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THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES
AND PROCEDURES 3-42.71**



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Tactical Doctrine

**EXPEDITIONARY MEDICAL SUPPORT (EMEDS)
AND AIR FORCE THEATER HOSPITAL (AFTH)**

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PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. AFTTP 3-42.71 provides the tactics, techniques, and procedures (TTP) for Expeditionary Medical Support (EMEDS) and Air Force Theater Hospital (AFTH) unit type codes (UTCs). Ensure all records created as a result of the processes prescribed in this publication are maintained in accordance with (IAW) AFPD 33-3, *Information Management*, and AFMAN 33-363, *Management of Records*, and disposed of IAW the Air Force Records Disposition Schedule (RDS) located at <https://www.my.af.mil/afrims/afrims/afrims/rims.cfm>. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication*. Route AF 847 through the appropriate chain of command and parent major command (MAJCOM).

SUMMARY OF CHANGES: This publication introduces the EMEDS Health Response Team (HRT), which replaces EMEDS Basic as the first increment of EMEDS capability. EMEDS HRT is the result of a reengineering effort to better support the full range of military operations and improve operational timelines. This publication has been substantially revised and should be completely reviewed.

APPLICATION: This publication applies to all Air Force military and civilian personnel, including Air Force Reserve Command (AFRC) and Air National Guard (ANG) units. The doctrine in this document is authoritative but not directive.

SCOPE: EMEDS and AFTH medical support packages provide individual bed-down and theater-level medical services for deployed forces or select population groups. The primary mission is to provide forward stabilization, resuscitative care, primary care, dental services, and force health protection and prepare casualties for evacuation to the next level of care. Their modular and scalable design allows the Air Force to deploy medical capabilities ranging from small teams that provide highly skilled medical care for a limited number of casualties to a large

medical system that can provide specialized care to a population at risk (PAR) over 6,500. Air Combat Command (ACC) is the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agency (MRA).

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Chapter 1

INTRODUCTION

1.1. Purpose. This publication provides general operational and planning guidance on Expeditionary Medical Support (EMEDS) and Air Force Theater Hospital (AFTH) capabilities. These capabilities are designed to support Air Expeditionary Forces (AEFs) during major combat, contingency, humanitarian assistance (HA), disaster relief (DR), defense support of civil authorities (DSCA), and stability operations. This publication provides a source document for developing standardized policies, operating procedures, training programs, and allowance standards (AS). Operation plans (OPLANs) and regional guidance provide more specific information that amplify and tailor the guidance contained in this publication.

1.2. Background. In September 1999, the United States Air Force Surgeon General (USAF/SG) approved the Concept of Operations (CONOPS) for the EMEDS/AFTH. Since then, EMEDS has been the main deployable ground medical asset for a variety of contingency operations.

1.2.1. Early Development. In February 1998, the 366th Medical Group at Mountain Home Air Force Base (AFB) developed a requirements-based medical package to support Operation DESERT SCORPION. This 24-person assemblage consisted of two squadron medical elements (SMEs), a mobile field surgical team (MFST), a critical care air transport team (CCATT), as well as dental, medical command and control (C2), and preventive medicine personnel. It served as the basis for the current EMEDS concept.

1.2.2. Operation ENDURING FREEDOM (OEF). In late 2001, using the EMEDS configuration, the Air Force Medical Service (AFMS) was among the first functional areas to deploy to Southwest Asia in support of OEF. The AFMS reengineered its tents, medical equipment, and supply packages in a continuing effort to reduce the EMEDS footprint and improve response timelines. By 2002, the EMEDS+25 configuration was one-third the weight and size of the typical 25-bed Air Transportable Hospital (ATH) of the Gulf War era. In January 2007, the Air Force assumed operational control (OPCON) of the U.S. Army combat support hospital at Bagram Airfield and began operating the newly opened Craig Joint Theater Hospital that spring. The 50-bed facility includes a four-bed trauma bay, three operating rooms, and a dental clinic and is one of the most advanced hospital facilities in the theater.

1.2.3. Operation IRAQI FREEDOM (OIF). From March 2003 to December 2011, EMEDS capabilities were deployed to multiple locations in support of OIF. In 2004, the Air Force assumed operational control of the trauma care mission at Joint Base Balad from the U.S. Army. The AFTH at Balad was a Role 3 trauma center and served as the theater's surgical trauma hub. In 2007, operations moved from an Army tent hospital to a new, approximately 100,000 square-foot facility with 20 critical care beds, 40 medical ward beds, and 8 operating tables. The Air Force operated the AFTH at Balad until November 2011.

1.2.4. Support for Humanitarian Assistance and Disaster Relief (HA/DR). In 2005, the Secretary of the Air Force directed the USAF/SG's Office to organize a medical-centric capability to respond to global disasters and humanitarian crises. The Humanitarian Relief Operation – Operational Capability Package (HUMRO-OCP), which included EMEDS, contingency response group (CRG), and base operating support (BOS) components, was approved in 2006 and exercised in 2008 in Pacific Lifeline. In October 2009, Pacific Air Forces (PACAF) deployed a tailored version to support earthquake relief efforts in Padang, Indonesia. In January and March 2010, tailored EMEDS+10 packages were deployed to support earthquake relief efforts in Haiti and Chile.

1.2.5. Current Initiatives. Based on lessons learned from operations in Indonesia, Haiti, and Chile, EMEDS capabilities have been reengineered to better support the full range of military operations and improve operational timelines. Validated through rigorous testing during a force development evaluation in February 2011 and exercises in Trinidad and Peru, the EMEDS Health Response Team (HRT) replaces EMEDS Basic as the first increment of EMEDS capability. EMEDS HRT adds a specialty care module that includes internal medicine, obstetrics/gynecology (OB/GYN), and pediatrics. It adds international health specialist (IHS) support. Pharmacy and radiology manning from the EMEDS+10 shifts to EMEDS HRT. New quick-erect shelters significantly decrease setup time and can connect to the existing Alaska small shelter system. Packaging improvements include a man-portable, functionally packed supply system, prioritized load plans, standardized packing lists, and secure, weather-proof containers. See Attachment 20 for more information on the transition plan.

Chapter 2

CAPABILITIES

2.1. Mission. EMEDS and AFTH packages provide individual bed-down and theater-level medical services for deployed forces or select population groups. The primary mission is to provide forward stabilization, resuscitative care, primary care, dental services, and force health protection and prepare casualties for evacuation to the next level of care. The modular and scalable design allows the Air Force to deploy medical capabilities ranging from small teams that provide highly skilled medical care for a limited number of casualties to a large medical system that can provide specialized care to a population at risk (PAR) over 6,500. EMEDS capabilities are grouped into distinct medical support packages that provide an incremental buildup of capability: EMEDS HRT, EMEDS+10, and EMEDS+25. AFTHs are built by adding medical specialty and augmentation unit type codes (UTCs) to an EMEDS+25 foundation. See Attachments 2-3 for more information on EMEDS and AFTH UTC build-up.

2.2. Scope of Care. EMEDS facilities and AFTHs provide essential care, deferring definitive care as dictated by the theater medical CONOPS. Deployed medical facilities normally do not provide reconstructive surgery or rehabilitative services.

2.3. Assumptions. Mission capabilities and tactics, techniques, and procedures (TTPs) are based on the following assumptions:

- Transportation is available to move personnel, equipment, and supplies.
- Expeditionary Combat Support (ECS) or BOS is available. See Chapter 6 for more information on ECS/BOS requirements.
- In combat operations, the PAR consists of the military population, emergency essential civilians and contractors, additive forces, and mobilization augmentees on base and excludes local nationals. In HA/DR and stability operations, patient throughput projections are based on estimated injury and regional disease rates.
- Deployed medical forces cannot depend on host-nation medical support.
- The supported U.S. military population has received pre-deployment medical screening, prophylaxis, immunizations, Self-Aid and Buddy Care (SABC) training, and applicable reporting instructions.
- Military personnel are either returned to duty or evacuated in accordance with (IAW) theater policy. During HA/DR and stability operations, medical personnel will coordinate movement of civilian patients with host nation and local hospitals.
- Members will deploy with, or have pre-positioned, adequate chemical warfare defense ensembles (CWDE) IAW reporting instructions.

2.4. EMEDS Health Response Team (HRT). EMEDS HRT is the first increment of EMEDS capability. It can stabilize and hold four patients (three of which can be critical) for 24 hours. Designed for rapid mobility and efficient setup, EMEDS HRT can deploy within 24 hours of notification, establish emergency room (ER) capability within 2 hours, operating room capability within 4 hours, and critical care capability within 6 hours. It can reach full operational capability (FOC) within 12 hours of arrival. Its primary goal is to stabilize patients and prepare them for movement to the next level of care. Patient evacuation within 24 hours is critical to mission success. EMEDS HRT is designed to support the early phases of military operations and requires reinforcement of personnel and equipment for operations longer than 10 days. It includes specialized personnel and equipment UTCs that can be tailored in or out, depending on the mission. EMEDS HRT is a Role 2 medical facility as defined in JP 4-02, *Health Service Support*.

2.4.1. Combat Operations. EMEDS HRT supports a PAR up to 3,000 and generally deploys with medical C2 and support services, surgical and critical care, flight medicine, dental, bioenvironmental engineering (BE), and public health support. The initial equipment package provides an estimated 10 days of supplies, depending on patient volume.

2.4.2. HA/DR and Stability Operations. Medical support focuses on estimated throughput and is not linked to a PAR. EMEDS HRT can triage and treat 350 patients per day with a surge capacity of 500. The preexisting health status of the affected population and the scope and severity of the event will impact patient throughput and supply duration. Due to anticipated high patient volumes, the estimate for initial supply duration is 5 days. EMEDS HRT generally deploys with medical C2 and support services, surgical and critical care, primary care, dental, BE, public health, IHS, and specialty care support (OB/GYN, pediatrics, internal medicine).

2.4.3. Personnel UTCs. EMEDS HRT provides a maximum of 40 personnel organized in the following personnel UTCs. See Table 2-1 for the manpower detail.

2.4.3.1. FFEP1, Critical Care Team. FFEP1 provides internal medicine and emergency medicine personnel to stabilize and prepare patients for movement to the next level of care. The team can stabilize and maintain four patients (three of which can be critical) for 24 hours.

2.4.3.2. FFEP2, EMEDS C2 and Administration Team. FFEP2 provides medical C2, administration, logistics, and information systems support. The team is led by a corps-neutral medical service colonel who functions as the EMEDS commander and a medical treatment facility (MTF) group superintendent who serves as the supervisor. The health services management craftsman provides communications and information systems support and must be special experience identifier (SEI) 260 qualified.

2.4.3.3. FFEP6, Nursing and Ancillary Support Team. FFEP6 provides nursing personnel to support forward stabilization and holding. A pharmacist and diagnostic imaging craftsman provide ancillary services.

2.4.3.4. FFF0C, Dental Team. FFF0C provides a dentist and dental assistant. A second dental team is added at the EMEDS+25 level.

2.4.3.5. FFHSR, Regional Health Specialist Team. FFHSR provides one medical officer with regional health specialist expertise. **Note:** This UTC is operation dependent and typically supports HA/DR and stability operations.

2.4.3.6. FFMFS, Mobile Field Surgical Team. FFMFS provides emergency medicine, general surgery, orthopedic, and operating room personnel to establish rapid-response resuscitative surgery and emergency medical support. This team is equipped to operate in locations forward of established healthcare support systems and is the primary disaster medical capability for EMEDS. FFMFS can provide resuscitative trauma surgery, advanced trauma life support (ATLS), and emergency medical care for 10 casualties requiring surgical intervention or for 20 non-operative resuscitations.

2.4.3.7. FFP01, Specialty Care Augmentation Team. FFP01 provides limited internal medicine, OB/GYN, and pediatric capability. **Note:** This UTC is operation dependent and typically supports HA/DR and stability operations.

2.4.3.8. FFPCM, Primary Care Team, or FFDAB, Flight Medicine Team. FFPCM provides medical support personnel to establish primary care for patients with routine and urgent conditions. FFDAB substitutes for FFPCM if flight medicine service is required (e.g., for combat operations). At least one aerospace medical service technician must be immunizations backup technician (IBT) qualified. FFPCM and FFDAB usually deploy to an EMEDS facility; however, they can function as a stand-alone capability with the addition of FFLGE, Air Transportable Clinic (ATC). See the *Air Combat Command Concept of Operations for the Air Transportable Clinic (ATC)*, for more information.

2.4.3.9. FFPM1, Preventive and Aerospace Medicine (PAM) Team 1. FFPM1 provides initial public health and occupational and environmental health (OEH) assessment, surveillance, intervention, and abatement. The team provides medical support planning and input into the layout of base facilities and operations. The aerospace medicine specialist and independent duty medical technician (IDMT) provide preventive medicine and limited clinical services for up to 500 personnel. Public health (PH) provides food safety and vulnerability assessments, field sanitation and hygiene, and infectious disease control. BE provides toxic industrial material (TIM) vulnerability assessments, water safety and vulnerability assessments, OEH assessment and surveillance, and limited medical chemical, biological, radiological, and nuclear (CBRN) defense.

2.4.3.10. FFPM2, PAM Team 2. FFPM2 provides BE and public health personnel augmentation. **Note:** This UTC is operation dependent and typically supports combat operations. If not included in EMEDS HRT, FFPM2 deploys with EMEDS+10.

2.4.4. Manpower Detail. Table 2-1 lists the manpower detail for each personnel UTC.

Table 2.1. EMEDS HRT Manpower Detail.

Title	AFSC	SEI	Grade	Quantity
FFEP1, Critical Care Team				Total: 3
Internist	044M3		04	1
Critical Care Nurse	046N3E		04	1
Cardiopulmonary Lab Craftsman	4H071			1
FFEP2, EMEDS C2 and Administration Team				Total: 6
Medical Commander	040C0C		06	1
Health Services Administrator	041A3		04	1
Group Superintendent	9G100			1
Medical Materiel Craftsman	4A171			1
Biomedical Equipment Craftsman	4A271			1
Health Services Management Craftsman	4A071	260		1
FFEP6, Nursing and Ancillary Support Team				Total: 7
Clinical Nurse	046N3		04	1
Pharmacist	043P3		04	1
Aerospace Medical Service Craftsman	4N071			4
Diagnostic Imaging Craftsman	4R071			1
FFF0C, Dental Team				Total: 2
Dentist, Comprehensive	047G3A		04	1
Dental Assistant Craftsman	4Y071			1
FFMFS, Mobile Field Surgical Team				Total: 5
Surgeon	045S3		04	1
Orthopedic Surgeon	045B3		04	1
Anesthesiologist	045A3		04	1
Emergency Services Physician	044E3A		04	1
Operating Room Nurse	046S3		03	1
FFPCM, Primary Care Team				Total: 3
Note: If flight medicine service is required, FFDAB deploys instead of FFPCM.				
Family Physician	044F3		04	1
Aerospace Medical Service Craftsman	4N071			1
Aerospace Medical Service Journeyman	4N051			1
FFDAB, Flight Medicine Team (Alternate for FFPCM)				Total: 3
Residency Trained Flight Surgeon	048R3		04	1
Aerospace Medical Service Craftsman	4N071			1
Aerospace Medical Service Journeyman	4N051			1
FFPM1, PAM Team 1				Total: 4

Title	AFSC	SEI	Grade	Quantity
Aerospace Medicine Specialist	048A3		05	1
Aerospace Medical Service Craftsman Independent Duty Medical Technician (IDMT)	4N071C			1
Bioenvironmental Engineer	043E3A		04	1
Public Health Officer	043H3		04	1
Operation-Dependent UTCs				
FFP01, Specialty Care Augmentation Team				Total: 7
Internist	044M3		04	1
Pediatrician	044K3		04	1
Obstetrician/Gynecologist	045G3		04	1
Clinical Nurse OB	046N3G		03	1
Aerospace Medical Service Craftsman	4N071			1
Aerospace Medical Service Journeyman	4N051			2
FFHSR, Regional Health Specialist				Total: 1
Health Services Administrator	041A3	H8B	04	1
FFPM2, PAM Team 2				Total: 2
Bioenvironmental Engineering Craftsman	4B071			1
Public Health Craftsman	4E071			1
				Total Manpower: 40
Note: Air Force Specialty Code (AFSC), grade, and skill-level substitutions are IAW the <i>War and Mobilization Plan, Volume 1 (WMP-1)</i> , <i>AFMS Supplement</i> , AFI 10-403, <i>Deployment Planning and Execution</i> , and the mission capability (MISCAP) statement.				

2.4.5. Equipment UTCs. EMEDS HRT includes the following equipment UTCs. See Chapter 9 for more information on the AS and resupply packages.

2.4.5.1. FFEPE, Critical Care Equipment. FFEPE provides the critical care team with initial supplies and equipment in man-portable field packs designed to help the team quickly reach initial operational capability (IOC). Based on the mission and mode of transportation, team members may be required to travel with their field packs and hand-carry them to the employment site.

2.4.5.2. FFHR1, EMEDS HRT Equipment. FFHR1 provides medical, surgical, critical care, and dental equipment and supplies to support operations up to 10 days. **Note:** In HA/DR and other operations with anticipated high patient volumes, the estimated supply duration is 5 days.

2.4.5.3. FFMF1, Mobile Field Surgical Equipment. FFMF1 provides the MFST with initial supplies and equipment in man-portable field packs designed to help the team quickly reach IOC. Based on the mission and mode of transportation, team members

may be required to travel with their field packs and hand-carry them to the employment site.

2.4.5.4. FFP0E, Specialty Care Augmentation Equipment. FFP0E provides the specialty care team with supplies and equipment to support operations up to 10 days, depending on patient volume. **Note:** This UTC is operation dependent and typically supports HA/DR and stability operations.

2.4.5.5. FFPM4, PAM Advanced Echelon (ADVON) Equipment. FFPM4 provides the PAM team with initial supplies and equipment in man-portable field packs designed to help the team quickly reach IOC. Based on the mission and mode of transportation, team members may be required to travel with their field packs and hand-carry them to the employment site.

2.4.5.6. FFPM5, PAM Sustainment Equipment. FFPM5 provides supplies and equipment to sustain PAM team operations for 30 days. It includes a small shelter system and equipment and supplies for disease, OEH, and CBRN surveillance, sampling and analysis, presumptive identification of biological threat agents, and personnel exposure monitoring.

2.5. EMEDS+10. EMEDS+10 is the second increment of EMEDS capability and builds on EMEDS HRT. This combined capability has a total of 10 medical/surgical beds and can support a PAR of 3,000-5,000. EMEDS+10 provides medical/surgical and critical care augmentation. Laboratory service is added, as well as additional BE, public health, administration, and medical logistics support. EMEDS+10 can reach FOC within 36 hours of arrival. **Note:** For HA/DR and stability operations, if the anticipated patient throughput exceeds the capabilities included with EMEDS HRT, additional specialty UTCs, such as pediatrics (FFPED/FFPE1) and OB/GYN (FFGYN/FFGY1), can be added to the EMEDS+10 configuration. EMEDS+10 is a Role 2 medical facility as defined in JP 4-02.

2.5.1. Personnel UTCs. EMEDS+10 adds the following personnel UTCs.

2.5.1.1. FFEP3, 10-Bed Personnel Augmentation Team. FFEP3 provides additional physician, surgical, nursing, critical care, medical logistics, and administration personnel to support the increased PAR. Expanded capabilities include advanced cardiac life support (ACLS), ATLS, medical ward, and lab. At least one nurse (046N) must be a major or above.

2.5.1.2. FFPM3, PAM Team 3. FFPM3 provides BE and public health augmentation for FFPM1 and FFPM2.

2.5.2. Manpower Detail. Table 2-2 lists the manpower details for each EMEDS+10 personnel UTC.

Table 2.2. EMEDS+10 Manpower Detail.

Title	AFSC	SEI	Grade	Quantity
FFEP3, 10-Bed Personnel Augmentation Team				Total: 24
Family Physician	044F3		04	1
Residency Trained Flight Surgeon	048R3		04	1
Clinical Nurse	046N3		04	1
Clinical Nurse	046N3		03	2
Aerospace Medical Service Craftsman	4N071			2
Aerospace Medical Service Journeyman	4N051			8
Emergency Trauma Nurse	046N3J		03	1
Critical Care Nurse	046N3E		04	2
Surgical Services Journeyman	4N151			1
Medical Laboratory Craftsman	4T071			1
Medical Materiel Journeyman	4A151			1
Biomedical Equipment Journeyman	4A251			1
Health Services Management Craftsman	4A071			1
Health Services Management Journeyman	4A051			1
FFPM3, PAM Team 3				Total: 3
Bioenvironmental Engineering Journeyman	4B051			2
Public Health Journeyman	4E051			1
				Manpower Added: 27
				Total Manpower: 67
Note: Air Force Specialty Code (AFSC), grade, and skill-level substitutions are IAW the <i>War and Mobilization Plan, Volume 1 (WMP-1)</i> , <i>AFMS Supplement</i> , AFI 10-403, <i>Deployment Planning and Execution</i> , and the mission capability (MISCAP) statement.				

2.5.3. Equipment UTCs. EMEDS+10 includes the following equipment UTCs. See Chapter 9 for more information on the AS and resupply packages.

2.5.3.1. FFEE2, EMEDS+10 Equipment. FFEE2 augments EMEDS HRT with additional supplies and equipment to support a PAR of 3,000-5,000 up to 10 days.

2.5.3.3. FF0X2, Deployable Oxygen Package. FF0X2 provides a deployable oxygen generation system (DOGS) to support patients awaiting evacuation at enroute care locations.

2.6. EMEDS+25. EMEDS+25 is the third increment of EMEDS capability and builds on EMEDS+10 and EMEDS HRT. This combined capability has a total of 25 medical/surgical

beds and can support a PAR of 5,000-6,500. EMEDS+25 provides expanded medical/surgical care, emergency/trauma care, dental care, and ancillary services, as well as additional medical C2, logistics, and patient administration support. It adds basic physical therapy and enhanced dietary services. EMEDS+25 can reach FOC within 60 hours of arrival. **Note:** For HA/DR and stability operations, if the anticipated patient throughput exceeds the capabilities included with EMEDS HRT, additional specialty UTCs, such as pediatrics (FFPED/FFPE1) and OB/GYN (FFGYN/FFGY1), can be added to the EMEDS+25 configuration. EMEDS+25 is a Role 3 medical facility as defined in JP 4-02.

2.6.1 Personnel UTCs. EMEDS+25 adds the following personnel UTCs.

2.6.1.1. FFEP4, 25-Bed Personnel Augmentation Team. FFEP4 provides additional physician, nursing, ancillary services, medical logistics, and administration personnel. The nurse administrator (046A3) must be a lieutenant colonel or above. At least one nurse (046N) must be a major or above.

2.6.1.2. FFEP5, Surgical Augmentation Team. FFEP5 provides a surgeon and additional surgical support personnel.

2.6.1.3. FFF0C, Dental Team. EMEDS+25 includes an additional dental team to support to the increased PAR.

2.6.2. Manpower Detail. Table 2-3 lists the manpower details for each EMEDS+25 personnel UTC.

Table 2.3. EMEDS+25 Manpower Detail.

Title	AFSC	SEI	Grade	Quantity
FFEP4, 25-Bed Personnel Augmentation Team				Total: 23
Nursing Administrator	046A3		05	1
Emergency Trauma Nurse	046N3J		04	1
Family Physician	044F3		04	1
Clinical Nurse	046N3		04	1
Clinical Nurse	046N3		03	2
Aerospace Medical Service Superintendent	4N091			1
Aerospace Medical Service Craftsman	4N071			2
Aerospace Medical Service Journeyman	4N051			3
Physical Therapist	042B3		04	1
Biomedical Laboratory Scientist	043T3		03	1
Medical Laboratory Journeyman	4T051			1
Pharmacy Craftsman	4P071			1
Diagnostic Imaging Journeyman	4R051			1
Diet Therapy Craftsman	4D071			1

Title	AFSC	SEI	Grade	Quantity
Medical Materiel Journeyman	4A151			1
Health Services Administrator	041A3		03	1
Health Services Management Journeyman	4A051			3
FFEP5, Surgical Augmentation Team				Total: 5
Surgeon	045S3		05	1
P-APN Nurse Anesthetist	046Y3M		04	1
Operating Room Nurse	046S3		04	1
Surgical Service Craftsman	4N171			2
FFF0C, Dental Augmentation Team				Total: 2
Dentist, Comprehensive	047G3A		04	1
Dental Assistant Craftsman	4Y071			1
				Manpower Added: 30
				Total Manpower: 97
Note: Air Force Specialty Code (AFSC), grade, and skill-level substitutions are IAW the <i>War and Mobilization Plan, Volume 1 (WMP-1)</i> , <i>AFMS Supplement</i> , AFI 10-403, <i>Deployment Planning and Execution</i> , and the mission capability (MISCAP) statement.				

2.6.3. Equipment UTCs. EMEDS+25 includes the following equipment UTCs. See Chapter 9 for more information on the AS and resupply packages.

2.6.3.1. FFEE3, EMEDS+25 Equipment. FFEE3 augments EMEDS HRT and EMEDS+10 with additional supplies and equipment to support a PAR of 5,000-6,500 up to 10 days.

2.6.3.2. FF0X2, Deployable Oxygen Package. EMEDS+25 includes an additional DOGS unit.

2.7. Air Force Theater Hospital (AFTH). AFTHs provide dedicated in-theater and en-route support to a PAR of 6,500 and above. They are usually located at an air hub to facilitate patient movement to definitive care facilities in the continental United States (CONUS) and designated facilities outside the continental United States (OCONUS). AFTHs are the largest of the Air Force deployed medical facilities with a minimum of 58 beds (12 critical care beds and 46 medical/surgical beds), six operating room tables, and approximately 260 personnel. They are built on an EMEDS+25 foundation and include medical/surgical specialties and supporting ancillary services and medical logistics functions. Medical/surgical specialties include otorhinolaryngology (ENT), infectious disease control, mental health triage and combat stress management, neurosurgery, OB/GYN, ophthalmology, oral and maxillofacial surgery, pediatrics, thoracic/vascular surgery, and urology. Additional ancillary services include a blood support center, computed tomography (CT), diagnostic radiology, and optometry. In a mature theater, specialty UTCs are centralized at one or more AFTH locations to provide a broader range of essential and subspecialty care with referral capability. The AFTH expansion packages are modular and can be added in multiple sets. AFTHs are Role 3 medical facilities as defined in JP 4-02. See Attachment 3 for more information on AFTH UTCs. See Attachment 12 for a notional layout of a 58-bed facility.

2.8. Augmentation Unit Type Codes (UTCs). Additional personnel and equipment UTCs are available to provide expanded medical capability tailored to a specific theater requirement, deployment scenario, or anticipated casualty rate. Examples include CBRN casualty management and prevention teams, mental health teams, contagious casualty management teams, and Air Force Forces Surgeon (AFFOR/SG) medical support staff. See Attachment 4 for more information.

2.9. Collectively Protected EMEDS (CP-EMEDS). CP-EMEDS equipment packages can be deployed into areas with a CBRN threat. When in place, CP-EMEDS allows continued operations after a CBRN incident without requiring a change to the shelter layout. The CP components should be installed during the initial EMEDS setup. The CP-EMEDS equipment consists of CP liners, chemically hardened environmental control units (ECU), filtered-air blowers, airlocks, and pressure alarm systems. A water distribution system (WDS) provides potable water flow and wastewater recovery to all areas of the medical facility that need support. The WDS requires ECS/BOS. Table 2-4 lists the CP components for each increment. The *Operation and Maintenance Manual for the Collectively Protected Expeditionary Medical Support (CP-EMEDS)/AFTH* provides information on CP-EMEDS setup, operations, and medical roles and responsibilities. This document is available on the [ACC/SG MEFPAK Playbook](#) under Collective Protection. **Note:** CP capabilities are only available for the Alaska small shelter system.

Table 2.4. CP-EMEDS Equipment.

Increment	CP-EMEDS UTCs
EMEDS HRT (Utilis Shelters)	
EMEDS HRT (Alaska Shelters)	<ul style="list-style-type: none"> • 2 FFCPS, CP Medical Tent with Airlock • 1 FFCPB, CP EMEDS Basic • 1 FFWDS, Medical WDS • 2 FFCPW, CP WDS without Airlock
EMEDS+10	<ul style="list-style-type: none"> • 1 FFCPC, CP EMEDS+10 • Plus, all EMEDS HRT CP equipment
EMEDS+25	<ul style="list-style-type: none"> • 1 FFCPD, CP EMEDS+25 • Plus, EMEDS HRT and EMEDS+10 CP equipment
AFTH	<ul style="list-style-type: none"> • 6 FFCPE, CP Hospital Surgical Expansion Package (HSEP) • 1 FFCPF, CP Hospital Medical Expansion Package (HMEP) • Plus, EMEDS HRT, EMEDS+10, and EMEDS+25 CP equipment

2.10. Initial Operational Capability (IOC). The MFST, critical care team, and PAM team are equipped with man-portable field packs and can provide initial medical capability within 15 minutes of arrival. These initial capabilities include essential emergency medical and surgical care, limited critical care, and initial health assessments of the area. Upon delivery of equipment, EMEDS HRT can reach IOC within the timelines defined in Table 2-5.

Table 2.5. EMEDS HRT IOC Timelines.

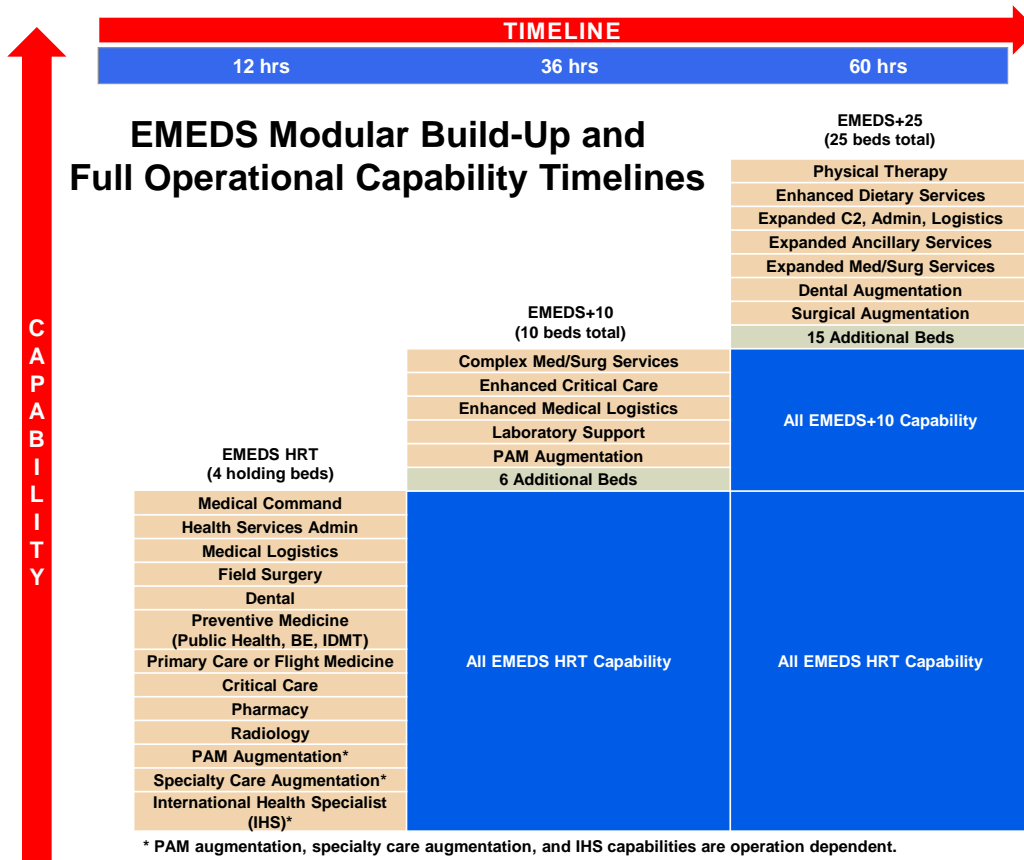
Capability	Timeline
ER ready to receive patients	2 hours
Operating room ready to receive patients	4 hours
Critical care holding area ready to receive patients	6 hours

2.11. Full Operational Capability (FOC). EMEDS FOC is defined as follows:

- Shelters and full infrastructure are in place (e.g., power, lights, ECU, heating, ventilation, air conditioning [HVAC], water, sanitation).
- C2 is functional.
- All medical/surgical functions are in place and ready to provide care.
- All mission-essential equipment and instrumentation are in place and functional.
- All medical support functions are in place.

As illustrated in Figure 2-1, as the scope of capabilities increase with each EMEDS increment, so does the timeline to achieve FOC. **Note:** Depending on manpower, CP-EMEDS setup can add up to 24 hours to the EMEDS FOC timelines.

Figure 2.1. EMEDS Buildup and FOC Timelines.



2.12. EMEDS Functional Area Descriptions. The following subsections describe the capabilities and staffing for each EMEDS functional area. See Attachments 3-4 for more information on AFTH and augmentation capabilities.

2.12.1. Aerospace Medicine. The aerospace medicine specialist serves as the Chief of Aerospace Medicine (SGP) for EMEDS. The SGP serves as the aeromedical consultant to the EMEDS commander and oversees the successful execution of aerospace medicine operations IAW AFI 48-101, *Aerospace Medicine Enterprise*.

2.12.1.1. Flight-Line Clinic. If required by the deployed commander, EMEDS may include a separate clinic near flight operations. FFDAB provides the staffing, which includes one flight surgeon and two aerospace medical service technicians. This geographically separated clinic requires its own space (minimum of 650 square feet) and ECS/BOS.

2.12.1.2. Preventive Medicine. FFPM1 provides the core preventive medicine, BE, and public health staff for EMEDS. FFPM1 typically deploys as early as possible to assist ECS/BOS teams in site selection and development and ensure the safe procurement of local food and water sources. FFPM1 is generally the first medical presence at the bed-down location, unless a global reach laydown (GRL) team is already in place. FFPM2

provides BE and public health augmentation for EMEDS HRT or EMEDS+10. (**Note:** Deployment with EMEDS HRT is recommended for combat support operations.) FFPM3 provides additional BE and public health support at the EMEDS+10 level. See AFTTP 3-42.23, *Preventive and Aerospace Medicine (PAM) Team*, (available on the AFMS Knowledge Exchange [KX]) for more information.

2.12.2. Ambulance Services. EMEDS facilities rely on pre-positioned ambulances, vehicles of opportunity, or rental vehicles for emergency transport. These vehicles are base transportation assets. Two vehicles are normally required to support flight line and emergency medical service (EMS) response. The EMEDS equipment package provides ample life-support equipment and supplies to support two ambulances. An ambulance augmentation package (FFAMB) may be requested if additional supplies are needed (e.g., to support an additional vehicle).

2.12.3. C2 and Administration. EMEDS C2 and administration functions include medical control center (MCC) operations, medical readiness, patient administration (to include patient movement coordination), and personnel administration. It is the focal point for all classified material handling and distribution, secure communications, and development of mass-casualty response plans. FFEP2 provides the core medical command and health services administration personnel for EMEDS. FFEP3 and FFEP4 provide additional health services management personnel at the EMEDS+10 and EMEDS+25 levels to support the increased patient administration workload.

2.12.4. Critical Care. EMEDS provides critical care, respiratory therapy, and post-anesthesia care to a variety of trauma, surgical, and medical patients. EMEDS HRT provides a critical care surge capability that can hold three critical care patients for 24 hours. FFEP1 provides the core critical care staffing for EMEDS. When their specialty skills are not needed, the critical care staff can provide cross-functional support in the ER and medical ward. At the EMEDS HRT level, all clinical functions share equipment and supplies from FFEPE, FFHR1, and FFMF1. The initial equipment set includes vital-sign monitoring devices, ventilators, defibrillators, and suction machines. At the EMEDS+10 and EMEDS+25 levels, FFEE2 and FFEE3 provide dedicated critical care supplies and equipment. FFEP3 provides additional critical care nursing personnel to support the increased PAR at the EMEDS+10 and EMEDS+25 levels.

2.12.5. Dental Clinic. EMEDS provides general dentistry services. Restorative capability is limited IAW theater policy. Limited dental laboratory capability is available. Staffing at the EMEDS HRT and EMEDS+10 levels consists of a comprehensive dentist and a dental assistant. The dentist may also serve as the triage officer. FFHR1 provides the core dental equipment, which includes one dental chair, x-ray equipment, and a portable dental delivery system. FFEE2 provides additional dental equipment and supplies to support the increased PAR at the EMEDS+10 level. At the EMEDS+25 level, dental capability is augmented with a second dental team (FFF0C). FFEE3 provides the dental equipment and supplies to support the additional team.

2.12.6. Emergency Medicine. Emergency medicine capabilities include EMS response, ACLS, trauma support, medical/surgical nursing care, basic management of toxicological emergencies, minor surgical stabilization procedures, and limited management of thermal injuries. The ER includes electrocardiogram (ECG) monitoring, defibrillation, transcutaneous pacing, and continuous oxygen saturation monitoring equipment. The emergency medicine physician from FFMFS provides the core staffing for EMEDS. The primary care physician from FFPCM (or flight medicine surgeon from FFDAB if tasked) and nursing staff from FFEP1 and FFEP6 provide cross-functional support as needed. FFEP3 and FFEP4 each provide an emergency trauma nurse and additional medical technicians to support the increased PAR at the EMEDS+10 and EMEDS+25 levels.

2.12.7. Infectious Disease Management/Infection Control. EMEDS personnel must follow infection prevention and control guidelines for field settings IAW AFI 44-108, *Infection Prevention and Control Program*. Public health provides support for surveillance and reporting activities. The EMEDS HRT floor plan does not have space readily available to physically isolate patients and requires a shelter of opportunity for patient isolation. EMEDS+10 and EMEDS+25 have space that can be adapted to physically isolate two patients. The public health officer, in conjunction with the flight surgeon, oversees communicable disease control and isolation procedures.

2.12.8. Information Systems. EMEDS deploys with communications and computer equipment and relies on base communications units to provide network access. FFEP2 provides one health services management craftsman with SEI information management/information technology (IM/IT) certification to support all EMEDS increments. EMEDS IM/IT assets must have the necessary certification and approvals to operate. See Chapter 5 for more information on communications and computer support requirements. See Attachments 17-19 for EMEDS network configuration diagrams.

2.12.9. International Health. If tasked, the IHS officer from FFHSR deploys with EMEDS HRT to provide cross-cultural medical expertise, regional skills, and (as available) language skills. IHS support is typically included in HA/DR and stability operations. See AFI 44-162, *International Health Specialist (IHS) Program*, for more information.

2.12.10. Laboratory. EMEDS HRT has no formal laboratory section or trained laboratory personnel. Providers perform their own lab testing. Lab testing is limited to waived or moderate complexity testing to include provider performed microscopy. At the EMEDS+10 level, FFEP3 provides one laboratory technician to perform hematology, urinalysis, and serology functions. At the EMEDS+25 level, FFEP4 adds one laboratory officer and a laboratory technician to perform comprehensive laboratory procedures and basic microbiology. FFEP3 provides an additional chemistry analyzer to support multiple chemistry analyses. See Attachments 5-7 for more information about lab supplies and capabilities for each EMEDS increment.

2.12.10.1. Blood Supplies. The Theater Armed Services Blood Program provides blood products for EMEDS. Requests for blood supplies should be routed through J-4, the Joint

Task Force (JTF) Surgeon's Area Joint Blood Program Office (AJBPO) representative, IAW AFH 44-152_IP, *Armed Services Blood Program Joint Blood Program Handbook*.

2.12.10.1.1. Emergency Transfusion and Blood Banking. EMEDS HRT has no blood grouping, typing, or crossmatching capability. Uncrossmatched Group O packed red blood cells (PRBC) will be issued for all casualty care. EMEDS+10 and EMEDS+25 have limited blood banking capabilities to include ABO/Rh determination and immediate spin crossmatching. Blood inventories at the EMEDS+10 and EMEDS+25 levels include group A, B, and O Rh negative and positive red blood cells (RBCs), fresh frozen plasma (FFP), and plasma frozen within 24 hours (PF24). Platelets and cryoprecipitate may be available depending on theater supplies.

2.12.10.1.2. Emergency Blood Collection. Emergency whole blood collection capability exists at all EMEDS levels if treatment needs exceed the on-hand inventories, if resupply is interrupted, or if medical indications determine component therapy is inadequate to treat the patient. The AJBPO representative should be consulted on theater requirements for maintaining a walking donor program.

2.12.10.2. Blood Storage. EMEDS HRT has a field blood refrigerator that can store 50 PRBC or liquid plasma units. A blood freezer must be acquired to maintain frozen plasma and cryoprecipitate inventories appropriate to the level of casualty care. EMEDS+10 adds a larger field blood refrigerator that can store 60 PRBC or liquid plasma units. It also includes a plasma freezer that can hold 78 plasma boxes. Blood products must be maintained within required temperature ranges:

Component	Temperature
PRBC and liquid plasma	1-6 degrees Celsius
Frozen blood products	-18 degrees Celsius
Platelets	20-24 degrees Celsius

Note: Emergency whole blood may be maintained at room temperature for limited time periods.

2.12.11. Medical Logistics. FFEP2 provides the initial medical logistics personnel for EMEDS. The medical materiel craftsman and biomedical equipment craftsman are responsible for all logistics, facility management, and maintenance activities. All EMEDS increments have a segregated, environmentally controlled storage area. Storage space is limited and personnel may coordinate with other units to share and optimize space. FFEP3 provides additional medical logistics personnel at the EMEDS+10 level. FFEP4 provides additional medical materiel support at the EMEDS+25 level. Medical logistics functions are IAW AFI 41-201, *Managing Clinical Engineering Programs*, and AFI 41-209, *Medical Logistics Support*.

2.12.12. Medical Ward/Patient Holding. Patient care supplies include intravenous fluids, oxygen, suction, monitoring equipment, and multiple-position field hospital beds. EMEDS

HRT can hold four patients (three of which can be critical) for 24 hours. FFEP1 and FFEP6 provide the core nursing staff to support the patient holding beds. Medical personnel from the other functional areas provide cross-functional support as needed. FFEP3 and FFEE2 are added at the EMEDS+10 level to provide additional medical staffing and equipment to support a 10-bed medical/surgical ward. FFEP4 and FFEE3 are added at the EMEDS+25 level to provide additional medical staffing and equipment to support a 25-bed medical/surgical ward.

2.12.13. Nutritional Medicine. EMEDS HRT and EMEDS+10 do not have a formal nutritional medicine section or dietary technician. Nutritional assessments are performed by clinicians in consultation with a designated dietary consultant. FFEP4 provides one dietary technician at the EMEDS+25 level. All EMEDS increments rely on ECS/BOS for meal procurement and preparation (including patient in-flight meals) and to obtain medical supplements to the standard meal kits. Ice and drinking water for patients should be obtained from ECS/BOS or from contract sources. Nutritional medicine guidelines must be followed IAW the Academy of Nutrition and Dietetics *Nutrition Care Manual (NCM)* and AFMAN 44-144, *Nutritional Medicine*. EMEDS personnel are responsible for ordering patient diets and supplements, meal delivery, and returning serving equipment for sanitation.

2.12.14. Operating Room/Surgery. FFMFS provides the core surgical staff for EMEDS. Staffing includes two surgeons, an anesthesiologist, and an operating room nurse. The FFMF1 man-portable field pack provides essential operating room equipment and supplies, allowing the team to provide initial surgical capability until the EMEDS HRT operating room reaches FOC. FFHR1 provides additional surgical instruments and supplies, monitoring devices, portable oxygen equipment, and a general anesthesia machine. EMEDS+10 provides additional surgical and postoperative instrumentation and supplies to support the increased PAR. The surgical area for EMEDS HRT and EMEDS+10 consists of one surgical tent and one operating table. When fully operational, EMEDS HRT and EMEDS+10 can perform 10 major surgeries or 20 non-operative trauma resuscitations. FFEP5 and FFEE3 provide a second surgical team, operating table, anesthesia machine, and additional surgical equipment and supplies at the EMEDS+25 level. Surgical capability increases to 20 major surgeries or 20 non-operative trauma resuscitations. Each operating table requires 100 square feet of operating space. The EMEDS configuration does not allocate separate space for pre-operative care.

2.12.15. Pharmacy. All EMEDS platforms have a pharmacy equipped to store and dispense medications. The EMEDS pharmacy is also responsible for resupplying the flight-line clinics. FFEP6 provides one pharmacist at the EMEDS HRT level. FFEP4 adds a pharmacy technician to provide additional support at the EMEDS+25 level. Controlled medications must be stored in locked rooms or containers. The pharmacist is responsible for accurate accounting of all medications.

2.12.16. Physical Therapy. The EMEDS platform has no specialized physical therapy equipment. Physical therapy capabilities at the EMEDS HRT and EMEDS+10 levels are limited to the care provided by the orthopedic surgeon and other clinicians. FFEP4 adds one

physical therapist at the EMEDS+25 level. The physical therapist may also support primary care and orthopedic functions as needed.

2.12.17. Primary Care. The outpatient clinic primarily cares for patients with non-life-threatening, routine conditions. The primary care physician and two medical technicians from FFPCM provide the core staffing for EMEDS. (**Note:** FFDAB can substitute for FFPCM if flight medicine capability is required.) The team provides cross-functional support in the ER and medical ward as needed. FFEP3 and FFEP4 each provide an additional family physician and additional medical technicians to support the increased PAR at the EMEDS+10 and EMEDS+25 levels.

2.12.18. Radiology. FFEP6 provides one radiology technician to provide initial radiology services. Trained dental technicians and clinicians can provide additional radiology support. FFEP4 adds another radiology technician at the EMEDS+25 level to support the increased PAR. Most EMEDS radiology equipment comes with EMEDS HRT. Equipment includes a mobile radiographic x-ray unit, portable ultrasound system, and a portable digital dental x-ray machine for intraoral radiology. EMEDS+10 provides additional accessory equipment. EMEDS radiology equipment includes software for capturing and storing diagnostic images locally. Picture Archiving and Communication System (PACS) capability is not available.

2.12.19. Specialty Care. If tasked, FFP01 deploys with EMEDS HRT to provide internal medicine, pediatric, and OB/GYN support. The team provides enhanced outpatient care and supports emergent procedures. When their specialty skills are not needed, team members provide cross-functional support in the ER and medical wards. FFP0E provides the equipment and supplies to support the team. Specialty care support is typically included in HA/DR and stability operations.

2.12.20. Sterile Processing Department (SPD). EMEDS HRT has no dedicated SPD to receive, clean, and sterilize instruments and other medical items. The operating room is equipped with a tabletop steam sterilizer. EMEDS+10 and EMEDS+25 have a separate area adjacent to the operating room. The EMEDS+10 equipment package provides a large sterilizer and water reclaimer unit, which should be placed in or near the operating room. The EMEDS+25 equipment package adds an ultrasonic cleaner and an additional sink.

Chapter 3

OPERATIONS

3.1. EMEDS Unit Type Code (UTC) Posturing. EMEDS UTCs are postured against units in the Unit Type Code Availability (UTA) database and Medical Resource Letter (MRL). EMEDS equipment and facility infrastructure packages may be pre-positioned in theater based on requirements from geographic Combatant Commanders (CCDRs) and the Commander, Air Force Forces (COMAFFOR).

3.2. Deployment Planning. Planners consider a number of factors, including pre-positioned materiel, host nation support agreements, contingency contracts, and acquisition cross-service agreements, in planning deployments and tailoring unit-level personnel and equipment requirements. Time-phased force deployment data (TPFDD) is built by the air component and flowed through the MAJCOMs to the wing plans and operations centers for action.

3.3. Deployment. Upon receipt of an alert, prepare to deploy, warning order (WARNORD), or other notification from higher headquarters, the medical readiness office should conduct a pre-deployment conference and review key documents and responsibilities with the deploying EMEDS commander and UTC team chiefs. This information may include the deployment order (DEPOD), TPFDD data, pre-deployment training requirements, force protection threats, and intelligence reports. Deploying personnel should follow the pre-deployment requirements in AFI 10-403 and AFI 41-106, *Medical Readiness Program Management*.

3.3.1. EMEDS Commander Pre-Deployment Tasks. The EMEDS commander is responsible for ensuring that all deploying personnel and equipment meet the tasking requirements defined by the supported command. The following paragraphs provide general guidelines on pre-deployment activities for EMEDS commanders.

3.3.1.1. Establish Lines of Communication. Meet with deploying EMEDS team members who are stationed with you and contact as many of the others as possible, using secure communication methods as necessary. Consider setting up an email group and recall roster to keep the team informed and help build rapport. Document events, key resources, contact information, and other useful reference materials for continuity records.

3.3.1.2. Establish Command Structure. Identify key leaders and establish a command structure. If possible, draft an organizational chart, disseminate to staff members, and post prominently. Medical personnel at the deployed location may be under separate chains of command and have missions that require the cooperation of personnel under different commanders. For example, Air Mobility Command (AMC) medical and aeromedical evacuation (AE) personnel supporting AMC missions remain under the command of the Director of Mobility Forces (DIRMOBFOR).

3.3.1.3. Review Pre-Deployment Documentation. Review pre-deployment documents, such as the WARNORD, operation order (OPORD), DEPORD, reporting instructions, and intelligence briefings. Review personnel rosters and cargo lists.

3.3.1.4. Conduct Personnel Assessment. Work closely with the medical readiness office and Personnel Support for Contingency Operations (PERSCO) to verify that all assigned personnel are eligible for deployment and meet mission training, pre-deployment health screening, and immunization requirements.

3.3.1.5. Gather Information on Destination. The AFFOR/SG staff can provide current medical and environmental intelligence on the deployed location. Contact communications, intelligence, logistics, and security force units for information about the services and capabilities available. If available, obtain base support plans and area maps. Public health staff can provide information on local health threats. IHS staff can provide information about the regional health structure, cultural considerations, language cards with common medical phrases and international symbols, and points of contact for the U.S. embassy, host nation military, and non-governmental agencies.

3.3.1.6. Review Deployment Schedules. The Deployment Control Center (DCC) will publish a deployment schedule of events (DSOE) to prepare units, personnel, and cargo to meet required delivery dates in theater. Due to size, deployment sequence, or availability, units may be split and have to travel separately. In this event, the senior line officer or enlisted member in the chalk will be appointed the troop commander. This person is usually not a medical officer. The EMEDS commander should check with the medical readiness office for information on personnel chalks, troop commanders, and transportation schedules. Personnel and equipment might deploy separately (e.g., if equipment is not collocated with the deploying unit or when personnel are travelling by commercial air).

3.3.1.7. Coordinate Required ECS/BOS. Ensure that ECS/BOS needs are coordinated with the appropriate agencies before deployment. To the extent possible, coordinate with supplying units in advance to exchange contact information, communicate arrival times, and negotiate support.

3.3.2. Provider Credentialing. To expedite privileging action, deploying medical units should provide an interfacility credentials transfer brief (ICTB) at least 15 days before the unit's arrival date when possible. Some host nations may require copies of various credentials such as licenses or Basic Life Support (BLS) or ACLS certification. All clinical providers should have a copy of their ICTB and current privilege list.

3.3.3. Equipment and Cargo. UTC team chiefs should assess the deployability of assigned equipment UTCs with medical logistics personnel and identify shortfalls. Deploying EMEDS commanders should ensure an adequate number of personnel are qualified in pallet build-up and cargo handling procedures (to include hazardous and protected cargo) to serve as cargo increment monitors during deployment and redeployment IAW AFI 24-203, *Preparation and Movement of Air Force Cargo*, even if equipment is not collocated with the

team. **Note:** Most CONUS-based EMEDS equipment is stored at consolidated storage and deployment centers (CSDCs) and is not collocated with the EMEDS teams.

3.3.3.1. Hazardous Cargo. EMEDS cargo includes compressed gases and other hazardous materials. Trained hazardous material personnel are responsible for preparing hazardous material for shipment IAW Defense Transportation Regulation (DTR) 4500.9-R, AFMAN 24-204_IP, *Preparing Hazardous Materials for Military Air Shipments*, and host nation requirements. EMEDS commanders should ensure an adequate number of EMEDS personnel are appointed and trained as packers, handlers, inspectors, and certifying officials.

3.3.3.2. Controlled Cargo. EMEDS cargo includes restricted and controlled narcotics that require special control and security as prescribed by law. A controlled medical item custodian should witness and verify the packaging of medically controlled items. At the deployed location, controlled items must be stored in locked rooms or containers and managed IAW AFI 41-209.

3.3.3.3. Munitions. Units must assign primary and alternate weapons and ammunition couriers to ensure the security and accountability of small arms munitions during transit IAW AFI 31-101, *Integrated Defense*, and AFI 21-201, *Conventional Munitions Maintenance Management*.

3.3.3.4. Classified Material. Classified material must be packaged, marked, safeguarded, and transported IAW DODM 5200.01, Volume 1, *DOD Information Security Program: Overview, Classification, and Declassification*, and AFI 31-401, *Information Security Program Management*. Units must assign appropriately cleared and trained couriers to accompany classified material.

3.3.3.5. Equipment Management. The health services administrator and medical materiel personnel should coordinate with AFFOR staff before deployment to formalize resupply and equipment repair channels. They should track outbound equipment UTCs, and upon arrival at the bed-down location, verify that all equipment has arrived.

3.4. Employment. During the initial phase of employment, priorities are to establish medical C2, provide limited clinical services, perform public health and OEH assessments, and provide input into site selection. FOC is established when the EMEDS infrastructure and clinical functions are in place.

3.4.1. EMEDS Commander Initial Activities. The following actions are critical to the mission's success and should occur within the first 48 hours of arrival. These actions are typically performed concurrently and are not listed in order of importance.

3.4.1.1. Assess Existing Medical Capability. Determine what level of health care and health care facilities already exist at the location. Determine which EMEDS components, other ground medical UTCs, and AE resources are in place and the timeline for arrival of

additional support. Determine what medical resources are available from other services and coalition forces.

3.4.1.2. Recommend Site Location. If necessary, find a location to house immediate clinical care (e.g., tent, building of opportunity). In coordination with civil engineers (CEs) and BE, recommend a proposed MTF site to the Air Expeditionary Wing (AEW) or Air Expeditionary Group (AEG) commander. Consider security (central location), flight-line access, accessibility to the patient population, proximity to environmental hazards (flight-line noise, sewage plant, power and communication lines), orientation to wind and weather patterns, and terrain. Identify areas for mass casualty triage, patient decontamination, contagious casualty management, and an alternate medical facility. Be prepared to relocate as the base expands. Consider alternate sites and have a relocation plan in place.

3.4.1.3. Secure Essential Services. Work with ECS/BOS to obtain food, water, shelter, and transportation for the medical staff. Secure power for the medical facility. If necessary, secure temporary refrigeration for medications, immunizations, and other medical supplies that require temperature control until the medical facility is set up.

3.4.1.4. Establish Medical C2. Identify the local and theater chain of command and establish contact with leadership. Brief the AEW/AEG commander on medical assets and capability and determine the AEW/AEG commander's expectations for health service support. Garner support for force health protection measures to maintain the health of deployed forces.

3.4.1.5. Determine Force Protection Condition and Security Threat. Consult with the Office of Special Investigations (OSI), intelligence, security forces, and CE to assess the security threat and obtain information on the current force protection condition, alarm signals and responses, shelter locations and procedures, and personal protective equipment (PPE) requirements (mask, chemical gear, etc.).

3.4.1.6. Account for Equipment and Supplies. Ensure that supplies and equipment required to establish medical capability have arrived. Pallets may be repacked during transit to maximize space, so packing lists on the outside of pallets may not reflect the actual contents. Medical logistics personnel are responsible for storing and safeguarding equipment and supplies.

3.4.1.7. Establish Communications Capability. Identify voice and data connectivity requirements and relay needs to base communications. Request support to establish Secret Internet Protocol Router Network (SIPRNET) and Non-Secure Internet Protocol Router Network (NIPRNET) access.

3.4.1.8. Report Arrival. Contact the AFFOR/SG to report your arrival, current medical capability, limiting factors (LIMFACs), and shortfalls. This should be accomplished automatically with your first situation report (SITREP).

3.4.1.9. Establish Contact with Squadron Medical Elements (SMEs). SMEs belong to operational squadrons but can integrate into medical operations as appropriate for mission and manning considerations. Meet with the local flying unit commanders to determine their medical support needs and a C2 mechanism for coordinating medical services between SMEs and the deployed medical unit.

3.4.1.10. Evaluate External Care Options. Determine the referral pattern for patients who require a higher level of care. Consult the AFFOR/SG's office or U.S. Embassy for information on local medical care options and patient movement policy. Consult the Patient Movement Requirements Center (PMRC) to clarify procedures on patient movement requests. Determine availability and access to medical support services in the area of responsibility (AOR) (such as ancillary services, supplies) to augment services not available at the EMEDS facility. IHS personnel can help assess local capabilities.

3.4.1.11. Assess Need for Specialty UTCs. The threat or mission may require support from additional specialty UTCs. Forward recommendations and concerns to the theater AFFOR/SG.

3.4.2. Public Health and OEH Assessments. Upon arrival, the PAM team conducts initial public health and OEH assessments and provides input on site selection. The public health officer and BE should participate in the Threat Working Group to ensure threats and vulnerabilities are adequately addressed and corrective actions are identified and implemented. Once FOC is established, the PAM team is responsible for providing ongoing surveillance, including weekly and monthly disease and injury reports, entomology, and OEH site assessments (OEHSA).

3.4.3. Reporting Requirements. All operational reports should be submitted IAW AFI 10-206, *Operational Reporting*, and specific CCDR, Joint Force Commander (JFC), and COMAFFOR requirements. After-action reports and lessons learned should be submitted IAW AFI 10-204, *Participation in Joint and National Exercises*, and AFI 90-1601, *Air Force Lessons Learned Program*.

3.4.4. Patient Movement. Casualties are typically reported for evacuation from EMEDS to the next appropriate level of care when they are not expected to return to duty within the timeframe prescribed in the theater evacuation policy. EMEDS patients who are transferred or evacuated are transported with their medical records, personal effects, and medically essential items. The attending physician initiates the process to evacuate patients, and the assigned flight surgeon provides the validation for movement IAW AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, and AFI 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*.

3.4.4.1. Evacuation Processing. Patient movement requests are submitted to the PMRC through the Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES). The PMRC is responsible for validating patient movement requests and for managing and coordinating the patient movement process.

3.4.4.2. Patient Movement Items (PMI). PMI are the medical equipment and durable supplies required to support patients during evacuation. When patient medical supplies and PMI are coordinated with the AE system in advance, most items can be provided from the AE staging base. Without advance coordination, the originating facility is responsible for providing these items.

3.4.4.3. Patient Movement Documentation. The attending physician is responsible for ensuring that all necessary forms are completed IAW AFI 41-307. These forms may include DD Form 602, *Patient Evacuation Tag*, or AF Form 3899, *Aeromedical Evacuation Patient Record*.

3.4.5. Mortuary Affairs. Should a death occur, medical personnel must coordinate with mortuary affairs IAW AFI 34-242, *Mortuary Affairs Program*, and local procedures.

3.4.6. Care for Enemy Prisoners of War (EPW). If EPWs are treated at an EMEDS facility, coordinate with security forces or equivalent authority to provide armed guards for prisoners. See AFI 31-304_IP, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees*, for guidance.

3.4.7. Care for Civilians and Non-U.S. Personnel. If a local national is injured or becomes ill as a direct result of U.S. Government operations in the area, the theater CCDR has approval authority to allow treatment at an EMEDS facility. Treatment is IAW State Department guidance, standardized treaties, and agreements with coalition forces. The patient is not charged for this humanitarian service. Any local commander may authorize the transport of a patient to the nearest suitable MTF when civilian facilities are not available. EMEDS may be deployed to support HA/DR operations in which civilians and non-U.S. personnel are part of the supported population. See Chapter 11 for more information.

3.4.8. Patient Safety. EMEDS commanders must appoint a patient safety manager to oversee the facility's patient safety program IAW DOD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation*, and AFI 44-119, *Medical Quality Operations*. One of the clinical nurses typically performs this function. The patient safety manager should complete the patient safety manager training for deployers before deployment. All clinical and administrative personnel should be educated about the DOD patient safety program and National Patient Safety Goals (NPSG) for hospitals. Patient safety guidelines for EMEDS facilities are available in the [Air Force Deployed Patient Safety Program Guide](#) on the AFMS Knowledge Exchange (KX) Clinical Quality Management (CQM) Patient Safety site.

3.4.9. Documenting Patient Care. Medical personnel must document the care provided to patients treated at an EMEDS facility IAW DODI 6490.03, *Deployment Health*, and AFI 41-210, *Tricare Operations and Patient Administration Functions*. The Theater Medical Information Program – Air Force (TMIP-AF) provides the electronic system of record for documenting patient care and OEH exposure data. Medical documentation created outside of TMIP-AF should be integrated into the member's permanent health record within 30 days of return to home station. See Chapter 5 for more information about TMIP-AF. See Chapter 11

for more information on medical documentation for civilians and non-U.S. personnel during HA/DR operations.

3.4.10. Maintenance and Disposition of Records. Records associated with EMEDS operations must be maintained and disposed of IAW AFD 33-3, *Information Management*, AFMAN 33-363, and AFI 33-364, *Records Disposition – Procedures and Responsibilities*. Patient medical records must be managed IAW AFI 33-332, *Air Force Privacy Program*, and AFI 41-210. Medical personnel must comply with Public Law 93-579 (as amended) Privacy Act of 1974, Public Law 104-191 (as amended) Health Insurance Portability and Accountability Act (HIPAA) of 1996, Freedom of Information Act, Drug Abuse and Treatment Act, and Comprehensive Alcohol Abuse amendments.

3.4.11. Chemical, Biological, Radiological, and Nuclear (CBRN) Incidents. EMEDS may deploy with CP based on mission requirements and threat assessments. CP-EMEDS allows medical care to continue inside the hospital for a maximum of 72 hours post exposure. In a contaminated environment, medical care at EMEDS facilities without CP is limited to those functions that can be performed while wearing individual protective equipment (IPE). EMEDS personnel must be familiar with the CBRN passive defense and consequence management procedures outlined in AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, and AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Environment*. FM 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3, *Multiservice Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*, provides guidelines on medical operations.

3.4.11.1. Patient Decontamination. The patient decontamination team (FFGLB) and equipment package (FFGLC) deploy with CP-EMEDS to CBRN threat environments. The team is responsible for decontaminating patients before entry into the CP-EMEDS facility. See AFTTP 3-42.33, *Expeditionary Medical Decontamination Team*, (available on the AFMS KX at <https://kx2.afms.mil/kj/kx3/Doctrine/Pages/home.aspx>) for patient decontamination procedures. At EMEDS facilities where FFGLB and FFGLC are not employed, expedient decontamination is limited to soap and water.

3.4.11.2. Equipment Decontamination. Operational decontamination of equipment, ECUs, generators, and shelters depends on the contaminating agent involved and the availability of replacement equipment. Decontamination may not be practical for some equipment (e.g., uncoated painted equipment).

3.4.12. Contagious Casualty Management. During a contagious disease outbreak or biological event, the EMEDS commander should work with the AEW/AEG commander to acquire additional space for housing contagious casualties. It is imperative that contagious casualties remain isolated from the uninfected or non-contagious population. EMEDS staff should use separate triage locations for potentially contagious patients to reduce potential exposure. In the event of a large-scale contagious casualty incident, the EMEDS commander should contact the AFFOR/SG immediately to request additional resources to contain and manage contagious patients. The EMEDS facility should be prepared to support a contagious

casualty incident without support from the patient movement system. See AFTTP 3-42.22, *Contagious Casualty Management*, (available on the AFMS KX at <https://kx2.afms.mil/kj/kx3/Doctrine/Pages/home.aspx>) for more information.

3.5. EMEDS Redeployment. The EMEDS commander must actively participate in redeployment planning. Plans for a time-phased reduction in medical services should be consistent with the deactivation of the deployed location, change in mission, or change in the threat scenario. Normally, EMEDS personnel and equipment depart with the bulk of the AEF. The EMEDS HRT, or a portion thereof, remains to provide emergency medical and surgical capability. EMEDS personnel are responsible for disassembling the EMEDS infrastructure and providing loading assistance. Medical logistics personnel are responsible for load plans and shipping manifests IAW theater and host nation requirements. Equipment and supplies should be decontaminated IAW theater policy and applicable U.S. Department of Agriculture guidelines. Items not suitable for redeployment (such as pharmaceuticals, blood and biological waste, and sterile supplies) should be appropriately redirected within the theater or disposed of. Most items can be redeployed. The shipment, disposal, or storage of biological and chemical agents is at the direction of the AFFOR/SG.

Chapter 4

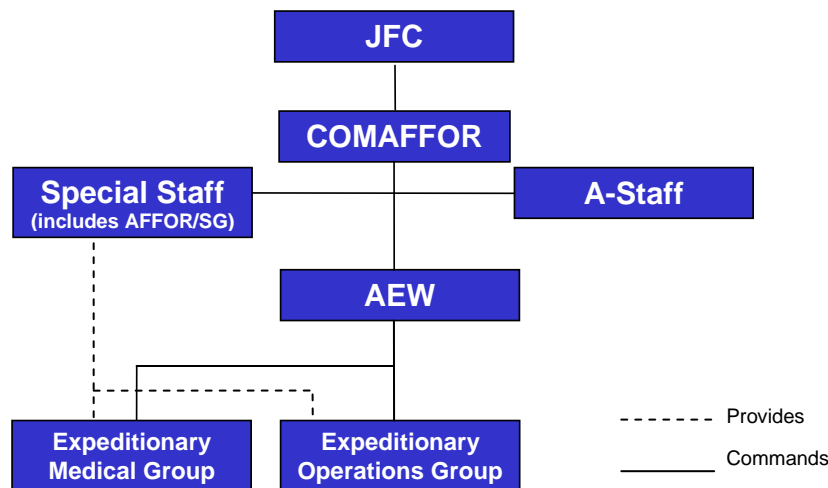
COMMAND AND CONTROL (C2) RELATIONSHIPS

4.1. Command and Control (C2) of Medical Teams. To support Air Force expeditionary and global engagement requirements, Line of the Air Force (LAF) and medical leadership must ensure C2 infrastructures are in place, understood, and executable. The chain of command for expeditionary medical units is through the LAF. Deploying personnel should receive a chain of command briefing before deployment.

4.2. ACC/SG Responsibility. As the MRA, ACC/SG has overall responsibility for EMEDS tactical doctrine. ACC/SG serves as the medical consultant for EMEDS operations, providing technical guidance and planning.

4.3. Air Expeditionary Task Force (AETF) Structure. Air Force elements deployed in an expeditionary role are designated as an AETF under the command of the COMAFFOR, as shown in Figure 4-1. The supported COMAFFOR retains administrative control (ADCON) of assigned and attached Air Force forces IAW Air Force Doctrine Volume 1, *Basic Doctrine*. EMEDS teams normally operate under the local direction of the deployed expeditionary unit commander (usually the EMEDS or AFTH commander). See Air Force Doctrine Volume 1 and Air Force Doctrine Annex 4-02, *Medical Operations*, for more information on C2 structure.

Figure 4.1. Notional AETF Structure under a Joint Task Force.



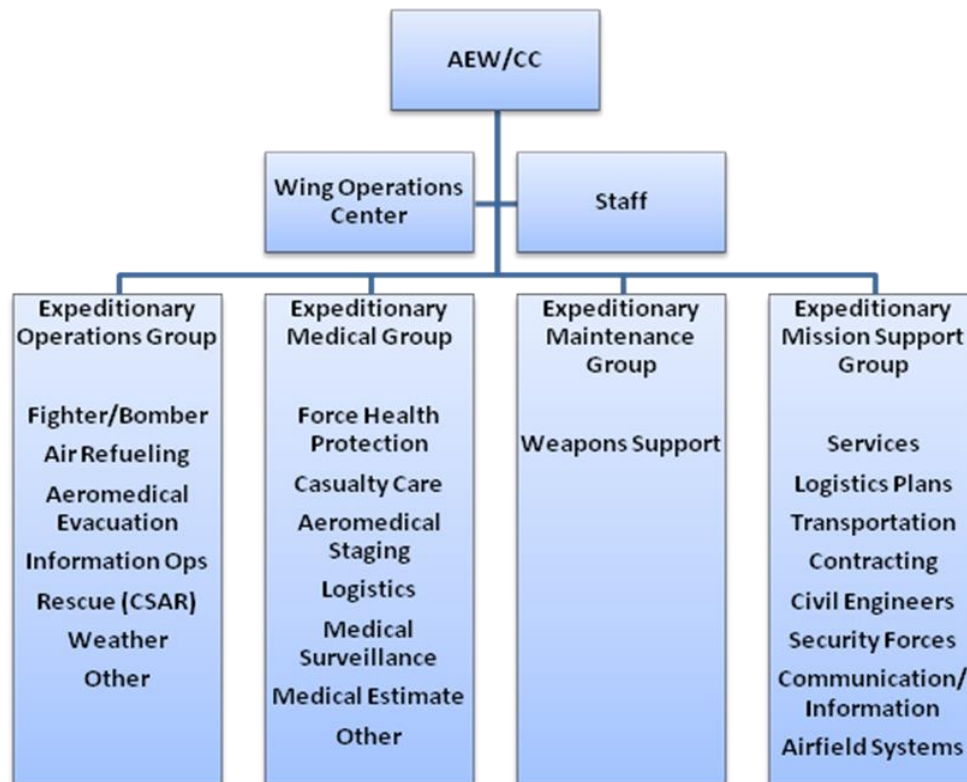
4.3.1. Commander, Air Force Forces (COMAFFOR). The COMAFFOR serves as the single voice air commander to the JFC. The COMAFFOR is responsible for all Air Force forces assigned or attached to the air component in joint or multinational operations. The COMAFFOR employs and sustains assigned and attached Air Force forces in theater.

4.3.2. Air Force Forces Surgeon (AFFOR/SG). The AFFOR/SG, a corps-neutral medical service officer usually at the rank of colonel, is a member of the COMAFFOR special staff and is the director of Air Force health service operations. The AFFOR/SG is responsible for

overall health resources management and provides information on health surveillance, risk assessments, sustainment, and other force health protection issues. The AFFOR/SG does not exercise command authority or direct control over medical forces but provides policy, planning, coordination, and oversight to the COMAFFOR.

4.3.3. Air Expeditionary Wing (AEW). An AEW normally is composed of the wing command element and two or more expeditionary groups. Figure 4-2 depicts a notional AEW structure. The AEW commander has ADCON of all assigned AEW assets. Medical support elements fall under the Expeditionary Medical Group (EMDG). The EMDG commander controls fixed MTFs, EMEDS facilities, AFTHs, ATCs, and En Route Patient Staging System (ERPSS) facilities. AE assets and SMEs fall under the Expeditionary Operations Group (EOG).

Figure 4.2. AEW Structure.



4.3.4. Expeditionary Medical Group (EMDG) Commander. The EMDG commander is designated on G-series orders specifically for the deployment and is accountable to the AEW/AEG commander. The EMDG commander is responsible for all installation medical services, including oversight and integration of non-EMEDS medics into a consolidated installation medical support and disaster response program. The EMDG commander communicates and coordinates with the AFFOR/SG on theater medical support issues and with other joint medical units at the location.

4.4. Joint and Multinational Operations. C2 of medical operations in joint, multinational, or United Nations (UN) operations is often defined in the warning, execution, or operations order.

Chapter 5

COMMUNICATIONS AND INFORMATION SYSTEMS

5.1. EMEDS Communications Equipment. EMEDS communications equipment includes DOD-approved radios and computer systems. ACC/SG determines the requirements for EMEDS IM/IT assets in partnership with ACC/A6, the TMIP-AF Program Management Office, and the Integrated Logistics Support (ILS) Manager (AFMOA/SGALW). Responsibilities and processes for acquisition, maintenance, and configuration management of deployable IM/IT assets are outlined in the *Integrated Logistics Support Plan (ILSP) for United States Air Force Medical Equipment War Reserve Materiel (WRM) Information Management/Information Technology (IM/IT)*. The CDR is responsible for all associated upgrades and sustainment costs and for ensuring that maintenance releases are applied to the EMEDS footprint once deployed.

5.1.1. Radios. EMEDS equipment includes Joint Tactical Radio System (JTRS) compliant wideband and multiband land mobile radios (LMRs). These radios are interoperable with existing DOD radio systems and joint networking waveforms, supporting secure voice, data, and video communication over mobile, ad-hoc internet protocol (IP) based networks. They support line of sight (LOS) and beyond line of sight (BLOS) communications such as convoy, ambulance to airfield operations, AE and medical evacuation (MEDEVAC) units, security, and local C2 networks. Radios are allocated IAW the AS and operational specific requirements. These assets support communications during deployment and redeployment phases and in austere environments where an established communications infrastructure may not be available. As common user communications availability becomes available, reliance on these organic radios is reduced. Communication planners must coordinate frequency allocation requirements through the appropriate installation, MAJCOM, or theater channels to ensure all radiating equipment is spectrum certified and frequency supportable IAW AFI 33-580, *Spectrum Management*. Radio frequencies used in operations outside the United States and its territories must be approved through the appropriate theater CDR.

5.1.2. Computer Systems. The ILS Manager, with support from the TMIP-AF Program Office and deploying units, is responsible for ensuring that all EMEDS communication and computer systems scheduled for deployment are current and compliant with deployed force information system naming conventions and information assurance (IA) requirements. All hardware solutions must be consistent with published theater minimum hardware standards.

5.2. Network Operations. Network Operations and Security Centers (NOSCs) at the theater level are responsible for ensuring the theater's operational and support systems remain fully capable. EMEDS facilities rely on deployed Network Control Centers (NCCs) for core network administration, network management, and IA services at the local level. Access to Air Force network resources and information systems is IAW AFI 33-115V1, *Network Operations (NETOPS)*, and AFI 33-115V2, *Licensing Network Users and Certifying Network Professionals*. See Attachments 17-19 for notional local area network (LAN) configurations for EMEDS HRT, EMEDS+10, and EMEDS+25. IT systems and networks require certification and accreditation IAW AFI 33-210, *Air Force Certification and Accreditation (C&A) Program (AFCAP)*.

5.3. Help Desk Support. The TMIP-AF help desk, Maxwell AFB, Gunter Annex, AL provides configuration control, technical, and help-desk support for AFMS UTCs. The help desk is available 24/7 and can be reached at the following telephone numbers and email address:

DSN: 312-596-5771

Toll Free: 877-596-5771

Commercial: 334-416-5771

Email: team1@gunter.af.mil

5.4. Software Applications. Computers issued to EMEDS teams include the DOD Standard Desktop Configuration (SDC) and TMIP-AF.

5.4.1. Theater Medical Information Program Air Force (TMIP-AF). TMIP-AF provides the medical information systems needed to support health care delivery, medical logistics, and medical C2 functions in theater. Table 5-1 lists the applications included in the TMIP-AF suite.

Table 5.1. TMIP-AF Applications.

Application	Purpose	Availability
Armed Forces Health Longitudinal Technology Application – Theater (AHLTA-T)	Electronic health record (EHR) for theater environments Note: AHLTA-T is based on the EHR system used at MTFs in CONUS and sustaining bases.	Locally installed
Defense Medical Logistics Standard Support (DMLSS)	Medical logistics management	Locally installed
Defense Occupational and Environmental Health Readiness System (DOEHRs)	OEH exposure tracking and surveillance	Web portal
Patient Movement Items Tracking System (PMITS)	AE medical equipment tracking	Web portal
Theater Medical Data Store (TMDS)	Theater medical record database Note: AHLTA-T uploads medical data to TMDS when network communications are available. TMDS updates the central Clinical Data Repository (CDR) in CONUS so that records can be retrieved electronically at the member's home MTF.	Web portal
TMIP Composite Health Care System (CHCS) Cache (TC2)	Ancillary services	Locally installed

Application	Purpose	Availability
Note: Locally installed TMIP-AF software applications come pre-installed and configured on EMEDS laptops. Web-based applications are accessed through a web portal, and EMEDS laptops may include a desktop shortcut.		

5.4.2. Specialty-Specific Applications. In addition to the medical applications included in TMIP-AF, EMEDS teams may have access to the specialty-specific applications listed in Table 5-2.

Table 5.2. Specialty-Specific Applications.

Application	Purpose	Availability
Corporate Dental Application (CDA)	Electronic dental record Note: CDA is a U.S. Army Dental Command application.	Web portal
Defense Blood Standard System (DBSS)	Blood operations	Web portal
Medical Situational Awareness in the Theater (MSAT)	Medical surveillance	SIPR system
Spectacle Request Transmission System (SRTS)	Optometry services	Locally installed
Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES)	Medical regulating and patient movement tracking	Web portal
Note: Locally installed applications come pre-installed and configured on EMEDS laptops. Web-based applications are accessed through a web portal, and EMEDS laptops may include a desktop shortcut.		

5.5. Information Awareness (IA) Policy. EMEDS personnel must understand and follow IA procedures, to include communications security (COMSEC) and computer security (COMPUSEC), IAW AFI 33-200, *Information Assurance (IA) Management*, AFMAN 33-282, *Computer Security (COMPUSEC)*, and associated Air Force IA guidance. Deploying EMEDS personnel must have current Air Force IA certification.

Chapter 6

INTEGRATION AND INTEROPERABILITY

6.1. Integration and Interoperability with Other Systems. Deployed medical personnel in a theater or area of operation may support elements of an AEF, components of the AE system, joint medical counterparts, Special Operations Forces (SOF) medical components, and other federal and civilian agencies. In some instances, theater planners may request medical support for bed-down locations not associated with a typical AEF or ECS/BOS infrastructure.

6.2. Expeditionary Combat Support/Base Operating Support (ECS/BOS) Requirements. EMEDS assets deploy with limited organic capability and require ECS/BOS. ECS/BOS requirements include (but are not limited to) billeting, messing and other consumable materials, power, water, ice, latrines, showers, laundry, waste management, exterior lighting, transportation (to include ambulances and general purpose vehicles), fuels, vehicle maintenance, equipment maintenance, general supplies, contracting, information and communications systems support, mortuary affairs, public affairs, chaplain, linguist, personnel and vehicle decontamination, and security. ECS/BOS services for EMEDS facilities and personnel will be provided using the host base's capabilities, deployable base systems, and contracted civilian support. ECS/BOS requirements for HA/DR and stability operations are tailored to the mission. See Attachment 8 for quantified estimates on required support.

6.2.1. Civil Engineer (CE) Support. CE support is required to assist with shelter and equipment siting, shelter setup, and to connect the EMEDS facility to the base infrastructure. EMEDS personnel and civil engineers will install and connect electrical power utilities, ECUs, and waste and water management utility systems, as appropriate. EMEDS facilities rely on CE forces for facility maintenance and maintenance of non-medical equipment (e.g., generators and ECUs). Servicing and repair of non-medical equipment beyond the scope of CE's capabilities may be contracted out. See Attachments 9-12 for recommended EMEDS layout configurations.

6.2.2. Billeting, Food, and Personal Hygiene Provisions. ECS/BOS for billeting, meals, showers, and latrines for EMEDS personnel should be commensurate with that provided for all deployed personnel.

6.2.3. Communications and Information Systems Support. EMEDS does not deploy with the communication infrastructure needed for independent operation. EMEDS facilities rely on the host base's communication units for support. EMEDS deploys with radios, STEs, and computers. EMEDS equipment does not include telephones or cryptographic controlled items (CCI) for STEs.

6.2.4. Equipment Movement. Base personnel will assist with moving and positioning EMEDS equipment at the deployed location.

6.2.5. Ice and Water. Potable water (bottled/bulk), ice, and dry ice are normally obtained on a contract basis. Depending on the operation, a reverse osmosis water purification unit

(ROWPU) may be deployed. Public health and BE personnel must be involved in the procurement or in-house treatment of potable water and ice.

6.2.6. Fire Emergency Services (FES). FES should be provided commensurate with that provided for other deployed personnel and resources.

6.2.7. Laundry. Laundry support is normally obtained on a contract basis but may be provided by ECS/BOS services.

6.2.8. Oxygen. EMEDS HRT includes mobile oxygen storage tanks (MOST), which provide a finite oxygen capability. Medically approved oxygen and other gases may be obtained on a contract basis for EMEDS facilities without the ability to generate their own supply. A DOGS unit is deployed at the EMEDS+10 level and above.

6.2.9. Petroleum, Oils, and Lubricants (POL). Fuel for vehicles, generators, and other equipment is normally obtained on a contract basis along with other base requirements.

6.2.10. Power. Base electrical power systems provide primary power generation. The EMEDS commander, in consultation with biomedical equipment technicians (BMETs) or CE, ensures that power is rationed appropriately. EMEDS+10 and above include generators, which are intended for initial operating capability and emergency backup power only. ECS/BOS provides ground power equipment specialists to connect EMEDS power distribution panels (PDPs) to commercial or base power. See Attachments 13-16 for recommended power grid configurations.

6.2.11. Transportation Support. EMEDS relies on ECS/BOS for access to vehicles for patient, personnel, and equipment movement and vehicle maintenance. These vehicles are base transportation assets and might not be permanently assigned to the EMEDS facility.
Note: Ambulances typically are not deployed at the EMEDS HRT level.

6.2.12. Waste Disposal. Medical and other waste disposal services will normally be obtained on a contract basis or will be provided as part of other base waste disposal services.

Chapter 7

SECURITY AND FORCE PROTECTION

7.1. Security Roles and Responsibilities. Medical personnel and equipment are non-combatant assets as defined by the Geneva Conventions and the Law of Armed Conflict (LOAC). Medical personnel and WRM assemblages are protected IAW AFI 31-101. Local security measures are outlined in the Integrated Defense Plan. EMEDS commanders are responsible for ensuring security measures are in place to protect patients and personnel at the EMEDS facility. Any training required for these duties (to include augmentation detail) should be requested from in-place security forces as part of pre-deployment mobility training. EMEDS personnel are responsible for following personal protection measures outlined in AFI 10-245, *Antiterrorism (AT)*, AOR security briefings, established force protection requirements, and other guidance. The EMEDS commander or appointed representative should be a member of the Integrated Defense Council.

7.2. Medical Convoy Protection. The EMEDS commander should coordinate with the defense force commander for tactical security element (TSE) support for medical convoys outside the base perimeter and to local host-nation medical facilities.

7.3. Operations Security (OPSEC). EMEDS staff must protect mission-critical information (to include medical or casualty information) IAW CCDR OPSEC policy and AFI 10-701, *Operations Security (OPSEC)*. Classified information must be transmitted by secure means and protected IAW AFI 31-401. SITREPs, medical surveillance, site locations, and compiled patient data are examples of information that may be classified.

7.4. Security of Weapons and Ammunition. EMEDS personnel may maintain issued weapons and ammunition when authorized by the EMEDS facility commander at the direction of the AEW/AEG commander. All weapons and ammunition must be secured IAW AFI 31-101, AFMAN 31-229, *USAF Weapons Handling Manual*, and local procedures. A weapons clearing barrel should be placed outside the EMEDS facility's main entrance when threats require personnel to carry loaded weapons. With the exception of security forces responding to a request for assistance, personnel should not be allowed to enter the EMEDS facility with a loaded weapon. Patients' weapons and ammunition should be transferred immediately to a member of their unit. The EMEDS facility may temporarily store the weapons until the patient's unit or AEW/AEG armory can accept responsibility. Weapons should be properly cleared and secured in a locked container.

Chapter 8

TRAINING

8.1. Medical Readiness Training Requirements. Medical personnel assigned to EMEDS UTCs must complete individual, deployment, and unit training requirements IAW AFI 41-106. Examples include Readiness Skills Verification Program (RSVP), CBRNE emergency preparedness and response, and clinical AFSC training. Completion of all medical readiness training and equivalency training must be documented in the Medical Readiness Decision Support System (MRDSS). Theater-unique training requirements will be identified in deployment reporting instructions, line remarks, or (for domestic CBRN response missions) the Defense Readiness Reporting System (DRRS).

8.2. EMEDS Unit Type Code (UTC) Training. Personnel assigned to EMEDS UTCs are required to complete EMEDS deployment training IAW AFI 41-106 and MRA guidance. Unit commanders are responsible for ensuring that all EMEDS-assigned medical personnel receive the appropriate training. UTC team integrity should be maintained to the maximum extent possible.

8.2.1. Formal Training. The EMEDS HRT formal course provides field operational training in EMEDS setup and pack out, deployed operations, equipment proficiency, and doctrine and is designed to promote team performance, cohesion, and cross-functionality. The curriculum includes training in CP-EMEDS. The EMEDS HRT formal course satisfies the field training requirements prescribed in AFI 41-106.

8.2.2. UTC Sustainment Training. UTC sustainment training occurs between formal course attendance cycles and provides team training in the skills and knowledge a UTC must possess to fulfill mission essential tasks (METs). UTC sustainment training credit may be granted for participation in MET-driven exercises, operational readiness exercises (OREs), local exercises, and joint exercises. Contact the ACC/SGX training branch for information on MRA-approved sustainment training exercises.

8.2.3. Mission Essential Task Lists (METLs). METLs are designed to help assess, measure, and report a unit's ability to perform its mission. Personnel assigned to an EMEDS UTC are expected to be proficient in the EMEDS Core METLs, as well as their UTC-specific METLs. Core METLs and UTC-specific METLs are available on the ACC/SG MEFPK Playbook.

8.3. Joint Operations Medical Managers Course (JOMMC). The JOMMC familiarizes and develops senior healthcare personnel to serve as JTF surgeons and staff members. Completion of the JOMMC or equivalent course is highly recommended for EMEDS commanders and deputy commanders. This course is offered through the Defense Medical Readiness Training Institute (DMRTI) at Ft. Sam Houston in San Antonio, TX.

8.4. Vehicle Operation Training. Operators of material handling equipment, ambulances, and other government motor vehicles must have a government driver's license and appropriate

certification IAW AFI 24-301, *Vehicle Operations*. EMEDS facilities require multiple qualified drivers to provide 24/7 coverage.

8.5. Weapons Training. Weapons training requirements are outlined in AFI 31-117, *Arming and Use of Force by Air Force Personnel*, AFI 36-2226, *Combat Arms Program*, and AFI 41-106. The theater CCDR may levy additional requirements, which are generally specified in the operation's execution order (EXORD) or reporting instructions. See the *Weapons and Munitions Forecasting Table for AFMS UTCs* on the [AFMS Medical Readiness site](#) for more information.

8.6. Communications and Information Systems Training. Specific training in the proper use of EMEDS communications and information systems is required. See Chapter 5 for more information on EMEDS communications systems.

Chapter 9

LOGISTICS

9.1. Expeditionary Medical Logistics (EML) System. The EML system provides time-definite resupply of materiel by synchronizing the flow of materiel, information, and funds from initial unit request to delivery. It links all partners in a complex supply chain (e.g., vendors, depots, carriers, third-party logisticians, and information managers). The EML system uses a pull process for resupply and a repair-and-return process for medical equipment maintenance to minimize inventory and airlift requirements. Within the EML system, a sustaining base is the materiel lifeline for deployed medical units. The sustaining base augments the deployed medical unit's limited logistical capability by assuming the bulk of the supply chain's administrative, sourcing, and tracking functions. The AFFOR/SG, in coordination with the Air Force Medical Logistics Operations Center (AFMLOC), determines the sustaining base. In a mature theater, a Theater Lead Agent for Medical Materiel (TLAMM) element may be linked to the combatant commands, JTF/SG, AFFOR/SG, deployed medical units, sustaining base, and AFMLOC. When a TLAMM is established, it becomes the deployed unit's primary point of contact for materiel and equipment support in theater. EMEDS relies heavily on rapid global mobility, a robust EML or Single Integrated Medical Logistics Management (SIMLM) system, and reliable reach-back communications capability. See AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System*, for more information.

9.2. Supplies and Equipment. Initial deployments include 30 days of supplies (the initial 10-day equipment package and two resupply packages). UTC team chiefs should coordinate subsequent resupply through the medical logistics function at the deployed location.

9.2.1. Initial Equipment. Table 9-1 lists the initial equipment UTCs and corresponding AS for each EMEDS increment. The AS lists the equipment and supplies included in the equipment package. UTC team chiefs should be aware of the contents of their equipment packages before deployment and should contact their medical logistics office for assistance with reviewing their AS.

Table 9.1. EMEDS Equipment and AS Matrix.

Increment	Equipment UTC	AS
EMEDS HRT		
	FFEPE, Critical Care Equipment	938J
	FFHR1, EMEDS HRT Equipment	938P
	FFMF1, Mobile Field Surgical Team Equipment	938G
	FFP0E, EMEDS Specialty Care Augmentation Equipment	917R
	FFPM4, PAM ADVON Equipment	916E
	FFPM5, PAM Sustainment Equipment	916F
EMEDS+10		
	FFEE2, EMEDS+10 Equipment	938B
	FF0X2, Deployable Oxygen Package	903A

Increment	Equipment UTC	AS
	Plus EMEDS HRT Equipment	
EMEDS+25		
	FFEE3, EMEDS+25 Equipment	938C
	FF0X2, Deployable Oxygen Package	903A
	Plus EMEDS+10 Equipment	
	Plus EMEDS HRT Equipment	

9.2.2. Resupply Packages. Table 9-2 lists the resupply UTCs and corresponding AS for each EMEDS increment. Each resupply package contains an additional 10 days of supplies.

Table 9.2. EMEDS Resupply and AS Matrix.

Increment	Resupply UTC	AS
EMEDS HRT	FFEE4, EMEDS HRT Resupply	938D
EMEDS+10	FFEE5, EMEDS+10 Resupply	938E
EMEDS+25	FFEE6, EMEDS+25 Resupply	938F

9.3. Medical Equipment Maintenance and Repair. BMETs provide routine maintenance and repair of medical equipment at the deployed location. Medical equipment deemed broken beyond the medical facility's ability to repair should be sent to the regional Medical Equipment Repair Center (MERC) or the manufacturer. Some MERCs are designated Loan Repair & Return Centers (LRRC). The LRRC loans some specialized equipment to augment a deployed location's capability when equipment cannot be repaired locally.

9.4. Equipment Upgrades and Modernization. Changes to the EMEDS assemblage may result from technology advances and lessons learned feedback. MRAs typically budget and plan for major equipment reviews every 3-5 years.

Chapter 10

DOMESTIC CIVIL SUPPORT

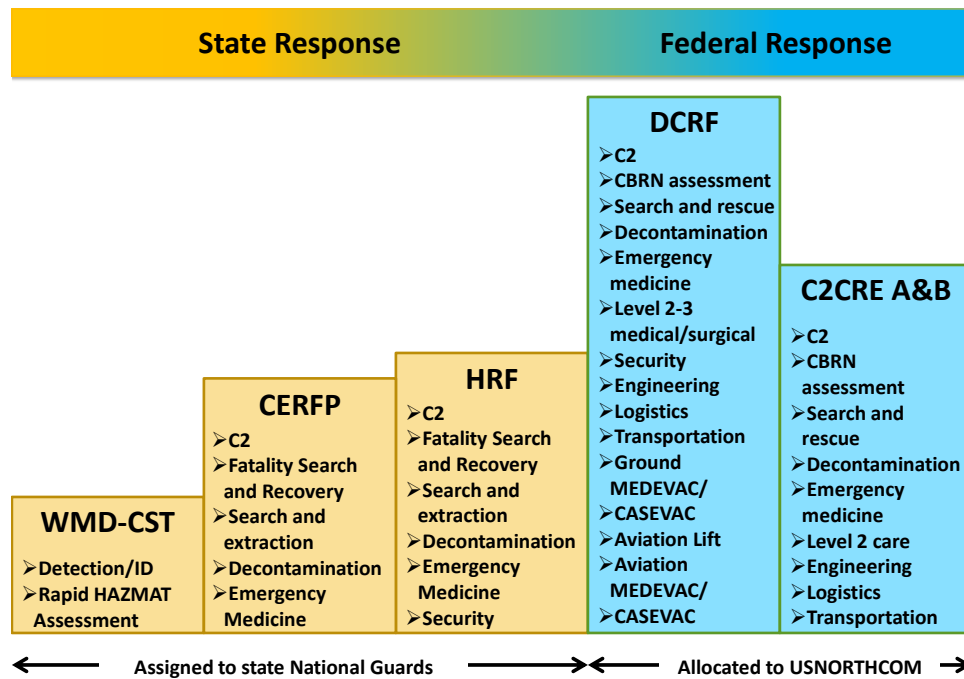
10.1. Purpose. This chapter covers the unique responsibilities and operational requirements of EMEDS UTCs allocated to support DSCA operations under the National Response Framework (NRF).

10.2. Mission. The Commander, United States Northern Command (CDRUSNORTHCOM) and the Commander, United States Pacific Command (CDRUSPACOM) assist civil authorities in responding to significant or catastrophic disasters or emergencies within the domestic portion of their respective AORs when directed by the President or Secretary of Defense. **Note:** United States Pacific Command (USPACOM) provides domestic civil support for Hawaii and Pacific territories. Operational instructions and command relationships are defined in the EXORD.

10.2.1. Natural Disasters and Emergencies. Upon direction by higher headquarters, EMEDS components will deploy to support DSCA operations following a national disaster or emergency. The primary mission is to provide rapid, initial medical response and help restore vital medical services. EMEDS assists the medical relief efforts of domestic civilian relief agencies. The military's role in these operations is intended to be limited in scope and duration. The typical mission duration for EMEDS personnel is less than 30 days. While the Federal Emergency Management Agency (FEMA) within the Department of Homeland Security is the lead in domestic response, DOD military personnel operate under a military chain of command. C2 typically resides under a joint force command structure where the EMEDS commander reports through a line chain of command or through the joint force surgeon. Specific C2 of medical operations is defined in the WARNORD, EXORD, or OPORD. See JP 3-28, *Defense Support of Civil Authorities*, and JP 4-02 for more information on health service support in joint civil support operations.

10.2.2. CBRN Response. The DOD provides domestic CBRN response (a specialized form of DSCA) through the CBRN Response Enterprise. The CBRN Response Enterprise is a dedicated, scalable military CBRN response capability that consists of state and federal military response forces, as shown in Figure 10-1. Federal military response forces consist of the Defense CBRN Response Force (DCRF) and Command and Control CBRN Response Elements (C2CRE A and B) and are allocated to United States Northern Command (USNORTHCOM). EMEDS UTCs allocated to the mission support the DCRF. Additional medical support for the C2CREs is handled through a request for forces process. The federal military response uses graduated CBRN response posture levels (CRPLs) to maintain response capabilities at an alert posture commensurate with a credible threat or in anticipation of potential required deployment. USNORTHCOM oversees planning and management of the CBRN Response Enterprise's DOD components in conjunction with the National Guard Bureau (NGB), USPACOM, United States Transportation Command (USTRANSCOM), and other service branches. See the *USNORTHCOM Concept Plan (CONPLAN) 3500, Civil Support*, for more information and CRPL timelines.

Figure 10.1. CBRN Response Enterprise.



Legend

WMD-CST—Weapons of Mass Destruction-Civil Support Team
 CERFP—CBRNE Enhanced Response Force Package
 HRF—Homeland Response Force
 DCRF—Defense CBRN Response Force
 C2CRE—Command and Control CBRN Response Element

10.2.2.1. Command Relationships. Upon arrival in the operations area, EMEDS personnel allocated to the CBRN Response Enterprise are under the OPCON of the joint forces commander appointed by CDRUSNORTHCOM or CDRUSPACOM. The COMAFFOR retains ADCON over EMEDS personnel through the AEW/AEG commander.

10.2.2.2. Training. USNORTHCOM, USPACOM, and NGB jointly oversee the CBRN Response Enterprise training program. DCRF and C2CRE training, exercises, and evaluations are conducted IAW the Joint Mission Essential Tasks (JMETs) and Joint Mission Essential Task List (JMETLs). The DCRF and C2CRE conduct confirmatory exercises annually and participate in select FEMA regional exercises. Joint training plans, schedules, and training records are maintained in the Joint Training Management Information System (JTIMS).

10.3. EMEDS Operations. The CDRUSNORTHCOM or CDRUSPACOM determine which EMEDS personnel and equipment UTCs support the domestic civil support mission within their

AORs, based on the mission scope, threat assessment, and availability of forces. Specific UTCs are identified in the TPFDD.

10.3.1. ECS/BOS Requirements. EMEDS deploys with limited organic capability and requires ECS/BOS. See Chapter 6 for more information. Historically, Air Force ground medical support for domestic civil support missions has been built on an augmented EMEDS+10 or EMEDS+25 platform. See Attachment 8 for baseline ECS/BOS requirements.

10.3.2. Medical Reports and Communication. All medical reports should be submitted IAW AFI 10-206 and specific guidance from the CCDR and JFC.

10.3.3. Patient Movement. All categories of DOD and American citizen patients (routine, urgent, priority, and contingency) requiring patient movement by fixed-wing or rotary-wing aircraft during CONUS DR operations will be reported to the appropriate PMRC.

10.3.4. Medical Logistics Support. A SIMLM designated by the CCDR provides the medical logistics support for DSCA operations. The SIMLM relies on a TLAMM to obtain and distribute Class VIII medical materiel. If the TLAMM is not fully operational, does not stock the required items, or the sustainment supply chain is disrupted, medical logisticians may reach back to the sustaining base. A DOD activity address code (DODAAC) is required to submit resupply requirements and create delivery and billing addresses. See JP 4-02 and AFTTP 3-42.8 for more information on the EML system and Chapter 9 for more information on EMEDS logistics support.

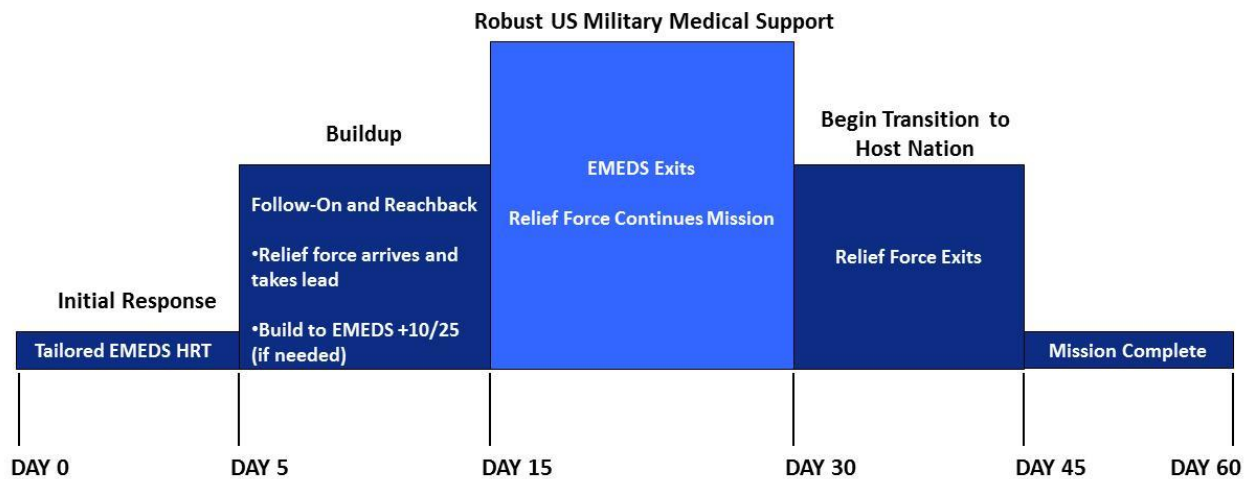
Chapter 11

HUMANITARIAN ASSISTANCE AND DISASTER RELIEF (HA/DR) OPERATIONS

11.1. Purpose. This chapter details the planning factors, operational considerations, and other factors unique to EMEDS foreign HA/DR operations.

11.2. Mission. Upon direction by higher headquarters, EMEDS and associated ECS/BOS components will deploy to support foreign HA/DR operations. The primary mission is to provide rapid, initial medical response and help restore vital medical services. EMEDS augments the medical relief efforts of partner nations, intergovernmental agencies, and civilian relief agencies. The military's role in these operations is intended to be limited in scope and duration. The typical mission duration for EMEDS personnel is less than 30 days. Figure 11-1 shows a notional EMEDS response timeline.

Figure 11.1. Notional EMEDS Response.



11.3. Operational Assumptions. EMEDS response is based on the following assumptions about the operational environment:

- Civilian authorities are in control of their government and the operational environment.
- U.S. forces are not responsible for host nation patient movement, including rotary wing or ground evacuation.
- EMEDS may be deployed in austere conditions with limited logistical support. ECS/BOS will be required if EMEDS is not collocated with ECS/BOS components at the airhead/runway.
- U.S. forces will be self-billeted.

- Food, potable water, electrical power, and fuel may not be locally available. U.S. forces will bring their own capability.
- If applicable, the host nation has airfield control, and the runway will be available to U.S. forces.
- Material handling equipment (MHE) is not available.
- Transportation from the airhead to the site (if not collocated) is not available in theater.
- Local communication systems are not available within the area of operations. The operating site will require communications setup and maintenance support.
- A Status of Forces Agreement (SOFA) or appropriate diplomatic notes will exist.
- Humanitarian Assistance Survey Teams (HAST), IHS, and Defense Institute for Medical Operations (DIMO) resources may be employed.

11.4. Medical Planning Factors. The supported population may include U.S. and partner nation forces, personnel from governmental agencies and non-government organizations (NGOs), and local nationals. Medical rules of engagement (ROE) should define the scope and level of care, types of patients who will be treated, plans for moving stabilized patients to the next level of care, patient referral policies, and other medical considerations. JP 3-29, *Foreign Humanitarian Assistance*, and JP 4-02 provide joint planning guidance.

11.4.1. Interorganizational Coordination. Participants may include U.S. and coalition military forces; U.S., state, or host nation government agencies; multinational partners; and private sector relief organizations. EMEDS personnel should understand the key organizations involved and their interrelationships, roles, and responsibilities, as well as formal coordination requirements, ROE, and reporting instructions.

11.4.2. Humanitarian Assistance Survey Team (HAST) Participation. The JFC may deploy a HAST to assess the situation and determine the appropriate response. The HAST should include a medical representative. An IHS representative from the regional health specialist team (FFHSR) may be tasked with this role. See AFI 44-162 for more information on IHS employment.

11.4.3. Cultural and Language Considerations. Cultural and language barriers may be an issue in providing medical triage and care. Medical providers may have limited access to effective interpreters. MAJCOMs and Component Numbered Air Forces (CNAFs) should consider basic language and cultural orientation for the medical staff before deployment.

11.4.4. Public Affairs Guidance. EMEDS commanders should be provided with public affairs guidance on theater and CCDR strategic themes and messages before departure from home station, if possible. All assigned personnel should follow active public affairs guidance. Communication on EMEDS capabilities should be realistic and specific. For

example, the AFMS is not organized, trained, equipped, or mobilized to treat medical conditions that require extended hospitalization or prolonged nursing care.

11.4.5. Patient Care Documentation and Records Disposition. Patient care documentation requirements for non-U.S. personnel (e.g., NGO personnel, partner nation forces) treated at an EMEDS facility is IAW State Department guidance, standardized treaties, and partner nation agreements. Patient care documentation and records disposition requirements for local nationals should be negotiated with the host nation. This documentation is typically paper-based so it can be shared with the host nation.

11.4.6. World Health Organization (WHO) Materiel. The EMEDS AS is designed to provide care for a predominately healthy active duty population and may not be appropriate for the host nation patient population. Providers should ensure that treatment options can be sustained locally. In emergent situations where there is no time to identify the regional availability of standard medications and supplies, medics and planners can use the WHO's recommended Essential Medicines List and Interagency Emergency Health Kit for guidance.

11.4.7. ECS/BOS Requirements. ECS/BOS requirements depend on operational conditions and mission directives. ECS/BOS requirements typically include airfield operations, security forces, CE, power production, transportation, and logistics support. The U.S. military is responsible for EMEDS site security and the protection of EMEDS personnel and equipment on and off site. A host nation may provide security augmentation or impose limitations on security operations outside the EMEDS area, as determined by agreements between the host nation and U.S. forces. Additional ECS/BOS requirements may include political advisory, judge advocate, civil affairs, linguist, and chaplain support. Attachment 8 provides the baseline ECS/BOS support requirements for EMEDS facilities.

11.5. Command Relationships. The State Department or the Office of U.S. Foreign Assistance (OFDA) within the U.S. Agency for International Development (USAID) is the U.S. government lead in foreign response. DOD military personnel operate under a military chain of command regardless of the lead agency. C2 typically resides under a joint force command structure where the EMEDS commander reports through a line chain of command or through the joint force surgeon. Specific C2 of medical operations is defined in the WARNORD, EXORD, or OPORD.

11.6. Standard of Care. Medics should apply U.S. medical standards when treating American forces. The medical ROE define the scope of care and triage guidelines for host nation patients based on the situation, other available health support capabilities, patient movement capabilities, and the host nation's request for support. Medical interventions typically are limited to procedures and therapies that are low risk, can be performed quickly, require limited follow-up, and do not undermine the host nation medical system.

11.7. Patient Movement. EMEDS may be employed with an ERPSS facility that can facilitate the intra-country movement of host nation patients. Due to Secretarial Designee status requirements, OCONUS host nation patients are not typically entered into the AE system for movement outside their nation.

11.8. Interoperability with Host Nation and Partner Providers. Healthcare professionals and volunteers from the host nation or other partner may assist EMEDS personnel in providing health support if they meet mutually agreed upon requirements for proof of credentials.

11.9. Blood Supply. Blood products are generally used for the direct support of military forces supporting the mission. EMEDS facilities should use DOD sourced or DOD collected blood products. If supply or resupply is not available from DOD sources, consult the AJBPO for direction. Blood policies for host nation patients should be IAW the medical ROE.

11.10. Property Donation. Serviceable medical equipment and supplies (Class VIII A medical materiel) may be made available to the host nation or NGOs IAW CCDR policy and direction. Property donations typically require coordination with logistics personnel, public affairs, legal, and the Defense Logistics Agency (DLA). Requests for property should be forwarded to the DOD for approval and funding authorization. Transfer and distribution of the property is the responsibility of the State Department IAW Title 10 United States Code (USC), Section 2557. Donated equipment or materiel should be appropriate and interoperable with host nation standards, maintainable by host nation capabilities and resources, and have a measurable positive impact on host nation health capacity.

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Surgeon General

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

- DOD 4500.9-R, *Defense Transportation Regulation (DTR), Part III, Mobility*, July 2011
- DOD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation*, 11 June 2004
- DODI 6490.03, *Deployment Health*, 11 August 2006
- DODM 5200.01, Volume 1, *DOD Information Security Program: Overview, Classification, and Declassification*, 24 February 2012
- JP 3-28, *Defense Support of Civil Authorities*, 31 July 2013
- JP 3-29, *Foreign Humanitarian Assistance*, 17 March 2009
- JP 4-02, *Health Service Support*, 26 July 2012
- Air Force Doctrine Volume 1, *Basic Doctrine*, 14 October 2011
- Air Force Doctrine Annex 4-02, *Medical Operations*, 21 June 2012
- AFH 44-152_IP, *Armed Services Blood Program Joint Blood Program Handbook*, 1 December 2011
- AFI 10-204, *Participation in Joint and National Exercises*, 21 April 2010
- AFI 10-206, *Operational Reporting*, 6 September 2011
- AFI 10-245, *Antiterrorism (AT)*, 21 September 2012
- AFI 10-403, *Deployment Planning and Execution*, 20 September 2012
- AFI 10-701, *Operations Security (OPSEC)*, 8 June 2011
- AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, 24 January 2007
- AFI 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*, 18 May 2010
- AFI 21-201, *Conventional Munitions Maintenance Management*, 7 March 2012
- AFI 24-203, *Preparation and Movement of Air Force Cargo*, 2 November 2010
- AFI 24-301, *Vehicle Operations*, 1 November 2008
- AFI 31-101, *Integrated Defense*, 8 October 2009
- AFI 31-117, *Arming and Use of Force by Air Force Personnel*, 29 June 2012
- AFI 31-304_IP, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees*, 1 October 1997
- AFI 31-401, *Information Security Program Management*, 1 November 2005
- AFI 33-115V1, *Network Operations (NETOPS)*, 24 May 2006
- AFI 33-115V2, *Licensing Network Users and Certifying Network Professionals*, 14 April 2004
- AFI 33-200, *Information Assurance (IA) Management*, 23 December 2008
- AFI 33-210, *Air Force Certification and Accreditation (C&A) Program (AFCAP)*, 20 September 2012

AFI 33-332, *Air Force Privacy Program*, 16 May 2011

AFI 33-364, *Records Disposition – Procedures and Responsibilities*, 22 December 2006

AFI 33-580, *Spectrum Management*, 17 January 2013

AFI 34-242, *Mortuary Affairs Program*, 2 April 2008

AFI 36-2226, *Combat Arms Program*, 24 February 2009

AFI 41-106, *Medical Readiness Program Management*, 1 July 2011

AFI 41-201, *Managing Clinical Engineering Programs*, 25 March 2003

AFI 41-209, *Medical Logistics Support*, 30 June 2006

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, 6 June 2012

AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, 20 August 2003

AFI 44-108, *Infection Prevention and Control Program*, 1 March 2012

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

AFI 44-162, *International Health Specialist (IHS) Program*, 7 July 2011

AFI 48-101, *Aerospace Medicine Enterprise*, 19 October 2011

AFI 90-1601, *Air Force Lessons Learned Program*, 22 September 2010

AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Environment*, 7 July 2011

AFMAN 24-204_IP, *Preparing Hazardous Materials for Military Air Shipments*, 3 December 2012

AFMAN 31-229, *USAF Weapons Handling Manual*, 12 May 2004

AFMAN 33-282, *Computer Security (COMPUSEC)*, 27 March 2012

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

AFMAN 44-144, *Nutritional Medicine*, 29 June 2011

AFFD 33-3, *Information Management*, 8 September 2011

AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System*, 5 October 2011

AFTTP 3-42.22, *Contagious Casualty Management*, 7 May 2007

AFTTP 3-42.23, *Preventive and Aerospace Medicine (PAM) Team*, 22 February 2006

AFTTP 3-42.33, *Expeditionary Medical Decontamination Team*, 7 April 2005

AFTTP 3-42.34, *Air Force Radiation Assessment Team (AFRAT)*, 19 September 2007

AFTTP 3-42.73, *Air Force Forces Surgeon (AFFOR/SG) Staff Support*, 4 February 2010

AFTTP 3-42.74, *Surgical Subspecialty Teams*, 30 November 2009

AFTTP 3-42.75, *Medical Pediatrics Team*, 3 December 2007

AFTTP 3-42.76, *Medical Ancillary Augmentation Teams*, 25 June 2010

AFTTP 3-42.78, *Medical Behavioral Health Teams*, 27 September 2007

AFTTP 3-42.711, *Blood Support Operations*, 19 April 2013

FM 4-02.7/MCRP 4-11.1/NTTP 4-02.7/AFTTP 3-42.3, *Multiservice Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*, July 2009

Academy of Nutrition and Dietetics, *Nutrition Care Manual (NCM)* [online publication]
Air Combat Command Concept of Operations for the Air Transportable Clinic (ATC), 15 October 2003
Air Force Deployed Patient Safety Program Guide, 21 March 2013
Air Force Medical Service Concept of Operations for the Biological Augmentation Team (BAT), 14 July 1999
Air Force Medical Service Concept of Operations for the Biomedical Equipment Maintenance Team, 1 March 2003
Air Force Medical Service Concept of Operations for the Critical Care and Critical Care Augmentation Teams, 21 April 2000
Air Force Medical Service Concept of Operations for the Medical Nuclear, Biological, and Chemical (MNBC) Defense Team, 2 October 2002
Air Force Medical Service Concept of Operations for the Medical Systems Augmentation Team, 19 January 2000
Air Force Medical Service Concept of Operations for the Theater Epidemiology Team, 1 October 1999
Integrated Logistics Support Plan (ILSP) for United States Air Force Medical Equipment War Reserve Materiel (WRM) Information Management/Information Technology (IM/IT), October 2011
Operation and Maintenance Manual for the Collectively Protected Expeditionary Medical Support (CP-EMEDS)/AFTH, 10 September 2002
 USNORTHCOM CONPLAN 3500, *CBRN Response*, 17 August 2011
War and Mobilization Plan, Volume 1 (WMP-1), Air Force Medical Service (AFMS) Supplement, 2 May 2012

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*, 22 September 2009
 AF Form 3899, *Aeromedical Evacuation Patient Record*, 19 August 2006
 DD Form 602, *Patient Evacuation Tag*, February 1963

Acronyms and Abbreviations

ACC—Air Combat Command
ACLS—Advanced Cardiac Life Support
ADCON—Administrative Control
ADVON—Advanced Echelon
AE—Aeromedical Evacuation
AEF—Air Expeditionary Force
AEG—Air Expeditionary Group
AETF—Air Expeditionary Task Force
AEW—Air Expeditionary Wing
AF—Air Force

AFB—Air Force Base
AFCAP—Air Force Certification and Accreditation Program
AFDD—Air Force Doctrine Document
AFFOR—Air Force Forces
AFH—Air Force Handbook
AFI—Air Force Instruction
AFMAN—Air Force Manual
AFMLOC—Air Force Medical Logistics Operations Center
AFMS—Air Force Medical Service
AFPAM—Air Force Pamphlet
AFPD—Air Force Policy Directive
AFRAT—Air Force Radiation Assessment Team
AFRC—Air Force Reserve Command
AFSC—Air Force Specialty Code
AFTH—Air Force Theater Hospital
AFTTP—Air Force Tactics, Techniques, and Procedures
AHLTA-T—Armed Forces Health Longitudinal Technology Application – Theater
AJBPO—Area Joint Blood Program Office
AMC—Air Mobility Command
ANG—Air National Guard
AOR—Area of Responsibility
AS—Allowance Standard
ASIMS—Aeromedical Services Information Management System
ATC—Air Transportable Clinic
ATH—Air Transportable Hospital
ATLS—Advanced Trauma Life Support
BAT—Biological Augmentation Team
BE—Bioenvironmental Engineering
BEAR—Basic Expeditionary Airfield Resources
BLOS—Beyond Line of Sight
BLS—Basic Life Support
BMET—Biomedical Equipment Technician
BOS—Base Operating Support
C2—Command and Control
C2CRE—Command and Control CBRN Response Element
CBRN—Chemical, Biological, Radiological, and Nuclear
CBRNE—Chemical, Biological, Radiological, Nuclear, and High-Yield Explosives
CCATT—Critical Care Air Transport Team
CCDR—Combatant Commander
CDA—Corporate Dental Application
CDR—Clinical Data Repository
CDRUSNORTHCOM—Commander, United States Northern Command
CDRUSPACOM—Commander, United States Pacific Command
CE—Civil Engineer
CERFP—CBRNE Enhanced Response Force Package
CHCS—Composite Health Care System

CNAF—Component Numbered Air Force
COMAFFOR—Commander, Air Force Forces
COMPUSEC—Computer Security
COMSEC—Communications Security
CONOPS—Concept of Operations
CONPLAN—Concept Plan
CONUS—Continental United States
CP—Collectively Protected, Collective Protection
CP-EMEDS—Collectively Protected Expeditionary Medical Support
CQA—Clinical Quality Assurance
CQM—Clinical Quality Management
CRG—Contingency Response Group
CRPL—CBRN Response Posture Level
CSDC—Consolidated Storage and Deployment Center
CT—Computed Tomography
CWDE—Chemical Warfare Defense Ensemble
DBSS—Defense Blood Support System
DCC—Deployment Control Center
DCRF—Defense CBRN Response Force
DD—Department of Defense (form)
DEPORD—Deployment Order
DIMO—Defense Institute for Medical Operations
DIRMOBFOR—Director of Mobility Forces
DLA—Defense Logistics Agency
DMLSS—Defense Medical Logistics Standard Support
DMRTI—Defense Medical Readiness Training Institute
DOD—Department of Defense
DODAAC—DOD Activity Address Code
DODI—Department of Defense Instruction
DODM—Department of Defense Manual
DOEHRS—Defense Occupational and Environmental Health Readiness System
DOGS—Deployable Oxygen Generation System
DR—Disaster Relief
DRRS—Defense Readiness Reporting System
DSCA—Defense Support of Civil Authorities
DSOE—Deployment Schedule of Events
DTR—Defense Transportation Regulation
ECIM—Expanded Capability and Infrastructure Module
ECG—Electrocardiogram
ECS—Expeditionary Combat Support
ECU—Environmental Control Unit
EHR—Electronic Health Record
EM—Emergency Management
EMDG—Expeditionary Medical Group
EMEDS—Expeditionary Medical Support
EML—Expeditionary Medical Logistics

EMS—Emergency Medical Service
ENT—Ear, Nose, and Throat (Otorhinolaryngology)
EOG—Expeditionary Operations Group
EPW—Enemy Prisoner of War
ER—Emergency Room
ERPSS—En Route Patient Staging System
EXORD—Execution Order
FEMA—Federal Emergency Management Agency
FES—Fire Emergency Services
FFP—Fresh Frozen Plasma
FM—Field Manual
FOC—Full Operational Capability
FY—Fiscal Year
GRL—Global Reach Laydown
GYN—Gynecology
HA—Humanitarian Assistance
HAST—Humanitarian Assistance Survey Team
HIPAA—Health Insurance Portability and Accountability Act
HMEP—Hospital Medical Expansion Package
HRF—Homeland Response Force
HRT—Health Response Team
HSEP—Hospital Surgical Expansion Package
HUMRO—Humanitarian Relief Operation
HVAC—Heating, Ventilation, Air Conditioning
IA—Information Assurance
IAW—In Accordance With
IBT—Immunizations Backup Technician
ICTB—Interfacility Credentials Transfer Brief
ICU—Intensive Care Unit
IDMT—Independent Duty Medical Technician
IHS—International Health Specialist
ILS—Integrated Logistics Support
ILSP—Integrated Logistics Support Plan
IM—Information Management
IOC—Initial Operational Capability
IPE—Individual Protective Equipment
IT—Information Technology
JFC—Joint Force Commander
JMET—Joint Mission Essential Task
JMETL—Joint Mission Essential Task List
JOMMC—Joint Operations Medical Managers Course
JP—Joint Publication
JTF—Joint Task Force
JTIMS—Joint Training Management Information System
JTRS—Joint Tactical Radio System
KX—Knowledge Exchange

LAF—Line of the Air Force
LAN—Local Area Network
LIMFAC—Limiting Factor
LMR—Land Mobile Radio
LOAC—Law of Armed Conflict
LOS—Line of Sight
LRRC—Loan Repair & Return Center
MAJCOM—Major Command
MCC—Medical Control Center
MCRP—Marine Corps Reference Publication
MEDEVAC—Medical Evacuation
MEFPAK—Manpower and Equipment Force Packaging
MERC—Medical Equipment Repair Center
MET—Mission Essential Task
METL—Mission Essential Task List
MFST—Mobile Field Surgical Team
MHE—Material Handling Equipment
MHS—Military Health System
MISCAP—Mission Capability
MOST—Mobile Oxygen Storage Tank
MRA—MEFPAK Responsible Agency
MRDSS—Medical Readiness Decision Support System
MRL—Medical Resource Letter
MSAT—Medical Situational Awareness in the Theater
MTF—Medical Treatment Facility
NCC—Network Control Center
NCM—Nutrition Care Manual
NCMI—National Center for Medical Intelligence
NETOPS—Network Operations
NGB—National Guard Bureau
NGO—Non-Government Organization
NIPRNET—Non-Secure Internet Protocol Router Network
NOSC—Network Operation and Security Center
NPSG—National Patient Safety Goals
NRF—National Response Framework
NTTP—Navy Tactics, Techniques, and Procedures
OB—Obstetrics
OCONUS—Outside the Continental United States
OCP—Operational Capability Package
OEF—Operation ENDURING FREEDOM
OEH—Occupational and Environmental Health
OEHSA—Occupational and Environmental Health Site Assessment
OFDA—Office of U.S. Foreign Assistance
OIF—Operation IRAQI FREEDOM
OPCON—Operational Control
OPLAN—Operation Plan

OPORD—Operation Order
OPR—Office of Primary Responsibility
OPSEC—Operations Security
ORE—Operational Readiness Exercise
OSI—Office of Special Investigations
PACAF—Pacific Air Forces
PACS—Picture Archiving and Communication System
PAM—Preventive and Aerospace Medicine
PAR—Population at Risk
PDP—Power Distribution Panel
PERSCO—Personnel Support for Contingency Operations
PF24—Plasma Frozen within 24 Hours
PMI—Patient Movement Items
PMITS—Patient Movement Items Tracking System
PMRC—Patient Movement Requirements Center
POL—Petroleum, Oils, and Lubricants
PPE—Personal Protective Equipment
PRBC—Packed Red Blood Cells
RBC—Red Blood Cells
RDS—Records Disposition Schedule
ROE—Rules of Engagement
ROWPU—Reverse Osmosis Water Purification Unit
RSVP—Readiness Skills Verification Program
SABC—Self-Aid and Buddy Care
SDC—Standard Desktop Configuration
SEI—Special Experience Identifier
SG—Surgeon General, Surgeon
SGP—Chief of Aerospace Medicine
SIMLM—Single Integrated Medical Logistics Management
SIPRNET—Secret Internet Protocol Router Network
SITREP—Situation Report
SME—Squadron Medical Element
SOF—Special Operations Forces
SOFA—Status of Forces Agreement
SPD—Sterile Processing Department
SRTS—Spectacle Request Transmission System
TC2—TMIP CHCS Cache
TCP—Transmission Control Protocol
TLAMM—Theater Lead Agent for Medical Materiel
TMDS—Theater Medical Data Store
TMIP-AF—Theater Medical Information Program-Air Force
TPFDD—Time-Phased Force Deployment Data
TRAC2ES—Transportation Command Regulating and Command and Control Evacuation System
TSE—Tactical Security Element
TTP—Tactics, Techniques, and Procedures

UDP—User Datagram Protocol
UN—United Nations
USAF—United States Air Force
USAID—U.S. Agency for International Development
USC—United States Code
USNORTHCOM—United States Northern Command
USPACOM—United States Pacific Command
USTRANSCOM—United States Transportation Command
UTA—Unit Type Code Availability
UTC—Unit Type Code
WARNORD—Warning Order
WDS—Water Distribution System
WHO—World Health Organization
WMD-CST—Weapons of Mass Destruction-Civil Support Team
WMP—War and Mobilization Plan
WRM—War Reserve Materiel

Attachment 2

EMEDS INCREMENTS AND CORRESPONDING UTCs

Personnel		FFEP4 (23 people)
Equipment		FFEP5 (5 people)
Operation-Dependent Personnel or Equipment		FFF0C (2 people)
		FF0X2 (AS 903A)
		FFEE3 (AS 938C)
	FFEP3 (24 people)	EMEDS+10 Platform
	FFPM3 (3 people)	
	FF0X2 (AS 903A)	
	FFEE2 (AS 938B)	
FFEP1 (3 people)	EMEDS HRT Platform	EMEDS HRT Platform
FFEP2 (6 people)		
FFEP6 (7 people)		
FFF0C (2 people)		
FFMFS (5 people)		
FFPM1 (4 people)		
FFPCM (primary care) or FFDAB (flight medicine) (3 people)		
† FFPM2 (2 people)		
* FFHSR (1 person)		
* FFP01 (7 people)		
FFEPE (AS 938J)		
FFHR1 (AS 938P)		
FFMF1 (AS 938G)		
FFPM4 (AS 916E)		
FFPM5 (AS 916F)		
* FFP0E (AS 917R)		
EMEDS HRT 5 tents, 17,000 sq ft 40 personnel 10 pallets	EMEDS+10 8 tents, 26,000 sq ft 67 total personnel 21 pallets	EMEDS+25 11 tents, 40,000 sq ft 97 total personnel 28 pallets
† Typically added to support combat operations		
* Typically added to support HA/DR operations		

Attachment 3

58-BED AFTH BUILDUP (NOTIONAL)

UTC	Title	Personnel	Reference
Ambulance Services		Total: 13	
FFGLE	AFTH Ambulance Team	13	Mission Capability (MISCAP) statement
FFAMB (x2)	Ambulance Supply Package		MISCAP
Ancillary Services		Total: 15	
FFANC	Ancillary Services Augmentation	9	AFTTP 3-42.76, <i>Medical Ancillary Augmentation Teams</i>
FFAN1	Ancillary Equipment		AFTTP 3-42.76
FFD0T	Optometry Augmentation Team	2	AFTTP 3-42.76
FFD01	Optometry Augmentation Equipment		AFTTP 3-42.76
FFHA4	CT Scan Team	2	AFTTP 3-42.76
FFHAG	CT Scan Equipment		AFTTP 3-42.76
FFRAD	Radiology Team	2	AFTTP 3-42.76
FFRA5	Radiology Equipment		AFTTP 3-42.76
Blood Support		Total: 6	
FFLBB	Expeditionary Blood Support Center Team	6	AFTTP 3-42.711, <i>Blood Support Operations</i>
FFLB1	Expeditionary Blood Support Center Equipment		AFTTP 3-42.711
Critical Care Expansion		Total: 20	
FFCCU	4-Bed Intensive Care Unit (ICU)	12	<i>Critical Care CONOPS</i>
FFCCV	4-Bed Critical Care Expansion Team	8	<i>Critical Care CONOPS</i>
FFCC1 (x2)	Critical Care Equipment		<i>Critical Care CONOPS</i>
Dental Augmentation		Total: 4	
FFF0C (x2)	Dental Team	4	Chapter 2
FFF0E	Dental Equipment		MISCAP
Emergency Medicine Expansion		Total: 4	
FFEDT	Emergency Medicine Team	2	MISCAP
Infectious Disease Control		Total: 3	
FFHA2	Infectious Disease Team	3	AFTTP 3-42.22
FFHAF	Infectious Disease Equipment		AFTTP 3-42.22
Medical Ward Expansion		Total: 26	
FFEW1	HMEP Personnel	26	MISCAP
FFEEW	HMEP Equipment		MISCAP
Surgical Expansion and Subspecialties		Total: 38	

UTC	Title	Personnel	Reference
FFEST	HSEP Personnel	20	AFTTP 3-42.74, <i>Surgical Subspecialty Teams</i>
FFEES (x2)	HSEP Equipment		AFTTP 3-42.74
FFENT	ENT Team	2	AFTTP 3-42.74
FFET1	ENT Equipment		AFTTP 3-42.74
FFEYE	Ophthalmology Team	2	AFTTP 3-42.74
FFEY1	Ophthalmology Equipment		AFTTP 3-42.74
FFGKT	Thoracic/Vascular Surgical Team	3	AFTTP 3-42.74
FFGKQ	Thoracic/Vascular Equipment		AFTTP 3-42.74
FFGYN	OB/GYN Team	5	AFTTP 3-42.74
FFGY1	OB/GYN Equipment		AFTTP 3-42.74
FFMAX	Oral Surgery Team	2	AFTTP 3-42.74
FFMA1	Oral Surgery Equipment		AFTTP 3-42.74
FFNEU	Neurosurgical Team	2	AFTTP 3-42.74
FFNE1	Neurosurgical Equipment		AFTTP 3-42.74
FFPPT	Urology Team	2	AFTTP 3-42.74
FFPP1	Urology Equipment		AFTTP 3-42.74
FFSOR	Orthopedics Augmentation Team	2	AFTTP 3-42.74
FFSPH	Surgical Physician Assistant Augmentation	1	AFTTP 3-42.74
FFSPL	Plastic Surgeon Augmentation	1	AFTTP 3-42.74
FFSTR	Trauma System Support Team	2	AFTTP 3-42.74
FFSU3	Surgery Team 3	3	MISCAP
Pediatrics		Total: 17	
FFPED	Pediatric Augmentation	8	AFTTP 3-42.75, <i>Medical Pediatrics Team</i>
FFPE1	Pediatric Equipment		AFTTP 3-42.75
Therapy Services		Total: 4	
FFT0T	Occupational Therapist	1	MISCAP
FFTPT	Physical Therapy Team	3	MISCAP
Medical Command and Administration		Total: 6	
FFAAT	Medical Management Augmentation	6	MISCAP
Medical Logistics		Total: 5	
FFBMM	Biomedical Equipment Maintenance Team	3	<i>Biomedical Equipment Maintenance Team CONOPS</i>
FFLG1	Medical Logistics Manpower Augmentation	2	<i>Medical Materiel Manpower Team CONOPS</i>
Information Systems		Total: 3	
FFSYS	Information Systems Augmentation	3	<i>Medical Systems Augmentation Team CONOPS</i>
		Total Augmentation: 164 Plus EMEDS+25: 97	

UTC	Title	Personnel	Reference
		Total AFTH: 261	
Note: An AFTH is built on an EMEDS+25. Referenced AFTTPs are available on the AFMS KX at https://kx2.afms.mil/kj/kx3/Doctrine/Pages/home.aspx .			

Attachment 4

ADDITIONAL AUGMENTATION UTCs

UTC	Title	Reference
AFFOR/SG Staff Support		
FFSGQ	AFFOR Medical Staff 1	AFTTP 3-42.73, <i>Air Force Forces Surgeon (AFFOR/SG) Staff Support</i>
FFSGT	AFFOR Medical Staff 2	AFTTP 3-42.73
CBRN Response		
FFBAT	Biological Augmentation Team (BAT)	<i>Air Force Medical Service Concept of Operations for the Biological Augmentation Team (BAT)</i>
FFBA1	BAT Equipment	<i>Air Force Medical Service Concept of Operations for the Biological Augmentation Team (BAT)</i>
FFGL1	Medical Nuclear, Biological, Chemical (MNBC) Defense Team	<i>Air Force Medical Service Concept of Operations for the Medical Nuclear, Biological, and Chemical (MNBC) Defense Team</i>
FFGL7	MNBC Equipment	<i>Air Force Medical Service Concept of Operations for the Medical Nuclear, Biological, and Chemical (MNBC) Defense Team</i>
FFGLB	Patient Decontamination Team	AFTTP 3-42.33
FFGLC	Patient Decontamination Equipment	AFTTP 3-42.33
FFRN1	AFRAT Crisis ADVON Team	AFTTP 3-42.34, <i>Air Force Radiation Assessment Team</i>
FFRN2	AFRAT Surveillance Team	AFTTP 3-42.34
FFRN3	AFRAT Surveillance Augmentation Team	AFTTP 3-42.34
FFRND	AFRAT Surveillance Augmentation Equipment	AFTTP 3-42.34
FFRN4	AFRAT Lab Team	AFTTP 3-42.34
FFRN5	AFRAT Lab Augmentation Team	AFTTP 3-42.34
FFRNB	AFRAT Lab Augmentation Equipment	AFTTP 3-42.34
FFRN6	AFRAT Dosimetry Team	AFTTP 3-42.34
FFRN7	AFRAT Dosimetry Augmentation Team	AFTTP 3-42.34
FFRNC	AFRAT Dosimetry Equipment	AFTTP 3-42.34
Contagious Casualty Management		
FFCCM	Contagious Casualty Management Equipment	AFTTP 3-42.22
FFHA2	Infectious Disease Team	AFTTP 3-42.22
Dental Clinic (Standalone)		

UTC	Title	Reference
FFF0C (x2)	Dental Team	Chapter 2
FFF0E	Dental Equipment	MISCAP
Epidemiology		
FFHA1	Theater Epidemiology Team	<i>Theater Epidemiology CONOPS</i>
FFHAE	Theater Epidemiology Equipment	<i>Theater Epidemiology CONOPS</i>
Mental Health		
FFBH1	Rapid Response Team, Psychology	AFTTP 3-42.78, <i>Medical Behavioral Health Teams</i>
FFBH2	Rapid Response Team, Social Work	AFTTP 3-42.78
FFBH3	Rapid Response Team, Psychiatry	AFTTP 3-42.78
FFBH4	Rapid Response Team, Nurse Practitioner	AFTTP 3-42.78
FFBH5	Rapid Response Team, Enlisted	AFTTP 3-42.78
FFBHE	Behavioral Health Equipment	AFTTP 3-42.78
FFBHS	Rapid Response Small Equipment	AFTTP 3-42.78
Additional Expansion (25-Bed Increments)		
FFEW1	HMEP Team 1	MISCAP
FFEW2	HMEP Team 2	MISCAP
FFEEW	HMEP Equipment	MISCAP
<p>Note: Referenced AFTTPs are available on the AFMS KX at https://kx2.afms.mil/kj/kx3/Doctrine/Pages/home.aspx.</p>		

Attachment 5

EMEDS HRT LABORATORY CAPABILITY

EMEDS HRT Laboratory Capability	
Blood Gases	Potential Hydrogen (pH), Carbon Dioxide Partial Pressure (PCO ₂), Oxygen Partial Pressure (PO ₂), Total Carbon Dioxide (TCO ₂), Bicarbonate (HCO ₃), Base Excess (BE), Sulfur Dioxide (SO ₂)
Chemistries/Electrolytes	Glucose (Glu), Sodium (Na), Potassium (K), Ionized Calcium (iCa)
Hematology	Hematocrit (Hct), Hemoglobin (Hgb)
Emergency Transfusion Capability	No ABO/Rh or crossmatch capabilities Up to 50 units of Group O PRBC only (type-specific not available) Emergency whole blood collection (Pre-screened Walking Donor Program required; consult theater JBPO)
Urine Based Analyses	Beta Human Chorionic Gonadotropin (BHCG) Drug Screen (Qualitative): Phencyclidine (PCP), Benzodiazepines (BENZO), Cocaine (COC), Amphetamine (AMP), Tetrahydrocannabinol (THC), Opiates (OPI), Barbiturates (BARB), Tricyclic Antidepressants (TCA) Urine or Saliva Ethyl Alcohol: Qualitative Kit Urinalysis, (Macroscopic Only, No Centrifuge): Test Glucose, Bilirubin, Ketone, Specific Gravity, Blood, PH, Protein, Urobilinogen, Nitrite, Leukocytes
Cardiac Analyses	Cardiac Troponin I, Creatine Kinase Muscle and Brain (CK-MB), Myoglobin
Miscellaneous Analyses	KOH Preps, Direct Preps Occult Blood Monospots D-Dimer Rapid Strep

Note: Lab testing at the EMEDS HRT level is limited to waived and moderate complexity testing to include provider performed microscopy.

Attachment 6

EMEDS+10 LABORATORY CAPABILITY

EMEDS+10 Laboratory Capability	
Blood Gases	Potential Hydrogen (pH), Carbon Dioxide Partial Pressure (PCO ₂), Oxygen Partial Pressure (PO ₂), Total Carbon Dioxide (TCO ₂), Bicarbonate (HCO ₃), Base Excess (BE), Sulfur Dioxide (SO ₂)
Chemistries/Electrolytes	Glucose (Glu), Sodium (Na), Potassium (K), Ionized Calcium (iCa), Chloride (Cl), Anion Gap, Urea Nitrogen (BUN), Creatinine (Crea)
Hematology	<p>White Blood Cells (WBC): Neutrophils NE%/NE#, Lymphocytes LY%/LY#, Monocytes MO%/MO#, Eosinophils EO%/EO#, Basophils BA%/BA#, Alanine Aminotransferase ATL%, ATL#, Immobilization IMM%, IMM#</p> <p>Red Blood Cells: Hemoglobin (HGB), Hematocrit (HCT), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), RBC Distribution Width (RDW)</p> <p>Platelet: Mean Platelet Volume (MPV), Plateletcrit (PCT), Platelet Distribution Width (PDW)</p>
Urine Based Analyses	<p>Beta Human Chorionic Gonadotropin (BHCG)</p> <p>Drug Screen(Qualitative): Phencyclidine (PCP), Benzodiazepines (BENZO), Cocaine (COC), Amphetamine (AMP), Tetrahydrocannabinol (THC), Opiates (OPI), Barbiturates (BARB), Tricyclic Antidepressants (TCA)</p> <p>Urine or Saliva Ethyl Alcohol: Qualitative Kit</p> <p>Urinalysis (Microscopic and Macroscopic Test): Glucose, Bilirubin, Ketone, Specific Gravity, Blood, PH, Protein, Urobilinogen, Nitrite, Leukocytes</p>
Cardiac Analyses	Cardiac Troponin I; Creatine Kinase Muscle

	and Brain (CK-MB), Myoglobin
Limited Blood Banking Capability	ABO/Rh and abbreviated crossmatch capabilities No antibody identification or antigen typing Mixed group/type PRBC (up to 50 units) FFP (limited quantities) storage and thawing Emergency whole blood collection (Pre-screened Walking Donor Program required; consult theater JBPO)
Coagulation Tests	ProThrombin Time (PT), Partial Thromboplastin Time (PTT)
Miscellaneous Analyses	Fibrin Degradation Products/D-Dimer (from EMEDS HRT) KOH Preps, Direct Preps, Rapid Strep Occult Blood Monospots Malaria, Thick and Thin Smears Grams Stain Cell Counts, Cerebral Spinal Fluid, Other Fluids and Aspirates

Attachment 7

EMEDS+25 LABORATORY CAPABILITY

EMEDS+25 Laboratory Capability	
Microbiology	Throat, Urine, Wound, Blood, Skin, Stool, Sputum, Urethral, Eye, Nasal, and Cerebrospinal Fluid Cultures; Basic Identification and Sensitivities; Ova and Parasitic Concentration and ID/Trichrome Staining for Protozoa Anaerobic Culture, Very Basic; Growth and Grams Stain, No ID
Chemistry	Glucose (Glu), Sodium (Na), Potassium (K), Ionized Calcium (iCa), Chloride (Cl), Anion Gap, Alkaline Phosphatase (ALP), Alanine Aminotransferase (ALT), Aspartate Aminotransferase (AST), Amylase (AMY), Albumin (ALB), Total Protein (TP), Total Bilirubin (TBIL), Urea Nitrogen (BUN), Creatinine (CRE), Calcium (CA), Glucose (GLU), Uric Acid (UA), Gamma Glutamyl Transferase (GGT)
Cardiac Analyses	Cardiac Troponin I, Creatine Kinase Muscle and Brain (CK-MB), Myoglobin
Complete Blood Count	White Blood Cells (WBC): Neutrophils NE%/NE#, Lymphocytes LY%/LY#, Monocytes MO%/MO#, Eosinophils EO%/EO#, Basophils BA%/BA#, Alanine Aminotransferase ATL%, ATL#, Immobilization IMM%, IMM# Red Blood Cells: Hemoglobin (HGB), Hematocrit (HCT), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), RBC Distribution Width (RDW) Platelet: Mean Platelet Volume (MPV), Plateletcrit (PCT), Platelet Distribution Width (PDW)
Coagulation Tests	ProThrombin Time (PT), Partial Thromboplastin Time (PTT)
Urine Based Analyses	Beta Human Chorionic Gonadotropin (BHCG) Drug Screen (Qualitative): Phencyclidine

	<p>(PCP), Benzodiazepines (BENZO), Cocaine (COC), Amphetamine (AMP), Tetrahydrocannabinol (THC), Opiates (OPI), Barbiturates (BARB), Tricyclic Antidepressants (TCA)</p> <p>Urine or Saliva Ethyl Alcohol: Qualitative Kit</p> <p>Urinalysis (Microscopic and Macroscopic Test): Glucose, Bilirubin, Ketone, Specific Gravity, Blood, PH, Protein, Urobilinogen, Nitrite, Leukocytes</p>
Limited Blood Banking Capability	<p>ABO/Rh and abbreviated crossmatch capabilities</p> <p>No antibody identification or antigen typing</p> <p>Mixed group/type PRBC (up to 50 units)</p> <p>FFP (limited quantities) storage and thawing</p> <p>Cryo and PLTS (limited quantities, if available in theater)</p> <p>Emergency whole blood collection (Pre-screened Walking Donor Program required; consult theater JBPO)</p>
Miscellaneous Analyses	<p>Fibrin Degradation Products/D-Dimer (from EMEDS HRT)</p> <p>KOH Preps, Direct Preps</p> <p>Occult Blood</p> <p>Monospots</p> <p>Rapid Strep</p> <p>Malaria, Thick and Thin</p> <p>Grams Stain</p> <p>Cell Counts, Cerebral Spinal Fluid, Other Fluids and Aspirates</p>

Note: See AFTTP 3-42.76 for more information on the ancillary laboratory specialty set for AFTHs.

Attachment 8

EXPEDITIONARY COMBAT SUPPORT (ECS) REQUIREMENTS

EMEDS ECS REQUIREMENTS				
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.				
	EMEDS HRT	EMEDS+10	EMEDS+25	AFTH
MOVEMENT REQUIREMENTS				
Calculations IAW AFPAM 10-1403 and DTR 4500.9-R, Part III				
Pallets (#)	10	21	28	104
C-27 (# aircraft)	4	7	10	35
C-130 (# aircraft)	2	4	5	18
C-17 (# aircraft)	1	2	2	6
C-5A (# aircraft)	1	1	1	3
M871 (# flatbed semitrailers)	4	7	10	35
M872 (# flatbed semitrailers)	2	5	6	21
SITE PREPARATION				
Square Footage (slight grade required)	17,000	26,000	40,000	62,000
Tents (#)	5	8	11	23 (plus 6 ISOs)
ECUs (# units)	5	8	11	29
Note: CE maintenance support is required for generator and ECU equipment.				
BASIC EXPEDITIONARY AIRFIELD RESOURCES (BEAR) REQUIREMENTS				
Latrine/Shower (# staff and patients)	44	77	122	318
# Staff	40	67	97	260
# Patients	4	10	25	58
Billeting (# personnel)	40	67	97	260
# Officer	21	29	42	115
# Enlisted	19	38	55	145
Meals (meals/day, staff and patients) (= 3 meals/day)	132	231	366	954
Staff (meals/day)	120	201	291	780
Patients (meals/day)	12	30	75	174
Laundry (lbs/week, staff and patients) (= 32 lbs/person/week)	1,408	2,464	3,904	10,176

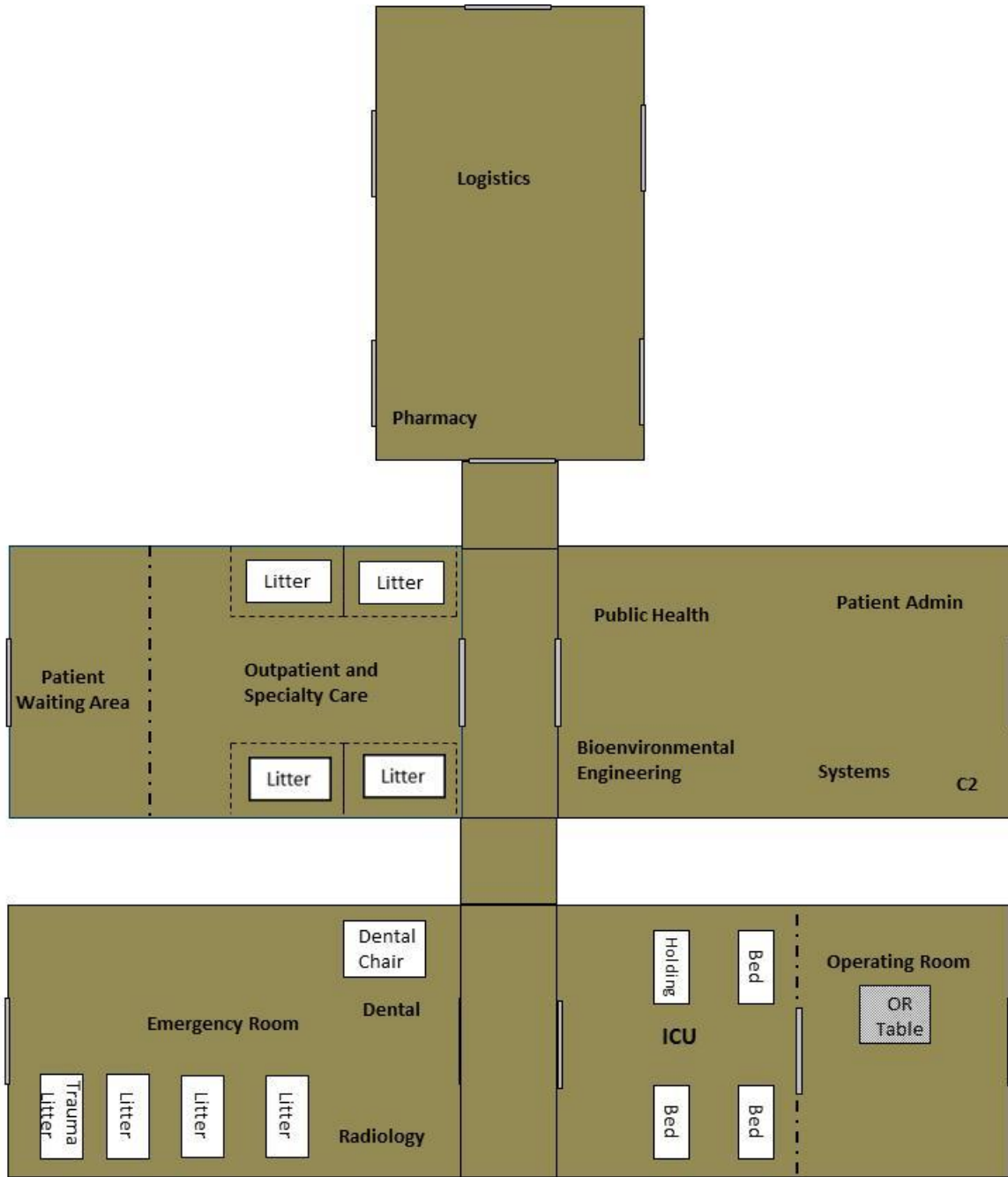
EMEDS ECS REQUIREMENTS				
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.				
	EMEDS HRT	EMEDS+10	EMEDS+25	AFTH
Ice (lbs/day, staff and patients) (= 4.4 lbs/person/day)	193.6	338.8	536.8	1,399.2
Staff (lbs/day)	176	294.8	426.8	1,144
Patients (lbs/day)	17.6	44	110	255.2
Potable Water (gal/day) (= # staff x 10 gal/day) + (# patients x 65 gal/day)	660	1,320	2,595	6,370
Staff (gal/day) (= # staff x 10 gal/day)	400	670	970	2,600
Patients (gal/day) (= # patients x 65 gal/day)	260	650	1,625	3,770
Power (kW) (3-phase)	75	125	200	550
Power with CP-EMEDS (kW) (3-phase)	100*	200	400	750
*Note: CP for EMEDS HRT is available only for the Alaska shelter system.				
CIVIL ENGINEERING REQUIREMENTS				
Medical/Biohazard Waste				
Liquid (gal/day, staff and patients) (= 0.7 x potable water rate)	462	868	1,761	4,459
Staff (gal/day)	280	413	623	1,820
Patients (gal/day)	182	455	1,138	2,639
Solid (lbs/day, staff and patients) (= 4 lbs x # people)	176	276	456	1,272
Staff (lbs/day)	160	236	356	1,040
Patients (lbs/day)	16	40	100	232
LOGISTICS REQUIREMENTS				
POL				
Diesel Fuel (gal/day) (=8.33 gal/hr x 24hrs)		400	400	2,000
Diesel Fuel, CP-EMEDS Mode (gal/day)		550	600	2,500
Unleaded Fuel (gal/day) (10kW backup generator)	60	60	60	60

EMEDS ECS REQUIREMENTS				
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.				
	EMEDS HRT	EMEDS+10	EMEDS+25	AFTH
Vehicles				
Vehicle Maintenance Support	Required for all			
Vehicle Requirements	UFMBJ: 1, 4x4 Pickup Truck	UFMBJ: 1, 4x4 Pickup Truck UFM82: 1, 4x2 Ambulance UFM83:1, 4x4 Ambulance UFMT4: 1, 2.5 Ton Cargo Truck UFMV2: 1, Mobile Water Trailer	UFMBJ: 1, 4x4 Pickup Truck UFM82: 1, 4x2 Ambulance UFM83: 1, 4x4 Ambulance UFMT4: 1, 2.5 Ton Cargo Truck UFMV2: 1, Mobile Water Trailer	UFMBJ: 1, 4x4 Pickup Truck UFM82: 1, 4x2 Ambulance UMF83: 1, 4x4 Ambulance UFMT4: 1, 2.5 Ton Cargo Truck UFMV2: 1, Mobile Water Trailer
Material Handling Equipment	10K forklift Flatbed truck	10K forklift Flatbed truck	10K forklift Flatbed truck	10K forklift Flatbed truck
COMMUNICATONS AND INFORMATION SYSTEMS REQUIREMENTS				
Communications Equipment				
Phone (# lines) (Note: None organic; external support required)	9 (4 cell, 3 land, 2 crash)	10 (4 cell, 4 land, 2 crash)	12 (4 cell, 6 land, 2 crash)	12 (4 cell, 6 land, 2 crash)
Satellite/Telemedicine (# equipment)	1	1	1	1
Land Mobile Radios (# equipment)	13	14	15	15
Secure Telephone Equipment (# equipment)	1	1	1	1
Controlled Cryptographic Items (Note: None organic; relies on base communications units for STE cards)	1	1	1	1
Information Systems and Network Support				
Laptop (# equipment)	14	24	29	29
Printers (# equipment)	2	3	8	8
Server Suite (# equipment)		1	1	1
SIPRNET Access	Required for all			

EMEDS ECS REQUIREMENTS				
ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.				
	EMEDS HRT	EMEDS+10	EMEDS+25	AFTH
NIPRNET Access	Required for all			
Operating System/Office Suite	DOD SDC			
RAM/Hard Drive	ITT Standard			
Clinical Applications	TMIP-AF			
Required Port Number/Protocol Access (TCP/UDP)	21/TCP; 443/TCP; 8080/TCP			
Required Website Access				
AHLTA	https://warrior-sa.lrmc.amedd.army.mil			
ASIMS	https://www.afchips.brooks.af.mil/webApp/USG_Notice_Consent.aspx?NextForm=login.aspx			
DOEHRS	https://doehrswww.apgea.army.mil/front.htm			
KX	https://kx.afms.mil/kxweb/home.do			
NCMI	https://www.intelink.gov/ncmi/index.php			
TRAC2ES	https://www.trac2es.transcom.mil/			
CHAPLAINCY SERVICE SUPPORT				
	Required for all			
SECURITY FORCES SUPPORT				
	Required if not collocated on Air Base			

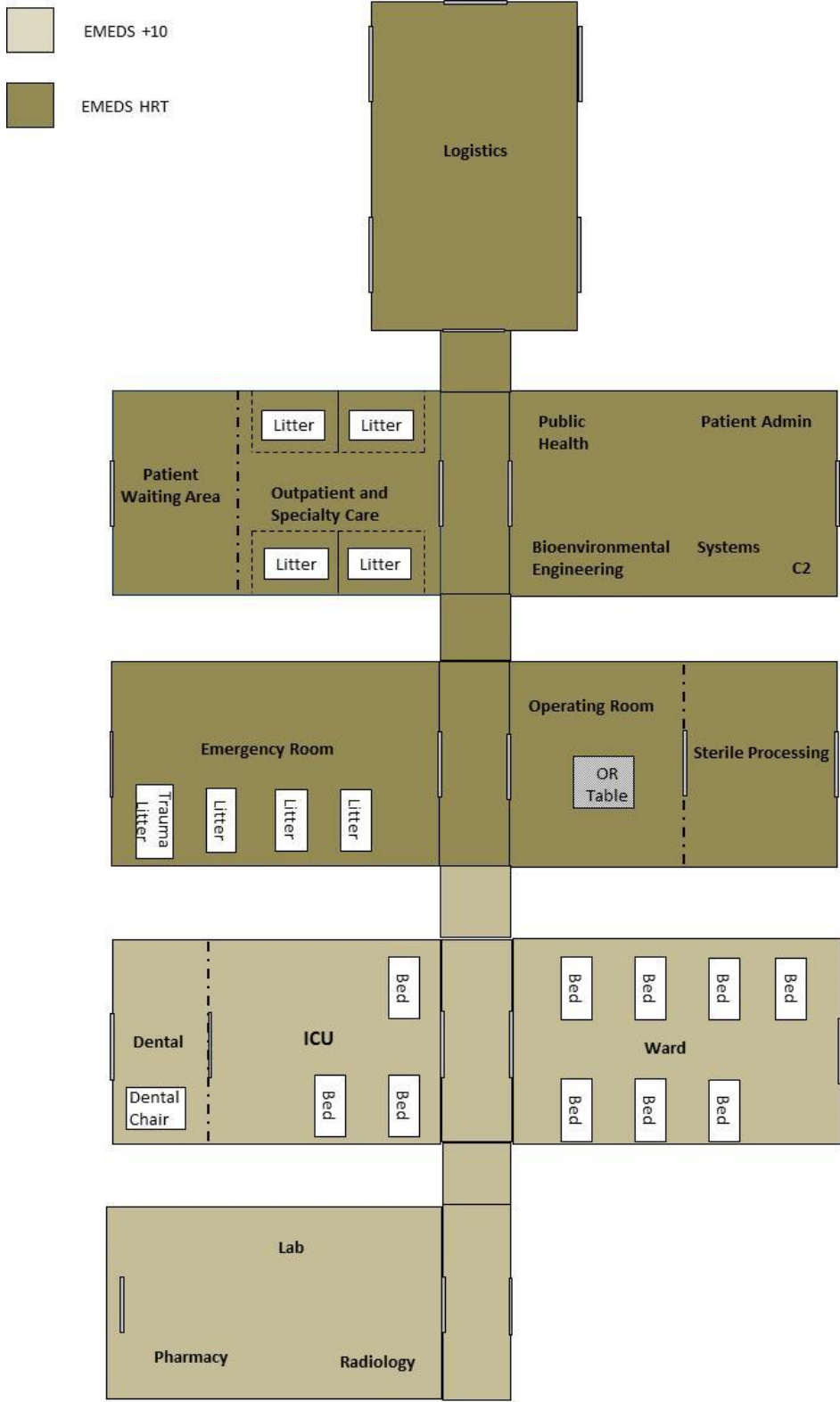
Attachment 9

EMEDS HRT LAYOUT



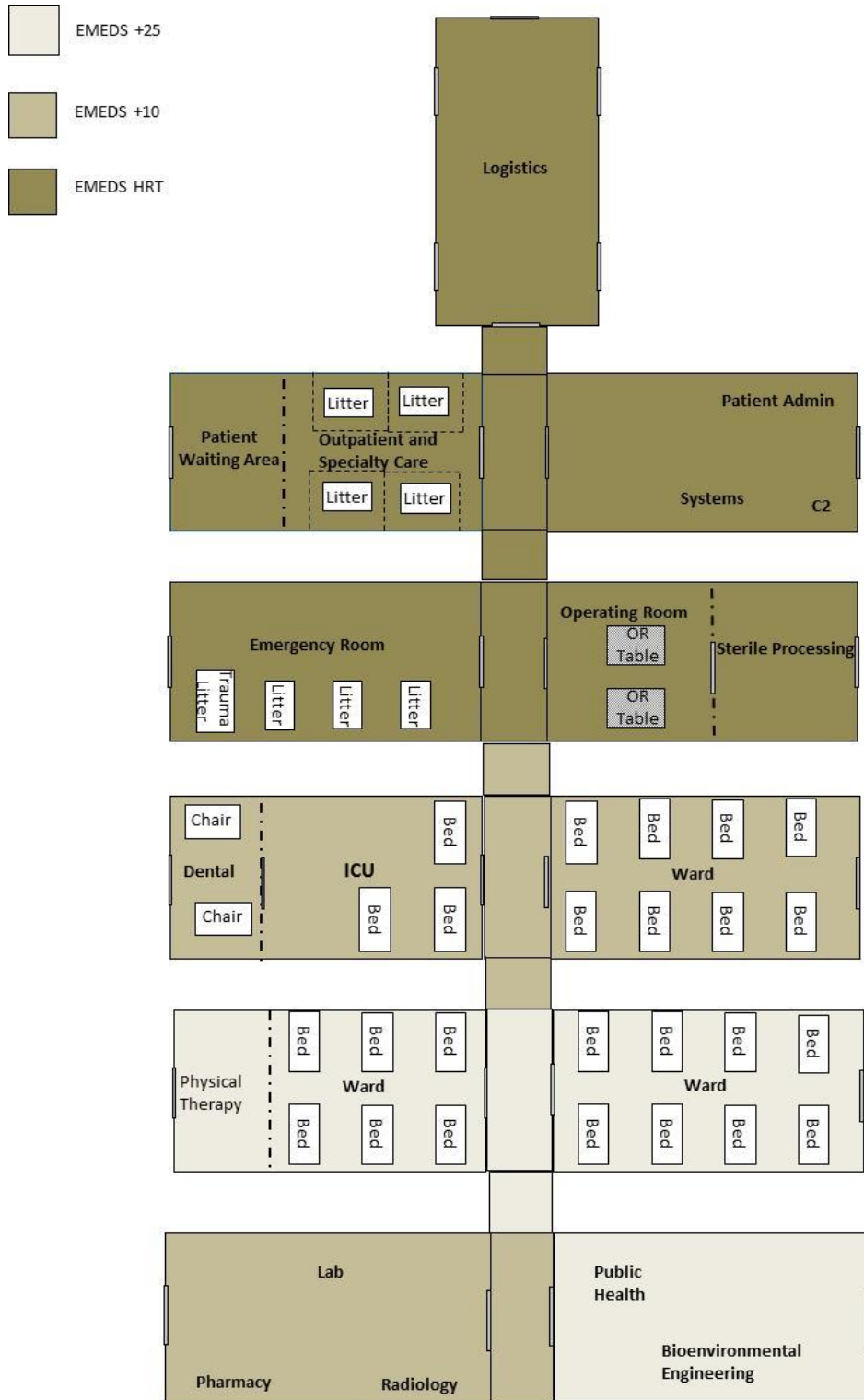
Attachment 10

EMEDS+10 LAYOUT



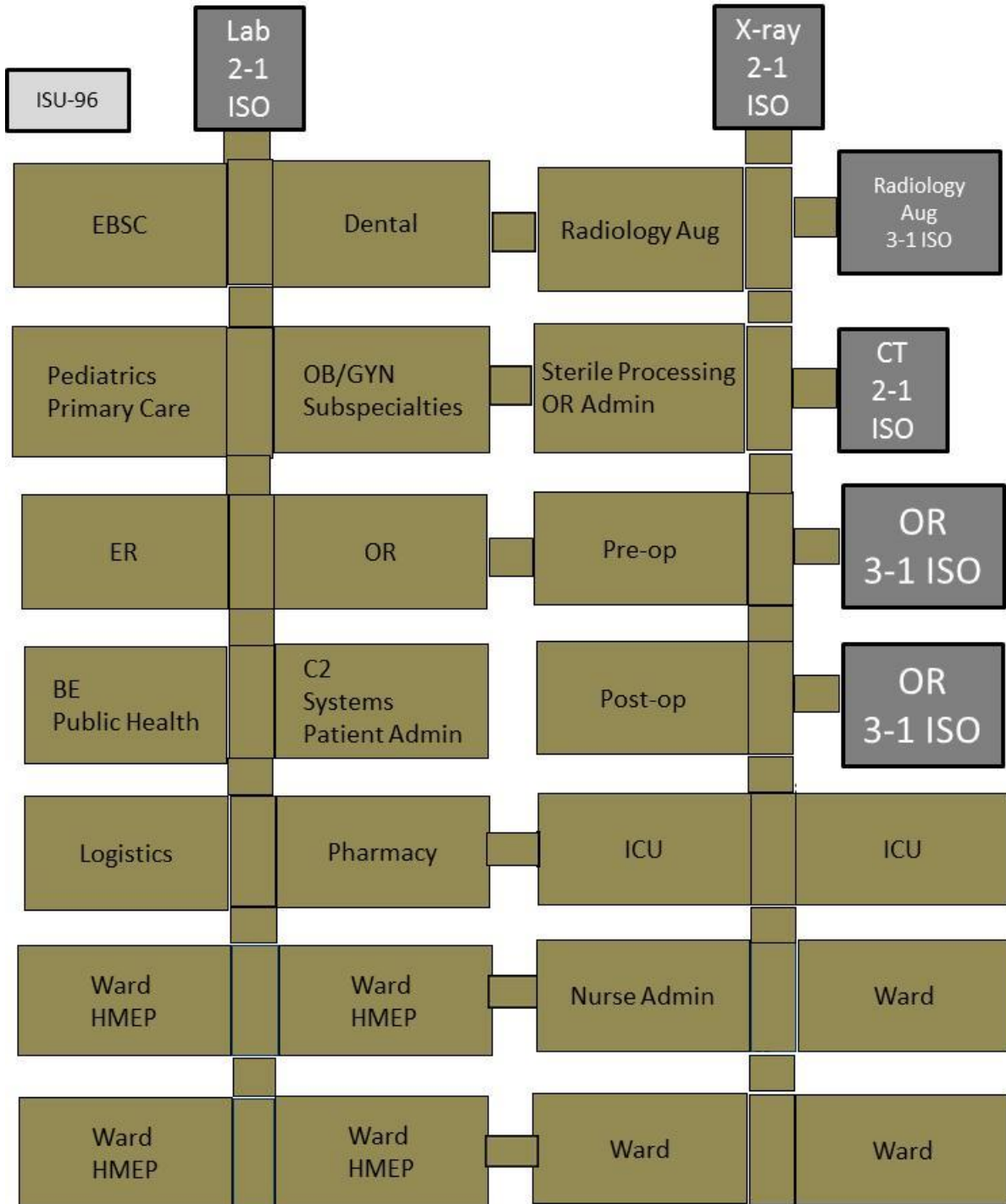
Attachment 11

EMEDS+25 LAYOUT



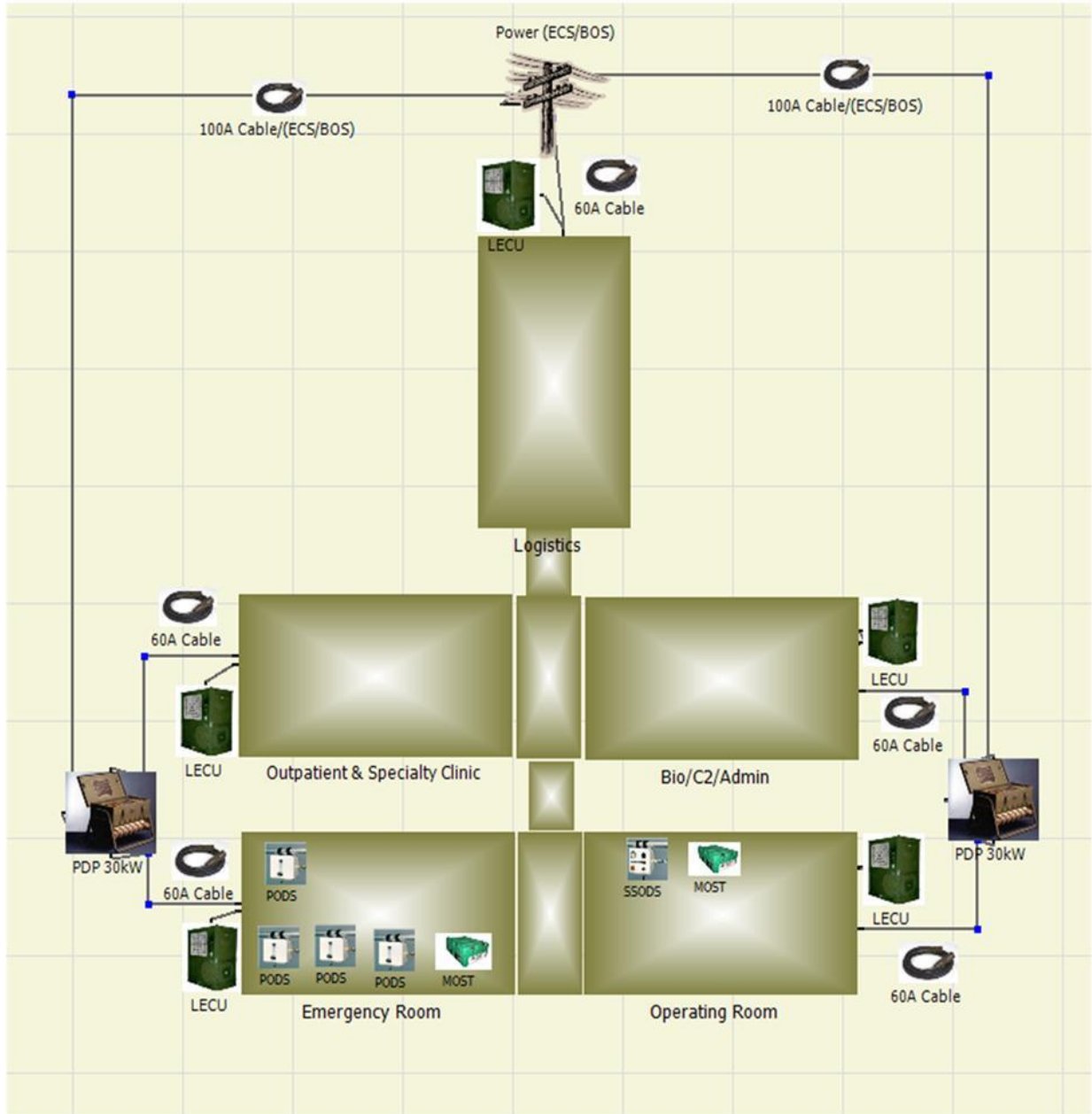
Attachment 12

58-BED AFTH LAYOUT (NOTIONAL)



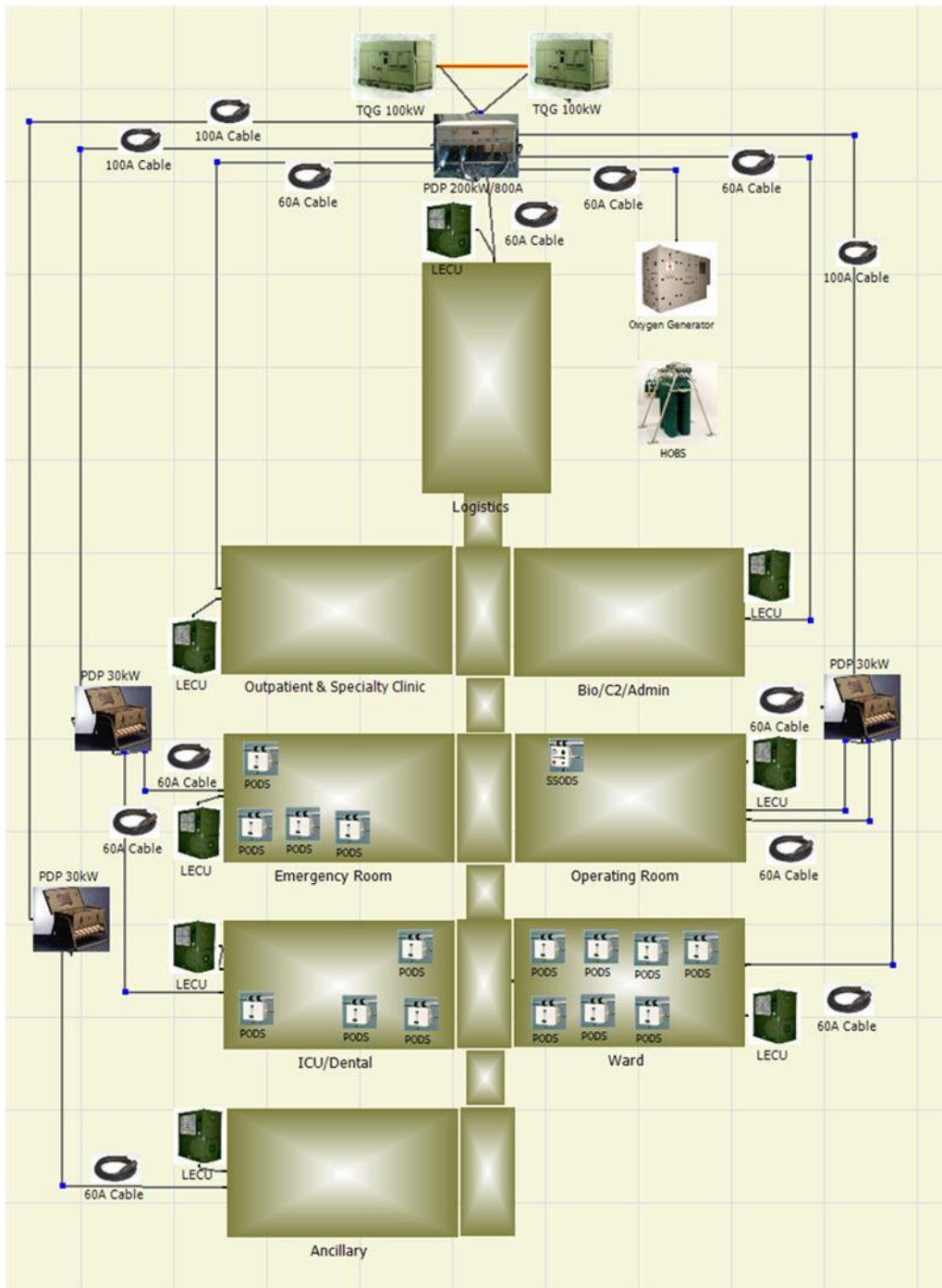
Attachment 13

EMEDS HRT POWER GRID



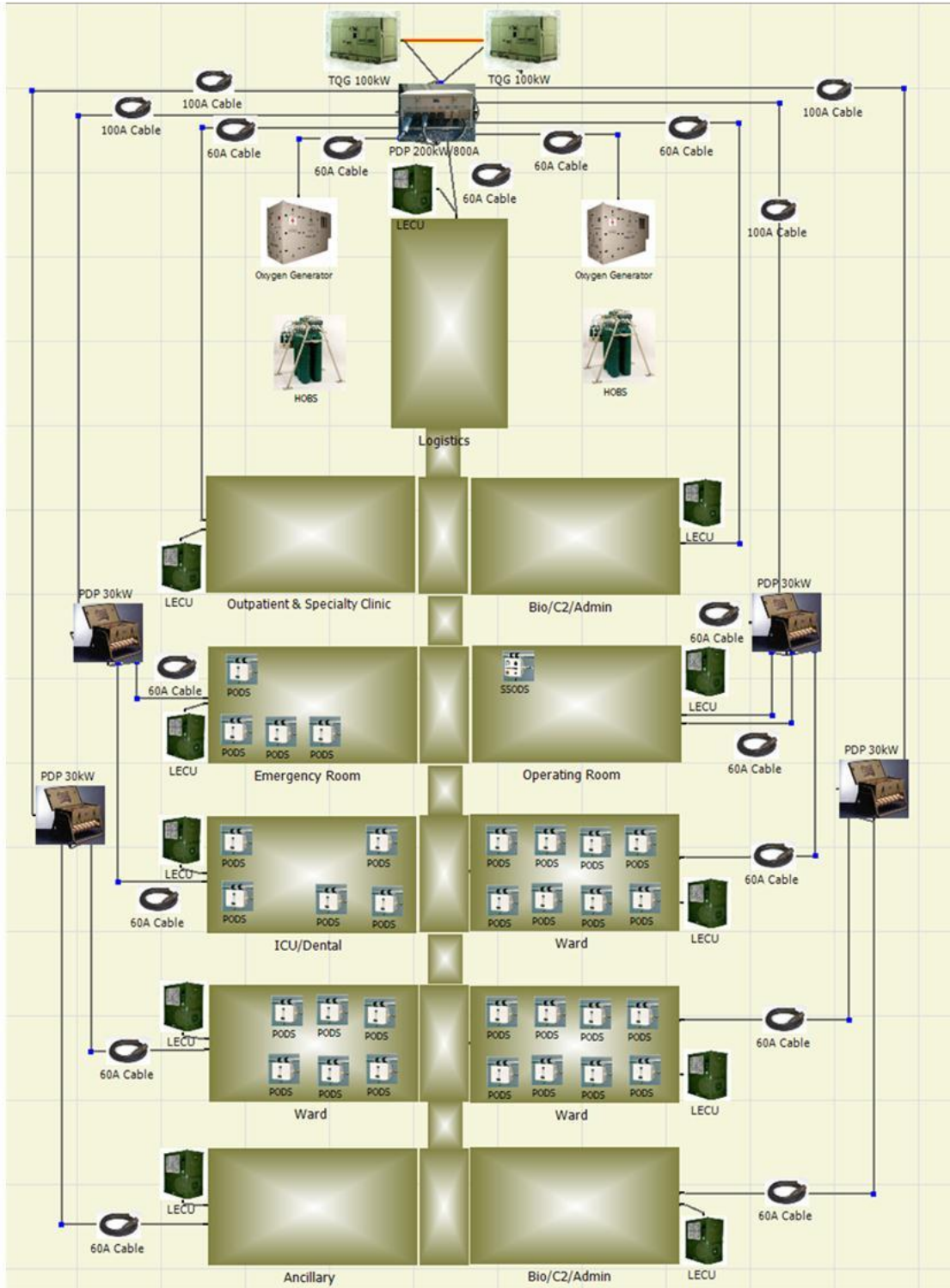
Attachment 14

EMEDS+10 POWER GRID



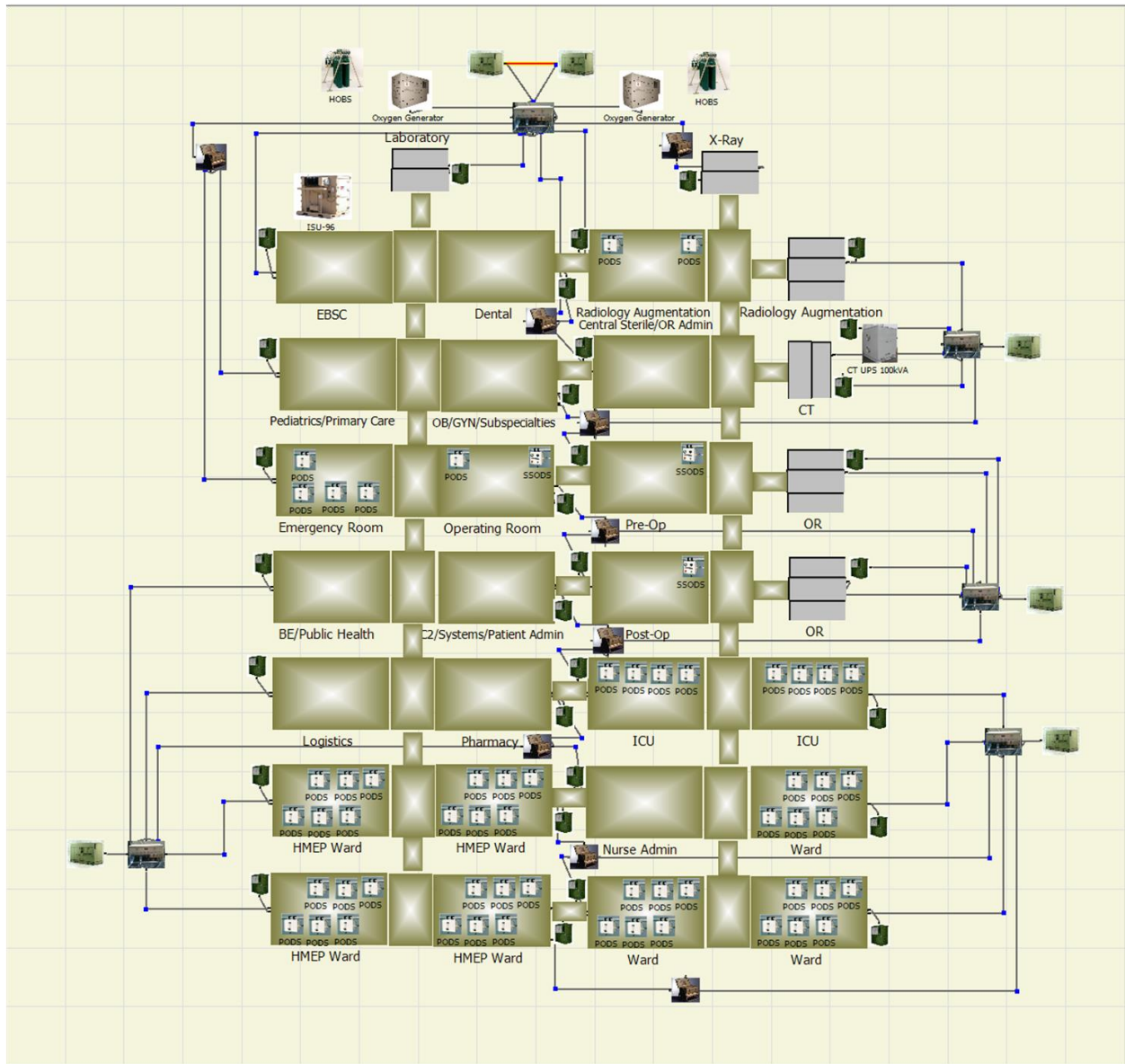
Attachment 15

EMEDS+25 POWER GRID



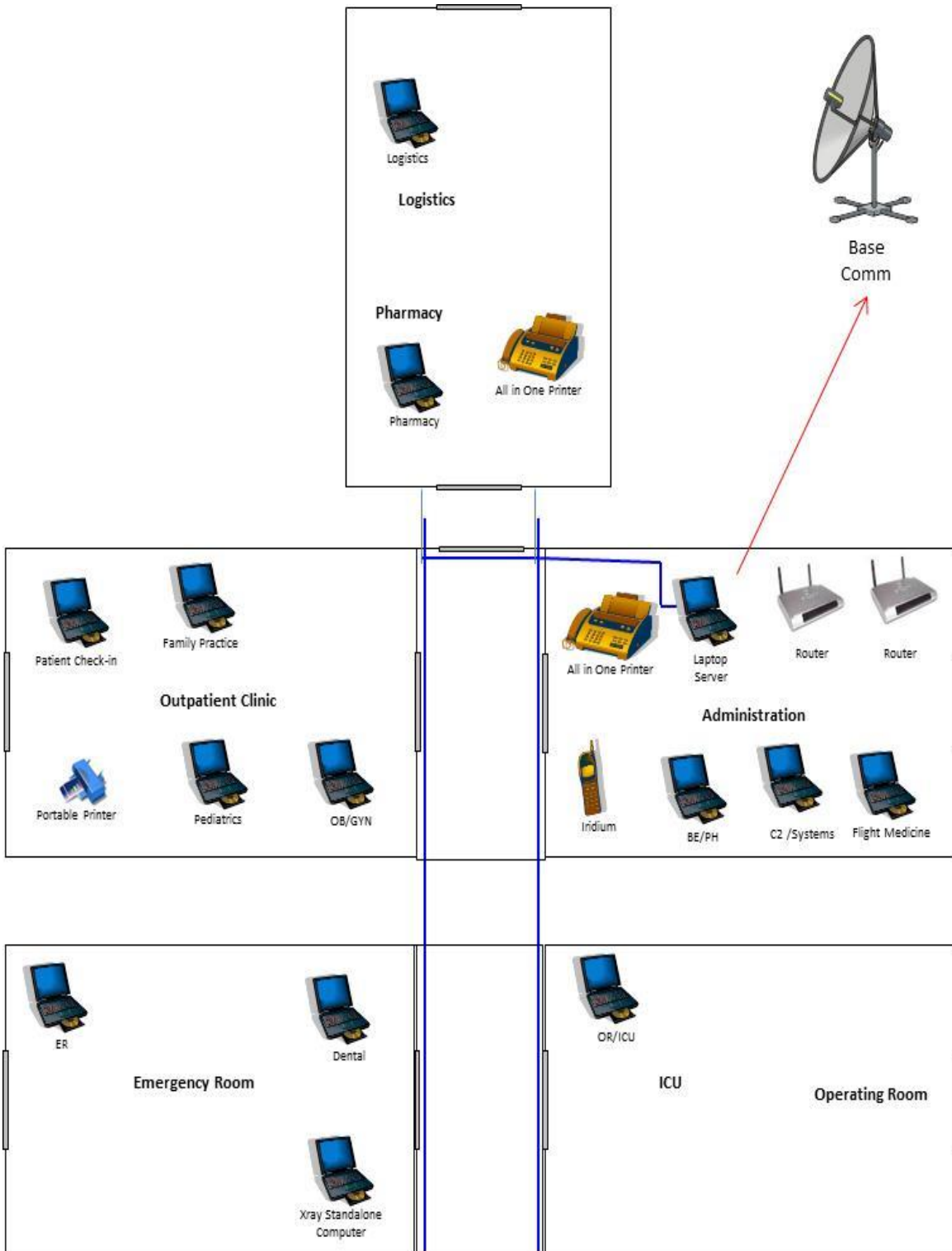
Attachment 16

58-BED AFTH POWER GRID (NOTIONAL)



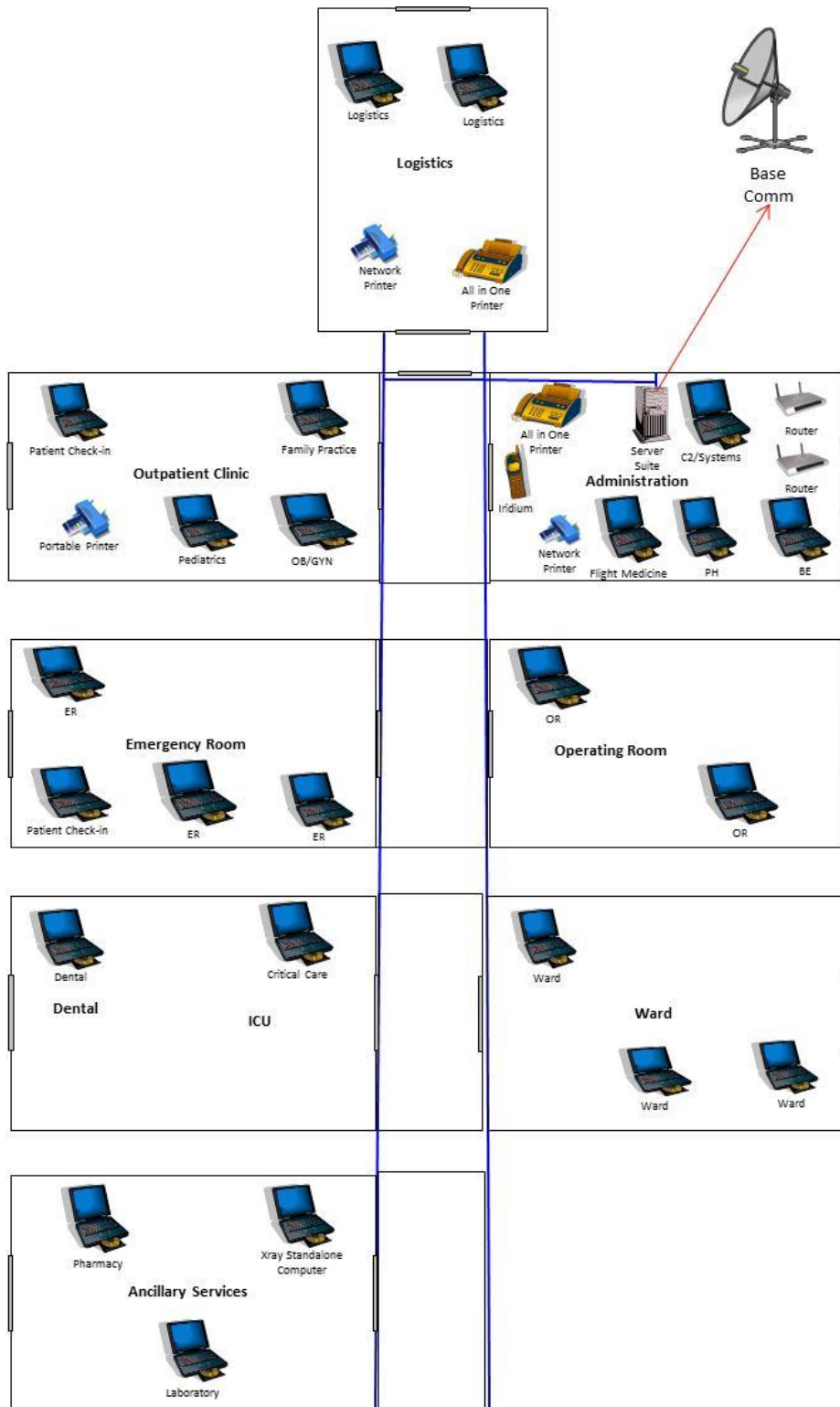
Attachment 17

EMEDS HRT NETWORK CONFIGURATION



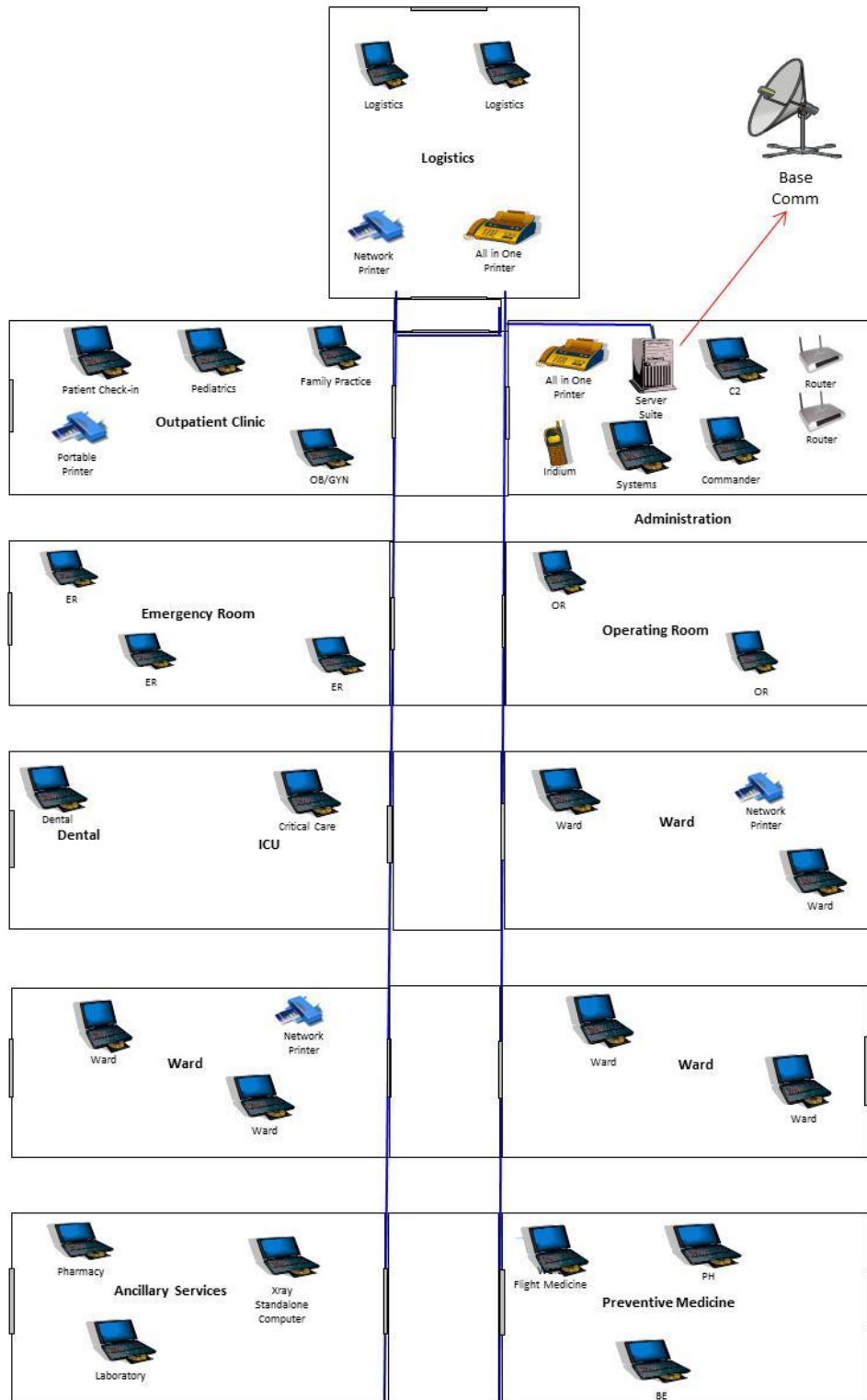
Attachment 18

EMEDS+10 NETWORK CONFIGURATION



Attachment 19

EMEDS+25 NETWORK CONFIGURATION



Attachment 20

EMEDS HRT TRANSITION PLAN

A20.1. EMEDS HRT Transition. The EMEDS HRT transition primarily involves improvements to the existing manpower and equipment packaging. FFHR1 consolidates the EMEDS Basic equipment UTCs: FFEE1, EMEDS Equipment, and FFEE8, Expanded Capability and Infrastructure Module (ECIM). EMEDS HRT features a new quick-erect shelter system, new weather-proof storage containers, and a more efficient pack out system. It includes one additional tent for a total of five tents. This change was driven by a validated need for more space to accommodate logistics functions and the additional personnel. Existing specialty care UTCs were tailored to create a new specialty care module that provides internal medicine, OB/GYN, and pediatric care. Pharmacy and radiology manning from EMEDS+10 were shifted to EMEDS HRT and IHS support was added. A strategic review of all EMEDS UTCs is planned for fiscal year (FY) 2014. During this review, the entire capability will be reviewed and modernized.

A20.2. Equipment Migration. The equipment migration is budgeted to start in FY 2012 with estimated completion in FY 2015. An initial 10 EMEDS HRT equipment packages are funded for FY 2012. Funding for the remaining equipment packages is in the outlying years. Based on analysis of readiness requirements and risk assessments, the AFMS decided to reduce the overall inventory from 42 sets to 36 starting in 2012. Table A20-1 shows the migration timeline.

Table A20.1. Inventory Migration Timeline.

Inventory Migration Timeline		
Fiscal Year	FFEE1/FFEE8 Inventory	FFHR1 Inventory
2011	42	0
2012	26	10
2013	26	10
2014	13	23
2015	0	36

A20.3. Open Issues. The following are known issues associated with the migration.

- No CP infrastructure is available for the Utilis quick-erect shelters purchased for FFHR1. EMEDS HRT will deploy with FFEE1 and FFEE8 (which include the Alaska small shelter system) and EMEDS Basic CP equipment if CP is needed.
- With 10 FFHR1 equipment packages in the initial inventory through FY 2013, continued use of the EMEDS Basic equipment package may be required.
- The EMEDS Basic equipment package has only four tents. Space will be an issue if the specialty care team needs to deploy to this setting.

A20.4. Alternate Configuration. Setup and configuration of the Alaska small shelter system can add up to 12 hours to the EMEDS FOC timelines, as shown in Table A20-2. Figure A20-1 shows the recommended layout for an EMEDS four-tent configuration using the EMEDS Basic equipment package. Figures A20-2 through A20-3 show the recommended configuration for EMEDS+10 and EMEDS+25 facilities built on an EMEDS Basic foundation.

Table A20.2. FOC Timelines for Alaska Shelter EMEDS Configurations.

Increment	FOC
EMEDS Basic	24 hours
EMEDS+10	48 hours
EMEDS+25	72 hours
Note: The addition of CP can add another 24 hours to the FOC timelines.	

Figure A20.1. EMEDS 4-Tent Configuration.

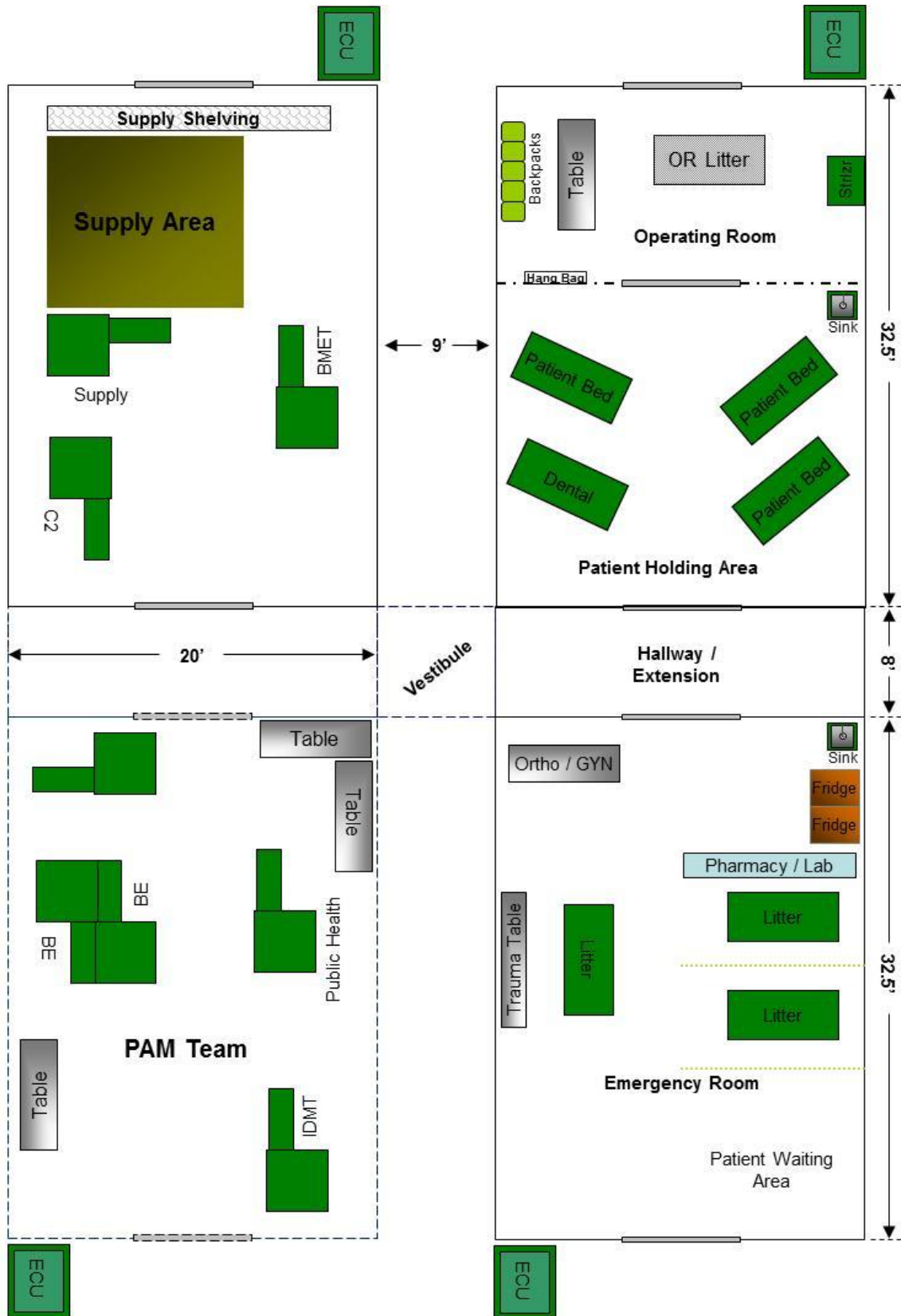


Figure A20.2. EMEDS+10 Configuration with EMEDS Basic Foundation.

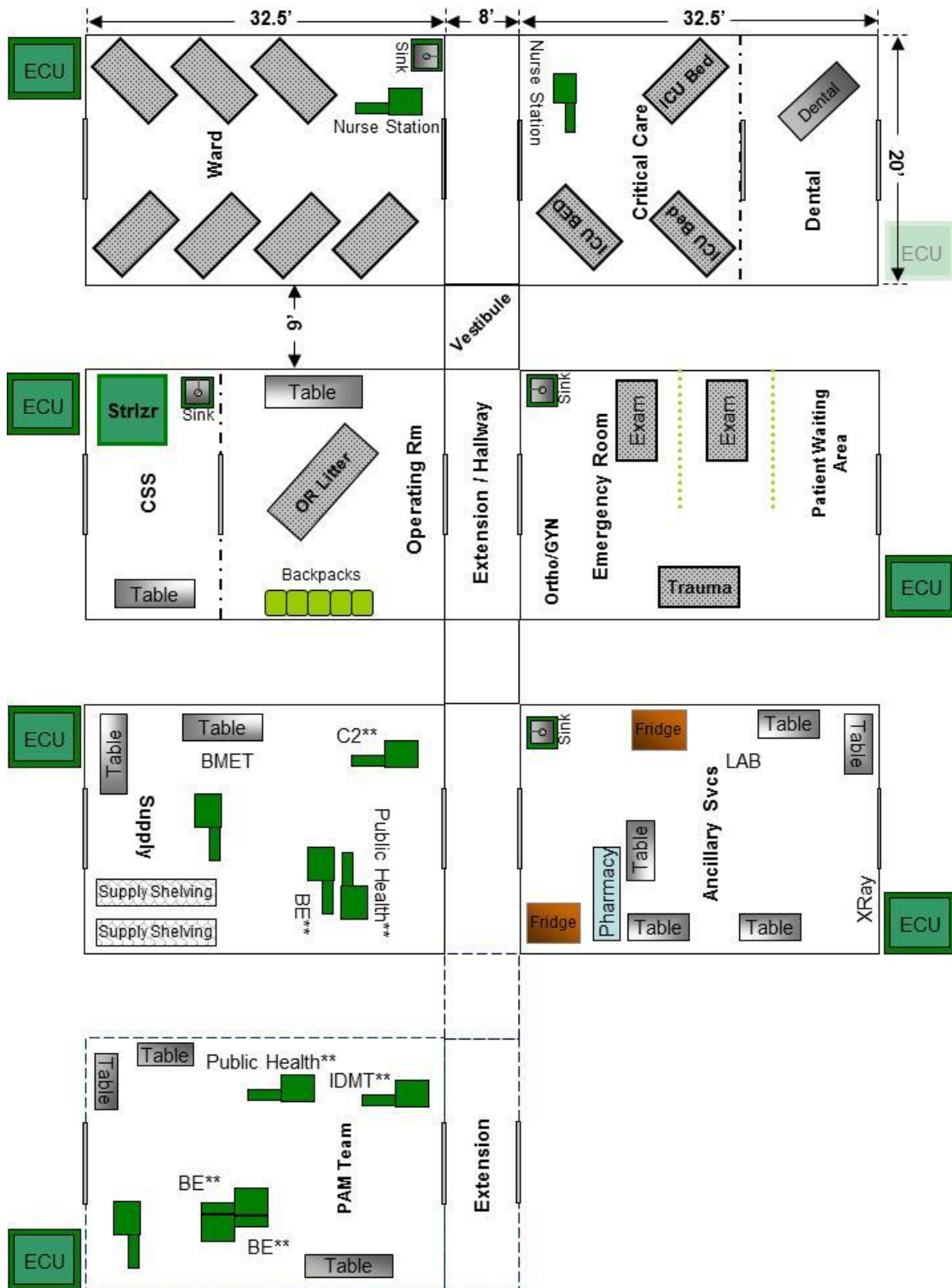


Figure A20.3. EMEDS+25 Configuration with EMEDS Basic Foundation.

