield and/or other locations to MTFs. MEDEVAC is a multifaceted mission accomplished by a combination of dedicated ground and air evacuation platforms synchronized to provide direct support, general support, and area support within joint operations.

MEDEVAC has generally implied the use of rotary wing aircraft with medical attendants. Helicopters are rotary-wing aircraft capable of horizontal, vertical, lateral, and hovering flight. Their ability to circumvent terrain and obstacles, and the minimum requirements for takeoff and landing enable them to operate from areas inaccessible to fixed-wing aircraft or surface vehicles. The helicopters' capability of flight at relatively slow speeds permits operations during periods of reduced ceiling and visibility. Helicopters are organic to the air ambulance (AA) units and aviation units of the division and corps.

The provision of en route care on medically equipped vehicles or aircraft enhances the patient's potential for recovery and may reduce long-term disability by maintaining the patient's medical condition in a more stable manner. MEDEVAC begins when medical personnel receive the wounded, injured, or ill soldier and continues as far rearward as the patient's medical condition warrants or the military situation requires.

Rotary wing medical evacuation

Medical evacuation is an Army Medical Department (AMEDD) function that supports and is an integral part of the Military Health System (MHS). The provision of en route care on medically equipped vehicles or aircraft greatly enhances the patient's potential for recovery and may reduce long-term disability by maintaining the patient's medical condition in a more stable manner.

Medical evacuation ground/air ambulance platforms are defined as platforms especially for the medical evacuation mission with allocated medical equipment specifically designed for the purpose of en route care and by trained medical personnel. The gaining MTF works with the losing MTF, when arranging for the evacuation of patients from the lower role of care. Medical evacuation begins when a request is initiated, and continues until the patient is released from the health system by medical authorities. Casualty evacuation is a term used to refer to the movement of casualties by nonmedical vehicles or aircraft.

Characterize desert warfare by extended battle zones, which increase evacuation distance and time. Combat health support units are located further to the sustainment distant area. Establishing an ambulance shuttle system is useful. Combat health support units require a greater number of vehicles for operating in deserts than in other environments. Air evacuation by fixed and rotary-wing aircraft is the preferred method due to their speed and range. Further, using aircraft reduces the load on ground vehicles. Augmentation from higher echelon may be required to meet the extended evacuation needs. The following table lists the most commonly used rotary-wing aircraft.

Most Commonly used Rotary-wing Aircraft			
Type	**Litter**	**Ambulatory**	**Combination**
UH–60 Blackhawk (fig. 2–2)	6	7	4 Litter / 1 Ambulatory
UH–60A Blackhawk (fig. 2–3)	3	4	4 Litter / 1 Ambulatory
UH–1H/V Iroquois (fig. 2–4)	6	9	3 Litter / 4 Ambulatory
CH–47 Chinook (fig. 2–5)	24	31	

Figure 2–2. The UH 60 Q Medevac Black Hawk Helicopter or “dustoff.”

Figure 2–3. UH–60A Blackhawk.

Figure 2–4. UH–1H/V Iroquois.

Figure 2–5. CH–47 Chinook.

Procedures

The determination to request medical evacuation and assignment of a precedence is made by the senior military person present or, if available, the senior medical person at the scene. This decision is based on the advice of the senior medical person at the scene (if available), the patient's condition, and the tactical situation.

Assignment of medical evacuation precedence is necessary. The precedence informs headquarters with information needed to determine priorities for scheduling evacuation. This is why ensuring the correct precedence assignment is essential. See the following chart for the priority listing and definitions.

Priority Listings	
Category	**Description**
Priority I-Urgent	Is assigned to emergency cases that should be *evacuated as soon as possible and within a maximum of one hour* in order to save life, limb, or eyesight, to prevent complications of serious illness, or to avoid permanent disability.
Priority IA – Urgent Surgical	Is assigned to patients who *must receive far forward surgical intervention to save life* and to stabilize them for further evacuation.

Priority Listings	
Category	**Description**
Priority II – Priority	Is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be *evacuated within four hours* or his or her medical condition could deteriorate to such a degree that he will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability.
Priority III-Routine	Is assigned to sick and wounded personnel requiring evacuation but whose *condition is not expected to deteriorate significantly*. The sick and wounded in this category should be evacuated within 24 hours.
Priority IV-Convenience	Is assigned to patients for whom evacuation by medical platform is a *matter of medical convenience rather than necessity*.
NOTE: The North Atlantic Treaty Organization (NATO) STANAG 3204 has deleted the category of Priority IV-Convenience; however, it is still included in the US Army evacuation priorities as there is a requirement for it on the battlefield.	

The patient's medical condition is the overriding factor in determining precedence. The air ambulance operates wherever needed on the battlefield. The AA crew is trained in aeromedical procedures to provide optimum en route patient care. It is the preferred method of evacuation for most categories of patients. An AA is a low-density, high-demand resource and is managed accordingly. To conserve these valuable resources, medical planners usually use AA to move Priority I and Priority IA patients. Other categories can be included on the manifest on a space-available basis. Patients will be picked up as soon as possible, consistent with available resources and pending missions.

NOTE: Depending on the length of time required to dispatch AA and arrive at the point of injury (POI), it might be prudent to evacuate the casualty by ground assets. Further evacuation could then be accomplished by AA.

Medical evacuation requests often are sent from the POI, through intermediaries, such as higher headquarters, who then transmit the request up to the nearest medical evacuation unit. The unit relaying the request must ensure that it relays the exact information originally received. The radio call sign and frequency relayed should be that of the requesting unit and not that of the relaying unit. However, the intermediaries contact information can be given as additional data if a callback is necessary to clarify details of the mission.

The nine-line Medical Evacuation Request contains the information required to transport patients. A technically capable enemy may be able to intercept a nonsecure nine-line request and strike at the pickup zone causing additional harm to the patients and the medical evacuation crew. In combat and when directed by higher headquarters, always use secure communications when requesting medical evacuation.

421. Overview Theater Medical Information Program-Joint

Theater Medical Information Program-Joint (TMIP-J) documents care patients receive while downrange, to include aeromedical evacuation information. This information system electronically bridges documentation of healthcare delivery in the theater of conflict to the sustaining base. The TMIP-J information system captures clinical information and other data and passes it to the Theater Medical Data Store (TMDS), where authorized healthcare providers can view and analyze it all over the world. Data in TMDS is also available on a classified network where Combatant Commanders can access it.

TMIP-J is also a medical component of the DOD Global Combat Support System Family of Systems. It supports protection of force health, and meets the mandates to maintain a life-long electronic patient record for the warfighter in the battlefield and during peacetime. In the theater environment, TMIP-J supports combatant and joint task force commanders by providing medical readiness data for

the combat force and by making recommendations to protect the combat force from medical threats. Capabilities include the following.

- Inpatient care.
- Outpatient care.
- Blood status.
- Medical surveillance.
- Tracking medical supplies.
- Occupational and environmental health.
- Tracking patients through aerovac system.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

420. Medical evacuation

1. What department is responsible for the support of medical evacuation?

2. Define the medical evacuation ground and air ambulance platform.

3. What are the most commonly used rotary-wing aircraft used for patient movement in battle zones?

4. What is the medical evacuation priority if a patient needs to be moved within four hours?

5. What is the medical evacuation priority if a patient needs to be moved within 24 hours?

6. What is the overriding factor in determining a patient's precedence for medical evacuation?

7. How are medical evacuation requests often sent?

421. Overview Theater Medical Information Program-Joint

1. What is Theater Medical Information Program-Joint?

2. What system takes this clinical information and other data and makes it available to other health professional worldwide?

3. What are some capabilities of TMIP-J?

2–3. Patient Movement Process

When you get the opportunity to deploy, you will see the medical evacuation patients come into the facility. As stated earlier, they can come by rotary wing, car, Humvee and so forth. This is where you, as the aeromedical evacuation clerk, start to play a major role in movement of the patient.

TPMRCs usually receive AE requests from DOD patient movement technicians located at MTFs throughout their respective AORs. Patients are reported as soon as the need for movement is determined. Once the patient movement technician receives the request from the attending physician, the process is set in motion. Figure 2–6 may help you understand the process a little better.

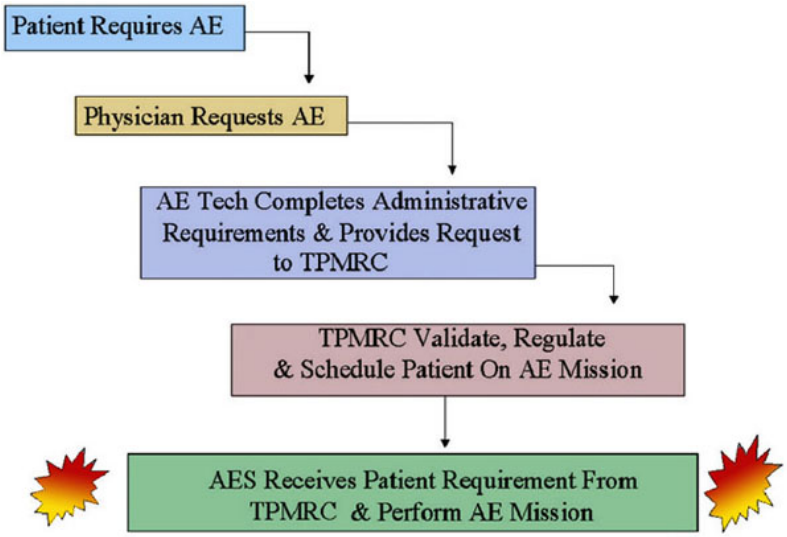


Figure 2–6. Patient movement process.

The patient movement process includes many steps, such as preparing the patient, coordinating with TPMRC, preparing appropriate documents, and meeting the flight when it arrives. However, before you read about that, you do need to know about the different patient classifications and precedence.

422. Patient classification and precedence

In this lesson, we discuss categorizing patients so that AE personnel can easily identify the types of patients they are receiving aboard their aircraft. Patient classification enables AE personnel to determine the priority for loading and unloading patients, as well as the approximate amount of room the patient will need while aboard the aircraft. For example, a patient that sits in a seat takes up little room compared to the patient traveling on a litter who is required to use special equipment. In addition, AE personnel must be aware of the patient's behavior as well as the type of actions the patient may display. For example, the flight nurse may need to pay closer attention to a mentally disturbed patient or one who recently experienced suicidal ideations as compared to an outpatient going for follow-up care.

Classification

The classification a patient is given is determined by his or her attending physician. The classification is critical in identifying to the medical aircrew those patients who must travel on a litter or in an ambulatory status, and whether or not the patient will need assistance in an aircraft emergency. It will

be your responsibility, as the patient movement technician, to manifest the patients by using Department of Defense (DD) Form 601, Patient Evacuation Manifest. Use the following six patient and attendant classification codes during normal peacetime operations.

Class 1: Psychiatric category

Pay close attention to patients with a psychiatric classification. They cannot have items that present a danger to themselves or others (e.g., sharp objects, matches, cigarette lighters). However, common sense should be the guiding factor in determining what is or is not dangerous. Class 1 has three categories.

1. *Class 1A:* Severe psychiatric litter patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times.
2. *Class 1B:* Psychiatric litter patients of intermediate severity. Patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus. Restraining apparatus must be sent with the patient for potential use.
3. *Class 1C*: Psychiatric walking patients of moderate severity. They are cooperative and reliable under observation.

Class 2: Litter inpatients

Patients that require rest during a long flight because of recent surgery or have difficulty safely ambulating are listed as litter patients. Class 2 has two categories:

1. *Class 2A*: Immobile litter patients (nonpsychiatric) who are not able to move about on their own volition under any circumstance.
2. *Class 2B*: Mobile litter patients (nonpsychiatric) who are able to move about on their own volition under certain circumstances.

Class 3: Ambulatory inpatients

Class 3 consists of patients who require minor attention en route. There are three categories in this class:

1. *Class 3A*: Ambulatory patients, nonpsychiatric and nonsubstance abuse, going for treatment or evaluation.
2. *Class 3B*: Recovered patients, returning to home station.
3. *Class 3C*: Ambulatory, drug or alcohol (substance) abuse patients going for treatment.

Class 4: Infant category

Children under the age of three are transferred under one of these five categories:

1. *Class 4A*: Infant, under three years of age, occupying an aircraft seat, going for treatment.
2. *Class 4B*: Recovered infant, less than three years of age, occupying an aircraft seat.
3. *Class 4C*: Infant requiring an Ohio incubator.
4. *Class 4D*: Infant under three years of age occupying a litter.
5. *Class 4E*: Outpatient under three years of age.

Class 5: Outpatient category

The following are six categories in the outpatient class:

1. *Class 5A*: Ambulatory outpatient, nonpsychiatric and nonsubstance abuse, going for treatment.
2. *Class 5B*: Ambulatory outpatient, drug or alcohol (substance) abuse, going for treatment.
3. *Class 5C*: Psychiatric outpatient, going for treatment or evaluation.
4. *Class 5D*: Outpatient on litter for comfort, going for treatment.

5. *Class 5E*: Outpatient returning from treatment, on a litter for comfort.
6. *Class 5F*: Returning outpatient.

Class 6: Attendant category

Classify individuals other than the patient traveling in the AE system as attendants in one of the following two categories.

Class 6A: Medical attendant

Medical attendants must be familiar with the patient and possess the level of skills appropriate to the patient's needs. They are the clinical authority for their patient's care. They may assist in care of or consult on other patients on the aircraft as needed. They are required to document all patient care given. At en route RON stops, they must brief the personnel who will be caring for their patient and remain available for consultations. They remain with the patient until accepted by a physician on arrival at the patient's destination medical facility.

Class 6B: Nonmedical attendant

One person, normally a family member, may accompany a patient as a nonmedical attendant (NMA) if deemed necessary by the attending physician. Guards that accompany patients are NMAs. Attendants must have sufficient money to pay for food and accommodations. All attendants *must* accompany the patient to the final destination. Attendants must be self-care and ambulatory. Physician recommendation for an NMA should be included on patient's medical record and DD Form 602, Patient Evacuation Tag.

The following table gives us a quick recap with the different classifications:

Patient Classification	
Class	**Category**
One	Psychiatric
Two	Litter inpatients
Three	Ambulatory inpatients
Four	Infants
Five	Outpatients
Six	Attendants

Precedence

Precedence is the word used in the patient movement request (PMR) to describe how quickly a patient needs to be moved. Precedence is not intended to convey complexity; instead, it is intended to convey the need for a patient to be moved quickly to a higher level of care in order for the patient to receive care not available at the current location and in a timeframe that meets clinical standards, and they are different from MEDEVAC. PMRs must accurately reflect any time sensitive elements in order to plan usage of aircraft, and AE Crews. The attending physician accomplishes the following:

- Determines movement precedence.
- Requests movement precedence in accordance with the urgency for delivery to the destination medical facility.
- Directs the accepting physician or representative to confirm acceptance of urgent and priority movement precedence by calling the TPMRC-A or theater AECC/TPMRC.

The three precedence categories are Urgent, Priority, and Routine.

Urgent

Urgent (U) is the highest precedence and is used when a patient is temporarily stabilized but needs to be moved to a higher level of care as quickly as possible to save life, limb or eyesight. The goal is to move these patients within 12 hours. The cargo mission will be disrupted to support the AE mission requirement. This process is called in-system select (ISS). It applies only to the need for immediate life, limb, or eyesight-saving procedures. The attending physician accomplishes the following:

1. Reports these cases directly to the TPMRC-A or theater AECC/TPMRC.
2. Coordinates with accepting physician at destination facility.
3. Requests accepting physician contact the TPMRC-A or theater AECC/TPMRC.

Priority

Priority (P) is the precedence used when a patient is stable, but needs to be moved to a higher level of care for a defined clinical reason, and cannot wait for the next scheduled AE mission. The goal is to move these patients within 24 hours. Stabilized mass trauma, open fractures and angina are conditions that would classify a patient as priority a patient. Hospitals may arrange a priority bed clearing flights if there is a sudden influx and they need to empty beds. ISS is often used for priority patient movements as well. It applies to the need for prompt medical care not available locally. The attending physician accomplishes the following:

1. Reports these cases directly to the TPMRC-A or theater AECC/TPMRC.
2. Coordinates with accepting physician at destination facility.
3. Requests accepting physician contact the TPMRC-A or theater AECC/TPMRC.

Routine

Routine (R) is the precedence used for stable patients capable of waiting up to 72 hours for evacuation on the next scheduled mission. Routine patients validated for movement must be monitored and if their clinical status or medications change, the PMR must be updated.

423. Initiate patient movement request

The attending physician at the requesting MTF plays a key role in the aeromedical evacuation of patients. Patient care is given according to the orders and instructions that the attending physician has provided while the patient is in the AE system. The attending physician's responsibility does not end until the patient is under the direct care of the accepting physician at the destination MTF. The AE crewmembers function as a nursing team during the transfer. They are responsible for implementing patient care and instructions of the physician.

Attending physician

It is the attending physician's responsibility to ensure all necessary paperwork for AE travel is completed. Although this burden rests on the shoulders of the attending physician, he or she relies heavily on the expertise of the HSM to ensure the information is properly completed and transferred to the appropriate offices and/or agencies. The following table provides some of the responsibilities of the attending physician:

Attending Physician of AE Patients		
Item No	**Responsibility**	**Explanation**
1	Complete AF Form 3899, Patient Movement Record, (figs. 2–7 and 2–8)	This is *the most important medical document that must accompany the patient* to ensure appropriate care during transport. It is an abbreviated medical record that was originally designed for wartime use. The physician must be specific concerning treatment and medication type, frequency, and dosage. All medications must be listed, even if the patient is self-medicating. En route treatment prescribed by physicians, including treatment to be provided during RON stops in ASFs must also be entered.

Attending Physician of AE Patients		
Item No	**Responsibility**	**Explanation**
2	Complete AE PMR form.	Now, through TRAC2ES this new form can be printed and utilized. The patient movement technician will use this new worksheet as a source document to input data onto the *PMR Data Entry Form* (discussed later). Usually the attending physician relies heavily on the patient movement technician for assistance with the completion of this form. But in the end, the attending physician is responsible for the completion and accuracy of the AE PMR.
3	Consult with accepting physician at destination MTF.	Self explanatory. Contact accepting physician.
4	Complete orders, treatments and medications.	For all treatments and medications that the patient may require during travel.
5	Ensure accuracy and currency of all patient information.	Self explanatory.
6	Prepare a narrative summary	Complete for all inpatients placed into the AE system.
7	Prepare a consultation sheet or DD 2161, Referral for Civilian Medical Care for outpatients placed.	Self explanatory.
8	Ensure documentation is completed for patients requesting that a *Do Not Resuscitate (DNR)* order be established.	For example, if a patient does not wish to have comprehensive recovery plan (CRP) administered (should a code develop), the attending physician must ensure the patient's request is legally noted and carried out by medical personnel. For more information contact the base legal office.
9	The attending physician will also *consider* the following:	• The degree of benefit to the patient which will result from the transfer. • The patient's suitability for AE, considering both the level of his or her stability and chance for survival during AE. • Can the patient tolerate the flight? • The timing for transfer or precedence (i.e., urgent, priority, or routine). How quickly must the patient be moved? • En route care needed. Need for nonmedical or medical attendants (such as a physician, special care nurse, or respiratory technician). Need for special medical equipment, such as a ventilator, cardiac monitor, or Stryker frame).

PATIENT MOVEMENT RECORD

DATA PROTECTED BY PRIVACY ACT OF 1974 — **PERMANENT MEDICAL RECORD**

(S) - Information needed to submit patient movement record

SECTION I — PATIENT IDENTIFICATION

(s) NAME (Last, First, Middle Initial): ANDREWS, PHILLIP J. | (s) SSN: 123-45-6789 | DATE OF BIRTH: 20130109

(s) AGE: 43 | (s) SEX: X M / F | (s) STATUS: AD | (s) SERVICE: USA | (s) GRADE: E-4 | (s) UNIT OF RECORD AND PHONE NUMBER: 132 INFANTRY BATTALION 555-6565 | CITE NUMBER:

SECTION II — VALIDATION INFORMATION

(s) Medical Treatment Facility Origination and Phone Number: BAGRAM AB, AFGHANISTAN 656-5454 | (s) Ready Date (Julian Date): 009 | APPOINTMENT DATE: 20130111 | NUMBER OF ATTENDANTS: (s) MEDICAL: | (s) NON-MED: 1

(s) Medical Treatment Facility Destination and Phone Number: LRMC, GERMANY (312)794-6565 | (s) CLASSIFICATION 1A-5F: 2A | AMBULATORY: | X LITTER | (s) PRECEDENCE:

(s) Reason Regulated: | Max # Stops: 3 | Max # RONS: 3 | Altitude Restriction: NONE | (s) CCATT Required: yes X no | Name, sex, weight, rank of attendants: JONE, MICHAEL MALE E-5 210 lbs | U: | P: | R: X

SECTION III — OTHER INFORMATION

(s) Attending Physician name, Phone Number and e-mail: JOHN WRINKLE john.wrinkle@us.af.mil 555-1111 | (s) Accepting Physician name, Phone Number and e-mail: MARY SIMMONS mary.simmons@amed.army.mil 312-794-6565

(s) Origination Transportation 24 Hour Phone Number: BAGRAM MTF 656-5454 | (s) Destination Transportation 24 Hour Phone Number: MILITARY TRANSPORT, RAMSTEIN AB 312-794-6565

(s) Insurance Company: TRICARE | Address: | Phone #: 800-538-2164 | Policy #: | Relationship to policy holder: SELF

(s) Waivers (med equip, etc):

SECTION IV — CLINICAL INFORMATION

(s) Diagnosis: AMPUTATION LOWER LIMB (84.1) TBI (850.0) | (s) Allergies: NKDA

LABS (Date and time drawn in Zulu): WBC 8.2 | HGB 9.0 | HCT 29.3 | Other Labs:

(s) WEIGHT: | (S) Blood type:

X battle casualty | disease | non-battle injury

Vital Signs (Date and time taken in Zulu):

Date	Time (Zulu)	B/P	Pulse	Resp	Pain Level	Last Pain Med	O_2 /LPM	Route
20130109	0300	120/75	118	18	0/10	EPIDURAL	0	

Baseline 02 Sat If Applicable: 98% Temp: 98.6°F

CLINICAL ISSUES

Infection Control Precautions: STANDARD | LMP: N/A

Date of last bowel movement: 20130111

High Risk for Skin Breakdown: X yes / no

Initial appropriate boxes:

Yes	No		Yes	No	
	X	Hearing Impaired		X	Hypertension
	X	Communication Barriers		X	Dizziness
	X	Vision Impaired	X		Voiding difficulty
	X	Cardiac Hx		X	*Takes long-term meds
	X	Diabetes		X	*Will self-medicate
	X	Motion Sickness	X		Has adequate supply of meds
	X	Ears/Sinus Problems		X	Knows how to take meds (verbalized understanding)
	X	Respiratory difficulty		X	
X		*Medication listed on physician's orders			

SPECIAL EQUIPMENT (Check all that apply):

X	Suction		Traction		Orthopedic devices
X	NG Tube		Monitor		Restraints
X	Foley		Trach		Chest Tubes
	Incubator	X	IV Pumps	X	IV Location: RFA 18g LAC 18g

OTHER: WOUND VAC TO RLE

Cast Location: Bivalved: yes / no

Ventilator Ventilator Settings:

DIET INFORMATION (Check all that apply):

X NPO | Soft | Full Lig | Cl Liq | Reg

Renal ___ Gm Protein ___ Gm Na ___ Meq K ___ Mag Sulfate

Tube Feeding ___ Type ___ cc/hr ___ Discontinue for Flight

Cardiac | Diabetic ___ cal | Infant formula: | Pediatric Age:

TPN:

X Other(specify): NPO FOR FLIGHT

SECTION V — PERTINENT CLINICAL HISTORY (Transfer Summary)

20130109 0300Z - 42 y/o MALE AD ARMY WHO STEPPED ON LANDMINE DURING DISMOUNTED PATROL ON 20130107. DX: RLE BKA, TBI, SCROTAL ABRASIONS, LLE PENETRATING INJURIES, LUE ABRASIONS. CT C/T/L SCAN NEGATIVE. NO FRACTURES. EBL 4L p̄ TWO SURGICAL REVISIONS AND WASHOUTS. NEGATIVE FOR HEMO/PNEUMOTHORAX. LUNGS CTA BILATERALLY. GCS-15. SKIN W/O INTACT. BS(+)x4 QUADRANTS. WOUND VAC TO RLE @125mmHg. REQUEST ROUTINE MOVEMENT TO LRMC. NOT AMBULATORY. MACE 25. WASHOUT SCHEDULED WITH REVISION ON 20130111. EPIDURAL FOR PAIN — JW

Physician's Signature: JOHN WRINKLE, MD John Wrinkle (J.W) | Date/Time: 20130109 0300 Z

Signature of Clearing Flight Surgeon: CATHERINE BACK, MD, FSO Cathy Back | Date/Time: 20130109 0330 Z

AF IMT 3899, 20060819, V1

Figure 2–7. AF Form 3899, Aeromedical evacuation patient record (front).

PATIENT MOVEMENT RECORD (continuation)

DATA PROTECTED BY PRIVACY ACT OF 1974 — PERMANENT MEDICAL RECORD

PATIENT MOVEMENT PHYSICIAN ORDERS (for continued care in the AE system and at enroute stops)

SECTION I. PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. GRADE	3. SSN#
ANDREWS, PHILLIP J.	E-4	123-45-6789
4. ALLERGIES	**5. ORIGINATING MTF**	**6. DESTINATION MTF**
NKDA	BAGRAM AB	LRMC

SECTION II. MEDICATION ORDERS (Drugs and IVs)

yes [X] no — patient will self-medicate with the following medications:

20130109 0300Z
- ANCEF 1GRAM IV q8° x 9 DOSES.
- D5½NS @100ml/hr
- MORPHINE 4mg IV q2° PRN Breakthrough pain > 4/10

** EPIDURAL IN PLACE **
- ROPIVICAINE 0.2% INFUSE VIA AMBIT PUMP
- BASAL RATE 6ml/hr
- ~~Bolus 2ml/hr~~ error q.w. MD 0300Z
- BOLUS 2ml q30minutes for pain > 2/10
- LOCKOUT 30ml every 4 hours.

USE INTRALIPIDS PRN IAW AMC POLICY FOR EPIDURAL TOXICITY & NOTIFY TVFS IMMEDIATELY.
- NARCAN 2mg IV PRN SUSPECTED OVERDOSE x 1 then CALL TVFS immediately
- ~~Colace 100mg PO TID~~ DC'd 0400 LW
- DR CATHERINE BACK Cathy Back M.D.
- NOTED 20130109 / 0330Z Lilly Wright
  LILLY WRIGHT, LT, NC

20130109 0330Z
- ~~DISCONTINUE COLACE 100mg PO TID~~ 0400 LW
- Change to Colace 100mg PO BID
- DR CATHERINE BACK MD Cathy Back MD
- NOTED 20130109 / 0400Z Lilly Wright
  LILLY WRIGHT, LT, NC

SECTION III. OTHER ORDERS (Procedures, Treatment, V/S Frequency, ETC)

20130109 0300Z
I&O q4 hrs.
VS q2° & S_pO_2, PAIN & SEDATION levels.
NPO for flight.
~~NGT (remove prior to air for flight)~~ DC'd 1100 JJ
Foley CARE q4°
WOUND VAC @ 125mmHg
- EPIDURAL PUMP CARE –
- EPIDURAL PUMP MUST BE LABELED "FOR EPIDURAL ANALGESIA".
- DOCUMENT RATE/DOSE/LOCKOUT q2° ON SPREADSHEET
- ASSIST WITH ALL ADL'S.
- FALL PRECAUTIONS
- AT EACH PATIENT CARE HANDOFF AND EVERY TWO HOURS, ASSESS PAIN SCALE, MAAS SCALE, DERMATOME LEVEL, VITAL SIGNS, MOTOR FUNCTION & DRUG SIDE EFFECTS.
- ASSESS EPIDURAL SITE FOR LEAKAGE q4° (DO NOT REMOVE IF LEAKING) ... REINFORCE DRESSING AND CALL TVFS IMMEDIATELY.

DR CATHERINE BACK MD Cathy Back MD
NOTED 20130109 / 0330Z Lilly Wright
LILLY WRIGHT, LT, NC

AF IMT 3899, 20060819, V1 *(REVERSE)*

Figure 2–8. AF Form 3899, Aeromedical evacuation patient record (back).

Patient movement technician

Now, the patient movement technician becomes the focal point in making sure the patient(s) get to their destination. As a team member in support of the aeromedical mission, the patient movement technician plays an important role. The attending physician, the patient, and unit personnel all rely on

the patient movement technician to ensure the process is efficient and accurate. The patient movement technician is also the focal point that TPMRC/JPMRC personnel will usually contact for questions in reference to a patient's movement.

The attending provider notifies the patient movement technician that a patient needs to move via AE when handing over the AF Form 3899, Aeromedical Evacuation Patient Record. Once the AF 3899 is received, the patient movement technician and attending physician start to work on the PMR.

The patient movement technician uses the AF Form 3899 as a source document to assist with the preparation of the PMR Data Entry Form. Alone, the patient movement technician would have difficulty completing all of the requirements on the form. However, with the help of the attending physician, the job becomes much more manageable. You cannot complete this worksheet properly without input from the attending physician. Additionally, the physician would encounter troubles if he or she tried to complete the PMR without the assistance of an HSM. Most of the items are self-explanatory yet there are a few that you may not be familiar with. Therefore, the following goes through the important aspects of the PMR; there are only about 85 entries so it should not take that long. The following table identifies and explains these entries.

AF Form 3899 Entries		
Section of the Form (extends across entire table)	**Block Entry**	**Block Entry Information**
PATIENT DEMOGRAPHICS section		
	NAME	Enter the complete name of the patient in the following format: last name, first name, and middle initial. For example: Dague David D.
	ORIGINATING MTF	Enter the MTF code plus the name of the facility where the patient's care originated. The codes and names can be found on the drop down menu in the TRAC2ES PMR screen. An example would be: A0069/Walter Reed Army Medical Center
	ORIGINATION international civil aviation organization (ICAO)	This is a four letter code which represents the flightline where the patient is to be transported from. For example: EGUN = Mildenhall AB flightline.
	READY DATE	This is the Julian date in which the patient is ready for travel.
	DESTINATION MTF	Enter the MTF code plus the name of the facility where the patient is being transferred for care. The codes and names can be found on the TRAC2ES PMR Administrative screen.
	DESTINATION ICAO	This is a four letter code which represents the flightline where the patient is to be transported to. For example ETAR = Ramstein AB flightline.
	REASON REGULATED	Enter statement for the justification of the need to move the patient. Acceptable reasons are listed on the pull down menu of the TRAC2ES PMR.
	APPOINTMENT	Enter the date of the patient's scheduled appointment.
	ATTENDING PHYSICIAN	Enter the name of the physician who is treating the patient at the originating MTF.

AF Form 3899 Entries		
Section of the Form (extends across entire table)	**Block Entry**	**Block Entry Information**
	DSN PHONE	Attending physician's DSN phone number.
	Commercial (COM) PHONE	Attending physician's commercial phone number.
	PMR SUBMITTED BY	Enter YOUR NAME, since you are completing the PMR
	DSN PHONE	Enter YOUR DSN phone number.
	COM PHONE	Enter YOUR commercial phone number.
	ACCEPTING PHYSICIAN	Enter the name of the physician at the destination MTF who has consulted with the attending physician and will provide care for the patient (if known).
	DSN PHONE	Enter the accepting physician DSN phone number.
	COM PHONE	Enter the accepting physician's commercial phone number.
	MAX STOPS	Enter the maximum number of stops the patient can safely tolerate during the AE. *Generally,* this is crucial when transporting immediate and urgent patients. Routine patients can *generally* afford to stop at as many stops as the scheduled mission deems necessary.
	MAX RONS	Enter the maximum number RONs that the patient can safely tolerate. Again, this is crucial for priority and urgent patients.
	ALTITUDE RESTRICTION	Or maximum cabin altitude. Identify if there is an altitude restriction ordered by the physician. If the answer is "YES" then the maximum cabin altitude must be entered. Although rare, some patients cannot fly over a certain altitude due to medical reasons. Occasionally, patients diagnosed with certain problems related to the ear may be candidates for altitude restrictions, i.e. these patients may not be able to effectively clear the ears causing too much pressure as the altitude increases. Altitude restrictions are not only important for the well being of the patient but it also effects the planning of the mission. When planning the mission, the pilot must take altitude restrictions into account to modify fuel consumption and distance traveled.
CLINICAL DATA section		
	PRIMARY MED SPEC	Obtain the medical specialty code from the physician or search for it on the TRAC2ES Clinical Diagnosis screen with the diagnosis name.
	PRIMARY DIAGNOSIS	Enter the diagnosis of the patient that is the chief concern and reason for movement to and from medical facilities as indicated by the attending physician.
	SECONDARY MED SPEC	If the patient has additional medical problems or diagnosis, enter the medical specialty here.
	SECONDARY DIAGNOSIS	Self explanatory.

AF Form 3899 Entries		
Section of the Form (extends across entire table)	**Block Entry**	**Block Entry Information**
	OTHER MED SPEC	Self explanatory.
	OTHER DIAGNOSIS	Self explanatory.
	PATIENT HISTORY	Enter a concise summary of the most current history of the patient's diagnosis, treatment, prognosis and any other medical information on the patient that will enhance the patient's care during the transport or movement.
MEDICATIONS & IVS section		
	MEDICATION NAME	Enter any medications or IV solutions ordered for the patient to be given during the patient's movement. Ensure that the physician ordered enough for a three-day supply for intratheater flight and a five-day supply for an intertheater flight.
	DOSE	Enter the data regarding the rate or occurrence that the medications ordered should be distributed.
	FREQUENCY	Self explanatory.
	IV LOCATION	Enter a concise description of the IV as provided by the physician.
	RATE CC/HR	If an intravenous additive or feeding is required, then describe the IV type. If more than one IV is required, list the IVs in sequence. Enter frequency and dosage of ordered IVs.
	SOLUTION	Enter the type of IV to be utilized. SPECIAL DIET. If a patient has a special diet, the specific diet will have to be reported to the TPMRC/JPMRC to ensure appropriate meals are ordered for the flight. Examples of special diets include low sodium diet or vegetarian diet.
	ALLERGIES	List any allergies the patient may have.
VITAL SIGNS & LABS section		
	T or TEMPERATURE	Enter the patient's most recent temperature. Obtain data from nursing staff or patient's record.
	P or PULSE	Enter the patient's most recent resting pulse rate. Obtain data from nursing staff or patient's record.
	R or RESPIRATION	Enter the patient's most recent resting breath rate. Obtain data from nursing staff or patient's record.
	BP or BLOOD PRESSURE	Enter the patient's most recent blood pressure (systolic and diastolic blood pressure reading). Obtain data from nursing staff or patient's record.
	Wt or WEIGHT	Enter the patient's weight. Obtain data from nursing staff or patient's record.
	HGB	Obtain the patient's most recent laboratory blood test and document the *hemoglobin* value.
	HCT	Obtain the patient's most recent laboratory blood test and document the *hematocrit* value.

AF Form 3899 Entries		
Section of the Form (extends across entire table)	**Block Entry**	**Block Entry Information**
	WBC	Obtain the patient's most recent laboratory blood test and document *the white blood cell count* value.
	DATE TAKEN	Enter the date the blood was drawn.
	OXYGEN RATE	Self explanatory.
	OXYGEN MODE	Self explanatory.
DRAINAGE/CAST Section Enter any information regarding drainage, casts or special equipment as prescribed by the attending physician. For instance if a patient has a cast, you may describe as follows: CAST. Left lower leg. ORTHOPEDIC DEVICE. Crutches.		
	DRAINAGE LOCATION	Self explanatory.
	TYPE	Self explanatory.
	SUCTION TYPE	Self explanatory.
	SUCTION AMOUNT	Self explanatory.
	ORTHOPEDIC DEVICE	Self explanatory.
	LOCATION	Self explanatory.
PMI DATA Section Enter any information regarding medical equipment needed or traction as ordered by the attending physician. Remember, if a patient needs a cardiac monitor, a medical attendant must accompany the patient. Other medical equipment may also require a medical attendant travel with the patient. If you see an order for such equipment, remember to ask the question!		
	CARDIAC MONITOR	Self explanatory.
	SUCTION	Self explanatory.
	PULSE OX	Self explanatory.
	INCUBATOR	**NOTE:** Incubators should not be requested for infants who weigh eight pounds or more (i.e., if an incubator is requested, field 8 must be less than 008).
	VENTILATOR	Self explanatory.
	PUMP	Self explanatory.
	STRYKER	**NOTE:** Wedge Stryker frames cannot be accommodated aboard Air Force aircraft and should not be requested or fitted to the patient for travel in this transportation mode.
	TRACTION	Self explanatory.
TRANSPORTATION INFORMATION Section This information is vital when the patient is receiving ground transportation from a civilian source and being moved to a civilian facility. It is extremely important that the civilian transport service know where to be and at what time! Failure to plan will cause undue delays. Remember, the aircraft will not leave once the patient is deplaned. The medical crew will wait until the proper authorities receive the patient. This causes delays for the remaining patients who may be traveling to other destinations for medical care.		

AF Form 3899 Entries		
Section of the Form (extends across entire table)	**Block Entry**	**Block Entry Information**
	ORIG TRANSPORT NAME	Enter the name of the transportation provider such as the ambulance service that is providing transportation to the flight line.
	POC	Enter the originating transport point of contact.
	COM PHONE	Enter the POC's commercial phone number.
	DSN PHONE	Enter the POC's DSN phone number.
	DEST TRANSPORT NAME	Enter the name of the transportation provider such as the ambulance service that is providing transportation to the final destination MTF or civilian hospital.
	POC	Enter the destination transport point of contact.
	COM PHONE	Enter the POC's commercial phone number.
	DSN PHONE	Enter the POC's DSN phone number.
ADMINISTRATIVE REMARKS Section This space is utilized to annotate if the patient is a "will return" or a "will not return." Enter a 'Y' if the patient is returning to his or her duty station or "no" if the patient will not be returning. This allows for forecasting of a possible return trip. Administrative remarks can also be utilized for documenting other information or expanding on information provided elsewhere. For instance, if an outpatient is to be transported from a civilian flightline to the final destination MTF by a family member, this would be an appropriate place to annotate that information and explain how the attending physician gave approval for this mode of travel.		
ATTENDANTS Section		
	ATTENDANT NAME	Self explanatory.
	STATUS	Military/civilian refers to the branch of service, civilian, prisoner of war etc. or other option for all other categories.
	GRADE	Enter the civilian grade or military rank.
	AGE	Enter date of birth or actual age.
	GENDER	Enter male or female.
	TYPE	Enter medical or non-medical attendant.

That is all there is to it. Now it is time to complete the PMR Data Entry Form. This document is what patient movement technicians should use to create a PMR request within TRAC2ES. Once in-putted, the PMR data Entry Form can be printed, completed, and utilized as a source document for patient entry.

Create a patient movement request in TRAC2ES

TRAC2ES is a global system accessible via the NIPRNET and SIPRNET. TRAC2ES-Web is the primary interface for the majority of users, including PMRCs staff, service medical regulating authority (MRA) staff, MTF personnel, and other users that can perform their functions using a Web browser interface.

There are times when Web browser interface is not always an option. In some deployed locations, access to the Internet is limited. Although access is limited, patients still need to be regulated for movement. In this scenario, for patient movement, technicians utilize TRAC2ES-Mobile website. This is an alternative interface that is used when consistent Web browser connection to TRAC2ES is

not realistic. In this case, the patient movement technician works offline and then connects online to send or receive TRAC2ES data. Once the PMR Form is complete, the patient movement will enter the PMR in TRAC2ES. Once entered, authorized users can edit, update and view PMRs through the patient movement system. PMRs typically are created at the facility where the request originates, the originating MTF.

424. Preparing for the mission

As the patient movement technician, you need to make sure documents are prepared for the flight. This includes the AF Form 3899, mission documents, medical records and documents, laboratory reports, medication and most importantly, the patient.

Print 3899

One of the documents you need to prepare for a mission is the Automated 3899. To prepare this document, all you have to do is print it from TRAC2ES (figs. 2–9, 2–10, and 2–11).

PATIENT MOVEMENT REQUEST
DATA PROTECTED BY PRIVACY ACT OF 1974

Created on: Lo-Side **Run Date:** 162 2014

PATIENT DEMOGRAPHICS Cite # 2415310015

Patient Name: Smith, Jane **Date of Birth:** 09/23/2030
Status: N11 **Tracking Number:** 15014101555223WN01828645 **Special Team:** None **Special:** N
ID: 049547015 **Grade:** O05 **Cite Number:** 2415310015 **Classification:** 2B **Precedence:** Routine
Nationality: UNITED STATES **Age:** 29 Year **Gender:** Female

UNIT INFORMATION Cite # 2415310015

Unit Name: 43 AES **Duty Station:** Naval Base/Pt Loma
City: San Diego **Com Phone:** 555-123-4567 **Com Fax:**
State/Province: NORTH CAROLINA **DSN Phone:** **DSN Fax:**
Country: UNITED STATES **PCS Code:**

POR INFORMATION Cite # 2415310015

Address: 1305 Elm St **City:** New Kensington **State:** PENNSLVANIA
Country: UNITED STATES **Postal Code:** 15068 **Phone:** 555-789-4376

MOVEMENT INFORMATION Cite # 2415310015

Injury Type: **Comm Transport?:** N **Transport Origin:**
Space Type: Ambulatory **Will Return:** N **Transport ID:**
Exception Policy: **Transport Destination:**
PEB completed Separation Date 15Jun14
Transport Other Comments:

Movement Remarks:
TPMRC-A UPDATE MA changed to Kate Jones, COL. DO aware. Per NMC, San Diego, the MA is a Medical necessity to fly with this patient.//PMCC/cml.
TPMRC-A UPDATE: JD156/2227z: PMR reviewed by TVFS Col Waldo; Pt validated Routine,1C with MA, San Diego, Ca to Portsmouth, Flight line to Flight line, Stops Unrestricted, RON unrestricted, CAR unrestricted. CAA Authorized/Approved.//NRA PMCC

ADMINISTRATIVE DATA Cite# 1415310015

Originating MTF: NMC-SAN DIEGO (PRC) **Ready Date:** 155 2014 0001
Destination MTF: PRC PORTSMOUTH (NMCP) **Reason Regulated:** BA
Appt: 160 2014 0001 **Casualty Event:** **Source System:** T-WEB
Transport Mode: MA **Planned Departure Date:** **Planned Arrival Date:**
Originating MTF: **DSN Phone:** **Com Phone:** 412-532-7058-Mr. Barker
Attending Physician: CDR B. Reina **DSN Phone:** **Com Phone:** 412-532-6200
Ward Name: 1- North **DSN Phone:** **Com Phone:** 412-532-6210
Destination MTF: **DSN Phone:** **Com Phone:** (424) 953-5919
Accepting Physician: CDR. J. Reed **DSN Phone:** **Com Phone:** 424-953-7374
Last PMR State Changed by: T_GOODWIN **DSN Phone:** 339-4200 **Com Phone:**
Max Stops: Unrestricted **Max RONs:** Unrestricted **Altitude Restriction:** None **Clr'd for Comm Trav:** N
Last Validated: 156 2014 2235

CLINICAL DATA Cite# 1415310015

Primary Med Spec: MPPG-Psychiatry (General Care) **Primary Diagnosis:** 296.01-BP I DISORD,1 MANIC EPISD,MILD
Secondary Med Spec: MPPG-Psychiatry (General Care) **Secondary Diagnosis:** 311-DEPRESSIVE DISORDER NEC
Other Med Spec: - **Other Diagnosis:** -

Patient History:29 y/o female with primary diagnosis of spinal cord compression and positive LOC. Pt currently A&O(x3). Pt able to move all extremities well. Good CMS to all extremities. Fingers and toes pink and warm with cap refill < 3 sec. C/o intermittent pain and tingling to BLE. Pain currently 2/10 to BLE. Denies any SOB or CP. Foley draining adq amt yellow urine. Tolerating regular diet. Sats >93% on 2LNC. VS are stable and pt is ready for AE flight. Check VS q 4 hrs. Neuro checks q 2hrs. Neurovascular checks q 4 hrs. Strict I & O's.

Figure 2–9. Patient movement request, page 1.

MEDICATIONS (17 Rows) Cite # 1415310015

Medication Name	Dose	Frequency	Route
Milk of Magnesia	30ML	TID	Oral
Lithium Carb	1200MG	QHS	Oral
Benztropine	1MG	BID	Oral
Omeprazole	40MG	Daily	Oral
Acetaminophen	975MG	Q8H- PRN for HA	Oral
Benadryl	50MG	Q6H - PRN-Offer	Oral
Benadryl	50MG	1st vice I.M. Q6H- PRN - severe Agitation	IM
Haldol	10MG	Q6H-PRN-offer	Oral
Haldol	10MG	PO 1st vice I.M. Q6h-PRN-severe Agitation	IM
Atarax	50MG	Q6H-PRN-severe Agitation	Oral
Ativan	1MG	Q4H-PRN	Oral
Ativan	2MG	Q6H-PRN- severe Psychosis	Oral
Ativan	2MG	Q6H-PRN-offer	IM
Zyprexa	10MG	PO before I.M. BID - PRN	IM
Imitrex	50MG	Daily- PRN- for Migraine	Oral
Ambien	5MG	QHS -PRN	Oral
Albuterol	1 Puff	Q2H - PRN for SOB	Inhaled

IV's (0 Rows) Cite # 1415310015

IV Location	IV Type	Solution	Rate cc/hr

Allergies:
Y-Phenergan / Percocet / Sulfa Drugs

VITAL SIGNS and LABS Cite # 1415310015

Temperature: 97.5 F **Pulse:** 66 **Respiratory:** 16 **BP:** 99 /51 **Wt:** 73.0 kgs
HGB: 12.7 **HCT:** 38.5 **WBC:** 5200 **Date Taken:** 155 2014
SPO2 Rate: **Oxygen Mode:** **Oxygen Rate:**
SPO2 Rate Comments:
pH: **PO2:** **PCO2:** **HCO3:** **BE:**
Ventilator Mode: **FIO2:** **TV:** **Rate:** **PEEP:** **PS:**

DRAINAGE (0 Rows) Cite #

Drainage Location	Type	Suction Type	Suction Amount

ORTHOPEDIC (0 Rows) Cite #

Type	Location

PMI DATA Cite # 2415310015

Cardiac Monitor: N **Suction:** N **Pulse Ox:** N **Incubator:** N **Wound Vac:** N
Ventilator: N **Pump:** N **Stryker:** N **Traction:** N **Backrest:** N
Other Equipment:

DIET INFORMATION Cite # 2415310015

Feeding Tube Type: **Formula:** **Pump:** N **Infusion Rate:**
Amount: **Special Diet:** Regular
Special Diet Other:

TRANSPORTATION INFORMATION Cite # 2415310015

Orig Transport Name: MaxCare **POC:** Dispatcher **Com Phone:** 800-603-4629 **DSN Phone:**
Dest Transport Name: Medevac Staff **POC:** OFMLOS-HM3 Walters **Com Phone:** 757-417-5483-Duty Cell **DSN Phone:**

Figure 2–10. Patient movement request, page 2.

ADMIN REMARKS: CITE #

ATTENDANTS (1 Rows) Cite # 2415310015

Attendant Name	Status	Grade	Age	Date of Birth	Weight	Gender	Type	Team Type	Commercial Ticket Cost	Commercial Ticket No.
Bayne, Catherine	Navy Active Duty	Officer Grade O6	52 Year	12/03/19 61	145	Female	Nurse			

Number of Attendants from Group PMR: 0

Attendant Names from Group PMR:

ITINERARY (2 rows) Cite # 2415310015

Mission ID	Aircraft	Origin ICAO	Destination ICAO	Proposed Departure Time	Proposed Arrival Time	Actual Departure Time	Actual Arrival Time
JLWGI461A161	STRATOTANKER	KNKX	KADW	161 2014 1630	161 2014 2055	161 2014 1655	161 2014 2110
OLAKA211B161	CIVILIAN AIR AMBULANCE	KADW	KORF	161 2014 2100	161 2014 2154	161 2014 2153	161 2014 2226

RON INFORMATION (0 rows) Cite #

RON Location	RON Period	RON Comments

BILLING INFORMATION Cite # 2415310015

Insurance Ranking
Policy Holder Last Name, First Name
Point of Contact
Billing Agency
Policy Number
Policy Holder SSN
Relationship to Holder
Memo:

Address
City, State/Province
Country, Postal Code
POC Phone

PMR Commercial Ticket Cost $.00 **PMR Commercial Ticket Number**

Figure 2–11. Patient movement request, page 3.

Request itinerary

When you request an itinerary from this screen you view the itinerary for that selected PMR.

Cancel patient movement record

When you click on CANCEL PMR button, it will cancel the PMR; however, you may not be able to cancel certain PMRs due to which state they are in.

Request a 3899

You will be able to select the pages of the Form 3899 that you want to view. If you do not select a specific page to view, the default will automatically provide the 3899 and 3899A pages.

Mission documents

Once all the PMRs are loaded, you want to ensure everyone you entered is on the manifest for the appropriate flight. To validate all patients are registered and accepted to a flight, you need to find the mission, and then print the Mission Manifest Report Cover Sheet from TRAC2ES. The mission document lists information such as mission legs, flight times, manifest, special equipment, and so forth. Additional documents that you will print from TRACE2ES include the Patient Listing, Patient

Baggage Listing, Patient Special Equipment Information, Patient Special Diet Information, and Patient Record Information (figs. 2–12, 2–13, 2–14, 2–15 2–16, 2–17, and 2–18).

Date/Time: 162 2014 1458

Mission Manifest Report - Cover Sheet

Created on: Lo-Side

Mission Information

Mission ID	Mission Type	Mission Precedence	Tail#	Call Sign	Total Manifested
JLGWI461B111	Air Evacuation	Routine	00346		0-1+1=2

Type Aircraft: KC135 - AE Modification

Crew Information (0 row(s) retrieved)

Name	Crew Type	Crew Org Info

Patients and Attendants Headcount Per Leg (2 airfield(s) retrieved)

ICAO	ICAO Name	Sched Arrival	Sched Departure	Enplane	Deplane	OnBoard
KNKX	MIRAMAR MCAS	-	161 1630	0-1+1=2	-	0-1+1=2
KADW	ANDREWS AFB	161 2055	-	-	0-1+1=2	-

Litter and Ambulatory Spaces Used Per Leg (1 leg(s) retrieved)

Origin ICAO	Dest ICAO	Litter Spaces Used	Seats Spaces Used	Litter Spaces Remaining	Seats Spaces Remaining	Max Altitude	Special	Special Team
KNKX	KADW	0	2	53	-2	None	N	N

Mission Remarks

Remarks Type	Remarks	Last Updated Date-Time	Last Updated By

Remarks

Figure 2–12. Mission document, Front.

Medical Crew Director Signature: _____ (name and grade)

Authentication Officer Signature: _____ (name and grade)

Figure 2–13. Mission document, Back.

QUALIFICATION TO POSSESS FIREARMS OR AMMUNITION

PRIVACY ACT STATEMENT

AUTHORITY: 18 U.S.C. 922(g)(9); E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain information to determine if you have been convicted of a crime of domestic violence which would disqualify you from shipping, transporting, possessing or receiving either Government-issued or private firearms or ammunition and to determine if reassignment, reclassification, detail or other administrative action is warranted. Your Social Security Number is solicited solely for purposes of verifying your identity.

ROUTINE USE(S): To the Department of Justice so that such information can be included in the National Instant Criminal Background Check System which may be used by firearm licensees (importers, manufacturers or dealers) to determine whether individuals are qualified to receive or possess firearms and ammunition.

DISCLOSURE: Mandatory for all personnel who are required to certify. Failure to provide the information may result in (1) (military only) the imposition of criminal or administrative penalties for failing to obey a lawful order, and (2) (civilian only) the imposition of administrative penalties, to include removal from Federal service. However, neither your answers nor information or evidence gained by reason of your answers can be used against you in any criminal prosecution for a violation of Title 18, United States Code, Section 922(g)(9), including (military only) prosecutions under the Uniform Code of Military Justice, based on a violation of Section 922(g)(9), for conduct which occurred prior to the completion of this form. The answers you furnish and any information resulting therefrom, however, may be used against you in a criminal or administrative proceedings if you knowingly and willfully provide false statements or information.

SECTION I - INSTRUCTIONS

An amendment to the Gun Control Act of 1968 (18 U.S.C. 922) makes it a felony for anyone who has been convicted of a misdemeanor crime of domestic violence to ship, transport, possess, or receive firearms or ammunition. It is also a felony for any person to sell or otherwise dispose of a firearm to any person so convicted.

The Department of Defense has, by policy, expanded the prohibitions contained in Title 18 Section 922(g)(9) to those military or civilian personnel who have felony convictions for crimes of domestic violence. Convictions of crimes of domestic violence do not include summary court-martial convictions, the imposition of nonjudicial punishment (Article 15, UCMJ), or deferred prosecutions (or similar alternative dispositions) in civilian courts. Furthermore, a person shall not be considered as having committed a "crime of domestic violence" for purposes of the firearms restriction of the Gun Control Act unless all of the following elements are present:

(1) the person was convicted of a crime;

(2) the offense has as its factual basis the use or attempted use of physical force, or threatened use of a deadly weapon;

(3) the convicted offender was at the time of the offense:
- (a) a current or former spouse, parent or guardian of the victim,
- (b) a person with whom the victim shared a child in common,
- (c) a person who was cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or
- (d) a person who was similarly situated to a spouse, parent, or guardian of the victim;

(4) the convicted offender was represented by counsel, or knowingly and intelligently waived the right to counsel;

(5) if entitled to have the case tried by jury, the case was actually tried by jury or the person knowingly and intelligently waived the right to have the case tried by jury;

(6) the conviction has not been expunged or set aside, or the convicted offender has not been pardoned for the offense or had civil rights restored, unless the pardon, expungement, or restoration of civil rights provides that the person may not ship, transport, possess or receive firearms.

If you have ever received a domestic violence conviction: (1) you may not possess any firearm or ammunition; and (2) you must return any Government-issued firearm or ammunition to your commander or immediate supervisor; and (3) you must take steps to relinquish possession of any privately owned firearms or ammunition. Furthermore, any previously issued authorization to possess a firearm or ammunition is revoked.

If you have any questions, or you are uncertain if you have such a conviction, you may wish to contact a legal assistance attorney, if eligible, or a private attorney, at your own expense.

SECTION II - QUALIFICATION INQUIRY *(Complete and return to your commander or immediate supervisor within 10 days of receipt)*

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME OF DOMESTIC VIOLENCE AS DESCRIBED ABOVE: *(Initial and date)*

YES	NO JND	I DON'T KNOW *(Provide explanation on reverse)*

2. IF YOU ANSWERED "YES" TO THE FIRST QUESTION, PROVIDE THE FOLLOWING INFORMATION WITH RESPECT TO THE CONVICTION:

a. COURT/JURISDICTION	b. DOCKET/CASE NUMBER
c. STATUTE/CHARGE	d. DATE SENTENCED *(YYYYMMDD)*

3. CERTIFICATION. I hereby certify that, to the best of my information and belief, all of the information provided by me is true, correct, complete, and made in good faith. I understand that false or fraudulent information provided herein may be grounds for criminal and/or administrative proceedings, to include (if civilian) adverse action, up to and including removal, and (if military) disciplinary action under the Uniform Code of Military Justice. I further understand that I have a continuing obligation to inform my Commander or Supervisor should I be convicted of a crime of domestic violence in the future.

a. NAME *(Last, First, Middle Initial)*	b. RANK/GRADE	c. SOCIAL SECURITY NUMBER
DOE, JOHN N.	SRA/E-4	123-45-6789

d. ORGANIZATION	e. SIGNATURE	f. DATE SIGNED *(YYYYMMDD)*
81st MDSS/SGSX		20140613

DD FORM 2760, DEC 2002 PREVIOUS EDITION IS OBSOLETE. Reset Adobe Professional 7.0

Figure 2–14. Patient listing.

Report Date: 162 2014 1458

PATIENT BAGGAGE LISTING

MISSION ID: **JLGWI461B111**

Created on: Lo-Side

Baggage Technician Name:_____Grade:_____Signature:_____

Name	Enplaning ICAO	Destination MTF	Deplaning ICAO	Baggage Tag #s	Signature for Baggage Received
Doe, Catherine -	KNKX -	PRC PORTSMOUTH (NMCP) -	KADW -	-	_
Smith, Jane	KNKX -	PRC PORTSMOUTH (NMCP) -	KADW -	001 -	_
Smith, Jane	- KNKX -	PRC PORTSMOUTH (NMCP) -	KADW -	002 -	_

OTHER BAGGAGE

Last Name	First Name	MI	Enplaning ICAO	Deplaning ICAO	Baggage Tag #s	Signature For Bag Received

Figure 2–15. Patient baggage listing.

TRAC2ES :: Manifest Report

Report Date: 162 2014 1458

PATIENT SPECIAL EQUIPMENT INFORMATION

MISSION ID: **JLGWI461B111**

Created on: Lo-Side

Patient Name	Enplaning ICAO	Deplaning ICAO	Special Equipment	Other Equipment Description
Smith, Jane	KNKX -	KADW -	-	-

Figure 2–16. Patient special equipment information.

TRAC2ES :: Manifest Report

Report Date: 162 2014 1458

PATIENT SPECIAL DIET INFORMATION

MISSION ID: **JLGWI461B111**

Created on: Lo-Side

Patient Name	Enplaning ICAO	Deplaning ICAO	Feeding Special Diet	Special Diet Description
Smith, Jane	KNKX -	KADW -	Regular -	-

Figure 2–17. Patient special diet information.

Report Date: 162 2014 1458

PATIENT RECORD INFORMATION REPORT

MISSION ID: **JLGWI461B111**

Created On: Lo-Side

Medical Crew Director: , / _____

Patient Last Name	Patient First Name	Enplaning ICAO	Deplaning ICAO	IP	OP	XR	DD 602	MED	Signature of Records Receiver
Smith -	Jane	KNKX-	KADW-						

Figure 2–18. Patient record information report.

Country requirements

Ensure patients and attendants meet passport, visa, and immunization requirements of the country in which the destination hospital is located. Your patient movement center will notify you of special administrative requirements your patients may require for the flight (i.e., visas). Although you may not be able to do everything for your patients, assist them as much as you can. For example, make them an appointment as required, and coordinate any paperwork prior to the appointment. Alleviating stress an ill or injured patient is going through can alleviate problems before they arise, and can lead to a smooth patient movement process.

Preparing travel orders

Prepare valid, funded travel orders for all US Armed Forces and non-US Armed Forces patients and attendants (revenue reimbursable/pay patients). To prevent patient movement delays, ensure Active-duty patients' orders authorize alternate methods of transportation. Finally, attach the "Secretarial Designee" letter (if applicable) authorizing AE and specifying the reimbursement rate.

Prepare medical records

Place all medical records (clinical records, outpatient treatment records, X-rays, and any other pertinent patient information) in an envelope affixed with a properly completed DD Form 2267, Aeromedical Evacuation-Medical Records, or clearly marked with the following:

- The patient's name.
- Rank or status.

- SSN.
- Nationality (if not a US citizen).
- Organization.
- Date of departure.
- Destination.

Labs

Print the patient's histopathological sections. Additionally, this information is transferred to the DD Form 602, Patient Evacuation Tag when the patient enters the AE system.

Medications

Make sure the attending physician writes orders for a 3-calendar-day (intratheater) or 5-calendar-day (intertheater) supply of all medications, intravenous fluids, tube feedings, and treatment supplies the patient requires.

Clothing patients

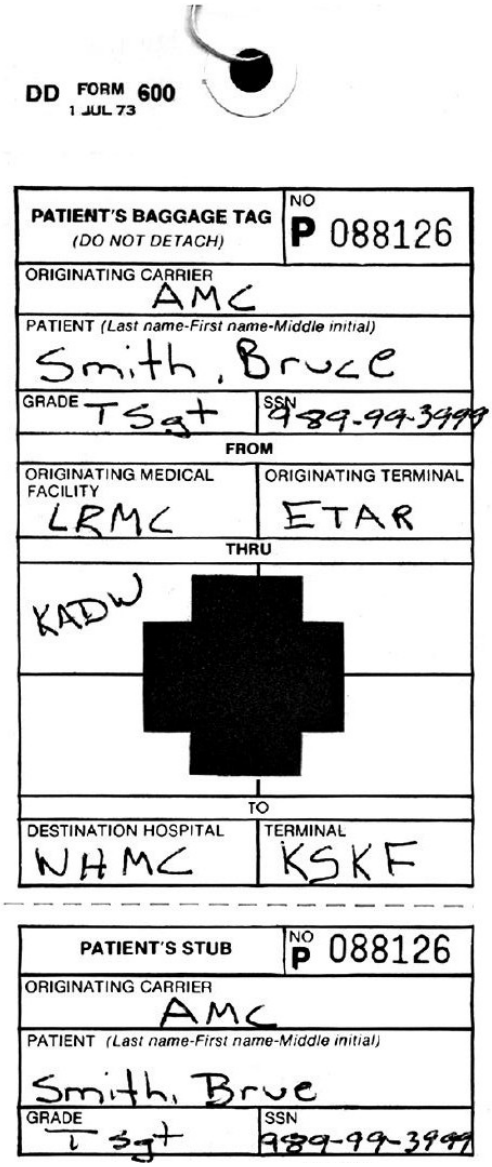
Ensure that patients who do not wear hospital pajamas wear appropriate conservative seasonal attire and ambulatory patients wear the appropriate service uniform or civilian clothes. **EXCEPTIONS*:*** These clothing requirements do not apply during field maneuvers, field exercises, or other unusual circumstances.

DD Form 600, Patient Baggage Tag

Complete the DD Form 600, Patient Baggage Tag for each piece of baggage to be checked and stowed. Most of the entries on it are self-explanatory. Look at the sample DD Form 600 on figure 2–19 as you review everything on the following table:

DD Form 600 Entries		
Item No.	**Block Entry**	**Explanation**
1	Originating Carrier	This entry will virtually always be AMC or Air Mobility Command. There may (rarely) be special circumstances when a beneficiary travels on some type of commercial carrier as opposed to AMC aircraft. But AMC is the predominant choice that most patient movement technicians will utilize in this field.
2	Patient	Self explanatory.
3	Grade	Self explanatory.
4	SSN	Self explanatory.
5	Originating Medical Facility	Enter the name of the facility requesting AE.
6	Originating Terminal	Enter the ICAO code of the flightline where the aircraft will be departing.
7	Thru Blocks (red cross area)	This information is helpful to the flight crew who are responsible for on-loading and off-loading of the baggage. Notice the ICAO code for Andrews (KADW) has been written in the block located to the left of the *red* cross. This informs the crew that patient Smith will be RONing at KADW prior to flying to his final destination at SAMMC. When the crew arrives at Andrews, they will know to unload TSgt Smith's baggage for his overnight stay.

DD Form 600 Entries		
Item No.	**Block Entry**	**Explanation**
8	Destination Hospital	Enter the name of the facility where patient is to receive treatment.
9	Terminal	Enter the ICAO code of the flightline where patient will deplane en route to the final destination MTF.
10	Patient's Stub	Information on the patient's stub of the DD Form 600 is self explanatory. This is given to the patient as a receipt for the checked baggage similar to the system you would find in most civilian airlines.


DD FORM 600
1 JUL 73

PATIENT'S BAGGAGE TAG
(DO NOT DETACH)
NO P 088126
ORIGINATING CARRIER AMC
PATIENT (Last name-First name-Middle initial) Smith, Bruce
GRADE TSgt
SSN 989-99-3999
FROM
ORIGINATING MEDICAL FACILITY LRMC
ORIGINATING TERMINAL ETAR
THRU
KADW
TO
DESTINATION HOSPITAL WHMC
TERMINAL KSKF

PATIENT'S STUB
NO P 088126
ORIGINATING CARRIER AMC
PATIENT (Last name-First name-Middle initial) Smith, Bruce
GRADE TSgt
SSN 989-99-3999

Figure 2–19. Sample DD Form 600, Patient's baggage tag.

DD Form 602, Patient Evacuation Tag

Prepare DD Form 602, Patient Evacuation Tag. This form serves as the patient's only chart during AE. The destination MTF files DD Form 602 in the patient's medical record.The attending physician ensures the DD Form 602 includes all essential patient information. The physician also completes orders for all treatments and medications that the patient requires during travel. The physician ensures the accuracy and currency of the information, and signs DD Form 602. The attending physician also ensures that medical personnel attach a legible copy of the Standard Form (SF) 502 to the DD Form 602 for all inpatients and patients placed into the aeromedical evacuation system (figs. 2–20 and 2–21).

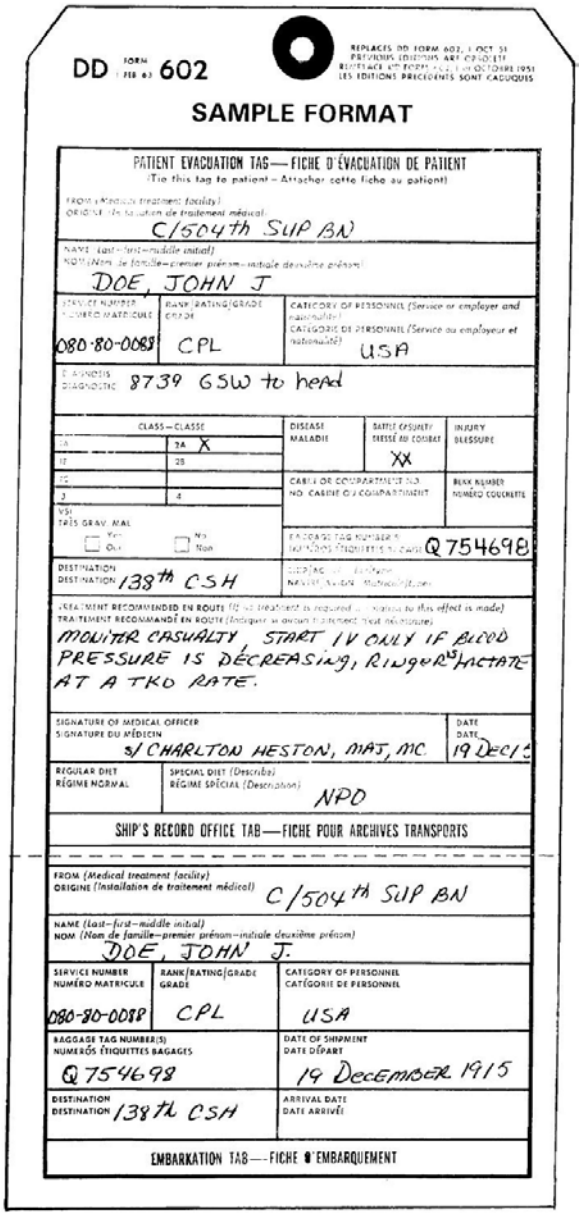


Figure 2–20. DD Form 602, Patient evacuation tag (front).

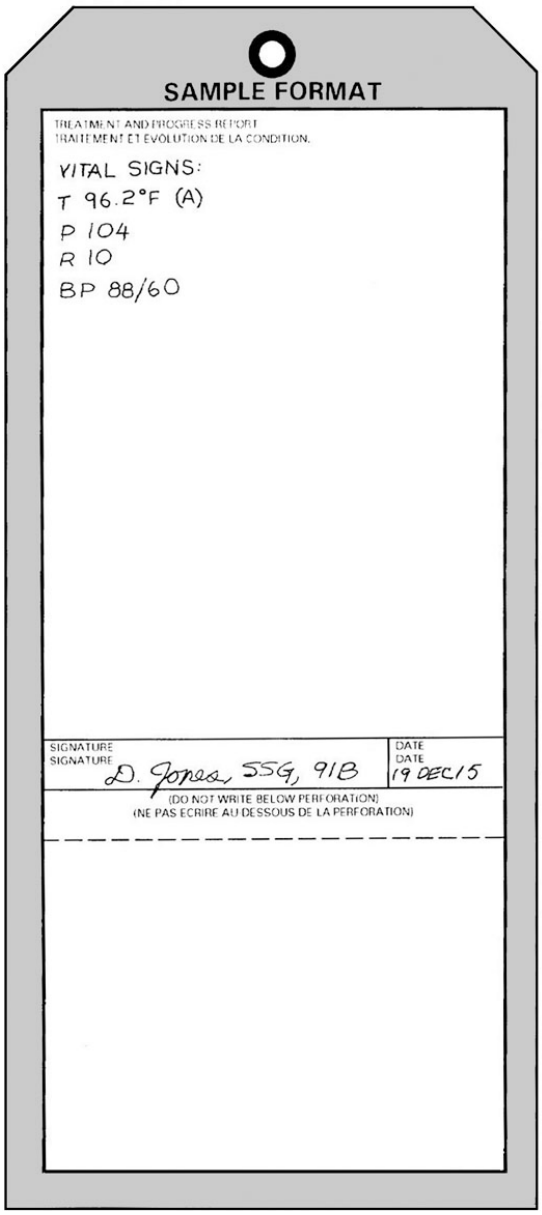


Figure 2–21. DD Form 602, Patient evacuation tag (back).

Brief patients

One very important step is to thoroughly brief patients and attendants before departure. Verbal or written briefings should include the following items (as applicable):

- Personal funds.
- Appropriate dress.
- Safety and egress procedures.
- No smoking on AE missions.
- An overview of the AE system.
- Availability of in-flight insurance
- Outpatient travel will be at own expense.
- Mandatory search of baggage and person.
- Accessibility of all checked baggage at all RONs.
- US Department of Agriculture & Customs inspections (if applicable).
- Responsibility to pay transportation charges and in-flight medical charges (if applicable).
- The potential for remaining overnight in the AE system and the possible regrouping of patients.
- A specific route (when known), including the estimated time and the number of planned stops (when known).
- Provide patients and attendants with a copy of the worldwide AE Patient Information brochure and Patient Reaction Survey.
- The expectations at the destination medical facility, including procedures for patients and non-medical attendants using aeromedical staging squadrons (ASTS).
- Baggage limitation for checked and hand-carried items. Stowed baggage may not have dimensions exceeding 72” in any one direction, or 100” overall (length + width + height), and must be sufficiently durable to withstand handling during transportation.
- Maximum weight for checked baggage is 66 pounds.
- Any other information helpful to the patient.

Anti-hijacking search

Accomplish anti-hijacking search certificate for each patient and attendant. See figure 2–22 for a sample. The patient movement technician must also conduct anti-hijacking procedures to include the following:

- Inspect patients and attendants either with a hand held or walk through metal detector.
- X-ray machine, or by a physical check.
- Inform passengers that they cannot carry weapons or explosives aboard. If authorized weapons are carried onboard, notify aircrew of seating location of individuals(s) with weapons.
- Conduct all inspections with the highest standard of military courtesy.
- Notify security police if you find suspicious items.
- Restrict inspected patients and attendants to a holding area.
- Redo the inspection for personnel who leave a holding area after you have finished.
- Inspect all hand carried items.
- Honor requests for visual inspection instead of using X-ray or metal detectors.
- Deny boarding to individuals refusing anti-hijacking inspection.

- Identify any patient or attendant showing suspicious behavior to the medical crew.
- Arrange for guards to accompany prisoner patients to their destination.
- Exempt classified materials held by official couriers from inspections.

Competent non-psychiatric patients may keep items such as small pens, knives (3-inch blades or less), shaving razors or small scissors. Additionally, you must honor requests for visual inspection in-lieu of X-ray or metal detectors.

NOTE: Only authorized personnel may carry weapons on board aircraft. Call security forces if you find weapons of non-authorized personnel for appropriate weapon disposition. Notify aircrew of seating location of individual(s) with authorized weapons.

ANTI-HIJACKING STATEMENT	MSN NUMBER

PATIENT/ATTENDANT NAME	GRADE	ONLOAD	OFFLOAD	REMARKS
Handler, Chelsea M.	E05	OAKN	OAIX	
Fallon, Jimmy E.	E07	OAKN	OAIX	
Fey, Tina M.	E03	OAKN	OAIX	
Samberg, Andy P.	CIV	OAKN	OAIX	
Murphy, Charlie W.	E05	OAKN	OAIX	
Williams, Katt S.	E04	OAKN	OAIX	
Samberg, George W.	CIV	OAKN	OAIX	
Wiig, Kristen A.	E05	OAKN	OAIX	

ANTI HIJACKING STATEMENT

IAW AFI 13-207, I CERTIFY THAT AN INSPECTION OF THE ABOVE LISTED PATIENTS, MEDICAL AND NON-MEDICAL ATTENDANTS, AND A PHYSICAL SEARCH OF THEIR HAND CARRIED ITEMS, WAS CONDUCTED PRIOR TO DEPARTURE FROM THEIR ORIGINATING STATION AND THAT NO EXPLOSIVE DEVICES, UNAUTHORIZED WEAPONS OR OTHER COUNTRABAND WAS FOUND;

_____

INSPECTOR OR AEROMEDICAL EVACUATION REPRESENTATIVE

Figure 2–22. Sample anti-hijacking search certificate.

425. Flight arrival

Finally, all the patients are ready for movement. The patients are briefed, searched and secure, and their documentation is secured and with you. Now, you are ready for the flight to land and complete the patient movement process.

Litters

Class 2 patients, or litter patients, are required to be on litters when they move; however, there are only three types of litters patients can be moved on. They are the NATO litter, Army decontamination litter, and the overweight patient litter.

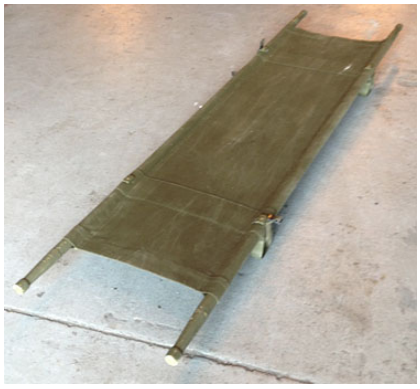


Figure 2–23. NATO litter.

North Atlantic Treaty Organization litter

The NATO litter is green canvas with wooden poles and lifting handles (fig. 2–23). The spreader bar allows the litter to fold or expand length-wise, in half. Do not use NATO litters for patients being transported on AE flights. Also, do not use NATO Litters with tears greater than 1 inch.

Army decontamination litter

The patient support material is green or black polypropylene with aluminum poles and nylon (telescoping) handles. Litter pole length can be adjusted from 90 inches to 94.4 inches to accommodate placement in helicopter. The spreader bar allows the litter to fold or expand length-wise, in half. Do not exceed a 350 pound maximum load on the Decon litter.

Overweight patient litter

The overweight patient litter (OWL) is used to transport non-ambulatory patients of excess weight and extreme abdominal girth (fig. 2–24). It is a bifold type litter designed to support patients and equipment to a maximum weight of 350 lbs. When fully extended, it measures 90” x 31” x 6.” It uses a nomex/kevlar blend material and has two seat belt type patient restraints attached at top and bottom of the litter.

Figure 2–24. Overweight patient litter.

Support

If you have litter patients, make sure you have the proper support to get the patient to the plane. If the patient is on a litter that is attached to wheels, one or two personnel should suffice. However, if you are in a deployed location, you may not be able to use a stretcher with wheels. You will have to make sure you have enough individuals to move the patients. A stretcher requires at least four people for movement (fig. 2–25). Other patients may require more people to carry the litter. For example, critical care air transport teams (CCATT) care for severely injured or ill patients that require advanced specialty medical equipment and care during evacuation (fig. 2–26). These patients can have an additional 100 pounds of medical equipment attached to them. If the patient weighs 215 pounds, then to total weight

with all of the equipment could easily be over 300 pounds! That is a lot of weight, and you need to give special consideration when planning to move these critically ill or injured patients. When planning movement, ensure there are enough people to safely lift and move the patient as required.

Figure 2–25. Transporting patients to the aircraft.

Figure 2–26. Transporting a CCATT patient.

Accepting patients

As an aerovac technician, you are also responsible for accepting patients though the aerovac system. If a patient returns from treatment, or if patients come to your hospital for treatment, you should know what to do.

Remaining over night

AE missions may require either scheduled or unscheduled RON stops. MTF commanders at locations where RONs occur are responsible for the care of patients and securing medical records and narcotics during the stop. If you do have a patient that needs to remain overnight, you should take the following steps:

1. Provide personnel to help get patients out of and back into the plane.
2. Admit and assign patients to the medical facility (civilian or military) or a billeting facility as appropriate.
3. Feed patients.
4. Prepare and manage records.
5. Consult with patients as appropriate.
6. Maintain medical equipment.
7. Provide medical supplies for the rest of the AE mission as needed.
8. Help shelter and transport AE crews.
9. Medically evaluate each patient daily.
10. Record evaluation, treatments, and medications on DD Form 602.
11. Prepare patients both clinically and administratively for further AE travel.
12. Provide safekeeping of patient valuables.

Release from the aerovac system

The AE clerk aids in the completion of documentation for patients wishing to be released from the AE system prior to completion of travel or treatment. A patient's signature on a release certificate indicates release of the AE system from responsibility and liability.The patient is advised that the purpose of the certificate is to release the US Government, its agents and employees from all responsibility for further AE services arising pursuant to the patient's movement, and all liability for damage resulting.

The release should indicate that the patient desires to be released from the AE system of his or her own free will. The patient must also certify that he or she will proceed by his or her own means of transportation. A determination will be made to ensure that the patient is sufficiently competent to understand the consequences of his or her decision. If not competent, advice is requested from a medical officer or the staff judge advocate (SJA) at the place of requested debarkation, if such personnel are available. Refusal to sign the certificate will be noted in the patient's medical record. Active duty personnel may *not* be released from the AE system against medical advice. If a military member wishes to leave the system, contact the individual's unit commander. Outpatients and patients returning from treatment who have been discharged, and do not require medical care, are not required to sign a release from medical care.

MTF personnel removing a patient from the AE system before the patient arrives at the destination hospital are responsible for immediately notifying the destination hospital, the referring provider and TPMRC/JPMRC.

Complete a patient movement request

After a patient has arrived at the destination MTF and the PMR is no longer playing an active role in tracking or monitoring, but *is* still needed for reports and trends analysis, the current business practice is to place that PMR in the completed state (marking the record as complete in TRAC2ES).

1. Open the PMR that needs to be completed by either searching for it or requesting it.
2. When the PMR appears, click on the 'Complete' button that is located in the Tabs bar. The complete PMR page appears and describes the fields of the complete PMR, which are

Planned Destination MTF, Actual Destination MTF, Arrival Date-Time, and Destination Remarks.

3. Enter the Actual Destination MTF if it is different from the planned Destination MTF.
4. Enter a remark in the Destination Remarks text field if you entered data in the Actual Destination MTF field.
5. Enter the actual Arrived Date – Time (ddd yyyy mmm).
6. Click on the COMPLETE button.

This will submit the changes you just made to the database and complete the patients' movement.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

422. Patient classification and precedence

1. Who determines the appropriate classification of a patient for movement within the AE system?

2. How many AE classification codes may be used for AE transportation?

3. What is the classification 1B?

4. What class is used for a recovered patient returning to home station?

5. What is classification 5C?

6. What are the three AE movement precedents?

7. Which precedence should be utilized for a patient who needs AE movement within 24 hours?

8. How long are routine patients capable of waiting for evacuation?

423. Initiate patient movement request

1. Within the AE system, when does the attending physician's responsibility to the patient end?

2. What AF Form does the attending physician have to complete for their patients AE travel?

3. Who needs to consult with the accepting physician at the destination MTF?

4. What SF Form(s) does the attending physician have to complete for their patients' AE travel?

5. Once the attending physician hands the patient movement technician the AF Form 3899, what form do they start working on?

6. What is a four-letter code that represents the flight line where the patient is to be transported from?

7. What does 'MAX STOPS' mean?

8. What are some reasons there may be an altitude restriction?

9. How much IV medication should the physician order for an intratheater flight?

10. What information should be in the 'RATE CC/HR' block?

11. What is the maximum allowable weight for infants if an incubator is required?

12. What website is used when web browser interface is limited?

424. Preparing for the mission

1. What information does the mission document provide?

2. When preparing medical records for the mission, what does 'medical records' include?

3. What form are the histopathological results also included on when the patient enters the AE system?

4. In what circumstances do the clothing requirements not apply?

5. What form is required for each piece of baggage that is checked and stowed?

6. What form serves as the patient's only chart during AE?

7. What is the baggage limitation for AE?

8. What should you do if you find a weapon on a non-authorized person?

425. Flight arrival

1. How many people should you have to carry a litter?

2. How much additional weight could a CCATT patient/equipment add to a litter?

3. What should be secured if you have a patient that will remain over night?

4. How often should a patient that is in 'RON' status be evaluated?

5. Who is not able to release themselves from the AE system against medical advice?

6. When MTF personnel remove a patient from the AE system before the patient arrives at the destination hospital, who are they responsible to immediately notify?

7. What is the final step when the patient is at the destination MTF and no longer being tracked?

Answers to Self-Test Questions

418

1. Forward, theater, strategic, domestic.
2. Aeromedical staging facility.
3. Mobile aeromedical staging facility.
4. C–130 Hercules, C–17 Globemaster, C–21 and the KC–135 Stratotanker.
5. Expeditionary Medical Support.
6. TRAC2ES.
7. Theater Patient Movement Requirement Center.

419

1. Clinical validation, limited patient in transit visibility, and evacuation requirements planning for intertheater patient movement and intratheater patient movement for CONUS.
2. Theater Patient Movement Requirement Center –Pacific.
3. Theater Patient Movement Requirement Center –Europe.
4. Deployable Joint Patient Movement Requirement Center.

420

1. Army Medical Department.
2. Platforms especially for the medical evacuation mission with allocated medical equipment specifically designed for the purpose of en route care and by trained medical personnel.
3. UH–60 Blackhawk, UH–60A Blackhawk, UH–1H/V Iroquois, and the CH–47 Chinook.
4. Priority II – Priority.
5. Priority III – Routine.
6. The patient’s medical condition.
7. They are often sent from the point of injury, through intermediaries, such as higher headquarters, who then transmit the request up to the nearest medical evacuation unit.

421

1. It is a system that records the patient’s medical evaluations while down range.
2. Theater Medical Data Store.
3. Inpatient care, outpatient care, blood status, medical surveillance, tracking medical supplies, occupational and environmental health and tracking patients through the aerovac system.

422

1. Attending physician.
2. Six.
3. Psychiatric litter patients of intermediate severity; patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus; restraining apparatus must be sent with the patient for potential use.
4. Class 3B.
5. Psychiatric outpatient, going for treatment or evaluation.
6. Urgent, priority, and routine.
7. Priority.
8. 72 hours.

423

1. When the patient is under the direct care of the accepting physician at the destination MTF.
2. AF Form 3899, Aeromedical Evacuation Patient Record.
3. The attending physician.

4. SF 502, Narrative Summary; SF 513, Consultation Sheet.
5. The patient movement request.
6. The origination ICAO.
7. The maximum number of stops that a patient can safely tolerate during the AE.
8. Some patients cannot fly over a certain altitude due to medical reasons. Occasionally, patients diagnosed with certain problems related to the ear may be candidates for altitude restrictions, i.e. these patients may not be able to effectively clear the ears, causing too much pressure as the altitude increases.
9. Enough for a three day supply.
10. If an intravenous additive or feeding is required, then describe the IV type. If more than one IV is required, list the IVs in sequence Enter frequency and dosage of ordered IVs.
11. Less than eight pounds.
12. The TRAC2ES-Mobile website.

424

1. Mission legs, flight times, manifest, special equipment, etc.
2. Clinical records, outpatient treatment records, X-rays, and any other pertinent patient information.
3. The DD Form 602.
4. During field maneuvers, field exercises, or other unusual circumstances.
5. DD Form 600, Patient Baggage Tag.
6. DD Form 602, Patient Evacuation Tag.
7. Stowed baggage may not have dimensions exceeding 72” in any one direction or 100” overall (length + width + height) and must be sufficiently durable to withstand handling during transportation. Maximum weight for checked baggage is 66 pounds.
8. Call Security Forces.

425

1. At least four people.
2. 100 pounds.
3. Medical records and narcotics.
4. Daily.
5. Active duty personnel.
6. Destination hospital, referring provider and TPMRC/JPMRC.
7. Mark the record as complete in TRAC2ES.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

Do not return your answer sheet to AFIADL.

39. (418) What phase of aeromedical evacuation (AE) provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and then to subsequent points of treatment within the combat zone?
    a. Theater.
    b. Forward.
    c. Strategic.
    d. Domestic.

40. (418) What phase of aeromedical evacuation (AE) provides airlift for patients between points of treatment outside the combat zone, within a theater of operations?
    a. Theater.
    b. Forward.
    c. Strategic.
    d. Domestic.

41. (418) Who approves the activation or inactivation of a designated aeromedical staging facility (ASF) or the partial curtailment of the mission assigned to an ASF?
    a. The President.
    b. AF Chief of Staff.
    c. Owning major command.
    d. Responsible combatant commander.

42. (418) The primary USAF aircrafts supporting intratheater aeromedical evacuation (AE) are all of the following, *except* the
    a. C–130 Hercules.
    b. C–17 Globemaster.
    c. KC–135 Stratotanker.
    d. UH 60 Q Medevac Black Hawk Helicopter.

43. (419) What patient movement requirement center (PMRC) is located at Scott Air Force Base (AFB)?
    a. JPMRC.
    b. TPMRC-A.
    c. TPMRC-E.
    d. TPMRC-P.

44. (420) Medical evacuation (MEDEVAC) typically is associated with what type of aircraft?
    a. Fixed wing.
    b. Heavy wing.
    c. Forced wing.
    d. Rotary wing.

45. (420) What priority is assigned to a patient who should be evacuated as soon as possible and within a maximum of one hour?
    a. I-Urgent.
    b. II-Priority.
    c. III-Routine.
    d. IV-Convenience.

46. (420) What priority is assigned to a patient who should be evacuated within 24 hours?
    a. I-Urgent.
    b. II-Priority.
    c. III-Routine.
    d. IV-Convenience.

47. (420) An air ambulance (AA) is typically conserved for what priority patient?
    a. I-Urgent.
    b. II-Priority.
    c. III-Routine.
    d. IV-Convenience.

48. (421) What information system does Theater Medical Information Program-Joint (TMIP-J) transfer so it can be viewed by authorized healthcare providers all over the world?
    a. CHCS.
    b. TMDS.
    c. ALTHA.
    d. Essentris.

49. (421) Which capability is not available in the Theater Medical Information Program-Joint (TMIP-J)?
    a. Blood status.
    b. Inpatient care.
    c. Notification status.
    d. Tracking medical supplies.

50. (422) A patient requiring the use of restraining apparatus, sedation, and close supervision at all times should be classified as a
    a. psychiatric walking patient of moderate severity.
    b. psychiatric litter patient of intermediate severity.
    c. litter patient other than psychiatric.
    d. severe psychiatric litter patient.

51. (422) Patients requiring rest during a long aeromedical evacuation (AE) flight because of recent surgery should be classified as
    a. litter.
    b. recovered.
    c. psychiatric.
    d. ambulatory.

52. (422) What classification is given to medical attendants flying in the aeromedical evacuation (AE) system?
    a. 6A.
    b. 6B.
    c. 5A.
    d. 5B.

53. (422) What classification is given to non-medical attendants flying in the aeromedical evacuation (AE) system?
    a. 6A.
    b. 6B.
    c. 5A.
    d. 5B.

54. (423) In the aeromedical evacuation (AE) system, the originating physician's responsibility for a patient ends when
    a. the patient is reported via the Transportation Command (TRANSCOM) Regulating and Command & Control Evacuation System (TRAC2ES).
    b. the Patient Movement Requirements Center (PMRC) assigns a cite number to the regulating request.
    c. the physician is notified by PMRC of the destination military treatment facility (MTF).
    d. the patient is under the direct care of the accepting physician at the destination MTF.

55. (423) Which individual is also a focal point that Theater Patient Movement Requirements Centers (TPMRC) personnel can contact for questions concerning a patient's movement?
    a. Admissions and dispositions technician.
    b. Unit inpatient records technician.
    c. Patient movement technician.
    d. TRAC2ES technician.

56. (423) The name of the attending physician entered on the AF Form 3899 is the
    a. patient's primary care manager (PCM).
    b. physician at the destination who is accepting the patient.
    c. physician who is treating the patient at the originating medical treatment facility (MTF).
    d. physician located were the patient will remain overnight (RON) and will take care of the patient.

57. (424) All of the following needs to be prepared for the flight, *except* for which item?
    a. Patient.
    b. Medical records.
    c. Laboratory reports.
    d. Attending physician.

58. (424) It's important to check the Mission Document for the flight in order to
    a. notify patient movement requirements center (PMRC) if there are changes to the patient movement request (PMR).
    b. make sure the patient movement request PMR information is correct.
    c. make sure everyone is entered is on the appropriate flight.
    d. make a change to the patient movement request PMR.

59. (424) Who will notify you of special administrative requirements your patients may require for the flight?
    a. The attending physician.
    b. The receiving physician.
    c. Patient Movement Center.
    d. Medical Readiness Office.

60. (424) What does the International Civil Aviation Organization (ICAO) code written to the left of the red cross on the DD Form 600, Patient's Baggage Tag represent?
    a. The facility where an aeromedical evacuation (AE) patient will remain overnight (RON) awaiting AE movement to the final destination.
    b. The civilian AE transport center where the patient will be transported.
    c. The patient's final military treatment facility (MTF) destination.
    d. The patient's originating MTF.

61. (424) Who's responsibility is it to ensure the DD Form 602, Patient Evacuation Tag, includes all essential patient information?
    a. The patient.
    b. The aerovac nurse.
    c. The attending physician.
    d. The patient movement clerk.

62. (424) The dimensions of stowed baggage for aeromedical evacuation patients must *not exceed*
    a. 78 inches in any one direction or 105 inches overall (length+width+height).
    b. 76 inches in any one direction or 105 inches overall (length+width+height).
    c. 74 inches in any one direction or 100 inches overall (length+width+height).
    d. 72 inches in any one direction or 100 inches overall (length+width+height).

63. (424) Which item listed below is *not* part of the anti-hijacking search?
    a. Inspect patients and attendants with either a hand held or walk through metal detector.
    b. Redo the inspection for personnel who leave a holding area after you have finished.
    c. Honor requests for visual inspection instead of using X-ray or metal detectors.
    d. Allow boarding to individuals refusing anti-hijacking inspection.

64. (425) All of the following are authorized litters for aeromedical evacuation, *except* the
    a. North Atlantic Treaty Organization (NATO) litter.
    b. Air Force decontamination litter.
    c. Army decontamination litter.
    d. overweight patient litter.

65. (425) When a patient is in remain overnight (RON) status, on which form should the evaluation, treatment and medication be documented?
    a. AF Form 3899, Patient Movement Physical Assessment.
    b. SF 600, Chronological Record of Medical Care.
    c. DD Form 602, Patient Evacuation Tag.
    d. Patient Movement Request.

66. (425) What is the primary purpose of a release certificate, which is signed by the patient when he or she desires to be released from the aeromedical evacuation (AE) system of his or her own free will?
    a. Prohibits the patient from receiving future AE services.
    b. Determines if the patient is sufficiently competent to understand the consequences of his or her decision.
    c. Releases the US government, its agents and employees from all responsibility, liability, and resulting damage.
    d. Demands reimbursement for travel costs expended and certifies that the patient will proceed by his or her own means of transportation.

Please read the unit menu for unit 3 and continue ➔

Student Notes

Unit 3. Disability Evaluation

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IN THE LAST TWO UNITS, YOU HAVE LEARNED ABOUT READINESS, deploying member to downrange locations, medical evacuation, and moving injured or ill patients out of the deployed scenario. However, that is not where the voyage often ends. When patients are seriously injured, they often undergo a medical evaluation to determine if they are fit to continue on active duty. The process they go through is the Integrated Disability Evaluation System.

3–1. Disability Evaluation System

This section will focus on general information pertaining to the Integrated Disability Evaluation System (IDES).

426. Integrated Disability Evaluation System overview

The Integrated Disability Evaluation System is a DOD program that exists to help the Air Force, Army, Navy, and Marine Corps determine whether wounded, ill or injured service members are able to continue to serve. IDES quickly returns those who are. For those who are not, the IDES process determines the disability ratings they will receive from DOD and the Veterans Administration (VA). The military services and VA joined to create IDES to integrate processes formerly executed separately. This new, streamlined system improves America's delivery of disability services and benefits to Airmen, veterans, and their families.

Airmen can be separated, discharged or retired from service if they meet the following terms (not all inclusive):

- Have a disqualifying medical diagnosis.
- Condition (physical or mental) prohibits or limits the individual from completing his or her duties.
- Condition routinely interferes with their ability to deploy.
- Condition restricts worldwide duty reassignment.
- Imposes unreasonable requirements on the military to either maintain or protect the member.

427. Fitness for duty and fast track evaluation

In order to ensure proper referral to the IDES, the Air Force built-in a two-step pre-IDES screening process on all potential medical evaluation board (MEB) cases. This two-step process is the fast track evaluation.

When a provider identifies a diagnosis that could be disqualifying for a member to continue active duty, the member must undergo a fitness for duty (FFD) evaluation. This evaluation does exactly as the name implies: it evaluates if a service member is fit to continue active duty. As described above, the disability evaluation system does this; however, the Air Force has a pre-evaluation prior to entering the member into the IDES process. This is a two-step process.

The first step of the pre-IDES screening is met when a patient's case is presented to the deployment availability working group (DAWG). These cases are initial reviews in lieu of (RILO) medical board, or initial RILO. The DAWG reviews them, and if appropriate, it transitions to the second step.

In this second step, the case is sent to HQ AFPC (AF Personnel Center)/DPANM (Medical Retention Standards Branch) which reviews case and provides disposition and adjudication. Only when DPANM determines a case is ready for evaluation will it enter the IDES process.

Generally, active duty Airmen, ARC, and USAF Academy Cadets are eligible for disability evaluation processing; however, the following identifies some personnel *not eligible*:

- College or University Reserve Officers' Training Corps (ROTC) cadets are not authorized entry to the US Air Force Disability Evaluation System. ROTC cadets, who incur (while in the line of duty) injury, illness, or death during official military training, or while traveling to or from the location of official military training, may be entitled to disability benefits or compensation from the Department of Labor.
- Airmen pending an approved, unsuspended, punitive discharge or dismissal.
- Airmen who are pending separation under provisions that authorize a characterization of service of under other than honorable (UOTH).
- Airmen facing court martial charges are not eligible for disability processing unless there is a question of mental capacity or responsibility or when the member's sentence of dismissal or punitive discharge is suspended.
- Airmen in an absent without leave (AWOL) status, in deserter status, or those who have been apprehended or arrested and are in police custody,
- Air Force Airmen sentenced to service dismissal or punitive discharge by a court martial, or those who are formally charged with a crime.
- Airman with conditions that existed prior to service (EPTS). This means there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service, during a break in service or during a period of inactive service.

Sometimes, Airmen who are pending involuntary separation or discharge are eligible for IDES processing. The SECAF makes the final disposition on these cases, which are termed dual-action cases since their adjudication occurs under both directives.

As with any effective process, a set of rules is in place to identify criteria and responsibilities of the personnel involved. This unit will cover those guidelines and processes. You will learn about the DAWG, the IDES, the Airman Medical Transition Unit, and the Wounded Warrior Program. Although the last two subjects are not technically part of the IDES process, they are intertwined with each other.

428. Deployment availability working group overview

The DAWG is a working group formed with members in the MTF that reviews personnel medical conditions. Their purpose is to review patients with medical records with a duty limiting condition (DLC) that impacts mobility, retention, or long-term physical fitness of an Airman. The group also identifies personnel not deployment eligible, and tracks progress of the medical condition. In order for the DAWG to do their job, there needs to be a system or process in place to notify them of the DLC. The DAWG finds out about these cases through trigger events, or profile reviews.

Trigger events

A trigger event is a condition or occurrence that may indicate a member has a health condition that is inconsistent with retention standards or deployability. The provider identifies the trigger event. Trigger events include, but are not limited to, the following:

- Provider identification of duty limiting condition(s) or deployment limitation(s).
- Although not an all-inclusive list, Chapter 5 of AFI 48–123, *Medical Examinations and Standards* specifies conditions that require evaluation for continued military service.
- Commander requests evaluation due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.
- HQ AFPC/DPANM may identify conditions via an annual or modified RILO and direct the MTF to submit an initial RILO package.
- PCS, temporary duty (TDY) or deployment cancellation or curtailment for a medical or mental health reason.

After recognizing a trigger event, the provider must notify the MTF physical evaluation board liaison officer (PEBLO) and medical standards management element (MSME). Once notified, the PEBLO will put together a package referred to as an initial RILO.

Unfitting conditions

Conditions that are not eligible for referral to the disability evaluation system are referred to as an unfitting condition.

Unsuiting conditions

Unsuiting conditions are different from unfitting conditions because they are handled using administrative action. Unsuiting conditions are listed in AFI 36–3208, *Administrative Separation of Airmen*, and do not qualify for disability processing.

Initial review in lieu of medical board paperwork

Preliminary review of a trigger event requires an initial RILO. The initial RILO should meet the next scheduled DAWG meeting; however, the RILO MEB should not exceed 45 days once the case is referred to the PEBLO or MSME.The following initial RILO documents are required in order to meet the DAWG:

1. Narrative summary (NARSUM).
2. Commander’s letter.
3. Medical records.
4. Consults or special examination.
5. Updated profile.
6. Other relevant information.

Profile

The physical profile system classifies individuals according to physical abilities, functional abilities, and long-term availability for worldwide duty. The MSME reviews all profiles and refers Airmen’s cases, as medical conditions require. However, before you learn about the different types of profiles and classifications, you need to understand the profile lingo.

Disqualifying defect

A medical condition that is unfitting for service in the Air Force is a disqualifying defect.

Duty limitation

A duty limitation is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.

Duty limiting condition

A medically related condition (injury or illness) that results in a duty limitation is a DLC.

Duty restriction

A duty restriction is a recommendation resulting from a medical evaluation, which, if applied explicitly, restricts the activities that an Airman may perform in carrying out any and/all required or directed Air Force duties or responsibilities. While maintaining physical fitness is a responsibility of all Airmen, fitness activities are not included in the definition of duty restrictions.

Functional (or physical) limitation

This is the inability of an Airman to perform specific physical movements or actions based on an assessment of the Airman's injury or illness by a medical professional.

Functional (or physical) restriction

On the other hand, the restriction is a report of an Airman's injury or illness, based on evaluation by a medical professional, that describes specific physical activities or functions recommended for the Airman to avoid allowing recovery or reducing risk of further injury.

Mobility restriction

A mobility restriction is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's participation in deployment or mobility actions.

Assignment availability codes

An assignment availability code (AAC) is not a medical code, but a personnelist code. It is an assignment deferment and availability code updated in the Military Personnel Data System (MilPDS). It precludes an Airman from moving while suitability to remain on active duty is in evaluation, or during a period of observation or rehabilitation. There are personnel codes for Airmen going through some type of administrative actions, and there are medical codes for Airmen going through evaluation. The following table provides the two codes reviewed by the DAWG related to the medical evaluation board.

Codes Reviewed by DAWG Related to the Medical Evaluation Board			
Code	**Title**	**Description**	**Deferment Period or Effective Date**
31	Medical deferment	Temporary disqualification for worldwide duty, including PCS (nonmobility profile)	Date of availability on AF Form 469, Duty Limiting Condition Report, (not to exceed 12 months from date medical problem incurred), or expiration of medical hold imposed by HQ AFPC/DPANM.
37	Pending MEB	Member deferred from PCS reassignment pending results of MEB or physical evaluation board (PEB)	Regardless of date of availability on AF Form 469, no assignment action is taken until the Airman is returned to duty through AFPC/DPANM, who removes the code 37 as Airman may be unfit for retention.

Forms

There are two forms used to record evaluation or diagnosis of disqualifying defects, the AF Form 469 and AF Form 422, Notification of Air Force Member's Qualification Status.

AF Form 469, Duty Limiting Condition Report

The AF Form 469is used to describe physical limitations and recommend duty restrictions to the commander when there is a potential risk to an Airman's health, safety, and wellbeing; the safety of the mission, or the ability of the Airman to effectively accomplish the mission. The MTF also uses this to notify the commander of limitations related to the AF Fitness Program (FP). In general, the AF Form 469 describes what an Airman is unable to do.

The AF Form 469 documents duty limitations. The profile is only good for a maximum of 365 days. The only time a profile is valid for longer than 365 days is when the member has met the medical evaluation board.

AF Form 422, Notification of Air Force Member's Qualification Status

The AF Form 422 (fig. 3–2) is primarily used to annotate if someone is qualified for the following:

- Initial qualification.
- Retirement or separation.
- Military retraining.
- PCS.
- Professional military education (PME).

It can also document exercise prescriptions, and describe what an Airman is qualified to do based on medical assessment. The AF Form 422 also conveys descriptions of physical capabilities, which are used for establishing suitability for continued military duty.

Both forms are updated annually during the physical health assessment (PHA) and when a duty or mobility restriction exists for six months and the condition may not resolve in the near future.

Guidelines for profiles

If a member requires a profile that meets the following guidelines, the DAWG will review the condition:

1. Fitness assessment exemptions with abdominal circumference (AC) exemptions (not including pregnancy profiles).
2. Fitness assessment exemptions for 365 days.
3. If a member is not qualified for their current AFSC, or qualified to retrain to another AFSC.
4. Cases previously reviewed by the DAWG that requires follow-up.
5. Mobility restriction for over 90 days.
6. If a member is on an AAC 31 that reaches 300 days cumulative for a single condition.

Membership

There are members of the MTF facility that must be present and accounted for during the DAWG meeting; their knowledge and expertise make them essential to the member's evaluation. These members include the chief, aerospace medicine (SGP); chief, medical staff (SGH); senior profiling officer (SPO); all available profile officers; MSME; PEBLO; a primary care manager (PCM) representative and exercise physiologist (EP). If mission requires, members of other organizations, such as Department of VA, mental health, women's health, and so forth can join the meetings.

Non-MTF staff may attend, but only for those portions of the meeting that do not address protected health information (PHI). For PHI-related portions of the meeting, DAWG attendance by non-MTF staff is limited to unit commanders or personnel designated by commanders to receive PHI. These

personnel may only attend portions of the DAWG applicable to Airmen under their designated command structure.

This form is governed by the Privacy Act of 1974. (Blanket PAS 1974, Routine Uses) Disclosure of requested information is mandatory. AFI 33-332

DUTY LIMITING CONDITION REPORT

Name (Last, First MI) Smith, John Q	RANK CMS	DATE 09/17/2014
SSAN 222222222	MAJCOM / INSTALLATION Shaw AFB (ACC)	Squadron / Unit Of Assignment USAFCENT
Squadron E-Mail Address workflow@us.af.mil		Duty Telephone: ☐ DSN ☑ Commercial 2222222222

HEALTH CARE PROVIDER'S MEDICAL RECOMMENDATION FOR THE SQUADRON COMMANDER

☑ DUTY RESTRICTIONS	☑ MOBILITY RESTRICTIONS	☐ 49 / 81

PHYSICAL LIMITATIONS / RESTRICTIONS (DO NOT Include medical condition or diagnosis)

RESTRICTIONS:
These limitations expire 09/17/2014
No weapons bearing activity while sleepy
Member should not work more than 12 hours a day
Member should have at least 8 hrs of sleep per night
Member requires reliable electricity at billeting when deployed
Member should not drive or operate heavy machinery while sleepy

These limitations expire 06/04/2014
Walk at own pace
No running for exercise
Able to run 100 yards in the event of an emergency

MEMBER CLEARED TO TEST ON:
1.5 Mile Run: NO
2 Km (1.2 Mile) Walk: NO
Push-ups: YES
Sit-ups: YES
Abd Circumference: YES

UNIT PT/EXERCISE:
Run: NO
Walk: YES - own pace
Push-ups: YES
Sit-ups: YES

ALC Code C2(Y): IAW AFI 10-203, member is required to report any change in medical condition to the Primary Care Manager

Release Dates: 31 37 81 MR 09/17/2014 DR 09/17/2014 FR 06/04/2014

Name and Grade of Health Care Provider Elias Ramirez, Lt Col, USAF, SFS, FACHE	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/17/2014
☐ 31 (ILLNESS OR INJURY WILL BE RESOLVED WITHIN 31-365 DAYS)	☐ 37 (MEDICAL DEFECT/CONDITION REQUIRES MEB OR PEB PROCESSING IAW AFI 41-210)	
Force Health Manager Antohny Smith, TSgt, USAF	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/19/2014
Profile Officer Review Catherine T. Robinson, Capt, USAF, MC	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/19/2014

SQUADRON COMMANDER'S REVIEW - MOBILITY RESTRICTIONS NOT VALID WITHOUT SIGNATURE

Squadron Commander	Signature	Today's Date

DUTY LIMITING CONDITION REPORT **AF FORM 469** Computer Generated

Figure 3–1. AF Form 469, Duty Limiting Condition Report.

This form is governed by the Privacy Act of 1974. (Blanket PAS 1974, Routine Uses) Disclosure of requested information is mandatory. AFI 33-332

NOTIFICATION OF AIR FORCE MEMBER'S QUALIFICATION STATUS

Name (Last, First MI) Smith, John Q	RANK CMS	DATE 09/17/2014
SSAN 222222222	MAJCOM / INSTALLATION Lackland AFB (AETC)	Squadron / Unit Of Assignment AF PUB AFFAIRS AG
Squadron E-Mail Address workflow@us.af.mil		Duty Telephone: ☐ DSN ☑ Commercial 2222222222
☐ DENTAL STATUS - UNKNOWN (CLASS 4)		☑ DENTAL TREATMENT - REQUIRED (CLASS 3)

☑ RECOMMENDATION

MEMBER IS CLEARED FOR:

- ☐ Overseas PCS
- ☐ Retraining/Special Duty Assignment
- ☐ Attendance at USAF PME Course (See AFCAT for Detailed Requirements)
- ☑ Other Form 4

FOLLOWING AN MEB, MEMBER RETURNED TO DUTY WITH
☑ AN ASSIGNMENT LIMITATION CODE "C" AS DETERMINED BY HQ/AFPC

SEE RECOMMENDED RESTRICTIONS FOR ADDITIONAL COMME

FHM: Check Appropriate C-Code Category Box Below

- ☐ Category C-1
- ☑ Category C-2
- ☐ Category C-3

☐ NOT APPLICABLE

PME, SPECIAL DUTY APPLICATION AND AFSC RETRAINING PHYSICAL PROFILE ASSESSMENT

P	U	L	H	E	S	SAT
-	-	-	-	-	-	-

☐ Initial Flight or Special Operational Duty Physical:

TYPE

Reading Aloud Test ☐ Sat ☐ Unsat

Color Vision Test ☐ Pass ☐ Fail

☑ Other (See Additional FHM Comments)

ADDITIONAL COMMENTS

Per HQ AFPC/DPAMM Dated 12-Sept-2013: ALC C-2 Member has been found fit and was returned to duty with the following restrictions: Member may be assigned or deployed to CONUS, Hawaii, or Alaska installations with fixed medical treatment facilities and (list specialty) treatment or referral 148 AFI41-210 22 MARCH 2006 capability. Member should not occupy a mobility position but may be deployed with approval of gaining MAJCOM Chief of Clinical Services. The gaining Command Chief of Clinical Services must approve exceptions to this restriction in writing. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. This ALC-C must be reviewed by DPAMM periodically. Submit a narrative summary in JUL 2014 with specialty consultations by Cardiology with Current AF Form 469 with all duty/deployment limitations.

☑ Force Health Manager identified in the signature block below has reviewed this recommendation in its entirety. The PIMR database and medical record of the member has been reviewed and any related action(s) to the condition to which this recommendation applies is noted. Date this condition (or related, previously diagnosed conditions) that render the member's qualification for retention questionable.

Name and Grade of Health Care Provider Elias Ramirez, Lt Col, USAF, SFS, FACHE	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/17/2014
Force Health Manager Antohny Smith, TSgt, USAF	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/19/2014
Profile Officer Review Catherine T. Robinson, Capt, USAF, MC	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 09/19/2014

AF FORM 422 *SUPERCEDES AF Form 422, APR 89* Computer Generated

Figure 3–2. AF Form 422, Notification of Air Force Members Qualification Status.

DAWG evaluation

During the meeting, the members of the DAWG have a heavy burden. They evaluate individual's medical conditions to ensure they can safely meet the requirements of the Air Force. The following items are some of the criteria members take into considerations when evaluating active duty members' medical conditions:

- Is timing appropriate for initial RILO referral? Verify the member's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable). In cases where there is no definitive diagnosis, but the preponderance of clinical evidence suggests a probable underlying cause in which the treatment progress, and/or progression of the condition, appears to be reasonably predictable, initial RILO processing may proceed without a definitive diagnosis.
- Is the case appropriate for initial RILO referral? Only unfitting conditions are eligible for referral. Unsuiting conditions are different from unfitting conditions because they process through administrative action.
- Is the member unable to reasonably perform the duties of his or her office, grade, rank, or rating due to a physical or mental condition which is not likely to resolve or improve such that he/she can perform the duties of his/her office, grade, rank or rating within 12 months?
- Is this a chronic condition, which imposes unreasonable requirements on the military to either maintain or protect the member?
- Is this a chronic condition that may preclude or limit the member's ability to safely and effectively deploy to field conditions?
- Has an initial RILO package been directed by DPANM?
- Is this a condition with 12 months of cumulative AAC 31 status for the same or related issue(s)?
- Is the member refusing required professional, medical or dental care, which would be necessary to achieve fitness for continued military service?

DAWG determinations

The DAWG review takes into account all available and appropriate information related to the case and then makes a determination. The disposition of the DAWG review may include case dismissal, initial RILO referral (for profile review) or refer for adjudication (for initial RILO review).

Case dismissal

The DAWG can decide the Airman is fit for continued military service and mobility based on the information considered, and dismiss the case. Although the case is dismissed, it does not mean the Airman cannot meet the DAWG review again in the future for the same condition if the Airman's status changes. A note is placed in the Airman's medical record indicating that the condition was reviewed for possible MEB and found to be fit without need for Initial RILO or MEB. Lastly, the AF Form 469 is updated appropriately and the case dismissed to routine medical care.

Initial review in lieu of Medical Board referral

During a profile review, if there is any doubt that the Airman is fit for continued unrestricted duty, the case becomes an initial RILO. Once the DAWG determines that the case warrants initial RILO, it is incumbent upon the PEBLO to ensure that all requirements for the initial RILO package are completed.

Refer for adjudication

When the case is referred for adjudication, the PEBLO acquires the required documents, prepares them and ensures they are signed by either the SGH or SGP. This step is a final quality review and is completed within 30 days of the DAWG initially reviewing the case.

Medical standards recommendations

AFPC/DPANM reviews the initial RILO packages, and advises the PEBLO of the disposition. The notification comes via the AFPC/FL4 (fig. 3–3), sent to the PEBLO. The types of determinations are return to duty, direct an MEB, and continued military medical observation and care.

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR FORCE PERSONNEL CENTER
MEDICAL STANDARDS BRANCH (DPANM)

PERSONAL DATA PRIVACY ACT OF 1974

**** A copy of these instructions must be placed in the member's medical record along with the medical evaluation****

LAST	Smith	FIRST	John Q	MI	Q
RANK	CMSgt				
TO		DATE	09/17/2014	AFPC STAFFER	CG

☒ Member returned to duty with Assignment Limitation Code C. Restrictions and holds (including Medical Hold) imposed by I-RILO/MEB/PEB processing are removed. **REMOVE AAC 37 CODE if present.** Limitations placed on the member as a result of "this condition" should be revised on the AF 469 and a copy placed in the member's medical record. See AFI 41-210 for stratifications.

Assigned ALC-C Stratification	C-2 (Y)		
Diagnostic Code 1	7005	**Diagnostic Code 3**	
Diagnostic Code 2		**Diagnostic Code 4**	
Alternative Codes			
Date Next RILO is due	At Next PHA (if PHA due in <6 months, then defer until next PHA after that)	**or Date**	
Specialty evaluation(s) required	Cardiology		
Additional Item(s) required	Current AF Form 469 with all duty/deployment limitations		

☐ DAWG: ◯ Full MEB ◯ RTD DPANM: ◯ Non Concur ◯ Concur

Notes **CONTINUE ALC-C2**

AFPC\DPANM FL4 THIS IS A COMPUTER GENERATED OFFICIAL AIR FORCE DOCUMENT Revised 30 Jan 2013

Figure 3–3. AFPC/FL4.

Return to duty

If the member is returned to duty (RTD), the PEBLO is notified by DPANM via the AFPC/FL 4. In turn, the PEBLO notifies the PCM and the MSME. A disposition of RTD does not mean the Airman cannot be considered for initial RILO again for the same condition if the condition changes or deteriorates enough to warrant re-consideration.

Direct MEB

If DPANM directs an MEB, the PEBLO is notified via AFPC/FL4. The PEBLO will then notify the PCM, the DAWG chair, and the SGH. The PCM will complete the VA Form 21–0819 VA/DOD Joint Disability Evaluation Board Claim form and return it to the PEBLO (fig. 3–4). The date the provider signs the VA Form 21–0819 is the date that the member officially enters into the IDES.

OMB Approved No. 2900-0704
Respondent Burden: 30 minutes

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

VA/DOD JOINT DISABILITY EVALUATION BOARD CLAIM

IMPORTANT - Please read the Privacy Act and Respondent Burden on the back before completing the form.

Section I: To be completed by Military Treatment Facility referring Service member to Disability Evaluation System *(DES)*

SERVICE MEMBER NAME *(First, middle, last)*: SMITH, JOHN E.	GRADE: E-3/A1C
COMPONENT: USAF/AD	UNIT ADDRESS: A UNIT, LACKLAND AFB TX
SOCIAL SECURITY NUMBER: 123-45-6789	DATE OF BIRTH (MM,DD,YYYY): 06/21/1991
SEX: ☐ MALE ☐ FEMALE	
NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER *(PEBLO)* *(First, MI, Last)*: PEBLO NAME	*Include Area Code*: 210-292-1234
NAME OF REFERRING MILITARY TREATMENT FACILITY *(MTF)*: 59 MDW, WHASC	DATE OF REFERRAL TO MEDICAL EVALUATION BOARD *(MEB)* (MM,DD,YYYY):

MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION *(List only conditions referred by physician):*

1. Pulmonary Embolus w/ associated pulmonary infract secondary to an inherited hyper-coagulable state; on long term coumadin therapy

PREPARED BY: PEBLO NAME	DATE PREPARED:

Section II: Tell us about yourself. Please provide a contact name and address. If you are on Temporary Duty, please indicate that on the VA Form 21-4138, Statement in Support of Claim available on the internet at www.va.gov/vaforms

1. WHAT IS YOUR ADDRESS?
101 DOWN THE STREET DR
Street address, rural route, or P.O. Box — Apt. number
LACKLAND AFB — City; TX — State; 78236 — ZIP Code; USA — Country

2. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)*
Daytime: PHONE
Evening: PHONE
Cell phone: PHONE

3. WHAT IS YOUR E-MAIL ADDRESS *(If applicable)*
ACCESSIABLE EMAIL ADDRESS

4. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ Yes ☒ No
(If "Yes," provide file number) *(VA File Number)*

5. POINT OF CONTACT NAME AND ADDRESS

6a. DID YOU SERVE UNDER ANOTHER NAME?
☐ Yes *(If "Yes," go to item 6b)* ☐ No *(If "No," go to item 7)*

6b. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER
n/a

7. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON
04 / 17 / 2012
mo day yr

8. PLACE OF ENTRY

Section III: Tell us about your military service. Enter complete information for your service. Tell us about your reserve duty or National Guard Duty

9. ARE YOU CURRENTLY ASSIGNED TO AN ACTIVE RESERVE UNIT OR NATIONAL GUARD UNIT?
☐ Yes *(If "Yes," provide date of activation below)*
☐ No
mo / day / yr

10a. WHAT IS THE NAME AND MAILING ADDRESS OF YOUR CURRENT UNIT?

10b. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*
( )

VA FORM OCT 2009 **21-0819** SUPERSEDES VA FORM 21-0819, JUN 2009, WHICH WILL NOT BE USED.

Figure 3–4. VA Form 21–0819 VA/DOD Joint Disability Evaluation Board Claim (front).

Continued military medical observation and care

Although infrequently used, these two options are an option for an initial RILO. This would also be listed using an AFPC/FL4, and it would provide further directions such as “Reevaluate in six months.”

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

426. Integrated Disability Evaluation System overview

1. Why was the Integrated Disability Evaluation System created?

2. What are some reasons a member could be medically separated or retired?

427. Fitness for duty and fast track evaluation

1. Why does the AF have the two-step evaluation process?

2. When a provider identifies a diagnosis that could be disqualifying for a member to continue active duty, what must the member undergo?

3. Once the deployment availability working group reviews the case, whom is it sent to?

428. Deployment availability working group overview

1. What is the purpose of the deployment availability working group?

2. What is a trigger event?

3. What AFI specifies conditions that require evaluation for continued military service?

4. Who can request medical evaluations due to poor duty performance or deployment concerns stemming from a potential medication condition?

5. What cases are not qualified for disability processing?

6. Once identified, how long does a Review in Lieu of MEB have to meet the DAWG?

7. What is a duty limitation?

8. What is an Airman's inability to perform actions based on an assessment of an Airman's injury or illness by a medical professional?

9. What assignment availability code cannot to exceed 12 months?

10. What assignment availability code is used for members pending a MEB?

11. When would you use an AF Form 469, Duty Limiting Condition Report?

12. When should an AF Form 422, Notification of Air Force Member's Qualification Status be used?

13. What kind of fitness exemptions are required to meet the DAWG?

14. Who is required to be part of the DAWG?

15. What are the determinations the DAWG can make?

16. If the DAWG refers the case for adjudication, how long does the quality review have to be completed?

17. What recommendations can DPANM make?

3–2. Integrated Disability Evaluation System

As stated at the beginning of this unit, the IDES process is the joint DOD-VA process that helps the Air Force, Army, Navy, and Marine Corps determine whether wounded, ill or injured Airmen are able to continue to continue active duty service. In the Air Force, the case is sent to the IDES by DPANM.

This section goes into detail on how the AF process merges with IDES process. This includes an overview of the Veterans Administration tracking log via the information portal, medical board procedures, and IDES timelines. However, before you get into all of that, you should first be familiar with the some of the major players' responsibilities.

429. Responsibilities

The MTF commander appoints a mature and experienced administrator as the MEB clerk and PEBLO. By its name, you may think that PEBLO must be a commissioned officer; however, most PEBLOs are mature, responsible enlisted or civilian personnel.

At the larger hospitals, the MTF commander appoints the PEBLO on published orders. At non-physical evaluation board referral hospitals (PEBRH), the PEBLO need not be on orders, but must be identified in each request for one-time PEB referral authority.

Provider responsibilities

Upon notification, the provider will complete and sign the VA Form 21–0819, VA/DOD Joint Disability Evaluation Board Claim, forward it to the Physical Evaluation Board Liaison, who will then send it to the VA via the military service coordinator (MSC).

MEB clerk

The MEB clerk provides the following administrative support functions for the MEB:

- Assembles and provides all pertinent reports and records, and schedules cases for board hearings.
- Completes AF Form 618, Medical Board Report; obtains signatures from the board members and the approval authority; and assembles the attachments to AF Form 618 (fig. 3–5).
- Ensures the evaluee or next of kin (NOK) has an opportunity to read the medical board report and NARSUM.
- Assists the evaluee in resolving any questions concerning the content of the report or summary, and advises the evaluee or NOK that he or she may submit a signed statement for consideration by the disposition authority if the evaluee takes exception to the content of the MEB report or NARSUM.
- Obtains evaluee or NOK signature on AF Form 618, forwards the completed MEB package to the disposition authority, and makes proper distribution of that authority's responses.

Physical evaluation board liaison officer

The PEBLO is responsible for obtaining, assembling, and forwarding all documents and records required by the PEB. In addition, the PEB is the focal point for accomplishing a variety of other actions essential for prompt, effective, and adequate case processing. In discharging these responsibilities, the PEB should communicate directly with the member's PCM, MSC, commander, Military Personnel Section (MPS), and Airman and Family Readiness Center (AFRC) to obtain any required information or assistance. The PEBLO duties and responsibilities include:

- Ensuring a request for retention for medical treatment or evaluation (fig. 3–6), necessary for placing an enlisted member on medical hold for IDES processing beyond their ETS, is obtained and a copy included in the initial MEB case file.

NOTE: Original must be provided to AFPC/DPANM.

- Counseling and referring members to the AFRC for pre-separation counseling when their case is referred to the Informal Physical Evaluation Board (IPEB). Pre-separation counseling is mandated by public law.
- Maintaining a close working relationship with consultants at the AFRC to ensure timely identification and counseling of members referred to the IPEB.

MEDICAL BOARD REPORT
(This form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)

1. INSTALLATION AT WHICH CONVENED	59 MDW
2. DATE CONVENED	20140522
3. NAME *(Last, First, Middle Initial)*	SMITH, JOHN E.
4. GRADE	E-3
5. SSN	123-45-6789
6. COMPONENT	ACTIVE DUTY
7. DEPT OR SERVICE	AIR FORCE
8. ORGANIZATION	324TRS LAFB, TX
9. SEX	F
10. DATE OF BIRTH *(Yr, Mo, day)*	19930519
11. AGE	21
12. SEPARATION/ RETIREMENT DATE	20200109
13. HOSPITAL INITIALLY ADMITTED	N/A
14. TRANSFERRED FROM	N/A
15. HOME ADDRESS	106 DOWN THE SOME PLACE , USA 12345
16. MILITARY OCCUPATIONAL SPECIALTIES — TITLE	BASIC TRAINEE
CODE	
17. TOTAL YEARS MILITARY SERVICE — ACTIVE	4
INACTIVE	
18. DATE ENTERED AD CURRENT TOUR	20140109
19. AERO RATING	
20. ON FLYING STATUS ON ADMISSION	☐ YES ☑ NO
21. DATE RELIEVED FROM FLYING STATUS	

22. BY DIRECTION OF THE APPOINTING AUTHORITY, THE BOARD CONVENED TO CONSIDER THE CASE OF THE ABOVE NAMED MEMBER.

A. UNDER PROVISIONS OF THE FOLLOWING DIRECTIVES:		B. FOR THE PURPOSE OF:	
☑ AFI 44-113 AND 48-123	MANUAL FOR COURTS-MARTIAL	☑ CONTINUED ACTIVE DUTY	EPTS DEFECTS
☑ OTHER *(Specify)* AFI 36-3212 & AFI 41-210		SEPARATION/RETIREMENT	OTHER *(Specify)*

23. DIAGNOSIS AND FINDINGS

AFTER CONSIDERATION OF CLINICAL RECORDS, LABORATORY FINDINGS, AND PHYSICAL EXAMINATION, THE BOARD ESTABLISHES THE FOLLOWING DIAGNOSIS: *(List all diagnoses, in accordance with applicable directives, which contribute or may contribute to make the qualifications of the individual for worldwide duty questionable. Include any competency determinations. (DFAS-DE MANUAL 177-173).* A	APPROXIMATE DATE OF ORIGIN B	INCURRED WHILE ENTITLED TO BASIC PAY YES C	NO D	EXISTED PRIOR TO SERVICE YES E	NO F	PERMANENTLY AGGRAVATED BY SERVICE YES G	NO H
1. Stress fracture, right femoral neck, resolved	EPTS		X	X			X
Administrative LOD: No, EPTS without SA (continuation)							

24. SANITY DETERMINATION *(To be completed for sanity board cases only.) (Manual for Courts-Martial)*	YES	NO
A. IS THIS A DISEASE OR DEFECT OF THE MIND AS DISTINGUISHED FROM A CHARACTER DEFECT?	☐	☐
B. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO APPRECIATE THE CRIMINALITY OF THIS CONDUCT?	☐	☐
C. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO CONFORM HIS/HER CONDUCT TO THE REQUIREMENTS OF THE LAW?	☐	☐
D. DID THE ACCUSED HAVE THE MENTAL CAPACITY TO FORM THE SPECIFIC INTENT OR REQUIRED STATE OF MIND?	☐	☐

25. ACTION RECOMMENDED BY BOARD *(or directed by higher authority)*

26. BOARD MEMBERS

TYPED NAME, GRADE, ARM OF SERVICE	SIGNATURE *(Place check after signature of psychiatrist)*	27. MINORITY REPORT ON REVERSE
PRESIDENT		
MEMBER		
MEMBER		☐ YES ☐ NO

28. HOSPITAL COMMANDER OR DESIGNEE

A. DATE REVIEWED	B. BOARD RECOMMENDATION [1]	C. TYPED NAME, GRADE, SERVICE	D. SIGNATURE
	☐ APPROVED ☐ DISAPPROVED	NOT REQUIRED PER AFI 41-210	

29. I HAVE BEEN INFORMED OF THE FINDINGS AND RECOMMENDATIONS OF THE MEDICAL BOARD.

A. DATE	B. SIGNATURE OF SERVICE MEMBER	C. LETTER OF EXCEPTION ATTACHED
		☐ YES ☐ NO ☑ N/A

[1] *If, applicable indicate reason for disapproval on reverse.*

AF IMT 618, 19951001, V2 PREVIOUS EDITION IS OBSOLETE.

Figure 3–5. AF Form 618, Medical Board Report.

- Ensuring the member has an opportunity to read the Medical Board Report (AF Form 618), NARSUM, and the VA compensation and pension (C&P) exams, providing a copy of those documents to the member before sending the case to AFPC, and assisting the member in resolving any questions concerning the content of the AF Form 618 or NARSUM.
- Advising members that they may request an impartial review and may submit signed statements for consideration by the PEB if they take exception to the contents of the medical board report or NARSUM.
- Ensuring accurate and complete case records are sent to the PEB. AFI 41–210, *TRICARE Operations and Patient Administration Functions* provides instructions on compiling case documentation and provides a MEB Case Checklist as seen in figure 3–7.
- Counseling members or next of kin on the PEB findings and recommended disposition. This includes counseling on the provisions for limited assignment status (LAS) if the member meets the eligibility criteria and is motivated to remain in the Air Force.
- Advising the patient administration or hospital services office of the final disposition of all cases where the member underwent PEB processing in an outpatient status.
- Maintaining close coordination with the IPEB on all matters affecting the processing of PEB cases.
- Requesting commander's letter (fig. 3–8) and keeping member's commander/first sergeant apprised of the member's case status.

9 May 2015

MEMORANDUM FOR: AFPC/DPFDD, Randolph AFB, TX 78150

FROM: SSGT (NAME) (123-45-6789)

SUBJECT: Request for Retention Beyond ETS

I hereby request to be retained on active military status beyond the date my term of service expires, for medical treatment or evaluation, and if necessary, for processing for disability separation. I understand I will be subject to the obligations of my military service in the same manner and to the same extent as if my term of enlistment had not expired.

NAME, SSgt, USAF
UNIT

The members original Sep/Ret date is_ 30 Jun 15 ____ (submit med hold memo when within 60 days)

MEB Status: ____Members case is at the IPEB pending Disposition_____

If there is a FL4 directing Medical Hold, please annotate the MEB Status above.

If a recent IRILO or MEB has not been submitted to AFPC, please have PCM contact AFPC/DPANM Medical Retention Standards to request Medical Hold.

Note: THIS MEMO MUST BE DIGITALLY SIGNED OR WET SIGNATURE ONLY.

Figure 3–6. Request for retention for medical treatment of evaluation template.

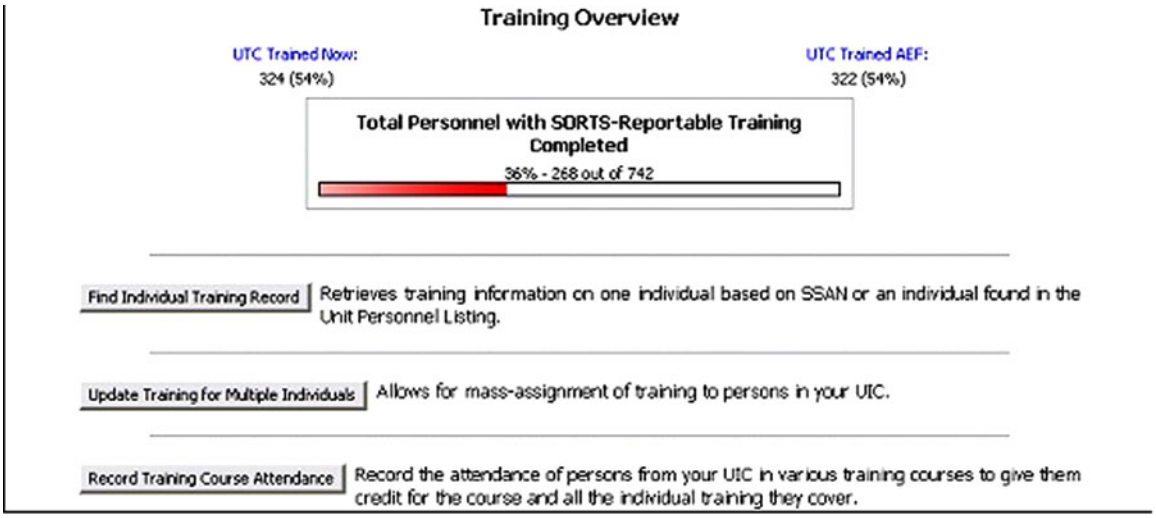

Figure 3–7. Medical evaluation board checklist.

SAMPLE
PreScreening information

DEPARTMENT OF THE AIR FORCE
WING LETTERHEAD

DATE

MEMORANDUM FOR Deployment Availability Working Group (DAWG)

FROM: XXXXXXX
XXXXXXX
XXXXXXX

SUBJECT: Commander's Input to DAWG Regarding XXX XXXXXXX XXXXXXX

Answers to the following four questions will assist the local DAWG and the Air Force Personnel Center (AFPC) to determine an appropriate disposition regarding the continued retainability and deployability of XXXXX XXXXXXX who has been diagnosed with a medical condition that is not compatible with continued unrestricted military service. This letter will be included with the medical package to indicate how the medical condition has impacted daily operations and mission support.

Please circle Yes or No, adding comments as required (use additional sheet if necessary):

a. Can the member perform all of the duties required by their current AFSC?
Yes / No

b. Can the member perform their AFSC's duties in a deployed location? Yes / No

c. Has missed work had an impact on mission completion? Yes / No

d. How many days of work has the member missed due to medical appointments or illness during the past year?

e. Should the member be retained in the Air Force? Yes / No

Please return this form and direct any questions to the MEB office at DSN XXX-XXXX.

Ima Rusty Flybouy, MD, MPH
Major, USAF, MC, SFS
DAWG ChService Member

Figure 3–8. Example commander's letter.

Timelines

Prior to integrating the services into one medical evaluation board, timelines for a member from case imitation to VA rating could take as long as three years. The new process goal is to shorten the time line with a joint, continuous, and efficient process. To achieve this, the DOD created the IDES timeline that the process is required to meet. Monitoring and updating the Veterans Tracking Application (VTA) will ensure you are following the timelines.

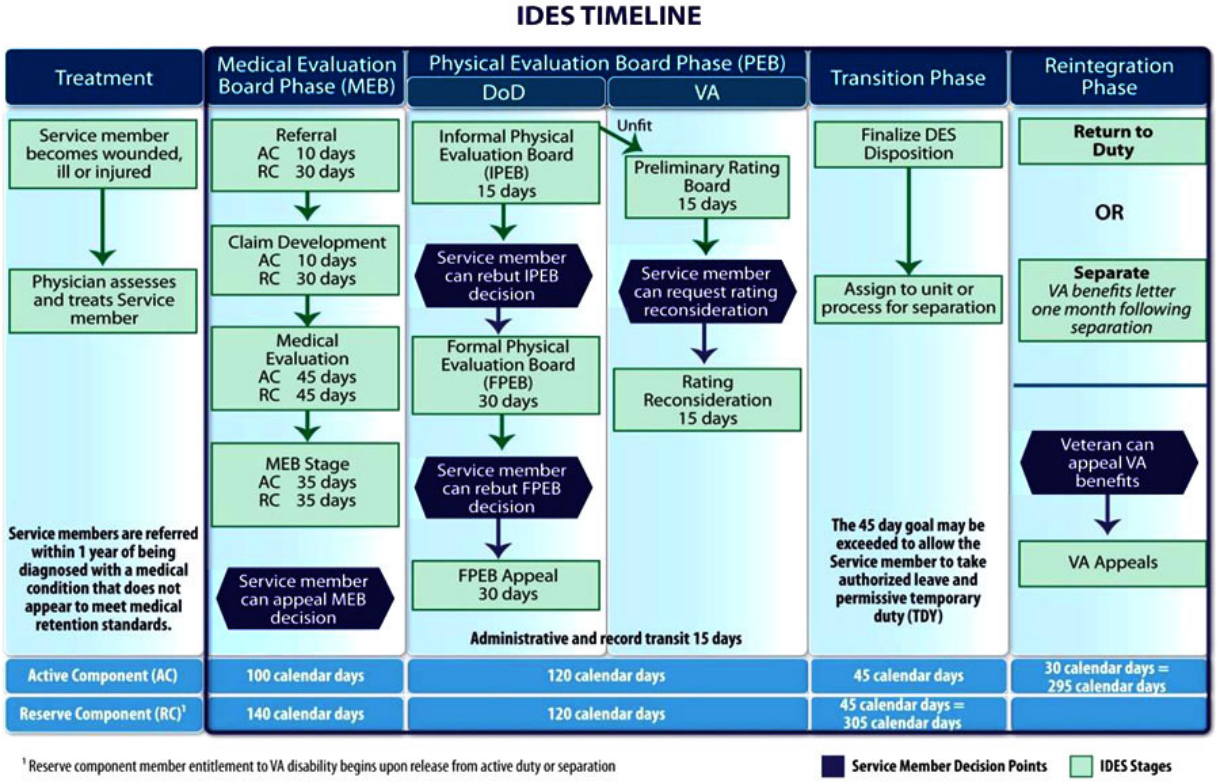

Figure 3–9. Integrated disability evaluation system timeline.

430. Veterans Affairs compensation and pension evaluation

The compensation and pension evaluation process includes all medical examinations and all administrative activities associated with case management from the time of referral by a military medical care provider to return to duty or completion of VA's benefits decision letter. It also includes the management of service members who are temporarily retired for disability through the IDES. The PEBLO informs the service member of the IDES process, assembles the disability evaluation system (DES) case file, enrolls the Service member in the Veterans Tracking Application, and refers the service member to a VA military service coordinator case manager.

Veterans affairs military service coordinator

The MSC is the VA's non-clinical benefits advisor to the member while going through the IDES. The MSC provides counseling and guidance about VA benefits and policies to the members and/or family. Additionally, the MSC assists the member and/or family in the preparation and tracking of VA claims. The MSC is the single point of contact for the member regarding potential VA benefit claims because of their disability evaluation. Upon completion of initial case development, the MSC informs the member of the disability process. The MSC completes the next portion of the VA Form 21–0819 claim and provides it to the member. If the service member does not claim additional conditions beyond those noted on Part 1 of the form, the MSC annotates this on the form and enters it as complete in the Veterans Tracking Application.

The VA MSC informs the member of the IDES process and schedules the medical examinations required to adjudicate the member's disability claim. Medical examiners perform the required exams and tests to adjudicate the fitness for duty determination and rating determinations. The VA MSC provides the completed medical examination results to the service member's PEBLO and the VA disability rating activity site (DRAS) of jurisdiction.

Veterans tracking application

The VTA is a joint application that supports the effective management and tracking of veteran and service member throughout the process. VTA tracks the initial arrival of members into the VA health system and monitors benefits applications and administrative details.

IDES is a module in VTA that tracks members referred to a MEB and has the following capability:

- VTA is a web-enabled tool that tracks member status during the IDES.
- The Veterans Information Portal (VIP) houses the VTA.
- Data collection creates reports for senior DOD and VA leadership for the IDES program.
- IDES case tracking does not replace local MTF database systems.
- DEERS (Defense Enrollment Eligibility Reporting System) directly feeds the demographic data.
- Each reporting agent's role determines permission rights within the database.

The VTA does not have an option to monitor RILO or those that are on the Temporary Disabled Retirement List (TDRL) coming back for re-evaluation. Each MTF monitors and tracks the RILOs but AFPC/DFPDD (TDRL Cell) monitors and tracks the TDRL cases.

Physical evaluation board liaison officer review

Once the VA completes the medical evaluations, the PEBLO receives the compensation and pension (C&P) examination results and provides them to the PCM, referring provider, or to a reviewing provider the DAWG assigns.

Once the PCM, referring provider, or reviewing provider receives the C&P exam results, the PCM will perform the following:

- Review the C&P report.
- Verify the NARSUM covers the full spectrum of potentially unfitting conditions.
- Add/update the NARSUM appropriately.
- Return the updated NARSUM to the PEBLO.

A signed/dated addendum with pertinent updates must be located at the end of the NARSUM, and must clarify inconsistencies between the initial NARSUM and C&P only for conditions, which are unfitting for continued military service. If there are no inconsistencies or updates, the provider will sign/date the following statement at the end of the NARSUM:

"I have reviewed the C&P exam results and find the information within the NARSUM to be current and complete."

This date now becomes the new date for NARSUM currency. The provider's duty title must be clearly discernable.

When there are multiple consult NARSUMs (PCM, specialty etc.), a single reviewing physician may review both the C&P Exam and the purpose and notification multiple specialty NARSUMs, and provide a signed and dated addendum on a continuation sheet, which will accompany the complete MEB package through routing. In this case, the date on the continuation sheet now becomes the new date of the NARSUM. The preparing and reviewing physicians will not include verbal or written comments relating to the expected disability process outcome.

431. Medical evaluation board process

Once the narrative summary is reviewed, updated and completed, it is returned to the PEBLO in order to meet the Medical Evaluation Board. However, before the member can meet the MEB, there are some additional steps that need to happen and other information to take into consideration.

Duty and assignment status while undergoing an MEB

Normally, members undergoing MEB processing are outpatient and can continue their active duty job while proceeding through the process.

Leave and TDY while undergoing an MEB

When identified for MEB processing, the PEBLO notifies the member's commander that the member may not go on leave outside of the local area, or TDY, without prior coordination with the PEBLO, except in emergencies. This ensures the evaluee is available for further medical testing, to sign documents and respond promptly to recommended disposition by the MEB and HQ AFPC. The evaluee must be available and able to report within one workday.

Utilization while undergoing an MEB

An MEB evaluee is available for unit duties or hospital work programs that do not negatively affect the patient's medical condition or treatment, and do not interfere with clinical evaluation and MEB processing. This includes MEB evaluees who are outpatients still assigned to their normal duty unit or inpatients attached to the hospital or assigned to the Airman Medical Transition Unit (AMTU). While undergoing an MEB evaluation and disability processing, the evaluee is on a temporary "4" profile to preclude his or her reassignment. A "4" profile is used if the member is disqualified from worldwide service.

Requirements

There are several instances where special consideration must be made based on the type of case involved. Let's look at a few of these instances.

Mental competence for pay and records

A medical board may be required to determine if a member is competent to receive pay and to conduct his or her own financial affairs. This determination is warranted only when specific psychiatric illness or illnesses are present.Financial irresponsibility due to habit, traits of character, or personality deviation is not appropriate for MEB consideration. The competency determination is made in addition to determination of worldwide duty qualification. If a military retiree needs a mental competency status determination, HQ AFPC will appoint or designate an MTF to conduct the competency board. When requested, a local MTF with the appropriate board members may conduct a competency board for any Air Force retiree or other retired uniformed service member receiving treatment in an Air Force MTF.

Sanity determination

When there are legal proceedings against an accused military member, a sanity determination of a psychiatric nature may be required as specified in the Manual for Courts-Martial (MCM), and by current legal decisions. A sanity report is determined by a board that consists of a psychiatric, mental, and related clinical evaluation. Answers are given that respond to such questions as the capacity of the accused to appreciate the criminality of his or her conduct, to adhere to what is right, and to take part in their legal defense. If the psychiatric findings show there is reason to doubt the member's qualifications for continued worldwide service or competency for pay and records, an MEB convenes to determine those issues.

General officers

When an active duty general officer is in the hospital for other than an annual or retirement physical examination, the MTF commander immediately notifies the General Officer Management Office

(HQ USAF/GOMO) of the hospitalization. If an MEB is required, HQ AFPC/DPANM designates an MTF to conduct the medical board.

Commanders

Commanders and officers, who have authority to convene and approve medical boards, may themselves undergo MEB action. When this situation occurs, these members receive clinical evaluation and medical board processing at an MTF that is not within their command, control, or official influence. HQ AFPC/DPANM grants waivers when it is medically appropriate.

Medical facility staff member

Officers of the Medical (MC), Dental (DC), Nurse (NC), Medical Service (MSC), and Biomedical Sciences (BSC) Corps must not receive a medical board evaluation or processing at their own MTF. Again, HQ AFPXC/DPANM may grant waiver of this restriction.

Airmen typically receive MEB processing at the MTF where they receive the majority of their care, or at the MTF closest to their duty location. However, if originating MTF cannot provide the necessary care or assessment, the MTF may refer the case to an MTF with appropriate services.

If an active member is hospitalized away from the member's installation of assignment or in a non-Air Force facility, the nearest Air Force MTF will accept administrative responsibility for the line of duty (LOD) and MEB process. The member's PCM should remain informed of the patient's condition.

An MTF does not conduct an MEB on an assigned enlisted staff member who has been or is currently a disciplinary problem, or when there would be concern for a conflict of interest. If DPANM requests a waiver, the MTF commander is required to include a brief statement indicating the nature of the disciplinary problem. Once received, DPANM will respond with disposition instructions.

Members under court martial charges or AWOL

Members sentenced to dismissal or punitive discharge by a court-martial, or who are under charges that may result in such a sentence, are not eligible for disability processing.

MEB reports on members who are AWOL, in deserter status, or in the hands of civil authorities are not submitted to the PEB until the evaluee has been returned to his or her duty station and it has been determined that a punitive discharge will not occur.

Dual-action cases

"Dual action" cases are those cases eligible for processing under MEB directives when involuntary separation or discharge under some other directive is also pending. The case is processed under both sets of directives, and the SECAF will make the final disposition under the directive that is most applicable.

Members who refuse professional medical care

An MEB convenes on any military member who refuses required medical, surgical, or dental treatment or diagnostic procedures.

Composition of the MEB

Only physicians may participate as voting members. The board is comprised of three privileged physicians, ideally active duty Medical Corps officers of the United States Uniformed Services. Physician interns and residents are not authorized members. Civilian physicians and/or consultants, and retired medical officers who hold privileges at the MTF may serve as board members. Note that privileges refer to a physician's granted privileges to practice medicine at the MTF, and not to a specific duty.

As a result, the medical board consists of clinical, rather than administrative professionals who determine the appropriate diagnosis and offer a professional opinion concerning the member's

physical and mental qualifications for continued worldwide duty and military service. The MTF commander or designee appoints the medical boards. Appointing orders identify specific individuals tasked for MEB duty.

The number of appointees should be large enough to provide at least three members (medical officers) without delaying the board and without interfering with normal clinical duties. New orders are *not* required for each convening of the board. There must be *only* one current order at each MTF.

If the case is urgent and not enough medical officers are available, or if not enough medical officers are assigned to the MTF, the board may meet with two medical officers, but the situation must be explained on the medical board report. When a finding of mental competency is required, the board *must* be composed of three medical officers.

Other then interns, all active duty medical corps officers sit on the medical board. Civilian consultants, as well as civilian physicians and retired military physicians who are civil service employees on the MTF staff, are eligible to serve on MEBs. However, at least two active duty medical corps officers must serve with them on any given board. The president of the MEB is the senior ranking active duty member present.

Only in certain psychiatric cases, in which a legal determination of competency and sanity must be made, is it necessary for at least one board member to be specialty-qualified in the aspect under consideration. The medical or surgical specialty qualification of board members is not of primary importance. Military medical experience and exposure to a broad spectrum of military operational and support activities are the most valuable assets for board members. Here are some other factors to consider when determining board composition:

- When competency for pay and records purposes is considered, the board must consist of at least three Air Force medical corps officers or physicians, at least one of whom is certified, or eligible for certification, by the American Board of Psychiatry.
- A credentialed clinical psychologist is eligible to serve on boards to determine competency for pay and records. However, the psychologist must not serve in place of the psychiatrist.
- For comatose patients, three medical corps officers can provide a determination of competency for pay and records; a psychiatrist is not required as an evaluator or MEB member.

Review and approval authority

The MTF commander or designee has review and approval authority over the AF Form 618, Medical Board Report. The commander of a hospital, or of a medical center, may delegate this authority to a senior active duty medical corps officer assigned to their staff. When the MTF has only three physicians assigned, or has a commander who is not a medical corps officer, the surgeon of the MAJCOM to which that MTF belongs exercises the review and approval authority. This authority may be delegated from the command surgeon to a senior active duty medical corps officer assigned to their staff or to the surgeon of an intermediate level of command.

MEB procedures

The recorder or president of the board must have a file or binder with all applicable directives, and samples of all forms needed. The MEB recorder assembles and provides to the board all pertinent reports, and records and completes preliminary data. The board procedures may be quite formal, including reporter and boardroom, or informal as circumstances dictate. However, professional decorum is always maintained. Personal appearance of the evaluee is not required, but may be helpful to the board. The evaluee may request to appear at the MEB. If appearing, the board members may question the evaluee, and the evaluee may make a statement about his or her medical condition or disposition. The evaluee does not have a right to representation, nor the option to challenge the board members. If presence of a bed side evaluee is desirable, a portion of the board proceeding may take place at the bedside. If the board determines that additional medical information or consultation is

required, the board may request the required material and recess until it becomes available. Now that you have an understanding of some of the more common MEB terms and procedures, let us take a closer look at how the board is conducted. We will also review some of the functions that the providers sitting on the board accomplish.

Conducting the MEB and follow-up actions

Board members must relate the evaluee's medical condition and prognosis to the military environment and give their professional medical opinion and recommendation on the evaluee's physical and mental qualification for military service. The evaluee must be able to perform in such a manner as to fulfill the purpose of his or her employment on active duty. In the following items, let us look at some factors the board members must consider:

- The evaluee must have the ability to perform not only in his or her current assignment, but, must also have the capacity to respond to more demanding duty. These duties could include combat, combat support, assignment to remote or isolated locations, and other more demanding situations that the evaluee could reasonably be expected to encounter.
- The evaluee must have the ability to perform duty worldwide without geographic or climate limitations.
- Specialty care that the evaluee needs may not be widely available.
- Will the evaluee need excessive medical care to maintain duty performance?
- Distinguish between whether the evaluee is indeed qualified for worldwide military service or merely requires an occupational restriction, such as a physical profile limitation, or retraining into a different career field to accommodate the medical impairment.
- The motivation and attitude of the evaluee toward the evaluee's duty should not influence the board unless the motivation or attitude is symptomatic of a disease process. The board must distinguish between poor motivation and psychophysiology or neurotic symptoms by using positive psychiatric diagnoses.

MEB recommendations

The proceedings of the MEB, review by the appointing authority, and acknowledgment by the evaluee are reported on AF Form 618, Medical Board Report. All items on this form must be complete. An entry of *N/A* may be used for items that are not applicable. The board members or review authority must initial any erasures or significant changes and identify actions recommended by the board in item 25 of this form. Although board recommendations vary, two common findings are "return to duty" and "refer to PEB."

Return to duty

The MEB recommends return to duty when the evaluee is physically qualified for continued military service worldwide. Imminent retirement or separation from service due to length of service or administrative reasons has no bearing on the evaluee's physical qualification to continue service.

Refer to PEB

The MEB refers cases to PEB when the evaluee is not medically qualified for continued military service and believes disposition by the Integrated Disability Evaluation System is appropriate.

Inappropriate MEB recommendations

There are some recommendations that are inappropriate and are not identified on AF Form 618. These include the following:

- Transfer to a specialty center for "separation" or for "retirement." The referring hospital cannot commit the receiving hospital or the disability evaluation system to any procedure or disposition.

- Assignment to a different geographic area or climate. The Personnel Assignment System cannot respond to such a recommendation. This recommendation is inappropriate because, with rare exceptions, the evaluee whose medical impairment precludes duty at his or her present location is not medically qualified for worldwide service and should be referred to the PEB.
- Refer to HQ AFPC or PEB for profile. This recommendation is inappropriate because physical profiling is a prerogative of the local medical authority. Neither HQ AFPC nor the boards and councils of the Air Force Disability System are authorized to award physical profiles.
- Refer to HQ AFPC or PEB for retraining. Retraining into a different career field is initiated by the evaluee's commander when medically recommended locally.

Board approval

Once the board has completed the proceedings, each member of the medical board signs the original AF Form 618 and initials all copies. For insanity or competency cases, a check mark is placed after the signature of the board member who is a psychiatrist.

Report processing

The appointing authority may approve the report, return the report for reconsideration, return the report to the board with instructions, or disapprove the report and change the findings and recommendation.

When disapproved, the reasons for disapproval are on the reverse side of the AF Form 618. The appointing authority cannot reverse a finding of competency or sanity. The appointing authority is concerned with the military medical aspects of each case. He or she relies on the medical professional staff to ensure the professional aspects of the case, such as diagnosis, therapy and prognosis, are sound. The appointing and review authority is most concerned with ensuring the following:

- The order appointing the medical board cites the governing directive and identifies the physicians who conducted that particular board.
- The clinical summary and other medical documents have adequate information to support the findings and recommendation of the board.
- The findings and recommendation of the board satisfy the purpose for which the board was convened and the recommendation is one of those authorized.
- LOD has been addressed and either administrative determination was made or the need for an information or formal investigation has been identified to the evaluee's commander.
- The clinical evaluation and the findings and recommendation are impartial and objective, ensuring that pertinent directives are applied uniformly regardless of the grade of the evaluee or whether service retirement or separation is pending.
- If competency is affected, competent or not competent appears in item 23 of AF Form 618.
- In a sanity determination, the Manual for Courts-Marital is checked in item 22A, and sanity is specified in item 22B.

Counseling the evaluee

After the medical board report is reviewed and approved by the MTF commander (or designee), the PEBLO ensures the evaluee has an opportunity to read the report and the NARSUM, and assists the evaluee with any questions concerning the content. The PEBLO will also ensure that blocks 1–27 of AF Form 618 are completed and then explain the options of the impartial review and/or rebuttal letter, and give the member three duty days to decide if he/she requests one of the following:

- An impartial review (with or without subsequent rebuttal letter).

- To decline the impartial review and submit a rebuttal letter within seven duty days of the decision.
- To decline the impartial review and the rebuttal letter options.

If the member declines the impartial review and rebuttal letter options, the PEBLO will ask the member to sign and date the AF Form 618, Medical Board Report, blocks 29(a) and 29(b) signifying that he or she has been informed of the findings and recommendations of the MEB.

- If the evaluee is unable or not available to sign the AF Form 618, the board recorder will enter *signature unavailable* in item 29B, and explain why on the reverse of the AF Form 618. The recorder must still sign opposite the footnote below item 29.
- If the evaluee is unwilling to sign, the board recorder will enter *evaluee unwilling to sign* in item 29B, place a brief explanation on the reverse of the AF Form 618 with signatures of two additional witnesses to the evaluee's briefing and refusal to sign, and sign opposite the footnote below item 29.

After the member signs the AF Form 618, the PEBLO signs opposite the footnote below item 29 to show that the PEBLO thoroughly briefed the evaluee on the findings, recommendation, and options. Finally, PEBLO assembles and forwards the MEB package to the IPEB per the instructions of the checklist in the Disability Counseling Guide for Physical Evaluation Board Liaison Officers, published by HQ AFPC/DPSD.

Impartial review

If the Airman requests an impartial review, an impartial physician or other appropriate healthcare professional (not involved in the Airman MEB process) reviews the medical evidence presented by the NARSUM and associated consults.

The impartial health professional should advise the member within five duty days on whether the MEB findings adequately reflect the complete spectrum of injuries and/or illnesses. For cases in which the impartial review does not validate the MEB findings, the impartial reviewer will contact the MEB board president (SGH or SGP who signed block 26 on AF Form 618) concurrently with notification to the member.

Rebuttal

The member may choose to submit a rebuttal letter to the MEB convening medical authority (CMA). The acting CMA for any particular case may not be one of the three physicians who served on the MEB, and may not be the impartial reviewer for that particular case. If the member requested an impartial review, the member will have seven calendar days from the date of impartial reviewer notification of review results to prepare a rebuttal letter and submit it to the MEB CMA. If the member elected to have an impartial review, include this documentation with the letter for the CMA to review. In turn, the CMA will have seven calendar days to consider the rebuttal letter and return the fully documented decision to the member.

Disposition of the evaluee awaiting final determinations

Evaluees recommended by the MEB for "Return to Duty," or "Refer to PEB," must remain readily available to sign documents and respond promptly to inquiries or recommended dispositions by the disposition authority.

Informal physical evaluation board

The informal physical evaluation board (IPEB) is located at the Air Force Personnel Center, JBSA-Randolph AFB, Texas, and is administratively supported by the Disability Operations Branch (DPFDD). The IPEB makes recommendations based solely on selected portions of the member's records: MEB report, medical NARSUM, VA C&P exams, clinical records, Personnel Data System

(PDS) information, commander's letter, LOD determination, and so forth. The member is not present when the case is considered.

A panel of at least three voting members consisting of field grade officers, colonels or civilian equivalent, one of whom must be a medical officer, considers each case. The IPEB must perform the following:

- Determine if the member is physically fit to perform the duties of his or her office, grade, rank or rating.
- Determine if the disability was incurred while the individual was entitled to basic pay (unfit members).
- Determine if the disability was caused by the member's intentional misconduct or willful neglect, or incurred during a period of unauthorized absence (unfit members).
- Determine if the condition(s) is/are combat related (unfit members).
- Determine if the degree of impairment has stabilized (unfit members).
- Recommend a final disposition based on the preceding determinations (all members).

The IPEB does not have the authority to direct reclassification, establish physical profile limitations, or direct assignments.

Under the IDES, the IPEB will determine if referred conditions make the member unfit for service. The IPEB makes one of the following determinations:

- Return to duty.
- Discharge with severance pay.
- Permanent retirement.
- Temporary retirement.

If the case is anything other than RTD, it is then referred to the Department of Veterans Affairs Rating Board (DVARB), who will assign preliminary rating percentages for all conditions claimed by the member at the time of their VA examination. The IPEB will then apply the VA-assigned rating percentages for Category I unfitting conditions and will recommend a final disposition. DPFDD sends the IPEB's findings and recommendation to the referral MTF for counseling of the member by the PEBLO.

After the PEBLO explains all the ramifications of the board's findings and recommended disposition, answered any questions that might arise, and advised the member of the right to discuss the case with legal counsel provided by the Air Force, the member must within 10 calendar days of notification decide whether or not to concur with the IPEB. If the member nonconcurs with any part findings and recommended disposition of the PEB, the member has the option of appealing to the formal physical evaluation board (FPEB) or request for rating reconsideration is the appropriate avenue for addressing their concerns.

Formal physical evaluation board

The FPEB adjudication process begins as soon as the member nonconcurs with the IPEB findings and recommendations and elects a formal hearing. The initial adjudication review affords the member the opportunity to have the contention considered by the FPEB prior to travel to San Antonio, potentially reducing processing time, TDY costs, and stress for the member. The cornerstone of the advanced adjudication process is early communication between the member and the Office of Airmen's Counsel (OAC).

Under the IDES, if the member concurs with the findings and recommendations of the FPEB, the member may exercise the right to request a one-time reconsideration of disability ratings from the VA. If the member nonconcurs, the Secretary of the Air Force Personnel Council (SAFPC) considers the case before the rating reconsideration can be processed.

Secretary of the Air Force personnel council

The SAFPC, acting on behalf of the SECAF makes the final disposition on each disability case. The Director, SAFPC, is empowered to determine appropriate disposition and announce the final decision of the Secretary. In turn, SAFPC has designated certain key officials in the USAF Physical Disability Division as Special Assistants to the Director, SAFPC. These assistants have the authority to finalize cases and announce the final secretarial determination in those cases not otherwise required to be finalized at SAFPC level.

432. Assignment limitation code-C

When the Air Force DES returns an active duty member to duty, DPANM reviews the case to determine if an assignment limitation code (ALC)-C needs to be entered in the Personnel Data System (PDS). This code restricts assignment and deployment availability to only CONUS, Alaska (Elmendorf), and Hawaii assignments. It also prevents reassignment anywhere else without prior approval by designated approval authorities. The intent of the code is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening condition, and to prevent the assignment of non-worldwide qualified personnel to overseas locations.

Types of assignment limitation codes

HQ AFPC/DPANM may assign the following ALC-C codes based on risk and medical requirement. They are also the only authority that can remove the ALC-C codes. The code is valid indefinitely, but should be reviewed or renewed at least annually unless otherwise specified by DPANM. Officials at DPANM will stratify members during each annual RILO review. There are three types of ALC codes:

ALC-C1

This code will be used primarily to identify individuals with temporary or mild conditions requiring medical follow-up but whose condition is clinically quiescent or unlikely to cause serious impact if untreated or treatment is limited to primary care during periods of deployment or assignment.

ALC-C2

This ALC-C will be used for medical conditions for which specialist medical care and referral within one year is likely, but could be deployed or reassigned OCONUS or to non-fixed environments if appropriate specialty care is available, or for short periods of time.

ALC-C3

This code stratification designates members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical condition.

Waivers

The ALC-C does not limit deployment and/or overseas assignments. It ensures that members with medical conditions are assigned and/or deployed to the appropriate location where care is available. This requires that waiver coordination between the losing base and the medical waiver approval authority occur in a timely manner.

Annual RILO

Those Airmen on an ALC-C will have an annual RILO to re-evaluate their medical condition. DPANM will notify the appropriate MTF the RILO is due. The requirements are the same as the initial RILO; however, the commander’s letter is not required unless directed by DPANM. As with an initial RILO, the adjudication could be return to duty, with or without a code C, or refer to IPEB.

433. Permanent disability retired list and temporary disability retired list

A member who is found physically unfit to perform his or her duties due to a disability incurred while entitled to receive basic pay and in line of duty may be retired. A member can qualify for two retirement categories: permanent or temporary.

Permanent retirement

If the degree of permanent impairment caused by the disabling condition is determined to be stable, the member may be permanently retired. When a member is permanently retired for disability, the member is entitled to all the rights and privileges of any other retiree. This includes entitlement to a military retired ID card, medical care, Base Exchange (BX) and commissary privileges, survivor benefit plan (SBP) election, and so forth. There are no provisions in the law for increasing or decreasing a member's compensable disability rating after the effective date of permanent retirement.

Temporary retirement

Those members who qualify for disability retirement but whose degree of impairment has not yet stabilized are temporarily retired; that is, their names are placed on the TDRL. Use of the TDRL prevents the government from permanently retiring a member who may partially or fully recover at a later date or may worsen in the near future.

By law, an individual may stay on the TDRL for no more than five years. While on the TDRL, the member is periodically reevaluated to determine if there has been a change in the condition(s) for which retired. The IPEB reviews the report of this examination to determine if retention on the TDRL is in order, or if permanent disposition of the case is appropriate. Officials within the Office of the Secretary of the Air Force may direct permanent disposition at any time during the five-year TDRL period if they determine the member's condition has stabilized. However, the case must be finalized at the expiration of five years on the TDRL regardless of the stability of the member's condition. When the IPEB recommends a final disposition, the individual is afforded full appeal rights, including a formal hearing of the case, if desired. A member whose name is *retained* on the TDRL is not provided the opportunity to appeal the action since there is no change in retired pay or other benefits.

Members who are determined to be fit upon reevaluation and who were on active duty when placed on the TDRL will be given the opportunity to return to AD unless ineligible to do so under other provisions of law. A member who was eligible to retire for years of service at time of placement on the TDRL may elect immediate service retirement rather than to return to active duty. Fit members who do not return to active or reserve duty will be discharged from the Air Force without disability benefits. However, they will be eligible to receive any separation or readjustment pay to which they would have been entitled when placed on the TDRL.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

429. Responsibilities

1. Whose responsibility is it to obtain signatures from the board members and the approval authority on the AF Form 618, Medical Board Report?

2. Who does the MEB clerk forward the completed MEB package to once the evaluee or NOK signs the AF Form 618?

3. When does the PEBLO refer an Airman to the Airman and Family Readiness Center for pre-separation counseling?

4. What provides instructions on compiling cases documentation and provides a MEB checklist?

430. Veterans Affairs compensation and pension evaluation

1. What function does the VA's Military Service Coordinator perform?

2. Who notifies the member of the IDES process and schedule the medical examinations required to adjudicate the member's disability claim?

3. What is a joint application that supports the effective management and tracking of Veteran and service member throughout the process, from the initial arrival of members into the VA health system and monitoring of benefits applications and administrative details?

4. When the PEBLO receives the C&P results back from the MSC, where should the results go?

5. If there are no inconsistencies or updates, what statement should the providers put on the narrative summary?

431. Medical evaluation board process

1. Why should members not be placed on leave or TDY outside of the local area?

2. What does a '4' on a profile indicate?

3. A competency for pay and records determination is made in conjunction with what other determination?

4. Who can waiver the restriction for MTFs to conduct a medical board on their own medical treatment facility staff officers?

5. What cases are eligible for processing under MEB directives when involuntary separation or discharge under some other directive is also pending?

6. Who can be voting member on a MEB?

7. Who appoints medical boards?

8. As a minimum, the number of medical board appointees should be large enough to provide at least how many medical officer members?

9. Are new orders required for each convening of the board?

10. Who serves as president of the MEB?

11. What are the most valuable assets that medical board members possess?

12. Who has review and approval authority over medical board reports?

13. Is personal appearance of the evaluee required?

14. What must the board members be able to do in order to give their professional medical opinion and recommendation on the evaluee's qualification for military service?

15. What are the two most common findings from the MEB?

16. What is an example of an inappropriate MEB recommendation?

17. Once the board has completed the proceedings, who signs the original AF Form 618 and initials all copies?

18. How is the psychiatrist identified on the AF Form 618 in cases of insanity or competency?

19. What finding cannot be reversed by the MEB appointing authority?

20. When competency is affected, what terminology is used in item 23, Diagnosis and Findings, on the AF Form 618?

21. What does the evaluee acknowledge by completing parts A, and B of item 29 on the AF Form 618?

22. Why does the PEBLO sign opposite the footnote below item 29 on the AF Form 618?

23. Who reviews the case if an Airman requests an impartial review?

24. How soon should the Airman hear back concerning an impartial review?

25. How long does the CMA have to respond to a rebuttal?

26. What does the IPEB base recommendations on?

27. How many voting members are required for the IPEB?

28. Once the IPEB determines which condition(s) make a member unfit for service, where is the package sent?

29. How long does the member have to concur/nonconcur with the IPEB?

30. When does the FPEB adjudication process begin?

31. Who has final disposition on each disability case?

432. Assignment limitation code-C

1. What does the ALC-C limit in the PDS?

2. What is the intent of the ALC code?

3. Who has the authority to remove ALC-C?

4. What ALC restricts deployment and assignment to where there are specialty medical capabilities?

5. What is the only difference in package requirement between an Annual RILO and an Initial RILO?

433. Permanent disability retired list and temporary disability retired list

1. When may a member be permanently retired?

2. What rights and privileges is the permanently retired member entitled to?

3. What does the use of the TDRL prevent the government from doing?

4. How long can a member stay on the TDRL?

3–3. Programs for Seriously Ill and Injured Patients

A majority of the Air Force service members that go through the IDES process is due to obstructive sleep apnea or asthma. Air Force members are not typically boarded due to grave injury or illness, let alone those sustained in war zone, however due to the sensitivity there are processes to help these individuals. There is a program available for seriously injured and/or ill patients and another for those that sustained an illness or injury while in the battle zone. This last section will cover these two programs: the Airman Medical Transition Unit and the Wounded Warrior Program.

434. Airman Medical Transition Unit

The intent of the Airman Medical Transition Unit (AMTU) is to place Airmen in MTFs best suited to address their medical needs. AF/SG and Air Force Personnel Center (AFPC) determine guidelines; however, AFPC/DPANM is the only office that approves active duty AMTU assignments. Two different patients may have the same diagnosis, but the condition and situation is unique to each member. Although each situation is unique, there must be guidelines for AFPC/DPANM to follow when assigning members to an AMTU. Headquarters has defined the following four situations when a member may qualify for assignment to an AMTU:

1. Required medical care is not available at the member's MTF or in the local areas.
2. There is overwhelming medical evidence which suggests the Airman is not likely to return to duty.
3. Hospitalization for Airmen stationed overseas is expected beyond his or her date eligible for return from overseas (DEROS).
4. An Airman is going through long and intensive treatment and it may benefit the patient to be close to their family. Although placement of the member near family or home of record may be considered when appropriate, it is not the goal of this program.

Patients are not in an AMTU in order to preserve terminal leave or retain a member beyond his or her date of separation or retirement. Additionally, Airmen are not retained as patients for rehabilitation in order to gain retention on active duty. Once an Airman is on terminal leave, he or she is not permitted to be attached to the AMTU without prior approval from AFPC/DPANM.

Unit responsibility

Any MTF in the AF, regardless of the size or location, can have an AMTU. Once established, it is a flight or an element under TRICARE Operations and Patient Administration (TOPA). The MTF commander assumes authority over all members assigned to the unit, and may appoint an officer to serve as the AMTU commander. Since the patients are assigned to the medical support squadron, the appointee is normally the medical support squadron commander. This means that the medical support squadron commander has administration oversight and Uniform Code of Military Justice (UCMJ) authority for all patients assigned to them. When AFPC/DPANM approves an assignment, the Airman the member relocates via official orders in either PCS or PCA capacity. When the member PCSs, they are *assigned* to the AMTU and do not count against the losing unit's staffing positions.

Occasionally, patients are TDY to the MTF for an extended time and *attached* to the AMTU. In this case, the MTF commander or appointee is still responsible for the patient, but the UCMJ authority remains with the member's home station commander. If patients are attached to a patient squadron, and their condition meets one of the four situations mentioned previously, the SGH can fill out an AMTU PCS worksheet and submit it to AFPC/DPANM. If approved, the member will receive orders assigning them to the appropriate MTF. Following TDY medical treatment, the AMTU commander will return the Airman to his or her home unit commander. Attaching patients to an AMTU does not require AFPC/DPANM approval; however, you can consult AFPC/DPANM for lengthy TDYs.

Re-assignment to duty

If an Airman is assigned to the unit, the DAWG follows the condition. If a member recovers from the illness or injury, the MTF completes a RILO and sends it to AFPC/DPANM for evaluation. If the member meets retention standards, AFPC/DPANM notifies the appropriate assignment manager at AFPC. The assignment manager notifies the local MPS with assignment instructions. Although the member may be ready to return to the home station, the member must meet minimum PCS retainability requirements.

435. Wounded Warrior Program

The military's Wounded Warrior programs provide assistance and advocacy for severely wounded, ill, and injured service members, veterans, and their families. These programs assist service members and their families as they return to duty or transition to civilian life.

An "Air Force wounded warrior" is any seriously or very seriously wounded, ill, or injured Airman identified on a casualty report, or recommended by the medical community as having highly complex medical conditions. Also included are Airmen who have been referred to the IDES for post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) and/or other mental health conditions.

The Wounded Warrior programs work with the service member and medical team to develop a comprehensive recovery plan that addresses specific recovery, rehabilitation and reintegration goals. These programs provide lifetime support for the service member; eligibility for participation in the program does not conclude when the service member is discharged from a military treatment facility. Typical non-medical support provided by the Wounded Warrior programs may include, but is not limited to, assistance with the following:

- Pay and personnel issues.
- Invitational travel orders.
- Lodging and housing adaptations for the wounded warrior.
- Child and youth care arrangements.
- Transportation needs.
- Legal and guardianship issues.
- Education and training benefits.
- Respite care.
- Traumatic brain injury/post-traumatic stress support services.

The Recovery Coordination Program is under the direction of the Undersecretary of Defense for Personnel and Readiness. They are often provided office space within the MTF; however, this is to assist the recovering service members. To help service members with their way through their recovery process, they may be assigned a recovery care coordinator (RCC), a Wounded Warrior advocate, a nonmedical case manager or a federal recovery coordinator (FRC) assigned to help them in their case management.

Recovery care coordinator and wounded warrior advocate

The RCC and Wounded Warrior advocates are typically assigned to seriously wounded, ill, or injured service members whose medical conditions are expected to last at least 180 days. The RCC or advocate is a member of the AF Wounded Warrior Program team and is trained to help build a CRP or a comprehensive transition plan (CTP) that identifies the Airmen's needs and lays out the path for him or her to meet personal and professional goals during his or her recovery, rehabilitation, and reintegration. The RCC or advocate works with Airmen and their families as well as their doctors, nurses, social workers, case managers, and Wounded Warrior Program staff.

Federal recovery coordinator

FRCs are assigned to members whose medical conditions are expected to result in their separation from active duty. Their goals are the same: to help get the right care and support from the right people at the right time. The FRCs, managed by the VA, help the more severely wounded, ill, or injured service members. FRCs develop a Federal Individualized Recovery Plan with input from the service member, the member's family or caregiver and the member's health care team. They track the care, management, and transition of a recovering Service member or veteran through recovery, rehabilitation, and reintegration.

Nonmedical case manager

A key part of the recovery plan is the identification of the benefits and compensation to which Airmen are entitled and then helping them apply for them. The nonmedical case managers will provide oversight and assistance. They assist wounded, ill, or injured service members with issues such as the following:

- Pay and personnel matters.
- Invitational travel orders.
- Lodging and housing adaptation.
- Child and youth programs.
- Transportation needs.
- Legal and guardianship issues.
- Education and training benefits.
- Commissary and exchange access.
- Respite care.
- TBI and PTSD support services.
- Other nonmedical support services.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

434. Airman Medical Transition Unit

1. What is the intent of the AMTU?

2. Who is the approval authority that approves active duty AMTU assignments?

3. Active duty Airmen stationed overseas may qualify for PCS reassignment to an MTF if their hospitalization is expected for how long?

4. Who assumes assignment and command authority over officers and enlisted members assigned to the AMTU??

5. Who assumes assignment and command authority over officers and enlisted members assigned to the patient squadron?

6. Who must approve assignment to the AMTU if a member is pending judicial or adverse administrative action?

435. Wounded Warrior Program

1. Who is an AF wounded warrior?

2. What does the Wounded Warrior Program do?

3. What four individuals are in place to help service members with their way through the recovery process?

4. If a seriously wounded, ill, or injured service member's conditions are expected to last at least 180 days, who are typically assigned to the member?

5. Who develops a Federal Individualized Recovery Plan with input from the service member, the member's family or caregiver and the member's health care team?

6. Who would assist the Wounded Warrior with things such as lodging and housing adaptation, respite care and TBI and PTSD) support services?

Answers to Self-Test Questions

426

1. To help the Air Force, Army, Navy, and Marine Corps determine whether wounded, ill or injured service members are able to continue to serve.
2. Have a disqualifying medical diagnosis, condition (physical or mental) prohibits or limits the individual from completing his or her duties, condition routinely interferes with their ability to deploy, condition restricts worldwide duty reassignment, imposes unreasonable requirements on the military to either maintain or protect the member.

427

1. To ensure proper referral to the IDES.
2. A Fitness for Duty (FFD) Evaluation.
3. HQ AFPC/DPANM.

428

1. To review patients with medical records with a DLC that impacts mobility, retention, or long-term physical fitness of an Airman.
2. It is a condition or occurrence which may indicate a member has a health condition that is inconsistent with retention standards or deployability.
3. AFI 48–123, *Medical Examinations and Standards.*
4. The commander.
5. Unsuiting.
6. Within 45 days.

7. A recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.
8. Functional (or physical) limitation.
9. Code 31.
10. Code 37.
11. To describe physical limitations and recommend duty restrictions to the commander when there is a potential risk to an Airman's health, safety, and wellbeing; the safety of the mission, or the ability of the Airman to effectively accomplish the mission. Additionally, the AF Form 469 is used to convey limitations related to the AF FP. In general, the AF Form 469 will describe what an Airman is unable to do.
12. For initial qualification, qualification for retirement or separation, military retraining, PCS, PME, and similar functions.
13. Fitness assessment exemptions with AC exemptions (excluding pregnancy) and fitness assessment exemptions for 365 days.
14. SGP, SGH, SPO, all available profile officers, MSME, PEBLO, a PCM representative and EP.
15. Case dismissal, initial RILO referral and refer for adjudication.
16. 30 days.
17. Return to duty, direct an MEB, and Continued Military Medical Observation and Care.

429

1. The MEB Clerk.
2. The disposition authority.
3. When their case is referred to the IPEB.
4. AFI 41–210, TRICARE Operations and Patient Administration Functions.

430

1. It is the VA's non-clinical benefits advisor to the member while going through the IDES. The MSC provides counseling and guidance about VA benefits and policies to the members and/or family. Additionally, the MSC assists the member and/or family in the preparation and tracking of VA claims.
2. The VA MSC.
3. Veterans Tracking Application.
4. To the PCM, referring provider, or to a reviewing provider who has been assigned by the DAWG.
5. "I have reviewed the C&P exam results and find the information within the NARSUM to be current and complete."

431

1. The evaluee needs to be available for medical testing, to sign documents and respond promptly to recommended disposition by the MEB and AFPC.
2. The member is disqualified from worldwide service.
3. Worldwide duty qualification.
4. HQ AFPC/DPANM.
5. Dual-action cases.
6. Only physicians.
7. The MTF commander or their designee.
8. Three.
9. No, there must be only one order current at each MTF.
10. Senior ranking active duty member present.
11. Military medical experience and exposure to a broad spectrum of military operational and support activities.

12. MTF commander or designee; this authority may be delegated to a senior active duty medical corps officer in his or her staff.
13. It is not required, but may be helpful to the board.
14. Be able to relate the evaluee's medical condition and prognoses to the military environment.
15. They are "return to duty" and "refer to PEB.
16. Any of the following:

    (1) Transfer to a specialty center for "separation" or for "retirement." The referring hospital cannot commit the receiving hospital or the Disability Evaluation System to any procedure or disposition.

    (2) Assignment to a different geographic area or climate. The Personnel Assignment System cannot respond to such a recommendation. This recommendation is inappropriate because, with rare exceptions, the evaluee whose medical impairment precludes duty at his or her present location is not medically qualified for worldwide service and should be referred to the PEB.

    (3) Refer to HQ AFPC or PEB for profile. This recommendation is inappropriate because physical profiling is a prerogative of the local medical authority. Neither HQ AFPC nor the boards and councils of the Air Force Disability System are authorized to award physical profiles.

    (4) Refer to HQ AFPC or PEB for retraining. Retraining into a different career field is initiated by the evaluee's commander when medically recommended locally.
17. Each member of the medical board.
18. A check mark is placed after the psychiatrist's signature.
19. Competency or sanity.
20. Competent or Not Competent.
21. That the member has been informed of the findings and recommendations of the MEB.
22. To show that the PEBLO has briefed the evaluee thoroughly on the findings, recommendation, and options.
23. An impartial physician or other appropriate healthcare professional not involved in the airman's MEB.
24. Within five duty days.
25. Seven calendar days.
26. MEB report, medical NARSUM, VA C&P exams, clinical records, information in the PDS, commander's letter, LOD determination, etc.
27. At least three.
28. Department of Veterans Affairs Rating Board.
29. Ten calendar days.
30. As soon as the member nonconcurs with the IPEB findings and recommendations and elects a formal hearing.
31. Secretary of the Air Force Personnel Council, acting on behalf of the Secretary of the Air Force.

432

1. This code restricts assignment and deployment availability to only CONUS, Alaska (Elmendorf), and Hawaii assignments. It also prevents reassignment anywhere else without prior approval by designated approval authorities.
2. To protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening condition, and to prevent the assignment of non-worldwide qualified personnel to overseas locations.
3. Only HQ AFPC/DPANM .
4. ACL-C3.
5. The commander's letter is not required unless directed by DPANM.

433

1. If the degree of permanent impairment caused by the disabling condition is determined to be stable.
2. The same as any other retiree, which includes a military retired identification card, medical care, BX, Commissary privileges, Survivor Benefit Plan (SBP) election, etc.

3. Permanently retiring a member who may partially or fully recover at a later date or may worsen in the near future.
4. For no more than five years.

434

1. To place Airmen in MTFs best suited to address their medical needs.
2. AFPC/DPANM.
3. Beyond his or her DEROS.
4. The MTF commander.
5. The MTF commander or appointee is still responsible for the patient, but the UCMJ authority remains with the member's home station commander.
6. The court martial convening authority or discharge authority.

435

1. Any seriously or very seriously wounded, ill or injured Airman identified on a casualty report, or recommended by the medical community as having highly complex medical conditions. Also included are Airmen who have been referred to the IDES for PTSD, TBI and/or other mental health conditions.
2. Works with the service member and medical team to develop a comprehensive recovery plan that addresses specific recovery, rehabilitation and reintegration goals.
3. A RCC, a Wounded Warrior advocate, a nonmedical case manager and a FRC.
4. RCC and Wounded Warrior advocates.
5. FRCs.
6. The nonmedical case managers.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field Scoring Answer Sheet.

Do not return your answer sheet to AFCDA.

67. (426) What service(s) is/are involved with the Integrated Disability Evaluation System (DES)?
    a. Air Force.
    b. Air Force and Army.
    c. Air Force, Army, and Navy.
    d. Air Force, Army, Navy, and Marine Corps.

68. (427) In general, Airmen are not eligible for disability due to all of the following reasons, *except*
    a. Airman with conditions that existed prior to service.
    b. Airmen in an Absent Without Leave status.
    c. Airmen pending honorable discharge.
    d. Airmen facing court martial charges.

69. (428) All of the following are examples of trigger events, *except* for
    a. provider identification.
    b. commander requests evaluation.
    c. permanent change of station (PCS) cancellation for administrative actions.
    d. Medical Retention Standards Branch (HQ AFPC/DPANM) identification and direction.

70. (428) What type of condition is not eligible for referral to the Disability Evaluation System (DES)?
    a. Unfit.
    b. Unsuiting.
    c. Duty limitation.
    d. Duty restriction.

71. (428) What is a report of an Airman's injury or illness, based on evaluation by a medical professional, that describes specific physical activities or functions that are *recommended* for the Airman to avoid allowing recovery or reducing risk of further injury?
    a. Functional (or physical) restriction.
    b. Functional (or physical) limitation.
    c. Duty restriction.
    d. Duty limitation.

72. (428) An AF Form 469 and AF Form 422 are good for a *maximum* of how many days?
    a. 90 days.
    b. 120 days.
    c. 180 days.
    d. 365 days.

73. (428) An Airmen should be referred to the deployment availability working group (DAWG) if a mobility restriction goes over how many days?
    a. 90 days.
    b. 120 days.
    c. 180 days.
    d. 365 days.

74. (428) Who from the following list is not required to attend the deployment availability working group (DAWG)?
a. Exercise physiologist.
b. Medical group commander.
c. Physical Evaluation Board liaison officer.
d. Medical Standards Management Element.

75. (428) What is an authorized disposition the deployment availability working group (DAWG) can make?
a. Case dismissal.
b. Return to duty with ACL-C.
c. Permanent Disability Retirement List.
d. Temporary Disability Retirement List.

76. (428) Once AFPC/DPANM (Medical Retention Standards Branch) reviews an initial review in lieu of (RILO), how do they notify the physical evaluation board liaison officer (PEBLO) of the determination?
a. E-mail from the organizational box.
b. Official memorandum.
c. AF Form 356.
d. AFPC/FL 4.

77. (429) Who appoints the Medical Evaluation Board (MEB) clerk and the Physical Evaluation Board liaison Officer (PEBLO), and by what means is the PEBLO tasked?
a. Military treatment facility commander; published orders.
b. Flight commander, patient administration; published orders.
c. Military treatment facility commander; official correspondence.
d. Flight commander, patient administration; official correspondence.

78. (429) Which of the following is a responsibility of the medical evaluation board (MEB) clerk?
a. Schedules cases for board hearings.
b. Ensures accurate and complete case records are sent to the physical evaluation board (PEB).
c. Requests commander’s letter and keeps member’s commander/first sergeant apprised of the member’s case status.
d. Advises the patient administration or hospital services office of the final disposition of all cases where the member underwent PEB processing in an outpatient status.

79. (429) Which of the following is a responsibility of the Physical Evaluation Board liaison officer (PEBLO)?
a. Obtains evaluee or next of kin (NOK) signature on AF Form 618, Medical Board Report, forwards the completed medical evaluation board (MEB) package to the disposition authority, and makes proper distribution of that authority’s responses.
b. Counseling members or NOK on the physical evaluation board (PEB) findings and recommended disposition as documented on AF Form 356, Findings and Recommended Disposition of USAF Physical Evaluation Board.
c. Completes AF Form 618, Medical Board Report; obtains signatures from the board members and the approval authority; and assembles the attachments to AF Form 618, Medical Board Report.
d. Assists the evaluee in resolving any questions concerning the content of the report or summary.

80. (429) Before the Integrated Disability Evaluation System (IDES) process existed, how long would the average medical evaluation board (MEB) take from case imitation to Veteran's Administration (VA) rating?
    a. 5 years.
    b. 4 years.
    c. 3 years.
    d. 2 years.

81. (430) Who is the non-clinical benefits advisor to the member while going through the Integrated Disability Evaluation System (IDES)?
    a. MEB clerk.
    b. VA-MSC.
    c. Provider.
    d. PEBLO.

82. (430) The Veterans Tracking Application
    a. retrieves data from the Temporary Disabled Retirement List (TDRL).
    b. retrieves data from comprehensive recovery plan (CRP).
    c. tracks review in lieu of (RILO).
    d. is a web-enabled tool.

83. (430) The Veterans Tracking Application
    a. is strictly used to create reports for Senior Department of Defense (DOD) officials.
    b. replaces the local military treatment facility (MTF) database system.
    c. is hosted on the Veterans Information Portal (VIP).
    d. tracks review in lieu of (RILO).

84. (430) When the providing care manager (PCM), or referring provider, reviews the compensation and pension (C&P) results, and does not note any inconsistencies, what should the PCM do?
    a. Rewrite the narrative/summary (NARSUM) in the approved Air Force format.
    b. Submit an addendum stating there were no inconsistencies.
    c. Endorse the NARSUM, stating it is current and complete.
    d. The provider is not required to review the C&P results.

85. (431) A medical board can be convened to determine an individual's mental competence for pay and records purposes when the member
    a. is not performing to the appropriate skill level and grade.
    b. has a specific psychiatric illness or illnesses.
    c. displays gross financial irresponsibility.
    d. has been under severe emotional stress.

86. (431) Who designates the military training facility (MTF) to conduct a Medical Evaluation Board (MEB) on a general officer?
    a. The board will be conducted at the originating MTF.
    b. Air Force Surgeon General.
    c. HQ AFPC/DPANM.
    d. HQ AF/CC.

87. (431) Who can authorize a military treatment facility (MTF) to conduct a military evaluation Board (MEB) on an assigned enlisted staff member who has been a disciplinary problem?
    a. AFPC/DPANM.
    b. MEB President.
    c. MAJCOM/SG.
    d. MTF/CC.

88. (431) Who can be voting member(s) on the medical evaluation board (MEB)?
    a. Physical evaluation board liaison officer (PEBLO).
    b. Physicians.
    c. Residents.
    d. Interns.

89. (431) Who appoints medical evaluation board (MEB) members, and by what means are they tasked?
    a. Physical Evaluation Board Liaison Officer (PEBLO); MEB report.
    b. Military treatment facility commander; appointing orders.
    c. MEB recorder; meeting minutes.
    d. Base commander; orders.

90. (431) Under normal conditions, how many board members are required for a medical evaluation board (MEB)?
    a. 2.
    b. 3.
    c. 4.
    d. 5.

91. (431) Who has review and approval authority over the AF Form 618, Medical Board Report?
    a. Military treatment facility commander or their designee.
    b. Physical Evaluation Board liaison officer.
    c. Medical Evaluation Board president.
    d. Attending physician.

92. (431) After the evaluee has been informed of the Medical Evaluation Board (MEB) findings, how many days does the member have to request an impartial review?
    a. Depends on whether the case has imminent death implications.
    b. Seven calendar days.
    c. Three duty days.
    d. Five duty days.

93. (431) If the impartial reviewer finds that the review does not support the medical evaluation board (MEB) findings, the reviewer should contact the
    a. MEB President concurrently with notification to the member.
    b. physical evalutation board liaison officer (PEBLO).
    c. patient’s primary care manager (PCM).
    d. MEB clerk.

94. (432) Although assignment limitation codes (ALC)-C are valid indefinitely, how often should the codes be reviewed?
    a. At least annually, unless otherwise specified by Medical Retention Standards Branch (DPANM).
    b. At least every 18 months, unless otherwise specified by DPANM.
    c. As determined by the Physical Evaluation Board.
    d. As prescribed by the attending physician.

95. (432) What assignment limitation code (ALC) is for members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical condition?
    a. ALC-C0.
    b. ALC-C1.
    c. ALC-C2.
    d. ALC-C3.

96. (433) A member may be permanently retired when the member has
    a. a disabling condition that is determined to be stable.
    b. more than three diagnosed conditions.
    c. at least 20 years in the military.
    d. 100% disability rating.

97. (433) What is the *maximum amount of time* a member is authorized to be on a Temporary Disabled Retirement List (TDRL)?
    a. 3 years.
    b. 4 years.
    c. 5 years.
    d. 6 years.

98. (434) Who appoints an officer to serve as the Patient Squadron commander?
    a. MTF/CC.
    b. Squadron/CC.
    c. The MAJCOM.
    d. AFPC/DPAMM.

99. (435) How long or when does the Wounded Warrior Program work with the service member and the medical team to develop a comprehensive recovery plan?
    a. Once the member is discharged from the military treatment facility.
    b. Only after the member is retired or separated.
    c. Until the member is retired or separated.
    d. It provides lifetime support.

100. (435) Recovery care coordinator (RCC) and Wounded Warrior advocates are typically assigned to seriously wounded, ill, or injured service members whose medical conditions are expected to last at least how many days?
    a. 90.
    b. 120.
    c. 180.
    d. 365.

Student Notes

Glossary

Abbreviations and Acronyms

AA	air ambulance
AAC	assignment availability code
AAR	after action reports
AB	Air Base
ADCON	administrative control
ADLS	Advanced Distributed Learning System
AE	aeromedical evacuation
AEF	Air and Space Expeditionary Force
AEG	air expeditionary groups
AECC	aeromedical evacuation control center
AEOO	aeromedical evacuation operations officers
AES	air expeditionary squadrons or aeromedical evacuation system
AETF	Air & Space Expeditionary Task Force
AEW	air expeditionary wings
AFB	Air Force Base
AFI	Air Force instruction
AFMS	Air Force Medical Service
AFPC	Air Force Personnel Center
AFSC	Air Force specialty codes
AFTH	Air Force Theater Hospital
ALC	assignment limitation code
AMEDD	Army Medical Department
AMTU	Airmen Medical Transition Unit
ANG	Air National Guard
AOC	airlift operations center
AOR	area of responsibility
ARC	Air Reserve Component
ART	Air and Space Expeditionary Force (AEF) reporting tool
ASF	aeromedical staging facility
ASTS	aeromedical staging squadrons
AWOL	absent without leave
BE	bioenvironmental engineering
BSC	Biomedical Sciences Corps
BSP	Base Support Plan
BW/CW	biological warfare/chemical warfare

BX	base exchange
C2	command and control
C_3	communication, command, and control
CAT	crisis action team
CBRNE	chemical, biological, radiological, nuclear and high- yield explosives
CBT	computer-based training
CCATT	critical care air transport teams
CCT	contamination control teams
CDC	career development course
CEMP	Comprehensive Emergency Management Plan
CENTCOM	US Central Command
CJCS	Chairman of the Joint Chiefs of Staff
C-levels	category levels
CMA	convening medical authority
CONUS	continental United States
C&P	compensation and pension (examination)
CRP	comprehensive recovery plan
CSAF	Chief of Staff of the Air Force
CTP	comprehensive transition plan
DAV	deployment availability
DAWG	deployment availability working group
DC	Dental Corps
DCAPES	Deliberate and Crisis Action Planning and Execution Segments
DCO	Defense Connect Online
DCP	disease containment plan
DD	Department of Defense
DEERS	Defense Enrollment Eligibility Reporting System
DEPORD	deployment order
DEROS	date eligible for return from overseas
DES	Disability Evaluation System
DLC	duty limiting condition
DMH	disaster mental health
DMRIS	Defense Medical Regulating Information System
DNR	do not resuscitate
DOC	designed operational capability
DOD	Department of Defense
DPANM	Medical Retention Standards Branch – office symbol
DPFDD	Disability Operations Branch

DRF	disaster response force
DRAS	disability rating activity site
DRMD	Deployment Requirements Manning Document
DRRS	Defense Readiness Reporting System
DSN	Defense Switched Network
DVARB	Department of Veterans Affairs Rating Board
E&T	education and training
EET	exercise evaluation team
EMEDS	expeditionary medical support
EOC	emergency operations center
EOD	explosive ordnance disposal
EP	exercise physiologist
EPTS	existed prior to service
ERPSS	En Route Patient Staging Systems
ESF	emergency support functions
ESSP	expeditionary site survey process
EST	expeditionary skills training
ETL	estimated tour lengths
EUCOM	European Command
FAM	functional area manager
FES	Fire and Emergency Services
FFD	fitness for duty
FP	fitness program
FPCON	force protection conditions
FPEB	Formal Physical Evaluation Board
FRC	federal recovery coordinator
GE	Germany
GPMRC	Global Patient Movement Requirements Center
GWD	get-well-dates
HAF	headquarters Air Force
HQ	headquarters
HQ AFPC/DPANM	Medical Retention Standards Branch
HSM	Health Services Manager
IC	incident commander
ICAO	international civil aviation organization
ICS	incident command structure
ICP	incident command post
ID	identification

IDES	Integrated Disability Evaluation System
IDO	installation deployment offices
IDP	installation deployment plan
IGESP	In-garrison expeditionary site planning
IPEB	Informal Physical Evaluation Board
IPPD	in-place patient decontamination team
IRILO	initial review in lieu of medial board
ISS	In-system select
JCS	Joint Chief of Staff
JOPES	Joint Operations Planning and Execution System
JPMRC	joint patient movement requirement center
JSPS	Joint Strategic Planning System
JTF	joint task force
LBDT	laboratory team and laboratory biological defense team
LMR	land mobile radios
LOD	line of duty
LOGDET	logistics detail
LOGFOR	Logistics Force Packaging Systems
LRMC	Landstuhl Regional Medical Center
LRS	logistics readiness squadron
MA	medical attendants
MAJCOM	major command
MANFOR	Manpower Force Packaging System
MASF	mobile aeromedical staging facility
MC	Medical Corps
MCC	medical control center
MCM	Manual for Courts-Martial
MCRP	medical contingency response plan
MEB	medical evaluation board
MEDEVAC	medical evacuation
MET	mission essential task
METL	Mission Essential Task Listing
MFEL	Manpower Force Element Listing
MHS	Military Health System
MICAS	Mobility Inventory Control and Accountability System
MilPDS	Military Personnel Data System
MISCAP	mission capability statement
MPF	military personnel flight

MPS	military personnel section
MR	medical readiness
MRA	Medical Regulating Authority
MRC	medical readiness committee
MRDSS	Medical Readiness Decision Support System
MRDSS ULTRA	Medical Readiness Decision Support System Unit Level Tracking and Reporting Application
MRL	medical resource letter
MRNCO	medical readiness noncommissioned officer
MRO	medical readiness office
MSC	military service coordinator or Medical Service Corps
MSME	medical standards management element
MSR	Manning Status Report
MTF	military treatment facility
NARSUM	narrative summary
NATO	North Atlantic Treaty Organization
NC	Nurse Corps
NCA	National Command Authority
NCOIC	noncommissioned officer-in-charge
NIPRNet	Nonsecure Internet Protocol Router Network
NLT	no later than
NMA	nonmedical attendant
NOK	next of kin
NRF	National Response Framework
NSC	National Security Council
OAC	Office of Airmen’s Counsel
OPCON	operational control
OPLAN	operation plan
OPR	office of primary responsibility
OWL	overweight patient litter
P	Priority
PACAF	Pacific Command
PCA	permanent change of assignment
PCM	primary care manager
PCS	permanent change of station
PDF	personnel deployment function
PDS	Personnel Data System
PEB	physical evaluation board
PEBLO	physical evaluation board liaison officer

PEBRH	physical evaluation board referral hospital
PHA	physical health assessment
PHI	protected health information
PME	professional military education
PMR	patient movement request
PMRC	patient movement requirements center
PMT	patient movement technician
POC	point of contact
POI	point of injury
PPBE	Planning, Programming, and Budgeting Execution
PPE	personal protective equipment
PTSD	post-traumatic stress disorder
QNFT	quantitative fit testing
R	Routine
RAM	random antiterrorism measures
RCC	recovery care coordinator
RILO	review in lieu of
RON	remain overnight
ROTC	Reserve Officers' Training Corps
RSVP	Readiness Skills Verification Program
RTD	returned to duty
SAC	self-assessment checklist
SAFPC	Secretary of the Air Force Personnel Council
SAMMC	San Antonio Area Military Medical Center
SBP	survivor benefit plan
SECAF	Secretary of the Air Force
SECDEF	Secretary of Defense
SF	Standard Form
SGH	chief of medical staff
SGP	chief of aerospace medicine
SGX	MAJCOM Readiness Office
SIPRNET	Secret Internet Protocol Router Network
SJA	staff judge advocate
SME	subject matter experts
SORTS	Status of Resources and Training System
SPC	Specialist
SPO	senior profiling officer
SSAN	Social Security Account Number

SSC	small-scale contingencies
TACON	tactical control
TBI	traumatic brain injury
TDRL	Temporary Disabled Retirement List
TDY	temporary duty
TMIP-J	Theater Medical Information Program-Joint
TOPA	TRICARE Operations and Patient Administration
TPFDD	time phased force deployment data
TPMRC	theater patient movement requirements centers
TPMRC-A	Theater Patient Movement Requirements Centers-Americas
TPMRC-E	Theater Patient Movement Requirements Center-Europe
TPMRC-P	Theater Patient Movement Requirements Center – Pacific
TRAC2ES	Transportation Command Regulating and Command & Control Evacuation System
TRANSCOM	Transportation Command
U	Urgent
UCC	unit control center
UCMJ	Uniform Code of Military Justice
UDM	unit deployment manager
UHF	ultra high frequency
ULTRA	Unit Level Tracking and Reporting Application
UMD	unit manpower document
UMPR	unit manpower personnel roster
UOTH	under other than honorable
USA	United States Army
USAFE	United States Air Force Europe
USAFR	United States and the United States Air Force Reserve
USCG	United States Coast Guard
USMC	United States Marine Corps
USN	United States Navy
UTC	unit task code
UTM	unit training manager
UU	unit user
VA	Veterans Administration
VHF	very high frequency
VIP	Veterans Information Portal
VTA	Veterans Tracking Application
WRAMC	Walter Reed Army Medical Center
WRM	war reserve material

Student Notes

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