CRITICAL CARE AIR TRANSPORT TEAMS (CCATT)

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PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for combat support capability. This document, AFTTP 3-42.51 provides tactics, techniques, and procedures (TTP) for CCAT of patients across the range of military operations, from steady state/peacetime engagements through war-winning operations. Critical care air transport is only one capability of the aeromedical evacuation (AE) system and the larger Department of Defense (DOD) mobility airlift enterprise. This guidance is designed to assist planners in the successful integration of CCATT into AE operations, and interface successfully with Air Force expeditionary medical support (EMEDS) or equivalent component service medical support and AE ground medical operations.

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

SCOPE: The United States Air Force (USAF) AE system provides a critical patient movement capability that cuts across traditional Service lines. Since World War II, the preponderance of AE patients generated during wars and contingency operations have come from Army and Marine Corps ground combat units. It is important that the AE system integrates well with the medical components of all Services, not just those of the Air Force. Moreover, during the past decade, it has become increasingly important that the USAF AE system continue to develop its capability to integrate with components of our nation's allies.
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Chapter 1

CRITICAL CARE AIR TRANSPORT TEAM (CCATT)

1.1 CCATT Mission. Critical Care Air Transport Teams (CCATTs) assist in carrying out the mission of the aeromedical evacuation (AE) system, which includes air transport of patients under medical supervision while delivering optimal care. CCATT/AE serves as a distributive medical treatment facility (MTF). The CCATTs are utilized as a supplementation package to the primary medical AE crew. CCATTs maintain/enhance the standard of care provided to critically ill/injured/burned patients who require continuous stabilization and advanced care during transport to the next level of care. Once deployed, the CCATTs are an AE asset and fall under the expeditionary AE squadron to which they are assigned/attached. CCATTs are a limited, rapidly-deployable resource available in selected situations to supplement the AE system. They are engaged after the patient has received essential, stabilizing care by supported ground medical support personnel. CCATTs are able to continuously monitor and maintain stabilization of critically ill/injured/burned patients during patient movement activities in either an inter- or intra-theater AE mission support role.

1.2 CCATT Concept. CCATTs will be utilized for a full spectrum of operations. This includes Aerospace Expeditionary Force (AEF) operations ranging from in-garrison care to humanitarian relief, civil disaster response, small-scale contingencies (SSCs), range of military operations (ROMO), homeland security, and major theater war (MTW). CCATTs are the enabler to AE’s critical care capability/asset and deploy to assist in carrying out the overarching patient transport mission of the AE system. Air Mobility Command is the manpower and equipment force packaging (MEFPAK) responsible command. Air Force Special Operations Command (AFSOC) employs a special operations forces (SOF) CCATT, unit type code (UTC) FFQC4. AFSOC is the MEFPAK for the SOF CCATT UTC. The AFMS provides medical UTCs to support theater requirements. At execution, command relationships are defined in the warning/execution/deployment order.

1.3 CCATT Scope of Care. CCATTs, in conjunction with AE crews or AE ground medical support elements, provide advanced specialty medical capability to evacuate critically ill, injured, or burned patients requiring continuous stabilization or advanced care during transport to the next level of care, whether intra- or inter-theater. Prior to transport the role of the CCATT is to prepare the critically ill patient for movement. The CCATT will normally accompany the patient from the originating facility to the aircraft and continue to monitor and intervene during in-flight operations as required. This team does not routinely provide primary stabilization and does not replace forward surgical or ground medical support team capabilities. These patients are usually in a state of dynamic, physiological flux. Examples of injuries/conditions requiring CCATT support include supportive/resuscitative care of shock/hemorrhage, respiratory failure, and multi-system trauma.

1.3.1 Each CCATT physician must verify transport readiness of patients transferred based on patient clinical status. This must be communicated and coordinated with the controlling Patient Movement Requirements Center (PMRC). CCATT intervention normally begins at the originating MTF.
1.3.2 The CCATT UTC FFCCT, in conjunction with the critical care air transport team equipment package (FFCCA), provides care for a maximum patient load of three high-acuity patients, or up to six lower-acuity stabilized patients, during a realistic duty day of 16 hours of patient care. Introduction of untreated or unstable patients will degrade CCATT capability and deplete resources accordingly unless augmented.

1.3.2.1 A pediatric equipment augmentation kit, UTC FFCC2, provides additional equipment/supplies to FFCCA equipment UTC to support FFCCT when the team is required to transport pediatric patients. This kit provides single mission support for a maximum of 2 pediatric patients weighing < 15 kg, and, a maximum of 2 pediatric patients weighing between 15 – 40 kg.

1.3.3 The CCATT extender team, UTC FFCCE (augmentation team), is not a stand-alone critical care transport capability. It is only to be deployed in conjunction with an FFCCT team when transporting critically ill/injured patients. The primary mission of the FFCCE capability is to serve to increase patient care capability of the FFCCT, particularly during strategic missions. The FFCCE team may function as a medical attendant (MA) capability for non-critically ill patients (ref: para 3.3.2.1). When employed with an additional FFCCA equipment package FFCCE teams can combine with a FFCCT team to increase the maximal patient load up to five ventilator patients, or up to ten lower-acuity stabilized patients based on the total patient acuity level for the mission.

1.3.4 The neonatal CCATT UTC FFCCN, in conjunction with a CCATT pediatric/neonatal equipment package, UTC FFCCC, provides care for one high-acuity neonate, or up to four low-acuity, stabilized neonatal patients, age range from birth to 3 months per transport.

1.3.5 The pediatric CCATT UTC FFCCP, in conjunction with a CCATT pediatric/neonatal equipment package, UTC FFCCC, provides care for 3 high-acuity pediatric patients, or up to 6 low-acuity stabilized pediatric patients, ranging from 3 months to 14 years per transport.

1.3.6 Deviations from maximum CCATT patient loads, or combinations of high-acuity (i.e. ventilated) and lower-acuity (i.e. non-ventilated) patients, will be at the discretion of the CCATT team leader and based on patient acuity, resources required/available, mission requirements, and any other factors affecting team ability to provide patient care without degrading capability.

1.4 CCATT Unit Type Codes & Team Compositions: Each CCATT UTC is constructed as follows: (grade and skill level substitutions are authorized in accordance with War & Mobilization Plan (WMP) 1, Annex F. Exception to substitution policy requires MAJCOM approval.).

1.4.1 CCATT UTC Compositions:

1.4.1.1 CCATT UTC consists of the following AFSCs/skill levels and quantities:
(1) Critical Care Physician (044Y3)--Lt Col/O5
(1) Critical Care Nurse (046N3E)--Maj/O4
(1) Cardiopulmonary Technician (4H071)

AFSC substitutions for the critical care physician are authorized as follows: 44Y3A, 44M3 all shreds, 44E3A, 45A3, 45S3, 45S3A, 44F3, 48R3. 46N3E may be substituted with 46N3J. 4H071 must have respiratory equipment/ventilator experience. 4H071 may be substituted with 46M3. All potential members of this team must have completed validation screening of Readiness Skills Verification (RSV) tasks through AFEMSI (ref: para 1.4.2).

1.4.1.2 Medical CCATT- Extender Team (FFCCE) UTC consists of the following AFSCs/skill levels and quantities:

(1) Critical Care Nurse (046N3E) -- Capt/O3
(1) Critical Care Nurse (046N3E) -- Capt/O3

One (1) critical care nurse may be substituted by one (1) emergency room nurse (46N3J). All potential members of this team must have completed validation screening of RSV tasks through AFEMSI (ref: para 1.4.2).

1.4.1.3 Medical CCATT - Neonatal (FFCCN) UTC consists of the following AFSCs/skill levels and quantities:

(1) Neonatologist (044K3E) -- Lt Col/O5
(1) Neonatal Critical Care nurse (046N3F) -- Maj/O4
(1) Cardiopulmonary Technician (4H071)

AFSC substitutions for neonatologist (44K3E) and neonatal intensive care nurse (46N3F) are not permitted. AFSC substitution for 4H071 with 46M3 is authorized. 4H071 must have respiratory equipment/ventilator experience. All potential members of this team must have completed validation screening of RSV tasks through AFEMSI.

1.4.1.4 Medical CCATT – Pediatric (FFCCP) UTC consists of the following AFSCs/skill levels and quantities:

(1) Critical Care Medicine, Pediatrics (044Y3A) -- Lt Col/O5
(1) Critical Care Nurse (46N3E) -- Maj/O4
(1) Cardiopulmonary Technician (4H071)
AFSC substitutions for 44Y3A are authorized as follows: 44K3B, 44K3E, AND 44K3J. Only 46N3E with pediatric critical care experience may be assigned. AFSC substitution for 4H071 with 46M3 is authorized. 4H071 must have respiratory equipment/ventilator experience. All potential members of this team must have completed validation screening of RSV tasks through AFEMSI.

1.4.1.5 Medical CCATT Equipment (FFCCA): this UTC provides advanced specialty medical equipment to support FFCCT and FFCCE teams; providing single mission support for up to 3 high-acuity or 6 lower-acuity adult patients. (Commonly known as the “Adult CCATT Kit.”)

1.4.1.6 Medical CCATT Equipment Resupply (FFCCB): this UTC provides the re-supply package to support FFCCA; provides 15 days support for one basic FFCCA.

1.4.1.7 Medical CCATT Pediatric /Neonatal Equipment (FFCCC): this UTC provides advanced specialty medical equipment to support FFCCP and FFCCN teams, providing single mission support for up to 3 high-acuity pediatric patients or 1 high-acuity neonatal patient.

1.4.1.8 Medical CCATT Equipment – Pediatric Augmentation Kit (FFCC2): this UTC provides advanced specialty medical care augmentation supply to support FFCCT. UTC FFCC2 provides equipment/supplies augmentation to FFCCA equipment UTC for transport of pediatric patients. This kit provides single mission support for a maximum of 2 pediatric patients weighing < 15 kg, and, a maximum of 2 pediatric patients weighing between 15 – 40 kg. Re-supply is provided within the AE system at staging locations or supported element.

1.4.1.9 CCATT Support Package (FFCCS): provides basic shelter to CCATT members and AE crewmembers positioned at far-forward, secured airfields. Package is deployed with FFCCT, FFCCE or AE crewmembers (UTC FFQDA) when required to support a maximum of 12 personnel; supplies food, water, and petroleum/oil/lubricants (POL) for 96 hours.

1.5 CCATT Member Selection:

1.5.1 All team members selected for CCATT duty by owning MTF/CC, SQ/CC and/or medical readiness office will undergo a position-specific validation process administered by the Air Force Expeditionary Medical Skills Institute (AFEMSI) under the authority of the HQ AMC/SG as MEFPAK.

1.5.2 MTF commanders are responsible for selecting, training, and preparing members for assignment to a CCATT UTC. The CCATT validation process does not remove these responsibilities from the commander. The process is an enhancement to the medical UTC assignment system to ensure that only skilled members are assigned to CCATT.
1.5.3 CCATT/AE serves as a distributive medical treatment facility. The addition of an intensive care unit capability on mobility airlift aircraft has added a new dimension to the AE mission. This capability ensures that the level of life-sustaining medical care for critically ill and injured patients during transport by air does not diminish. The CCATT UTC is a capabilities-based mission platform. The current AF system of assigning members to fill UTC positions is strictly AFSC-based; the system is not designed to sort out capabilities. This is insufficient for assignment to a CCATT UTC. Mission capability statements (MISCAPs) are limited in scope and are inadequate to fully develop complete screening criteria for CCATT assignment requirements.

1.5.4 CCATT is a unique, capabilities-based UTC and requires the highest degree of professional members distinctly skilled and experienced in the practice of critical care. Skilled, knowledgeable professionals in medical practice yield positive patient outcomes with fewer patient complications – this is especially decisive in the environment in which CCATTs perform their mission. In addition to being required to exercise the highest degree of skill, expertise, and excellence in the performance of critical care duties, CCATTs must perform these duties in an extremely non-traditional environment: a cargo aircraft at altitude – a situation that is, in fact, hostile to providing the kind of highly-specialized patient care required in an ICU.

1.5.5 The CCATT validation process will assist MTF commanders in their responsibility of finding and assigning only those individuals with the requisite skills and experience to fill a position on a CCATT UTC and the capability to perform the mission. It is also designed to assist commanders in determining what experience and training personnel must obtain in order to successfully perform as a member of a CCATT UTC should someone fall short in skill/training/experience. The review committee is required to expeditiously conduct and complete their assessment. This enhancement will not delay the process of filling UTC positions.

1.5.6 Selection review packages must be prepared for each proposed CCATT member and forwarded to AFEMSI for review and validation prior to assignment to UTC positions. (Process flow chart is included as Attachment 3. Sample submission cover letter is included as Attachment 4.) The address for AFEMSI is:

USAFSAM/IEC  
2601 Louis Bauer Dr.  
Brooks CB TX 78235-5130  

Candidates for CCATT membership must be world-wide qualified and able to meet the requirements for physician, nurse, or respiratory therapy technician positions as set forth in paras 1.5.8.1, 1.5.8.2, and 1.5.8.3 (respectively) below. They must be able to obtain Operational Support Flier status IAW AFI 11-402, Aviation and Parachutist Service, Aeronautical Ratings and Badges, and have a minimum of a Secret security clearance. Only new personnel nominated for assignment to a CCATT UTC after the effective date of this TTP are required to go through the validation process described herein. Members assigned to CCATT UTCs and who have attended the CCATT Basic Course prior to the effective date of this TTP will re-validate through attendance at the Center for...
1.5.7 A Clinical Validation Committee (CVC) composed of deployment-experienced CCATT members will review packages for recommended CCATT members. To ensure ARC representation a qualified physician, critical care nurse, and respiratory technician representative from the ANG and AFRC will be standing members of the CCATT clinical validation committee and will be appointed by ANG/SG and AFRC/SG respectively. Members of the CVC may not be in a CCATT candidate’s direct chain of command. Each package will be assigned to one lead CVC member for review and processing. A structured interview of the proposed member will be accomplished. Two additional CVC members will review the package concurrently. Validation status will be assigned by consensus of the three CVC members. Any irresolvable conflicts between the CVC members will be referred to the Director, AFEMSI.

The validation process will be completed within a 2-week period, with expedited review for ARC candidates to prevent a delay in the accession process. Based on the committee’s decision each candidate will be assigned to one of the following groups:

1.5.7.1 Approved – Allows immediate assignment to a CCATT UTC and admission to the CCATT Course at Brooks City-Base, Texas and the remainder of the CCATT training pipeline.

1.5.7.2 Provisional – Awaiting additional information or additional training/experience required. This status will be changed to “approved” once additional verified information is received and/or additional training/experience is accomplished. If additional training is required, a training plan will be issued to the individual and his/her home unit by AFEMSI. Members may not be assigned to the UTC while in “provisional” status; all provisional items must be satisfactorily completed before “approved” status is designated. Personnel on provisional status will not be admitted to the CCATT Course until “approved” status is designated. Once the training plan is completed, member’s home unit will forward documentation of completion to AFEMSI. AFEMSI will review the completed training plan prior to changing member status to “approved.” Failure to complete provisional items will result in “disapproved” status.

1.5.7.3 Disapproved – Does not meet eligibility requirements for assignment to a CCATT UTC. "Disapproved" applicants may appeal the decision through their unit commander to HQ AMC/SG. The appeal package must include the original selection package, a letter of rebuttal to the disapproval, and any additional supporting documentation. (see Attachment 8 for sample letter of rebuttal)

1.5.8 Selection Review Package Contents.

1.5.8.1 Physician selection review package requires (see Attachment 5 for sample package layout):

1.5.8.1.1 Current curriculum vitae including a statement of attestation from the member affirming 800 hours of active critical care patient
management experience within the past 2 years. (Critical care patient management experience is defined as patient care requiring continuous cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.)

1.5.8.1.2 Current Hospital Privilege List (AF Form 1562 or equivalent)

1.5.8.1.3 Current copies of medical license(s), BLS, and ACLS. One-time ATLS certification and on-going contemporary clinical experience is required. Current ATLS certification is desired; current PALS certification is desired for FFCCT. Current PALS certification is required for FFCCP and FFCCN.

1.5.8.1.4 Current copy of 44Y3 Readiness Skills Verification (RSV) checklist for UTC FFCCT position; copy of 44K3E RSV checklist for UTC FFCCN position; or copy of 44Y3A RSV checklist for UTC FFCCP position.

1.5.8.2 Nurse selection review package requires (see Attachment 6 for sample package layout):

1.5.8.2.1 AFSC: 46N3E, 46N3J, or 46M3 with current critical care experience.

1.5.8.2.2 Current resume including a statement of attestation from the member affirming 800 hours of active critical care patient management experience within the past 2 years. (Critical care patient management experience is defined as patient care requiring continuous cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.)

1.5.8.2.3 Current nursing job description and 2 references.

1.5.8.2.4 Current copies of nursing license(s), BLS, and ACLS. (PALS, CCRN, TNCC, and ATCN certification is recommended, but not required. If certification in these areas is held, please include as applicable.)

1.5.8.2.5 Current copy of 46N3E RSV checklist for UTC FFCCT, FFCCCE, or FFCCP position; or copy of 46N3F RSV checklist for UTC FFCCN position. 46M3 will submit current copy of RSV checklist for that AFSC.

1.5.8.3 Respiratory therapist package requires: (see Attachment 7 for sample package layout):

1.5.8.3.1 Documentation of current 5-skill level or higher.

1.5.8.3.2 Current resume including a statement of attestation from the member affirming 800 hours of active critical care patient management
experience within the past 2 years. (Critical care patient management experience is defined as patient care requiring continuous cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.)

1.5.8.3.3 Certified Respiratory Therapist eligible; CRT status preferred. Registry status encouraged.

1.5.8.3.4 Current copies of respiratory license, BLS, and ACLS.

1.5.8.3.5 Current copy of RSV checklist.
Chapter 2

COMMAND AND CONTROL AND ITS COMMUNICATIONS SYSTEM SUPPORT

2.1 Introduction. Command and control (C2) functions exercised over AE missions are consistent with those for all air mobility missions and are conducted in accordance with the C2 processes described in Joint Publication 3-17, Joint Tactics, Techniques, and Procedures for Air Mobility Operations; AFDD 2, Organization and Employment of Aerospace Power; and AFDD 2-6, Air Mobility Operations. In contingency operations, AE-specific items will be outlined in the operation orders (OPORD) in Annex C Appendix 30 and general patient movement guidance will be in Annex Q. AE assets are integrated within the inherent mobility structure established to support airlift operations through the Air Mobility Division (AMD) to the wing and down to the assigned expeditionary AE squadron/element.

2.2 Patient Movement Concepts. Patient evacuation from point of injury to initial treatment at an expeditionary medical support (EMEDS) or equivalent component service ground medical platform is the responsibility of each Service component. AE is not the only mechanism for movement of patients by air. Casualty evacuation (CASEVAC), a term used by all Services, refers to the movement of unregulated casualties by non-medical units aboard non-medical assets (vehicles or aircraft) without en route care by medical professionals. Medical evacuation (MEDEVAC), on the other hand, traditionally refers to US Army, Navy, Marine Corps, or Coast Guard patient movement using pre-designated tactical or logistics vehicles and/or aircraft equipped and staffed for en route care. MEDEVAC has generally implied the use of rotary wing aircraft with medical attendants (MA). Medical evacuation of casualties forward of level 3 medical facilities is a Service responsibility. Typically, AF AE begins once a validated patient movement request (PMR) is passed to the AF component agency for execution and infers patient movement on fixed-wing aircraft. (There may be occasions when PMRs are not issued, but the AE system is tasked to provide patient transport, i.e. emergency disaster relief operations.)

2.3 Contingency AE Structure (refer to AFDD 2-6. See Figure 2.1.) Deployed expeditionary air and space forces are organized to ensure unity of command. Deployed AE forces will be organized within the constructs of the Air and Space Expeditionary Task Force (AETF) and will be tailored based on the size and scope of the operation. C2 of theater AE forces in contingency operations will be defined in the warning/execution/OPORD. AE assets may be under the operational control (OPCON) of the Joint Force Commander (JFC), through the Commander, Air Force Forces (COMAFFOR)/Joint Force Air Component Commander (JFACC) and, when not appointed as the JFACC, the Commander, Air Force Forces (COMAFFOR) for administrative control (ADCON). The AE commander is authorized to communicate directly with the joint forces surgeon (JFS) who is assigned to the staff of the JFC.

2.4 Command and Control (C2). When CCATTs are deployed for contingency AE operations in support of a geographic combatant commander (COCOM), the CCATT team(s) will fall under the OPCON or TACON of the COMAFFOR/JFACC under the guidance and coordination of the Director of Mobility Forces (DIRMOBFOR-Air), and are assigned to a deployed aeromedical evacuation squadron. When deployed in support of AMC AE operations, CCATTs will fall under the OPCON or TACON of the 18 AF/CC and operate under the guidance of the Tanker/Airlift Control Center (TACC). In turn, OPCON or TACON may be delegated to the AE senior representative of some or all medical AE assets. The senior CCATT physician in a theater
of operations will be designated by the Theater Air Force Forces (AFFOR) Surgeon General as “Theater CCATT Clinical Director” to work CCAT issues with the Theater Validating Flight Surgeon. The AFFOR Surgeon may assign this position to a physician of lesser rank but greater CCAT experience.

**Figure 2.1. Contingency AE Structure.**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE</td>
<td>Aeromedical Evacuation</td>
</tr>
<tr>
<td>AECM</td>
<td>AE Crewmembers</td>
</tr>
<tr>
<td>AEG</td>
<td>Air Expeditionary Group</td>
</tr>
<tr>
<td>AELT</td>
<td>AE Liaison Team</td>
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<tr>
<td>AEOT</td>
<td>AE Operations Team</td>
</tr>
<tr>
<td>AESC</td>
<td>AE Support Cell</td>
</tr>
<tr>
<td>AEW</td>
<td>Air Expeditionary Wing</td>
</tr>
<tr>
<td>AMC</td>
<td>Air Mobility Command</td>
</tr>
<tr>
<td>CC</td>
<td>Command Center</td>
</tr>
<tr>
<td>CCATT</td>
<td>Critical Care Air Transport Team</td>
</tr>
<tr>
<td>EAES</td>
<td>Expeditionary AE Squadron</td>
</tr>
<tr>
<td>JTF</td>
<td>Joint Task Force</td>
</tr>
<tr>
<td>MASF</td>
<td>Mobile Aeromedical Staging Facility</td>
</tr>
<tr>
<td>TACC</td>
<td>Tanker/Airlift Control Center</td>
</tr>
<tr>
<td>USTC</td>
<td>United States Transportation Command</td>
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</tbody>
</table>
2.4.1 When deployed, teams will operate under the direction of the deployed expeditionary aeromedical evacuation squadron (EAES) command. A CCATT Director will be designated by the EAES commander and serve as liaison for the AE command section. The director will be responsible for managing each of the CCATTs assigned to the squadron, establishing the rotational schedule, communicating with the crew management cell, and addressing other team issues that may arise. This position may be assigned to an officer of lesser rank but greater CCATT experience. The CCATT director reports directly to the EAES commander and is integrated into the EAES command structure at the equivalent level of the director of operations and the chief nurse. (See Figure 2.2.) CCATTs will organizationally align under the AE command structure and will be a supporting element of the staging facility or any other AE element to which they are assigned/attached. The CCATT director and chief nurse report to the EAES commander on CCATT and nursing issues and perform advisory roles for CCATT teams and AE crews.

**Figure 2.2. Expeditionary AE Squadron**

2.4.2 While in flight, teams will operate under the direction of the medical crew director (MCD). However, the CCATT physician will be responsible for clinical management and care of patients assigned to the CCATT. If there is conflict between patient care and safety of flight, then the CCATT chief on-board will defer to the MCD for further guidance. Safety of flight consideration must take precedence.

2.4.3 CCATTs will receive medical intelligence reports through the aeromedical evacuation control team (AECT) or AE command section.
2.4.4 Prior to flight operations, teams will be briefed by the MCD on any information discussed in the crew brief.

2.5 Communications & Computer Support. Teams will utilize communications and computer systems support within the AE elements to which they are assigned/attached. The following are descriptions of the communication systems employed within the AE system, including organic HF, VHF, UHF, and satellite communications (SATCOM) radio assets as a means of providing communications capability to the AE system. (See Figure 2.3) Trained AE communication systems specialists (3C1X1) are assigned to set up, initiate, and maintain communications between elements and respond to a variety of transmission modes, formats, and conditions.

Figure 2.3 AE UTC Communication Support Matrix

<table>
<thead>
<tr>
<th>AE Unit Type Codes</th>
<th>HF</th>
<th>UHF MILSAT</th>
<th>INMARSAT</th>
<th>Iridium</th>
<th>XTS 5000 Handheld</th>
<th>XTS 5000 Base Station</th>
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<tbody>
<tr>
<td>AE Command Squadron - AECS (FFQC1)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>AE Liaison Team - AELT (FFQL1)</td>
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<td>MASF-10 (FFQM1)</td>
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<td>AE Operations Team - AEOT (FFQN1)</td>
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<td>AE Support Cell - AESC (FFQS1)</td>
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<td>CASF Command (FFVCF)</td>
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2.5.1 AN/PRC-150(C) is a self-contained, manpack or vehicular mounted, HF and VHF radio set. Capabilities include frequency coverage of 1.6 to 60 MHz in SSB/CW/AM and FM in the VHF band with 100 preset channels. DC power to the radio set is either from the rechargeable 24 VDC batteries (MRC-2590) or the equivalent Ref: AN/PRC-150(V)(C) Publication Number:10515-0103-4100, May 2001

2.5.2 Land Mobile Radio (LMR) is a program to acquire non-tactical communications equipment for worldwide use. It consists of hand-held radios, vehicular adapters; base stations, and other ancillary equipment. The radio equipment provides clear and secure voice that is interoperable with a wide variety of DOD military and commercial radios operating in the 30-88 MHz, 136-174 MHz, or 403-470 MHz frequency bands. The LMR is a cryptographic controlled item (CCI) and classified to the level of the encryption key when loaded.

2.5.2.1 Motorola XTS 5000 Hand Held Radio. Consists of the receiver/transmitter set: programmer unit (RKN4105), base station (P2061), key loader (T6717), battery charger and conditioner (WPLN4108AR). Ref: Owners/Operators Instruction Manual
2.5.2.2 Motorola XTVA transportable base station is designed to enhance the operation of an XTS 3000 or XTS 5000 portable radio. The XTVA is packaged in a lightweight horizontal carbide black lockable aluminum suitcase. This product provides the versatility and flexibility of a fixed or transportable base station. It operates with AC or DC power input, and allows in-vehicle or out-of-vehicle portable radio battery charging operation. Also included is an RF power amplifier, which corresponds to any of the three offered frequency bands. REF: Owner/Operators Manual

2.5.3 STU III/STE is a secure/non-secure telephone used to place official calls concerning sensitive and classified information. The STU III/STE is a CCI and classified to the level of the encryption key when loaded. Ref: Owner/Operators Manual

2.5.4 International Maritime Satellite (INMARSAT) is a commercial system used to provide initial communications for the AECE UTC. It is comprised of an INMARSAT ‘M4’ terminal, antenna and requires a STU III/STE for secure voice operations. Under normal operating conditions, it is capable of providing communications to almost anywhere in the world. Ref: Owner/Operators Manual

2.5.5 AN/PSC-5 Spitfire is a portable UHF, Demand Assigned Multiple Access (DAMA) capable, military satellite communications terminal with embedded communications security (COMSEC) capable of secure voice and data. This item of equipment can also provide UHF line-of-sight operations. The AN/PSC-5 is a CCI and classified to the level of the encryption key when loaded. Ref: TO 31R2-2PSC5-1 & TO 31R2-2PSC5-2

2.6 Medical Oversight. Both expeditionary and overall medical oversight for CCATT missions aligns under the same theater structure as that of the parent AE system. The presence of a critical care physician is unique to CCAT in the AE system, adding direct medical oversight at the site of patient care.
Chapter 3
OPERATIONS

3.1 Scope. The CCATTs function as components of the AE system and are not trained or equipped to operate as a stand-alone expeditionary capability. As an AE asset, teams will be involved in the full spectrum of operations to move critically injured and/or ill patients to the next level of care. CCATTs provide advanced specialized medical care to critically ill, injured, or burned patients requiring continuous stabilization or advanced care during air transport. SOF CCATTs are utilized for SOF casualties transiting the SOF casualty evacuation system. SOF CCATTs fall under different command relationships and have a different operational interface, which are outlined in the AFSOC Medical Concept of Operations.

3.2 Force Health Protection. Global Engagement charges Aerospace Expeditionary Forces to rapidly deploy in different parts of the world at a moment’s notice. People, systems, and facilities of supporting bases are essential to the launch, recovery, and sustainment of aerospace platforms, usually as part of an Air Expeditionary Force (AEF). Air Force medical services are crucial to base defense and resumption of operations during a wide spectrum of AEF operations. It is assumed medical personnel may potentially operate in a biological/chemical environment. CCATTs must be deployed with appropriate training and individual protective equipment (IPE). As an AE asset, will be exposed to the same conditions as AE crews or AE elements.

3.2.1 Flight Operations Protective Clothing and Equipment. CCATT members must be properly equipped to include aircrew-specific personal protective clothing items to perform duties in the flying environment. CCATT members must have the same flight personal protective clothing, equipment, and IPE as the organic AE crew. A list of initial-issue minimum-required protective clothing/equipment items for CCATT flight operations is shown in Attachment 8. A list of minimum-required protective clothing/equipment items for CCATT flight operations in a deployed location is shown in Attachment 9. Each CCATT member must be provided the required protective clothing and equipment for flight operations to perform AE missions.

3.2.2 CCATTs are not considered, nor do they qualify to obtain, rated or non-rated aircrew status. CCATTs are designated as operational support fliers (OSF). (Exception: active flight surgeons holding an API/RPI 5 position performing duties as CCATT.) As OSF, CCATTs do not fall under the Operations Group for training and equipping and do not receive support from Life Support personnel. It is the responsibility of the home station MTF/CC to properly train and equip each member identified to fill each CCATT position requirements.

3.3 Employment:

3.3.1 CCATT relationship with AE. As an AE asset, CCATTs are not considered a part of the AE aircrew, UTC FFQDA, and are not AE crewmembers (AECMs). CCATT personnel should be regarded as a vital and equal members of the AE team during deployments and patient transport missions. Ultimately, it is the responsibility of the AE commander to ensure unit cohesiveness. It is the responsibility of the MCD assigned to a
particular mission to ensure crew-team cohesiveness and integrity between CCATTs and AECMs.

3.3.2 Operational Support Flier (OSF) Status: CCATTs fly in OSF (non-crewmember) status and must comply with AFI 11-401, Aviation Management, and AFI 11-402, Aviation and Parachutist Service, Aeronautical Ratings and Badges. CCATTs are authorized to perform in-flight duties on US fixed-wing and rotary aircraft. (NOTE: authorization for CCATTs to fly on other than USAF aircraft must comply with AFI 11-401, paras 1.6, 1.7, and 1.11.) CCATTs must have completed the CCATT Basic Course (B30ZYCCATT-000), be medically qualified according to AFI 48-123, Medical Examination and Standards, and have completed appropriate physiologic training IAW AFI 11-403, Aerospace Physiological Training Program, to participate in flying activities. Once these qualifications have been met, a CCATT member will be placed on OSF status. Personnel may not be employed or deployed as CCATT until they meet all requirements for OSF status.

3.3.2.1 Upon meeting the qualifications for OSF status, CCATT members must report to their home-station Host Aviation Resource Management (HARM) or Squadron Aviation Resource Management (SARM) office. The HARM office will create a flight record folder and, when required, provide CCATT members with aeronautical orders (AO) authorizing participation in flight operations. CCATT members must be on AOs to participate in flying operations (exception: verbal order of the commander IAW AFI 11-401). As OSF, CCATT members are authorized to log flight time on AFTO Form 781, ARMS Aircrew/Mission Flight Data Document and are eligible for hazardous duty incentive pay (HDIP). Only “primary” time logged counts toward credit for HDIP; CCATTs only log “primary” time when actually performing critical care duties with a critical care patient on-board the aircraft. CCATT members tasked to fly as medical attendant(s) (MA) for non-critically ill patients will not log time and are not eligible for HDIP for MA missions, i.e. FFCCE team when functioning as MA (ref: para 1.3.3).

3.3.2.2 Aviation Service Code/Flight Authorization Code. The assigned aviation service code (ASC) for CCATT members performing duties as operational support fliers is "ASC 9C." The flight authorization duty code for CCATTs on OSF is "FZ."

3.3.2.2.1 Active Flight Surgeons may be employed as CCATT members provided they also hold one of the qualifying AFSCs required for CCATT duty as outlined in the UTC mission capabilities (MISCAP) statement and manpower force (MANFOR) packaging document. Active flight surgeons will log "FS" crew position and primary-time duty credit, record "ASC 8A, and will qualify for aviation career incentive pay (ACIP).

3.3.2.2.2 Inactive flight surgeons may also be employed as CCATT members provided they, too, hold one of the qualifying AFSCs as outlined in the CCATT MISCAP. Because they are rated officers, their ASC must remain "8J" (based on no API 5/no ACIP authorized), their AO must
reflect a "FAC 8" IAW AFI 11-401, table 2.2 (rated officer performing non-crew duty), and they must log crew position "FZ" time IAW AFI 11-401, table A2.3 on CCATT missions. In addition, the AO remarks for these inactive flight surgeons must reflect the additional comment, "Rated officers authorized to perform non-crew, FAC 8 duty." Following this guidance, inactive flight surgeons employed as CCATTs qualify for HDIP.

3.3.2.3 AFTO Form 781. AFTO Form 781 is the source document for recording and reporting operational flight information for each individual authorized to take part in a mission. This form is the primary record of both personnel and aerospace vehicle flying hours. It is also the official record to validate pay eligibility for qualified members required to fly. Complete AFTO Form 781 IAW AFI 11-401, Attachment 2. CCATT duties must be logged in the remarks section on the AFTO Form 781 and certified (SIGNED) by the aircraft commander. NOTE: per AF/XO Exception to Policy Letter, dated 4 June 2004 [Authentication of AFTO Form 781, Operational Support Flying (OSF) Duties], the MCD may certify this section for CCATTs. CCATT members will include their home station HARM/SARM base, DSN phone number, and fax number in the remarks section on the back of the (original and extract) AFTO Form 781. (See AFI 11-401, Figure A2.1, for a sample AFTO Form 781.)

3.3.3 CCATT Utilization. CCATTs are a limited, rapidly deployable resource, available in selected situations to enhance AE capability. The patient movement requirement center (PMRC) validates the requirement for CCATT patient movement/regulation. The CCATT is then tasked by the AECT and/or TACC AE cell, through the AE command element. CCATTs may be tasked to supplement theater evacuation requirements as directed by the Chief of AECT or for inter-theater evacuation as tasked by the TACC AE cell. Requirements for support will be based on expected casualties, location, available medical capability, and en route care requirements. The number and mix of personnel are based on the requirement identified at execution.

3.3.4 CCATT Tasking. A primary critical care air transport team (FFCCT) and the extender team (FFCCE) may be deployed/employed with AE elements based on operational requirements. The request for CCATTs comes through a coordinated effort between the originating physician, PMRC validating flight surgeon, and destination-accepting physician. The PMRC validating flight surgeon will work with the sending, accepting, and the transporting CCATT physician when planning and coordinating the patient’s transfer. The CCATT work/rest cycle will be considered when launching the team (refer to paragraph 3.5.1.1.). The transporting CCATT physician will make the final determination whether or not a patient will be transported after assessment while considering the patient’s ability to tolerate transport and operational considerations. The CCATT physician will work with the MCD to notify the PMRC as mission requirements dictate. Tasking of CCATTs will mirror the same process as AE crews. Consultation will be required prior to mission execution to determine the ideal provider mix to transport neonatal and pediatric critical patients. CCATTs will deploy and employ as teams with complete equipment sets. At execution, the theater validating flight surgeon will determine the number of CCATTs on each mission, and may consult with the theater
CCAT clinical director when warranted. When employed, each CCATT will be a dedicated asset of the AE system. The patient care and in-flight requirements will determine the mix and placement of this unit type code. The FFCCT, when employed with the FFCCA equipment package, provides capability to support and provide care for a maximum patient load of 3 high-acuity ventilator patients or up to 6 lower-acuity stabilized patients. FFCCE teams, when employed with an additional FFCCA equipment package, combine with a FFCCT team to increase the maximum patient load up to 5 high-acuity ventilator patients or 10 relatively lower-acuity, stabilized patients based on the total patient acuity level for the mission. Additional CCATTs, FFCCT and/or FFCCE, may be required on a given mission depending on the acuity and number of the patients being transported.

3.3.4.1 A pediatric or neo-natal critical care air transport team (FFCCP or FFCCN, respectively) will most likely be notified for AE missions when pediatric or neonatal requirements have been identified for patient movement from originating station. FFCCPs will generally be utilized to transport critically ill patients between 3 months and 14 years of age. FFCCNs will generally be utilized to transport patients from birth up to 3 months old. The limiting factor in determining a “maximum/minimum” patient age of 3 months between the FFCCP teams and FFCCN teams is the size of the transport isolet. Weights and body lengths of infant children can vary. Close coordination between the PMRC and the sending facility considering such factors as patient acuity, transport care requirements, age, weight, and size of child is necessary in determining which team may be most appropriate for a particular mission.

3.4 In-flight Operations:

3.4.1 CCATT Mission Responsibilities. The CCATTs will work in conjunction with the AE crews. AE crewmembers will continue with standard in-flight duties and assist CCATTs as required to enhance AE mission capability. The AE crew will provide all power and oxygen support for CCAT missions. The CCATT physician is responsible for all clinical decisions regarding critically ill patients under their care during patient movement, including medical management and recommendations to the MCD for diverting the aircraft to meet patient requirements. The CCATT will advise and/or support other patient care issues when requested by the MCD or indicated by observed patient deterioration or instability. Depending on the mission’s critical care requirements, the MCD will incorporate the CCATT capabilities into pre-mission planning and briefings for patient emergencies. The team exists to manage patients requiring critical care in the AE environment and may be required by command to move a patient by air without an AE crew. If this happens, HQ AMC/A37VM will provide guidance IAW AFI 11-2AEV3, para 3.2.2.1.

3.4.2 Rotary Wing Operations. CCATT personnel may transport critically ill or injured patients on rotary wing aircraft when patient requirements dictate, and it is necessary to save life or limb. Utilization of CCATTs on rotary wing aircraft must be approved through the command and control agency governing the CCAT team (usually the execution arm of the Air Mobility Division). On fixed-wing AE missions, CCATTs normally fly with AE crewmembers; AE crewmembers are not required to fly along with
CCATTs on rotary wing aircraft. Prior to transporting patients on any rotary wing aircraft CCATT members must be thoroughly briefed on ground operations, flight safety, egress, patient loading/unloading, etc. by the rotary wing aircraft crewmembers. It is the responsibility of the CCAT team chief to ensure members are adequately briefed prior to a rotary wing mission. Due to space and weight limitations on some rotary wing aircraft, it may be necessary to pare and tailor both the personnel and equipment. The CCATT physician, in close coordination with the tasking authority, will evaluate the mission requirements to ensure patient and mission needs are met with whatever team and equipment complement is utilized.

3.4.3 CCATT Duty/Rest Cycle Day. Under typical operating conditions the FFCCT, FFCCE, FFCCP, and FFCCN are capable of a work/rest cycle of 16/8 hours, which can be continued for 5 days before a scheduled rest day is required. The 16-hour work period is based on patient-care time and begins when the team assumes responsibility and initiates care for their assigned patient(s), not when the team is first alerted for a mission. The work-period ends when the team has delivered the patient(s) to the next level of care and the receiving facility assumes care responsibilities for the patient. The duty day may be shortened during operations in certain conditions such as extreme temperature, a chemical/biological weapons environment, or when the team has consistently managed a large number of high-acuity patients. Under certain circumstances the CCATT chief may recommend extending the duty day beyond 16-hours. In making this decision, the team chief needs to consider potential benefits to include improved continuity of patient care and potentially harmful delays in transport while awaiting the availability of a replacement CCATT. The team chief also needs to consider the ability of the entire team to rest when not engaged in patient care, the appropriateness of the team resting in shifts while engaged in patient care, the team’s response to fatigue countermeasures, and individual team member factors affecting operational risk management. Any recommendation of extended duty day for CCATT members must be discussed with the MCD to ensure adequate coordination of potential operational mission impact.

3.4.3.1 There may be times (inclement weather, winds, crew duty day, aircraft maintenance issues, etc.) when the AE crew must remain over-night (RON) at fields where local medical care is less capable than that provided by the CCATT. To maintain standard of care the CCATT may be required to continue caring for the patient, impacting work/rest cycle. The local MTF commander (or equivalent), MCD, and CCATT team leader should collectively determine the optimal solution to satisfy both competing requirements. A major factor to be considered is the CCATT duty day and rest cycle. In instances where the CCATT duty day is projected or has exceeded the recommended 16-hour period, the CCATT team leader has the authority to determine if any of the CCATT members are in need of rest/sleep and authorize rest/sleep if deemed necessary.

3.4.3.2 It will be the responsibility of the en-route AE element to help the CCATT return to the theater of operation as soon as the team has had time for rest and the replenishment/reconstitution of their expended supplies.

3.4.3.2.1 Any CCATT whose total duty day has extended beyond 24 hours, inclusive of mission support and patient care activities, will have a
minimum 10 hours of uninterrupted rest/sleep prior to returning to the area of operation. During this time teams will not perform any duties other than restocking expended supplies. The exception to this item is when the patient flow is elevated resulting in a shortage of teams in theater. If tasked for a mission in that situation, the CCATT chief will assess whether the team is mentally and physically able to safely complete the mission and provide satisfactory critical care. If the team is assessed as unsafe, the AE Operations Team (AEOT) will coordinate mission retasking with the PRMC/AECT/TACC as applicable.

3.4.3.2.2 Any CCATT that has been caring for and transporting patients for less than 12 hours from the time of assuming responsibility for the patient(s) to the time of patient transfer to the receiving MTF can be returned to the area of operation without a rest period. If tasked for a patient transport mission where the total mission time of the consecutive missions will exceed 16 hours, the CCATT chief will assess whether the team is mentally and physically able to safely complete the mission and provide satisfactory critical care. If the team is assessed as unsafe, the AEOT will coordinate mission retasking with the PMRC/AECT/TACC as applicable.

3.4.3.3 To ensure adequate time for rest/sleep cycles for CCATT, a rotational schedule must be established among the deployed teams at a particular location and communicated to the AEOT. The CCATT director will establish the rotational schedule and communicate the schedule to the AEOT. In special circumstances, this rotational schedule may be disrupted according to the flow of patients or when the CCATT director (or designee, if not available) determines that it is medically or operationally necessary to accomplish the mission successfully. An example of such a circumstance would include the need for a cardiologist for a patient with an acute myocardial infarction when it is not the cardiologist’s turn to do the mission. Out-of-cycle team utilization should be a rare occurrence but may be required if a patient’s condition dictates the need for a particular specialty.

3.4.4 Documentation. AF Form 3899, Aeromedical Evacuation Patient Record, should accompany each patient to ensure appropriate care is documented during transport and serves as the legal record of patient care while in the AE system. This document is used to direct and record en route care. If available, copies of patient medical documentation including operative reports should be provided to CCATT team chief.

3.4.5 CCATT Mission Report. CCATTs are required to complete a CCATT Mission Report (Attachment 10) during/after each mission and forward the report to HQ AMC/SGP, per the instructions on the document. The mission report is a vital record of particular operational and medical aspects of a critical care air transport mission. Critical statistical, operational, and clinical information is gleaned from these reports to change/update training, and concepts of operation or identify trends and equipment issues, etc. Mission reports should be completed and sent to HQ AMC/SGP typically at the end of each mission. Deployed CCATTs may accumulate mission reports over the
duration of the deployment and forward the reports to HQ AMC/SGP prior to departing the deployed location or upon return to home station. A copy of the CCATT Mission Report can be found on the HQ AMC CCATT website:

3.5 Ground Operations. While deployed, the CCATTs will fall under the supervisory control of the AE element OIC. The CCATT physician manages clinical decisions. The AE units should regard the CCATTs as critical care medical consultants, available to provide advice whenever questions arise about critical care patient movement. CCATT personnel occasionally may supplement local MTF staff to maintain clinical proficiency and continuity of care, when practical and not on primary call/alert. The CCATT director approves this after coordination with the AE element OIC. While the CCATT members fall under the expeditary AE squadron/element OIC and only supplement the MTF, all parties should be flexible to ensure the best utilization of highly trained personnel for any given situation. The CCATT director will be the primary liaison between AE and other ground patient care facilities and will determine involvement of CCATT in ground operations. CCATT personnel must not be scheduled for regular duty hours in a MTF due to the nature of the ever-changing flying environment – these duties should not interrupt AE duties, work/rest cycle, or mission-ready status. Adequate rest cycles must be maintained for all CCATTs due to the marked variability of mission tasking and possible maximal team utilization in the deployed environment.

3.5.1 Mission Support Operations. The CCATTs will be fully integrated into the AE staging and ground mission support operations and may be included in all duties related to expeditary squadron/element deployment, employment (including camp set-up), and re-deployment activities while maximizing mission readiness and appropriate work/rest cycles. Launch and recovery operations and standard aircraft configuration are the responsibility of AEOT and AECM personnel. CCATT personnel may participate in aircraft configuration duties and other ground operations alongside experienced AE personnel when authorized by the CCATT director, not on primary call, and governed by the 16/8-hour work/rest rule. Before being assigned tasks, CCATT personnel must be fully oriented and trained in the performance of ground mission support duties and may perform these duties only under the supervision of experienced AE ground support personnel. Under no circumstances should CCATT personnel be required to perform launch and recovery of aircraft, aircraft configuration, and other ground support activities without proper orientation/training and without experienced AE ground support personnel.

3.5.1.1 Non-CCATT Patients: The CCATTs can help support non-CCATT patient reception and triage at the AE staging location or other AE patient interface point as befitting the team’s clinical skills. The CCATT Director should ensure that this support does not interfere with their primary assigned duties, work/rest rule, and their mission-ready status.

3.5.1.2 CCATT Patients:

3.5.1.2.1 For critically ill patients, assessment of the patient’s clinical status for flight should be accomplished by the CCATT at the originating MTF whenever feasible.
3.5.1.2.2 Patients should be transitioned to CCATT equipment and assessed for stability in an MTF environment when geographically feasible. Any interventions required to enhance stability for transport should be performed prior to transport.

3.5.1.2.3 Determination of continuing pre-flight care requirements must be ongoing as change in clinical status may require postponement or cancellation of the patient’s scheduled transport.

3.5.1.2.4 At the completion of the AE mission the patient must be transferred to the receiving expeditionary medical platform/MTF without degradation in the standard of care.

3.6 Security: Medical personnel and equipment are non-combatant assets. Personnel may be armed as dictated by theater instructions. Security for CCATT personnel and equipment is the responsibility of the host unit. If CCATT personnel require weapons, all team members will be issued M-9s, IAW AFI 41-106, Medical Readiness Planning and Training. CCATT personnel must maintain qualification in the M-9.
Chapter 4  

TRAINING  

4.1 Introduction. Initial and sustainment training are required in order to maintain the operational and clinical proficiency of CCATT-assigned personnel. CCATT members will not be employed or deployed in a CCATT capacity unless they meet all initial and sustainment training requirements IAW this TPP and AFI 41-106.  

4.2 Entry into CCATT Training. Personnel are selected at the unit level for consideration for appointment/nomination as CCATT members. Validation for entry into the CCATT training pipeline will be performed by the Clinical Validation Committee administered by AFEMSI, under the authority of HQ AMC/SG. Ref: para 1.4.2.  

4.3 CCATT Coordinator: A CCATT coordinator will be established at each unit that has a CCATT UTC. The medical commander will appoint this person in writing. Examples of the unit CCATT coordinator’s responsibilities are as follows: (1) central point of contact within the unit for all matters pertaining to CCATT interface with the unit, MAJCOM, and higher headquarters for CCATT issues, (2) establishing and maintaining six-part training folders for each CCATT member assigned, (3) ensuring all initial and sustainment training requirements are scheduled to be met/current, (4) initiating all required forms and documentation for all new CCATT members, (5) ensuring CCATTs are properly equipped for AE missions, (6) identifying and scheduling personnel to meet initial training and sustainment training requirements in coordination with the training office and the medical readiness office, (7) coordinating with the medical readiness office to ensure members are ready to deploy, and, (8) other responsibilities that may be assigned and necessary for unit-level CCATT administration. NOTE: this does not apply to AE units when CCATTs are temporarily assigned/attached for completion of the AE mission. When CCATTs are assigned to an AE squadron, a CCATT director is assigned for management of CCATTs. Ref: para 2.3.1.  

4.4 Training Pipeline (see Attachment 11, Table A11.1):  

4.4.1 UTC Training - CCATT Basic Course (B3OZYCCATT-001). Training for personnel assigned to CCATT UTCs will be conducted by the School of Aerospace Medicine (USAFSAM). All CCATT personnel will attend the CCATT Basic Course within 6 months of appointment to the UTC, with priority given to those UTCs scheduled in the AEF cycle to meet contingency/steady-state requirements. All CCATT members must successfully complete this formal training prior to employment/deployment as CCATT. EXCEPTIONS: personnel who were assigned to the CCATT mission prior to formal establishment of the CCATT Basic Course in Oct 1997, and/or were assigned as instructor staff of the CCATT Basic Course or the Center for Sustainment of Trauma and Readiness Skills (C-STARS), and/or were assigned to a CCATT UTC in support of a deployed theater aeromedical evacuation system (TAES) and performed critical care patient evacuation missions prior to 1 Apr 2002. These personnel may request a waiver of requirement to attend the CCATT Basic Course. Waiver requests should be signed by the member’s unit commander and directed to HQ AF/SG for approval. (See Attachment 12 for sample waiver letter.)
4.4.2 UTC Training - CCATT Advanced Course (B4OZYSTARS-C11). All CCATT personnel must complete UTC formal training requirements IAW AFI 41-106. HQ AF/SG has established the Centers for Sustainment of Trauma and Readiness Skills (C-STARS) [CCATT Advanced Course] located at Level I trauma centers as the model to fulfill the requirement for CCATT UTC formal training. The C-STARS platforms are administered by AFEMSI. C-STARS Cincinnati and C-STARS Wilford Hall have been designated by the, HQ AMC CCATT MEFP, as the programs specifically for CCATTs. The pilot unit establishes sustainment requirements in cooperation with the CCATT Working Group and AFEMSI. Active component CCATT personnel will complete C-STARS training once every AEF cycle, normally beginning in the AEF pair immediately following the one in which they completed the initial CCATT Course, a minimum of 30 days prior to AEF rotation. ARC CCATT personnel will complete C-STARS training every other AEF cycle, normally beginning in the AEF pair immediately following the one in which they completed the initial CCATT Course, a minimum of 30 days prior to AEF rotation/deployment. CCATT members who are identified for deployment during the AEF cycle in which they completed the CCATT basic course must also complete C-STARS prior to employment/deployment as CCATT in support of AE operations regardless of when they completed the CCATT basic course. All CCATT members must complete C-STARS prior to employment/deployment. Most students will be expected to complete C-STARS training 90-120 days prior to deployment. Attendees who fail or are unable to successfully complete C-STARS training will be assigned probationary status and will require remediation prior to deployment as a CCATT member. The remediation-training plan will be issued to the individual and his/her commander by the training C-STARS director. Requirement to complete C-STARS training is not waiverable.

4.4.3 Contingency Training. CCATT teams will undergo initial contingency operations training at the Aeromedical Evacuation Contingency Operations Training (AECOT) course located at Sheppard AFB TX. Primary introduction to CCATT integration into deployed AE operations as well as hands-on experience with the Base Operations Support (FFCCS) package will occur at AECOT. All CCATT personnel must complete initial AECOT IAW AFI 41-106, para 5.3.5.5. Active component CCATT personnel will complete initial AECOT within 12 months of completion of initial CCATT Course. ARC CCATT personnel will complete initial AECOT within 18 months of completion of initial CCATT Course. Initial AECOT training may be waived based on experience gained/roles played as a member of a CCATT UTC during assignment to a deployed TAES, Joint Readiness Training Center (JRTC) rotation, or participation in an exercise that encompassed a fully deployed TAES. Member must have been assigned to a deployed TAES, JRTC rotation, or TAES exercise for at least 7 consecutive days and participated in at least 2 live (operational deployment) or simulated (JRTC/exercise) CCATT missions to be considered for initial AECOT waiver. Waiver requests for initial AECOT will be processed through the unit medical readiness office, signed by the unit commander, and forwarded to HQ AMC/SGP for review/approval. Initial AECOT training for CCATT will only be waived by HQ AMC/SGP. See Attachment 13 for a sample Initial AECOT waiver request.

4.4.3.1 TAES Sustainment Training. TAES sustainment training requires participation in a CCATT UTC during assignment to: (1) an exercise that
encompasses a fully deployed TAES, i.e. a rotation at JRTC Ft. Polk LA, Patriot (FYXX) exercise, Pacific Warrior exercise, etc., or, (2) a deployed TAES operation. IAW AFI 41-106, completion of TAES sustainment training is required every four AEF training cycles not to exceed 60 months.

4.4.4 **Operational Support Flier.** All CCATT personnel must complete the requirements for operational support flier (OSF) status IAW AFI 11-402, Chap 8. CCATT personnel must maintain currency in OSF requirements as long as they are assigned to a CCATT UTC. Personnel may not be employed or deployed as CCATT members if they have not completed or are not current in OSF requirements.

4.4.5 **Operational Exercises.** Some sustainment training and RSVs may be completed at operational exercises provided the exercise meets the following criteria.

4.4.5.1 Have a written training plan outlining day-to-day objectives. Training plan must follow UTC mission essential task list (METLs) and must be approved AMC/SGP.

4.4.5.2 Must have an Observer Controller (OC)/Standard Evaluator (SE) who has been approved by AMC/SG, as a trainer/instructor. Requesting unit will pay for individual(s) to participate in exercise as OC/SE. There will be one OC per CCATT.

4.4.5.3 OC/SE Qualifications. HQ AMC/SGP will establish guidelines and selection criteria for selecting OC and SE personnel.

4.4.6 **Readiness Training.** Personnel who have not completed the initial CCATT Course, all readiness training, RSV tasks, OSF requirement, and C-STARS training requirements IAW this TTP will be considered non-deployable.

4.4.7 **High Risk of Capture (HRC) Training.** HRC training is mandated for fliers involved in air operations over specific areas within or flying into a combatant command AOR during contingency operations. The training requirement is identified in the AOR Operations Order (OPORD). HRC training is to be conducted by a certified Survival, Evasion, Resistance and Escape (SERE) instructor. Each wing life-support duty section can provide HRC training. Each CCATT must attend HRC training prior to deployment to a combat zone. HRC training is good for 2 years. Training must be documented on an AF Form 1522, *ARMS Additional Training Accomplishment Report*. The event identifier is SS07 (Contingency SERE Indoctrination). After the training is complete a copy of the AF Form 1522 must be retained in the individual’s CCATT training folder and the date recorded on the section 3 record of training form. Training is also recorded on the Isolated Personnel Report (ISOPREP), block 24. Prior to training, all personnel must have their security clearance (Secret) verified by their unit CCATT coordinator or readiness office. A guide for completing HRC training can be found on the AMC CCATT website, URL currently: [https://amc.scott.af.mil/sg/ccatt/ccatt.cfm](https://amc.scott.af.mil/sg/ccatt/ccatt.cfm).

4.4.7.1 **Isolated Personnel Report (ISOPREP).** The ISOPREP is a Department of Defense Form (DD 1833) containing information designed to identify and
authenticate an evader by a recovery force. The ISOPREP is maintained on all
HRC personnel. It contains personal data known only to the isolated individual
and is used by recovery forces to positively authenticate the survivor. An initial
form is completed and then reviewed at least every 6 months. Once completed,
the ISOPREP is classified Confidential and is maintained by the appropriate unit
intelligence, SERE, or operations personnel. The ISOPREP is prepared by home-
station intelligence personnel for deploying members prior to departure to an
AOR where ISOPREP and HRC training is required. A guide for completing
ISOPREPs can be found on the AMC CCATT website, URL currently:

4.4.8 N95 Mask Fit Testing/Training. CCATT personnel are potentially exposed to
highly communicable diseases during patient care and transport. IAW Occupational
Safety and Health Act of 1970, the Air Force Occupational Safety and Health Program
(AFOSH), and AFI 41-307, Aeromedical Evacuation Patient Considerations and
Standards of Care, state that personnel must be medically cleared, fit-tested, and trained
for wear of an N95 respirator prior to first use. Personnel must receive subsequent fit-
testing and training annually. Reference AFOSH Std 48-137, Respiratory Protection
Program, for specific requirements and contact the supporting occupational health staff
for support.

4.4.9 Medical Survival, Evasion, Resistance, Escape (SERE) Training. This course
(B3AZYBLMD-000) is recommended but not mandatory. Since it is not an AF
requirement for CCATTs, central funding for CCATT personnel is not available. Units
requesting this training for CCATT personnel will be required to support with unit funds.
The medical SERE course trains medical personnel who are preparing for flying duties or
those currently on flying status. Topics covered include, but are not limited to, parachute
decent procedures, and principle and techniques on the employment of survival, evasion,
resistance, and escape (SERE) regardless of climate or hostile environments which will
permit them to survive and care for their patients and/or passengers and assist in their safe
recovery. Additionally, this course is designed to train selected personnel in their rights
and responsibilities, guidelines for behavior, and procedures for returning to friendly
forces without rendering aid or comfort to an enemy with or without organized recovery.
Course length is 9 training days. Graduates of this course receive credit for Level B
wartime and peacetime Code of Conduct Training. Contact the USAF School of
Aerospace Medicine (USAFSAM) for information.
Chapter 5

LOGISTICS

5.1 Allowance Standards. CCATT equipment packages are to be used in conjunction with the standard AE in-flight kit and the patient movement item (PMI) system to provide focused critical care capability.

5.1.1 Standard Operations. Each CCATT adult kit (FFCCA) has the capability to support up to six stabilized patients per intra- or inter-theater missions. FFCCB is the adult resupply equipment package. One pediatric augmentation package (FFCC2) should be deployed to support up to 3 FFCCT teams at locations where pediatric casualties are likely. Specialized equipment items not available in the PMI system will be included in the CCATT allowance standard (AS). A basic adult mission would require the adult kit with initial 5-day capability.

5.1.2 Neonatal/Pediatric Operations. For missions requiring FFCCN or FFCCP CCATTs, the Neonatal/Pediatric Kit, UTC FFCCC, can support up to three high-acuity pediatric patients, or one high-acuity neonate per transport. This kit will provide support for pediatric (3 months to 14 years) patients weighing between 15-40 kg and neonatal (birth to 3 months) patients weighing < 1.5kg. There is no resupply package for the pediatric/neonatal equipment package. Units tasked with pediatric/neonatal UTCs will utilize existing in-use neonatal transport.

5.1.3 Pediatric Humanitarian Operations During Contingencies. During contingency operations where FFCCT CCAT teams are deployed in support of critical care patient movements, there may be occasions when it is necessary to transport pediatric patients on humanitarian missions. The Adult CCATT Kit, UTC FFCCA, does not provide equipment to support pediatric patients. A pediatric equipment augmentation kit, UTC FFCC2, has been developed which provides additional equipment/supplies to FFCCA equipment to support FFCCT when a team is required to transport pediatric patients. This kit provides single mission support for a maximum of 2 pediatric patients weighing < 15 kg, and, a maximum of 2 pediatric patients weighing between 15 – 40 kg).

5.1.4 Equipment requirements will be supported to the greatest extent possible by the PMI pool. Packing lists and pharmaceutical lists for individual kits are provided on the Air Force Medical Logistics website (URL currently: https://afml.ft-detrick.af.mil/afmlo/index.cfm), in the medical readiness section. The allowance standards for the various equipment UTCs are as follows:

FFCCA – Adult Basic Kit: 887N

FFCCB – Adult Basic Kit Re-supply: 887H

FFCCC – Pediatric/Neonatal Kit: 887I

FFCC2 – Pediatric Augmentation to Adult Basic Kit: 887O

FFCCS – CCATT Base Operating Support Package: 887J
5.2 Pre-flight of Equipment. CCATT equipment will be checked prior to flight to ensure operability IAW AFI 41-309. When deployed, teams are responsible to frequently assess PMI equipment operational capability and ensure adequate battery life. CCATTs should ensure appropriate charging capabilities are available for PMI equipment prior to declaring full operational capability.

5.3 Narcotics Accountability. CCATT personnel will ensure accountability of narcotics IAW AFI 11-307, Aeromedical Evacuation Patient Considerations and Standards of Care.

5.4 Base Operating Support. Integration of deployed CCATTs is critical to successful AE operations. CCATTs are not stand-alone units. The gaining AE unit will be responsible for providing all required support to the CCATTs, including billeting, food, water, shelter, power, transportation, medical oxygen support, computer support, and communications. During missions away from home base, CCATTs will receive base ops support from the enroute AE element. The CCATT Base Operations Support Package (FFCCS) should be deployed when engaged in a bare-base deployment with early-entry AE forces without full logistical support from the gaining base.

5.4.1. CCATT Support Package General. FFCCS is designed to provide essential, basic shelter and equipment storage for CCATTs and AECMs deployed to secure, forward airfields in support of tactical operations where their presence exceeds requisite shelter-support capability of the host site. Additionally, the requirements of CCATTs for power and refrigeration exceed the standard support provided to similar size units. The FFCCS may be employed at locations with AF or other component service assets.

5.4.2. Initial Response. The support package contains a modular general purpose tent system (MGPTS) to provide shelter and equipment storage space for a maximum of 12 personnel (CCATT teams and AECMs). It includes infrastructure items to support power, refrigeration, and environmental control. The package is designed for transport on a high-mobility multipurpose-wheeled vehicle (HMMWV; aka: Humvee). Other vehicles of opportunity may also be used.

5.4.3. Support. Suitable real estate (approx. 1440 square feet) is required to erect the shelter. To sustain operations for the duration of the employment period, this UTC is dependent upon the host location for subsistence (food and water), fuel, communications, transportation, civil engineering, and site security. Support requirements are to be arranged for and provided by the host component service.

5.4.4. Training. Every CCATT should have hands-on training of erecting and tearing down MGPTS tentage. Training for CCATTs and AECMs on assemblage and conducting operations in a contingency environment will be provided at AECOT. When able, training should also be provided at TAES exercises or at JRTC.

5.4.5. Assembly and Storage. CCATT support package assets will be assigned, stored, and maintained at CONUS or OCONUS locations in a “ready” mode for rapid employment. Storage facilities will provide security and adequate environmental controls to prevent damage. All equipment must be reliable and regularly inspected and maintained by the host medical logistics office.
5.4.6. **Mobilization.** Requirements for employment of CCATTs, AE crews, and equipment packages will be identified and requested by the theater SG. In order to support initial operating capabilities during the opening phases of an operation, CCATTs, AECMs, their equipment, and the CCATT support package should be marshaled together at specific CONUS or overseas locations. Personnel, equipment, and the support package must be deployed together on the same carrier if initial operating capability timelines are to be achieved at the operating location.

5.5 **Resupply and Patient Movement Items (PMI).** Teams will have to coordinate with AE control elements for re-supply of medical items that are not part of the standard PMI pool for CCAT kits. FFCCB (adult resupply package) should be staged for theater deployment within the first few days of deployment to an active theater. PMI issues should be coordinated with the Medical Equipment Repair element associated with the AE command element. It is assumed that CCAT teams will either carry PMI with them or this equipment will be made available at the next point of use via the PMI system. While not in use, PMI items will be appropriately accounted for by PMI tracking cells via the PMI tracking system; however, they will be signed over via appropriate receipt and maintained with CCAT team equipment packages. When patient medical supplies and patient PMIs are coordinated with the AE system in advance, most items can be provided from the AE staging base. The originating facility will be responsible for providing these items and should provide a one-day minimum of medical supplies. Patients entering the A/E system in a contingency environment will not self medicate with any controlled medications. Patients may self medicate with non-controlled medications only when designated by the Flight Surgeon. The originating facility will provide medications and supplies; for intra-theater movement, a 3-day supply; for inter-theater movement, a 5-day minimum supply is required. During time of war, intra and inter-theater medication supply levels will be based on command directives. (Ref: AFI 41-209, Medical Logistics Support)

5.6 **Interoperability.** If a patient transport mission terminates at a location different from the host AE unit’s or deployed AE unit’s location, the MCD will ensure the CCATT receives required support (billeting, ground transportation, etc.) while awaiting transportation. CCATTs will receive all base support from the enroute AE element. If the CCATTs are separated from the AE crew, the CCATT chief is responsible to ensure required support by contacting the base command post and controlling C2 agency (i.e. TACC, AMOCC).
### Attachment 1

**ACRONYMS AND ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACIP</td>
<td>Aviation Career Incentive Pay</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
</tr>
<tr>
<td>ADCON</td>
<td>Administrative Control</td>
</tr>
<tr>
<td>AE</td>
<td>Aeromedical Evacuation</td>
</tr>
<tr>
<td>AECM</td>
<td>Aeromedical Evacuation Crew Member</td>
</tr>
<tr>
<td>AECOT</td>
<td>Aeromedical Evacuation Contingency Operations Training</td>
</tr>
<tr>
<td>AECT</td>
<td>Aeromedical Evacuation Control Team</td>
</tr>
<tr>
<td>AEF</td>
<td>Aerospace Expeditionary Force</td>
</tr>
<tr>
<td>AEOT</td>
<td>Aeromedical Evacuation Operations Team</td>
</tr>
<tr>
<td>AES</td>
<td>Aeromedical Evacuation System</td>
</tr>
<tr>
<td>AFDD</td>
<td>Air Force Doctrine Document</td>
</tr>
<tr>
<td>AFEMSI</td>
<td>Air Force Expeditionary Medical Skills Institute</td>
</tr>
<tr>
<td>AFFOR</td>
<td>Air Force Forces</td>
</tr>
<tr>
<td>AFMLO</td>
<td>Air Force Medical Logistics Office</td>
</tr>
<tr>
<td>AFMS Kx</td>
<td>Air Force Medical Service Knowledge Exchange</td>
</tr>
<tr>
<td>AFRC</td>
<td>Air Force Reserve Command</td>
</tr>
<tr>
<td>AFSOC</td>
<td>Air Force Special Operations Command</td>
</tr>
<tr>
<td>AFTTP</td>
<td>Air Force Tactics, Techniques, and Procedures</td>
</tr>
<tr>
<td>ALICE</td>
<td>All-purpose Lightweight Individual Carrying Equipment</td>
</tr>
<tr>
<td>AMC</td>
<td>Air Mobility Command</td>
</tr>
<tr>
<td>AMD</td>
<td>Air Mobility Division</td>
</tr>
<tr>
<td>ANG</td>
<td>Air National Guard</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>AO</td>
<td>Aeronautical Order</td>
</tr>
<tr>
<td>AOR</td>
<td>Area of Responsibility</td>
</tr>
<tr>
<td>ARC</td>
<td>Air Reserve Component</td>
</tr>
<tr>
<td>ASC</td>
<td>Aviation Service Code</td>
</tr>
<tr>
<td>ATCN</td>
<td>Advanced Trauma Care for Nurses</td>
</tr>
<tr>
<td>ATLS</td>
<td>Advanced Trauma Life Support</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>C2</td>
<td>Command and Control</td>
</tr>
<tr>
<td>C4</td>
<td>Command, Control, Communications, and Computers</td>
</tr>
<tr>
<td>CASEVAC</td>
<td>Casualty Evacuation</td>
</tr>
<tr>
<td>CASF</td>
<td>Contingency Aeromedical Staging Facility</td>
</tr>
<tr>
<td>CC</td>
<td>Commander</td>
</tr>
<tr>
<td>CCAT</td>
<td>Critical Care Air Transport</td>
</tr>
<tr>
<td>CCATT</td>
<td>Critical Care Air Transport Team</td>
</tr>
<tr>
<td>CCRN</td>
<td>Critical Care Registered Nurse / Certification in Critical Care Nursing</td>
</tr>
<tr>
<td>COCOM</td>
<td>Combatant Commander</td>
</tr>
<tr>
<td>COMAFFOR</td>
<td>Commander Air Force Forces</td>
</tr>
<tr>
<td>COMSEC</td>
<td>Communications Security</td>
</tr>
<tr>
<td>CONUS</td>
<td>Continental/Contiguous United States</td>
</tr>
<tr>
<td>CRT</td>
<td>Certified Respiratory Therapist</td>
</tr>
<tr>
<td>C-STARS</td>
<td>Centers for Sustainment of Trauma and Readiness Skills</td>
</tr>
<tr>
<td>CVC</td>
<td>Clinical Validation Committee</td>
</tr>
<tr>
<td>DIRMOBFOR</td>
<td>Director of Mobility Forces</td>
</tr>
<tr>
<td>EMEDS</td>
<td>Expeditionary Medical Support</td>
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</table>
HARM  Host Aviation Resource Management
HDIP    Hazardous Duty Incentive Pay
HMMWV  High Mobility Multipurpose Wheeled Vehicle (Humvee)
HRC     High Risk of Capture
ISOPREP Isolated Personnel Report
JFACC   Joint Forces Air Component Commander
JRTC    Joint Readiness Training Center
LUM     Low Unit of Measure
MA      Medical Attendant(s)
MAJCOM  Major Command
MANFOR  Manpower Force Packaging System
MASF    Mobile Aeromedical Staging Facility
MCD     Medical Crew Director
MEDEVAC Medical Evacuation
MEFPAK  Manpower and Equipment Force Packaging
MGPTS   Modular General Purpose Tent System
MISCAP  Mission Capability
MRO     Medical Readiness Office/Officer
MTF     Medical Treatment Facility
OCONUS  Outside the Continental/Contiguous United States
OPCON   Operational Control
OPORD   Operation Order
OSF     Operational Support Flier
PALS    Pediatric Advanced Life Support
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>PMI</td>
<td>Patient Movement Items</td>
</tr>
<tr>
<td>PMR</td>
<td>Patient Movement Request</td>
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<tr>
<td>PMRC</td>
<td>Patient Movement Requirements Center</td>
</tr>
<tr>
<td>RSV</td>
<td>Readiness Skills Verification</td>
</tr>
<tr>
<td>SARM</td>
<td>Squadron Aviation Resource Management</td>
</tr>
<tr>
<td>SG</td>
<td>Surgeon General</td>
</tr>
<tr>
<td>SOF</td>
<td>Special Operations Forces</td>
</tr>
<tr>
<td>SQ</td>
<td>Squadron</td>
</tr>
<tr>
<td>TACON</td>
<td>Tactical Control</td>
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<tr>
<td>TACC</td>
<td>Tanker/Airlift Control Center</td>
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<td>TAES</td>
<td>Theater Aeromedical Evacuation System</td>
</tr>
<tr>
<td>TNCC</td>
<td>Trauma Nursing Core Course</td>
</tr>
<tr>
<td>TTP</td>
<td>Tactics, Techniques and Procedures</td>
</tr>
<tr>
<td>USAFSAM</td>
<td>United States Air Force School of Aerospace Medicine</td>
</tr>
<tr>
<td>URL</td>
<td>Universal Resource Locator</td>
</tr>
<tr>
<td>UTC</td>
<td>Unit Type Code</td>
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</tbody>
</table>
Attachment 2

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DOD Instruction 6000.11, *Patient Movement*
JP 3-17, *Joint Doctrine and Joint Tactics, Techniques, and Procedures for Air Mobility Operations*
JP 4-02, *Doctrine for Health Service Support in Joint Operations*
AFDD 2, *Organization and Employment of Aerospace Power*
AFDD 2-4.2, *Health Services*
AFDD 2-6, *Air Mobility Operations*
AFPD 10-21, *Air Mobility Lead Command Roles and Responsibilities*
AFPD 11-2, *Aircraft Rules and Procedures*
AFPD 41-3, *Worldwide Aeromedical Evacuation*
AFJI 41-306, *Physician’s Roles and Responsibilities in Aeromedical Evacuation [Draft]*
AFJH 41-313, *Aeromedical Evacuation Documentation [Draft]*
AFI 11-301V1, *Aircrew Life Support (ALS) Program*
AFI 11-401, *Aviation Management*
AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*
AFI 11-403, *Aerospace Physiological Training Program*
AFI 41-106, *Medical Readiness Planning and Training*
AFI 41-209, *Medical Logistics Support*
AFI 41-301, *Worldwide Aeromedical Evacuation System*
AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*
AFI 41-309, *Aeromedical Evacuation Equipment Standards*
AFI 44-102, *Community Health Management*
AFI 44-119, *Clinical Performance Improvement*
AFI 46-101, *Nursing Services and Operations*
AFI 48-123, *Medical Examination and Standards*
AFTTP 3-42.5, *Aeromedical Evacuation (AE)*
AMCPAM 10-210, *Stage Crew Management*
HQ AMC CCATT website URL: [https://amc.scott.af.mil/sg/ccatt/ccatt.cfm](https://amc.scott.af.mil/sg/ccatt/ccatt.cfm) (mil domain computers only)
Attachment 3
Validation Process Flowchart
MEMORANDUM FOR USAF SAM/IEC
   CCATT CLINICAL VALIDATION COMMITTEE
   (Address)

FROM: (UNIT OF ASSIGNMENT/CC or designated representative)
   (Address)

SUBJECT: Recommendation for CCATT UTC Assignment – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and is nominated for appointment to a CCATT Unit Type Code (UTC). The member meets all standards and requirements for this appointment as set forth in AFTTP 3-42.51, AFI 41-106, and AFI 11-402.

2. Documentation is attached to this request to verify member’s qualification/experience. Request review of the selection package, and concurrence on member’s appointment to a CCATT UTC.

3. My POC for this request is (Rank, Name, e-dress, DSN or commercial phone number).

   (Signature)
   TYPED NAME, Grade, USAF, CORPS
   Commander or designated representative

Attachment(s):
   (List supporting documentation)
Read in these Skills
Verificatio
chec
PALS certification (if applicable - desired only)

ATLS certification (or equivalent clinical experience)

BLS certificate

ACLS certificate

Hospital Privilege List (AF Fm 1562 or equivalent)

Medical License(s)

Curriculum Vitae

Cover Letter

Readiness Skills Verification checklist
Attachment 6

SAMPLE CCATT NURSE SELECTION REVIEW PACKAGE

- Cover Letter
- Current Resume
- Current Nursing Job Description
- 2 References
- Nursing License(s)
- BLS certificate
- ACLS certificate
- Additional certifications (if applicable - desired only)
- Readiness Skills Verification checklist
SAMPLE CCATT RESPIRATORY THERAPIST SELECTION REVIEW PACKAGE

- Cover Letter
- Documentation of award of 5 skill-level or higher
- Current Resume
- Phase II Training certificate (CRT eligibility)
- CRT certificate (if applicable)
- Respiratory License
- BLS certificate
- ACLS certificate
- Readiness Skills Verification checklist
MEMORANDUM FOR HQ AMC/SG

FROM: (UNIT OF ASSIGNMENT/CC)

SUBJECT: Letter of Rebuttal: Member Disapproved for CCATT Selection – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and was nominated for appointment to a CCATT Unit Type Code (UTC). Member was deemed acceptable for appointment to CCATT and a selection review package was forwarded to the Air Force Expeditionary Medical Skills Institute (AFEMSI) for formal consideration by the CCATT Clinical Validation Committee.

2. On (date), I received notice from the CCATT Clinical Validation Committee that the member was disapproved for appointment to a CCATT UTC. I am writing to respectfully protest the disapproval.

3. (Provide sufficient justification to reverse/amend the disapproval. Attach additional documentation.)

4. Request your review and consideration to approve member for appointment to CCATT.

(Signature)

TYPED NAME, Grade, USAF, CORPS
Commander

Attachment(s):
(List supporting documentation)

cc:
USAFSAM/IEC

1st Ind, HQ AMC/SG

MEMORANDUM FOR (UNIT OF ASSIGNMENT/CC)

My staff has reviewed the request. Member is approved / provisionally approved / disapproved for assignment to CCATT UTC.

(Signature)

TYPED NAME,
Grade, USAF, CORPS
Surgeon General (or designated representative)

cc:
USAFSAM/IEC
## Attachment 9

**CCATT MIMIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS (INITIAL)**

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<thead>
<tr>
<th>ITEM DESCRIPTION</th>
<th>U/I</th>
<th>QTY</th>
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<tbody>
<tr>
<td>Coveralls, Flying, Nomex (flight suit)</td>
<td>EA</td>
<td>2</td>
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<tr>
<td>Boots, Flying</td>
<td>PR</td>
<td>1</td>
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<tr>
<td>Gloves, Fly, Nomex</td>
<td>PR</td>
<td>1</td>
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<tr>
<td>Gloves, insert, 8415-00-269</td>
<td>PR</td>
<td>1</td>
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<tr>
<td>Gloves, shell, 8415-00-261</td>
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<tr>
<td>Jacket, Fly, CWU-36/P Summer</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>Jacket, Fly, CWU-45/P Winter</td>
<td>EA</td>
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<tr>
<td>Drawers, Flier’s, heat resistant</td>
<td>PR</td>
<td>2</td>
</tr>
<tr>
<td>Undershirt, Flier’s, heat resistant</td>
<td>EA</td>
<td>2</td>
</tr>
<tr>
<td>Watch Cap, black/dark blue</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>Reflective Belt, Safety</td>
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</tr>
<tr>
<td>Flashlight, crook-neck, o.d./blk, 2 D-cell</td>
<td>EA</td>
<td>1</td>
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<td>Bag, Flier’s (helmet)</td>
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<td>Kit Bag, Flier’s</td>
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### ADDITIONAL TEAM EQUIPMENT

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<tbody>
<tr>
<td>Headset, David Clark</td>
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<td>1 (per team)</td>
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## Attachment 10

### CCATT MIMIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS (DEPLOYED)

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<td>3</td>
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<tr>
<td>2. Boots, Flying, Desert (see notes)</td>
<td>PR</td>
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<tr>
<td>3. Gloves, Flying, Nomex, (see notes)</td>
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<tr>
<td>4. Gloves, insert, 8415-00-269</td>
<td>PR</td>
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<td>5. Gloves, shell, 8415-00-261</td>
<td>PR</td>
<td>1</td>
</tr>
<tr>
<td>6. Jacket, Fly, CWU-36/P Summer -or- CWU-45/P Winter (see notes)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>7. Drawers, Flier’s, heat resistant</td>
<td>PR</td>
<td>3</td>
</tr>
<tr>
<td>8. Undershirt, Flier’s, heat resistant</td>
<td>EA</td>
<td>3</td>
</tr>
<tr>
<td>9. Watch Cap, knit, black/dark blue</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>10. Neckerchief, cotton, brown 436</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>11. Reflective Belt, Safety</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>12. Flashlight, blk finish, (Inova™ X5MT LED or equivalent)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>13. Bag, Flier’s (helmet)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>14. Kit Bag, Flier’s</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>15. Pants, Gortex, (see note)</td>
<td>PR</td>
<td>1</td>
</tr>
<tr>
<td>16. Jacket, Gortex (see note)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>17. Multi-tool (Leatherman™, Gerber™, SOG™, Schrade™, or equiv.)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>18. Goggles, sun/sand/dust (Wiley X™ SG-1 or equivalent)</td>
<td>EA</td>
<td>2</td>
</tr>
<tr>
<td>19. Holster, for M-9 handgun (shoulder or hip)</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>20. A.L.I.C.E.-type backpack/ruck-sack</td>
<td>EA</td>
<td>1</td>
</tr>
<tr>
<td>21. Ballistic Body Armor, Level-IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) vest: minimum level III-A protection IAW NIJ Standard 0101.03, woodland outer shell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) level III-A full side ballistic protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) front &amp; back 10&quot; X 12&quot; plates, level IV protection (H&amp;M Ranger Interceptor or equivalent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(w/additional desert outer shell); groin protector preferred option</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL REQUIRED ITEMS

- Government passport
- NATO orders
- Aeronautical Orders and AFTO Forms 781 (CCATT personnel must be OSF-qualified)
- All other deployment/mobility and theater-required clothing and equipment

### ADDITIONAL TEAM EQUIPMENT

<table>
<thead>
<tr>
<th>ITEM DESCRIPTION</th>
<th>U/I</th>
<th>QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Headset, David Clark</td>
<td>EA</td>
<td>1 (per team)</td>
</tr>
</tbody>
</table>

1. Not intended to be an all-inclusive list of required deployment/mobility clothing/equipment. This list addresses the minimum required items for conducting flight operations while deployed. Verify theater reporting instructions for other required items.

2. Desert tan flight clothing is strongly preferred for deployed team members conducting missions within/into the Middle-East and/or Central Asia AORs. However, if desert tan flight suits are not available, green flight suits “may” be substituted. Verify theater reporting instructions for proper color requirements. If green flight suits and clothing are substituted, do not issue items in addition to member’s initial clothing issue. Flightsuits and flight jackets must be of the same color; do not mix colors. One additional flight suit to the initial issue is required for deployed operations.

3. Do not issue if item was included in member’s/team’s initial clothing/equipment issue. (NOTE: One additional flight suit to the initial issue is required for deployed operations.) Consider color requirements.

4. Body armor is required for CCATT flight operations. Do not substitute flak vest/fragmentation vest. Life Support does not issue aircrew body armor to CCATT during flight operations into hostile or potentially hostile areas, as they do for front-end and back-end (AE) aircrew members.
## CCATT MISSION REPORT

Information placed on this form is confidential and privileged in accordance with 10 U.S.C. 1102. Do not file or refer to this form in a patient record.

### CCATT Mission Report

<table>
<thead>
<tr>
<th>Cite Number:</th>
<th>Patient Status(circle):</th>
<th>Service(circle):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AD RC Ret Dep Civ</td>
<td>AF Army USN USMC</td>
</tr>
</tbody>
</table>

1. CCATT Members/Unit/ total hours in duty day (CCATT + non-CCATT duties):
   - Physician________________________________________
   - RT________________________________________
   - Nurse__________________________________________
   - Other_______________________________________

2. AE Crew: (#FNs) _________     (#AETs) ________    Unit __________________________________________

3. Aircraft Model:  C-21       C-17       C-141       C-130       KC-135     Other: __________________________

4. Patient Origin MTF____________________________  Patient Destination MTF _________________________

5. Mission sequence:
   - a. Initial notification
   - b. Take-off with pt.
   - c. Land at destination

<table>
<thead>
<tr>
<th>Step</th>
<th>Location</th>
<th>Zulu time</th>
<th>Date</th>
<th>Pt. Transport Times:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ground 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Air</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ground 2</td>
</tr>
</tbody>
</table>

6. Number of Enroute Stops:______           Number of RON:______           Unscheduled Stops: _______

7. Diagnosis:______________________________________________________________

8. Patient Condition:  Critical            Guarded   Stable

9. Equip/Serial #: Ventilator___________________ I/V pump_______________ Suction_____________ Other ________

10. Patient on Vasoactive/Medication Drips: No/Yes Names_____________________________________________

11. Invasive monitoring used: No/Yes  monitors____________________________________________________

12. Laboratory Testing used: (circle)
   - No  ABG  Chem  H/H  Coag  Other:__________

13. Procedures performed in transport: (circle)
   - No    IV         A-line         Intubation         Central line         Chest tube        Other:__________

14. Adverse events: (circle) YES/NO  If yes, fill out AE Event/ Near Miss

15. Capability shortfalls:       No  Yes _____________________________________________________

16. Was CCATT required:      No  Yes ____________________________________________________________

### Post mission patient report (brief description):

Mail, fax, or e-mail completed report to:
HQ AMC/SGP, 203 W. Losey St., Suite 1610, Scott AFB IL 62225-5219
FAX DSN 779-5357, CML 618-229-5357
donald.tweedel@scott.af.mil  amc.sgp@scott.af.mil

Information placed on this form is confidential and privileged in accordance with 10 U.S.C. 1102. Do not file or refer to this form in a patient record.
### Attachment 12

**CCATT TRAINING MATRIX**

#### Table A11.1. CCATT Training Requirements

<table>
<thead>
<tr>
<th>Training Requirement</th>
<th>Frequency</th>
<th>Duration</th>
<th>Definition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE REQUIREMENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTC Training – CCATT Basic Course (B30ZYCCATT-000)</td>
<td>One-time</td>
<td>12 days</td>
<td>The CCATT Basic Course is designed to prepare active, reserve, and guard personnel assigned to CCATT UTCs to meet the wartime mission of caring for critically ill and injured patients in the aeromedical evacuation environment.</td>
<td>All FFCCT/E/N/P UTCs must attend initial formal training course, within 6 months of appointment to the UTC, as part of UTC training and will be SORTS reportable (AFI 41-106, para 5.3.5.5.; Table A3.1.)</td>
</tr>
<tr>
<td>UTC Training – CCATT Advanced Course (C-STARS, Cincinnati OH) (B40ZYSTARS CI-1)</td>
<td>Every AEF training cycle (ARC FFCCT/E will complete every other AEF cycle)</td>
<td>14 days</td>
<td>The CCATT Advanced Course is designed specifically for personnel assigned to the CCATT UTC. The emphasis is on critical care and there will be didactics on the air-evacuation system culminating in a field exercise involving a flight out of Wright-Patterson AFB. This course enables the rotator to complete the AFSC specific RSV's and the CCATT sustainment training items. The course is designed to meet 100% of the RSV's for the individuals assigned to the CCATT UTC.</td>
<td>All FFCCT/E/N/P UTCs must attend advanced formal training course, once every AEF cycle beginning in the AEF cycle immediately following the one in which the CCATT Basic Course was completed, as part of UTC training; all FFCC* UTCs must attend advanced formal training prior to deployment. 59MDW CCATT personnel complete Wilford Hall Medical Center C-STARS. (AFI 41-106, paras 5.3.5.6., 5.9.5.)</td>
</tr>
<tr>
<td>Aeromedical Evacuation Contingency Operations Training (AECOT) (J3OZR4000-014)</td>
<td>One-time</td>
<td>6 days</td>
<td>AECOT is an orientation/familiarization course concentrating on the Aeromedical Evacuation process. The course is designed to provide cognitive and performance-based field training to officers and enlisted personnel assigned to UTCs supporting the</td>
<td>All FFCCT/E/N/P UTCs must attend AECOT. Active component CCATT personnel will complete initial AECOT within 12 months of completion of initial CCATT</td>
</tr>
</tbody>
</table>
Theater Aeromedical Evacuation System. Course. ARC CCATT personnel will complete initial AECOT within 18 months of completion of initial CCATT Course. Initial AECOT training may be waived based on experience gained/roles played during assignment to a deployed Theater Aeromedical Evacuation System (TAES), Joint Readiness Training Center (JRTC) rotation, or participation in an exercise that encompassed a fully deployed TAES. Initial AECOT for CCATTs will only be waived by AMC/SG. (AFI 41-106, paras 5.3.5.1., 5.3.5.5.)

<table>
<thead>
<tr>
<th>Training Requirement</th>
<th>Frequency</th>
<th>Duration</th>
<th>Definition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theater Aeromedical Evacuation System Sustainment Training (TAES)</td>
<td>Every four AEF training cycles (not to exceed 60 months)</td>
<td>Varies</td>
<td>Participation in a CCATT UTC during assignment to an exercise that encompasses a fully deployed TAES, i.e. Joint Readiness Training Center (JRTC) Ft. Polk LA, Patriot (FYXX), Pacific Warrior, etc., or a deployed TAES operation.</td>
<td>None (AFI 41-106, paras 5.3.5.3. – 5.3.5.5.)</td>
</tr>
<tr>
<td>CCATT Basic Course (B30ZYCCATT-000)</td>
<td>One-time</td>
<td>12 days</td>
<td>See above</td>
<td>A copy of the course certificate must be turned in to the Base Host Aviation Resource Management (HARM) Office for inclusion in member's flight record.</td>
</tr>
<tr>
<td>Current AF Form 1042, Medical Recommendation for Flying or Special Operational Duty Log</td>
<td>Annually</td>
<td>N/A</td>
<td>Conveys medical qualification for flying or special operational duty. Ref: AFI 48-123, Medical Examinations and Standards, Chapter 9</td>
<td>Physiologic training standards (AFI 48-123, Attachment 8, para A8.4.) qualifies individuals for non-rated duties in ASC 9C (operational support flier)</td>
</tr>
</tbody>
</table>
**Current AF Form 702, Individual Physiological Training Record**

Every 5 years

2-day initial; 1-day refresher

Documents altitude chamber qualification and training.

Required for operational support fliers assigned ASC 9C.

(AF1 11-403, Aerospace Physiological Training Program, paras 2.1.1.2., 2.1.4.)

<table>
<thead>
<tr>
<th>OTHER REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training Requirement</strong></td>
</tr>
<tr>
<td>High Risk of Capture</td>
</tr>
<tr>
<td>Isolated Personnel Report (ISOPREP)</td>
</tr>
<tr>
<td>N95 Mask Fit Testing/Training</td>
</tr>
</tbody>
</table>
APPLICATION FOR WAIVER OF CCATT BASIC COURSE

(Date)

MEMORANDUM FOR HQ USAF/SG

(Address)

FROM: (UNIT OF ASSIGNMENT/CC)

(Address)

SUBJECT: Request for Waiver for CCATT Basic Course Attendance – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and is appointed to a CCATT Unit Type Code (UTC). Request waiver of requirement for member to attend the CCATT Basic Course for the reasons listed below:

   a. Provide justification per requirements in TTP 3-42.51, para 4.4.1.

   b. Expand on member’s critical care skills, experience, CCATT deployment, etc. as necessary.

2. Documentation is attached to this request to verify assignment to CCATT prior to Oct 1997/CCATT Basic Course instructor experience or C-STARS instructor experience/CCATT deployment experience prior to 1 April 2002. [After-action Report(s), CCATT Mission Report(s), assignment orders, deployment orders, AF Form(s) 781, etc.]

(Signature)

TYPED NAME, Grade, USAF, CORPS

Commander

Attachment(s):

(List supporting documentation)

cc:

HQ AMC/SGP

USAF/ATF

1st Ind, HQ USAF/SG

(Date)

MEMORANDUM FOR (UNIT OF ASSIGNMENT/CC)

Waiver is approved / disapproved.

(Signature)

TYPED NAME,

Grade, USAF, CORPS

Surgeon General (or designated representative)

cc:

HQ AMC/SGP

USAF/ATF
APPLICATION FOR WAIVER OF INITIAL AECOT

MEMORANDUM FOR HQ AMC/SGP

FROM: (UNIT OF ASSIGNMENT/CC)

SUBJECT: Request for Waiver of Initial Aeromedical Contingency Operations Training (AECOT) Attendance – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and is appointed to a CCATT Unit Type Code (UTC). Request waiver of requirement for member to attend Initial AECOT for the reasons listed below:

   a. Provide justification per requirements in TTP 3-42.51, para 4.4.2.; i.e. Member was deployed as part of a CCATT UTC in support of Operation XXX/participated as CCATT during Joint Readiness Training Center Rotation #__/participated as CCATT during Exercise ____ which encompassed a fully deployed theater aeromedical evacuation system, from “date” to “date.”

   b. Member was deployed to Operation XXX/JRTC/Exercise ____ for at least 7 or more consecutive days and performed 2 or more live/simulated critical-care-patient aeromedical evacuation missions as CCATT.

2. Documentation is attached to this request to verify deployment/JRTC/exercise experience. (After-action Report(s), CCATT Mission Reports, assignment orders, deployment/TDY orders, AF Form(s) 781, etc.)

  (Signature)
  TYPED NAME, Grade, USAF, CORPS
  Commander

Attachment(s):
(List supporting documentation)

1st Ind, HQ AMC/SGP

MEMORANDUM FOR (UNIT OF ASSIGNMENT/CC)

Waiver is approved / disapproved.

  (Signature)
  TYPED NAME, Grade, USAF, CORPS
  Chief, Aerospace Medicine Division
  Office of the Command Surgeon