Administrative Change to AFI 48-101, *Aerospace Medicine Enterprise*

OPR: AF/SG3P

Paragraph 6.8.1. line 7, delete “airsickness management”

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SECRETARY OF THE AIR FORCE

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Aerospace Medicine

AEROSPACE MEDICINE ENTERPRISE

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This instruction implements AFPD 48-1, Aerospace Medicine Enterprise. It provides guidance and establishes procedures for conducting the multidisciplinary aspects of the Aerospace Medicine Enterprise (AME). It describes the key Aerospace Medicine programs in support of the operational aerospace mission and links them to the desired operational effects: Promote and Sustain a Healthy and Fit Force, Prevent Illness and Injury, Restore Health, and Sustain Human Performance. This instruction addresses the requirement for development of Team Aerospace. This instruction interfaces with Air Force 10-, 11-, 36-, 40-, 41-, 48-, 60-, 61-, 62-, 63, and 90 series publications. This publication applies to the regular Air Force and the Air Reserve Components. Any organizational level may supplement this instruction. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, Recommendation for Change of Publication; route AF Form 847 from the field through the appropriate chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, Management of Records, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at https://www.my.af.mil/gcss-af61a/afrims/afrims/rims.cfm.

SUMMARY OF CHANGES

This publication has been substantially revised and requires complete review. All Flight and Operational Medicine guidance has been moved to AFI 48-149, *Flight and Operational Medicine Operations*. This publication serves as a program management outline for the AME and the six subordinate programs. It provides a strategic overview of the objectives, desired

effects, metrics and reporting requirements for the Aerospace Medicine programs. Tactical management of the subordinate programs is referenced to the appropriate publications.

Chapter 1

INTRODUCTION AND OVERVIEW

1.1. Introduction and Overview. This instruction provides guidance, responsibilities, and procedures for execution of the AME. The AME provides direct support to Air Force operations by promoting and sustaining force health, preventing injury and illness, restoring health, and sustaining human performance. These key mission effects are accomplished at the unit level through effective management of six major Aerospace Medicine programs. These are:

1.1.1. Flying, Operations, and Special Duty Program

1.1.2. Occupational and Environmental Health Program

1.1.3. Force Health Readiness Program

1.1.4. Community Health Program

1.1.5. Human Performance Sustainment Program

1.1.6. Emergency Response / Disaster Management Program

1.2. AME Unit-Level Management

1.2.1. Management of the Aerospace Medicine programs to achieve objectives and desired effects will follow established principles of program management.

1.2.1.1. Establish clear objectives and goals

1.2.1.2. Define tasks and responsibilities necessary to achieve objectives

1.2.1.3. Specify clear and reasonable timelines

1.2.1.4. Ensure accountability

1.2.1.5. Measure effectiveness of reaching the objectives and desired effects

1.2.1.6. Redirect local plans, guidance, and practices as needed to better achieve desired effects

1.3. AME Scope

1.3.1. The AME is comprised of personnel (Team Aerospace (TA)) and activities that include, but are not limited to: Aeromedical Evacuation (AE), Aerospace & Operational Physiology (AOP), Aeromedical Staging, Bioenvironmental Engineering (BE), Flight and Operational Medicine (FOM), Occupational Medicine (OM), Optometry, Public Health (PH), Personnel Reliability Program (PRP), as well as education, research and development activities related to these programs. TA personnel work collaboratively for the success of the 6 Aerospace Medicine programs. Medical treatment facilities (MTF) AMEs are represented to the Air Force Medical Service (AFMS) corporate structure for the purposes of planning and programming by the Aerospace Operations (AO) panel.

1.3.2. The AME is implemented at locations wherever there is an AF mission. This includes active duty (AD), Air National Guard (ANG), and Air Force Reserve (AFRC) installations with full MTF capability, Geographically Separated Units (GSU), sites with a Limited Scope

Medical Treatment Facility (LSMTF), sites with a medical aid station (MAS), sites with no assigned medical personnel, and deployed locations.

1.3.3. Sites with a MTF will implement the appropriate scope of the AME with assigned personnel as the base operational mission demands. Defining the scope of the AME and missions covered will be the responsibility of the base Chief of Aerospace Medicine (SGP), squadron and Medical Group (MDG) commander in consultation with the base line command and Major Command (MAJCOM)/SGP.

1.3.4. GSU's, sites with a LSMTF, MAS, or no assigned medical personnel will implement the AME with the assistance of a supporting MTF designated by the MAJCOM/SG. The overall responsibility for the execution of the AME at supported sites will reside with the supporting MTF/CC. If the nearest MTF is from another MAJCOM, the supported site will arrange through Memorandum of Understanding (MOU) or Support Agreement (SA) with that MTF after consultation with the MAJCOM/SGP for the appropriate support.

1.3.5. Deployed sites will implement all Aerospace Medicine programs tailored to support the operational mission. As these sites mature, phasing in of more robust AME is indicated as directed by the Combatant Command (COCOM) or Numbered Air Force (NAF)/SGP. The timeline for phasing in will be developed by the local SGP after coordination with the appropriate COCOM, NAF or MAJCOM/SGP.

1.3.6. ANG or AFRC medical units will implement the AME either utilizing organic capabilities or they will ensure the quality of the AME through an actively enforced host-tenant support agreement (HTSA). The overall responsibility for ensuring the execution of the AME will reside with the ANG or AFRC medical unit, even though AME services may be provided through HTSA or contract.

1.3.6.1. AD units will be responsible for services and program support agreed to in a HTSA.

1.3.7. AF units in a supported relationship on a joint base will implement the appropriate scope of the AME through organic capabilities or they will ensure the quality of the AME through agreement with the host base.

1.4. Specific Organizational Responsibilities

1.4.1. The Office of the Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR) serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets addressing medical readiness and health promotion of active and reserve component members.

1.4.2. The Office of the Assistant Secretary of the Air Force for Installations, Environment, and Logistics (SAF/IE) shall provide direction and oversight of matters pertaining to the formulation, review and execution of policies, plans, programs, and budgets relative to environment, safety and occupational health (ESOH) resources and missions.

1.4.3. The Office of the Assistant Secretary of the Air Force for Acquisition (SAF/AQ) shall establish acquisition policy for Human Systems Integration (HSI). Acquisition policy shall require the identification, assessment, mitigation, and formal acceptance of HSI, human

performance, and health-related risks in the development, acquisition, sustainment, and support for weapon systems, munitions, and other materiel systems.

1.4.4. The Director of Operations (AF/A3O) shall,

1.4.4.1. Prescribe the operational qualification requirements for flight surgeons (FS).

1.4.4.2. Provide guidance on physiological training requirements for aircrew and special duty personnel.

1.4.4.3. Oversee physical standards guidance established by AF/SG3 for aircrew and special duty personnel.

1.4.4.4. Serves as approval authority for use of pharmacological fatigue countermeasures and coordinates implementation guidance with AF/SG3.

1.4.5. The AF/SG shall provide strategic guidance, resources, policies and procedures to execute the AME.

1.4.6. The AF/SG3 shall provide guidance necessary to successfully execute the AME.

1.4.6.1. Oversee strategic planning and programming activities.

1.4.6.2. Maintain liaison with Department of Defense (DOD) agencies for aircrew health, disease prevention, occupational and environmental health, and crew performance issues.

1.4.6.3. Advise AF/A3O on physical standards, physiological training requirements for aircrew and special duty personnel, and operational countermeasure guidance for physiologic stressors.

1.4.7. The AF/SG3P shall develop guidance to optimize the health, safety, and performance of the USAF, including physical standards, force protection, environmental safety, and occupational and operational medicine programs, as defined in HAF MD 1-48

1.4.7.1. Chair the Aerospace Operations (AO) panel in development of programming recommendations to support strategic guidance of AF/SG.

1.4.7.1.1. Support field identification and root-cause analysis of human performance problems and advocate for their mitigation or resolution through non-materiel means (e.g., doctrine, organization, training, leadership, personnel, etc), materiel means (e.g., technology), or some combination thereof.

1.4.7.1.2. Develop an AME oriented research/discovery/forecasted requirement strategy, plan, and prioritized programming recommendations.

1.4.7.1.3. Guide research programming and investment strategy within the AFMS to support the prioritized list of AME research gaps, needs, and requirements.

1.4.7.2. Chair the Aerospace Medicine Corporate Board

1.4.7.2.1. Membership composed of Air Force Medical Support Agency (AFMSA)/SG3P Branch Chiefs/Corp Chiefs, and MAJCOM and Direct Reporting Units (DRU) (United States Air Force Academy (USAFA) and Air Force District of Washington (AFDW)) SGP's.

1.4.7.2.2. The Corporate Board shall provide strategic guidance and programming recommendations to the AO Panel for the AME.

1.4.7.2.3. Convene annually or as needed.

1.4.7.3. Develop plans and programs, provides consultative services, and executes the AME in support of and at the direction of AF/SG3.

1.4.7.4. Ensure integration and coordination of AME initiatives and guidance with line Headquarters AF (HAF) entities when appropriate.

1.4.7.5. Provide consultants in all TA disciplines on behalf of AF/SG to MAJCOM, HAF, and other agencies.

1.4.7.6. Interface with all MAJCOM/SGPs to facilitate successful execution of all aspects of the AME.

1.4.7.7. Maintain liaison with other Services and Federal agencies.

1.4.7.8. Appoint an AFMSA assigned FS (AFSC: 48A4) as the casualty management officer point of contact (POC) for Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) guidance development and implementation.

1.4.7.9. Appoint an AFMSA-assigned FS (AFSC: 48A4) as the Public Health Emergency Officer (PHEO) action officer for guidance development and implementation.

1.4.7.10. Develop objective indicators to measure the success of the AME.

1.4.7.11. Coordinate prioritization of AME requirements with AF/SG9 (Directorate of Modernization).

1.4.7.12. Coordinate follow-on funding and Program Objective Memorandum (POM) actions with SG9 for material and process solutions that will require transition from Modernization panel to AO panel funding.

1.4.8. The AF/SG3P Branch Chiefs/ Corp Chiefs shall,

1.4.8.1. Chair Functional Corporate Boards with membership composed of MAJCOM and DRU (USAFA and AFDW) functional branch chiefs and the senior enlisted advisor for the respective Air Force Specialty Code(s) (AFSC).

1.4.8.2. Provide strategic guidance and programming recommendations to the AO Panel.

1.4.8.3. Convene semi-annually or as needed.

1.4.9. The AFMSA/SG9 shall work with MAJCOMs, Air Force Medical Operations Agency (AFMOA), AF/SG3, and MTF's to identify, analyze, and select the modernization initiatives that have the greatest potential of satisfying AF and AFMS capability gaps and requirements.

1.4.9.1. Coordinate prioritization of AME requirements from AF/SG3P and AF/SG3P branch chiefs into the Medical Research, Development, and Acquisition (RD&A) portfolio.

1.4.9.2. Coordinate transition planning with AF/SG3P, to include sustainment funding and POM actions for material and process solutions

1.4.10. The MAJCOM/SG shall,

1.4.10.1. Organize, facilitate training, and advocate for necessary resources and personnel to support AME execution within their command.

1.4.10.2. Appoint a MAJCOM/SGP, and provide appropriate MAJCOM staffing to successfully execute the AME.

1.4.10.3. Assign a supporting MTF for each LSMTF, GSU, Munitions Support Squadron site (MUNSS), or other site without medical capability within their Area of Responsibility (AOR) to assist with the execution of the Aerospace Medicine programs at those sites. Where designated, the supporting MTF carries ultimate responsibility for the execution of the Aerospace Medicine programs at the supported site.

1.4.10.4. Ensure SG personnel provide acquisition program offices appropriate support in the identification, assessment, mitigation, and formal acceptance of HSI, human performance, and health-related risks in the development, acquisition, sustainment, and support for weapon systems, munitions, and other materiel systems.

1.4.11. MAJCOM/SGP's shall,

1.4.11.1. Develop guidance to assist subordinate installation medical units to properly execute all aspects of the AME.

1.4.11.2. Identify personnel and resource requirements and establishes resource and manpower priorities for successful execution of the AME throughout the command.

1.4.11.3. Use AF/SG3P derived objective indicators to gauge success of the AME at subordinate facilities.

1.4.11.4. Collect human weapon systems problems, validates event-driven human performance problem reports from all field units in the MAJCOM, and forwards these products to AF/SG3P for review and analysis.

1.4.12. The 711th HPW shall,

1.4.12.1. Provide education and training for all disciplines of the AME.

1.4.12.2. Conduct research and development in support of AF operational Defense Health Program (DHP) requirements and objectives.

1.4.12.3. Provide consultative and analytical services to support AME through the Aeromedical Consultation Service, the Epidemiology Consultation Service, and the Occupational and Environmental Health Team.

1.4.12.4. Provide HSI training and consultative support to both Line of the Air Force (LAF) and AFMS organizations and agencies.

1.4.12.5. Provide reach-back support to base level AME personnel for the Human Performance Sustainment Program.

1.4.13. The MDG/CC shall, (Wing/CC for Air Reserve Component (ARC) Units):

1.4.13.1. Ensure resources and personnel and provide guidance for successful execution of the AME at their installation.

1.4.13.2. Ensure AME personnel are properly led, trained and resourced to successfully execute the AME at deployed locations.

1.4.13.3. Appoint the most qualified FS as the SGP. If he/she is not the Aerospace Medicine Squadron Commander, will be a stand-alone 3-digit functional manager aligned directly subordinate to and rated by the MDG/CC. The SGP must be a FS with sufficient experience and formal training, optimally a graduate of the AF Residency in Aerospace Medicine (RAM) program, to be knowledgeable in all aspects of clinical and operational Aerospace Medicine. If there is a RAM assigned as Sq/CC or below, he/she should normally be designated as the SGP. Dual duty as SGP and Sq/CC is not ideal but is allowable. When no RAM is assigned, the SGP will be the most qualified FS in terms of training, experience, and aptitude. If not a RAM, then attendance at the SGP course is required within 12 months of assignment as SGP.

1.4.13.4. Is responsible for the execution of the AME at their location and at other supported sites as directed by the MAJCOM/SG.

1.4.13.5. Request additional MTF personnel to meet the requirements to support assigned GSU or MUNSS sites based on current manpower models and increased workload.

1.4.14. The Squadron/CC under whose command the AME resides shall**,**

1.4.14.1. Leadership:

1.4.14.1.1. Serve as a member of the medical treatment facility's Executive Council/Committee.

1.4.14.1.2. Ensure execution of Aerospace Medicine activities using an integrated team approach through the Aerospace Medicine Council (AMC) and the SGP.

1.4.14.2. Planning/Programming:

1.4.14.2.1. Ensure the formulation of plans, policies and procedures for delivering health care services and health care support for operational missions.

1.4.14.2.2. Ensure availability of medical support to meet operational requirements.

1.4.14.2.3. Ensure coordination of AME activities within the MTF and other medical activities.

1.4.14.2.4. Review, coordinates, and negotiates host-tenant support agreements, MOUs, inter-service support agreements, letters of agreement, etc.

1.4.14.2.5. Ensure contingency support requirements for squadron assets are codified and are properly executed.

1.4.14.3. Funding/Financial Oversight:

1.4.14.3.1. Direct squadron financial budget and execution activities.

1.4.14.3.2. Ensure fiscal accuracy and responsible stewardship within the squadron.

1.4.14.3.2.1. Project and advises medical treatment facility and higher headquarters leadership of financial requirements for mission accomplishment.

1.4.14.4. Manpower Personnel Programs:

1.4.14.4.1. Assure squadron personnel meet training requirements.

1.4.14.4.2. Identify new personnel requirements to meet mission needs and ensure their proper communication to higher authority.

1.4.14.4.3. Evaluate and rate subordinate personnel.

1.4.14.4.3.1. See AFI 48-149, *Flight and Operational Medicine Program,* for Squadron Medical Element (SME) personnel rating policies.

1.4.15. The MTF/SGP shall,

1.4.15.1. Maintain clinical currency in the practice of Aerospace Medicine, and is responsible for developing and maintaining a strong relationship with the LAF to facilitate the effectiveness of the AME.

1.4.15.2. Maintain at least an active Top Secret security clearance. If this level of clearance is not already possessed, as soon as the SGP is selected, he/she shall be processed for the appropriate clearance.

1.4.15.2.1. The SGP is the medical consultant to the operational AF, its mission and personnel. If a mission or operation is classified, then the SGP shall receive appropriate security clearance and be read in to the degree required to provide operational, occupational, environmental, aeromedical, and general medical support to the personnel and operation.

1.4.15.2.2. If personnel that work in classified operations/systems have medical, occupational, or environmental health concerns, they should consult with the MTF/SGP who will evaluate their operational, occupational, and environmental health concerns and liaison with the MTF for the appropriate intervention.

1.4.15.3. Be completely familiar with all flying and operational activities at their assigned location to effectively provide flight and operational medicine support to the commander and mission.

1.4.15.4. Provide programmatic oversight of the AME.

1.4.15.4.1. Oversee all aspects of the AME and coordinate all Aerospace Medicine activities. These programs directly support the line mission by ensuring a healthy and fit force, preventing injury and illness, restoring health, and sustaining human performance.

1.4.15.4.2. Chair the AMC, the Occupational and Environmental Health Working Group (OEHWG) (the SGP may delegate this to an experienced Occupational Medicine Physician assigned if available), the Deployment Availability Working Group (DAWG), the Wing Public Health Emergency Working Group (PHEWG) (if designated as PHEO), and the Flight and Operational Medicine Working Group (FOMWG) (may delegate to Flight Medicine Flight Commander).

1.4.15.4.3. Serve as the senior profile officer, and the Lead Competent Medical Authority (CMA) for the Personnel Reliability Program (PRP).

1.4.15.5. Wing Aerospace and Operational Medicine Consultant:

1.4.15.5.1. Serve as the medical treatment facility and installation authority, consultant, and subject matter expert in the medical specialty of Aerospace Medicine

and in all Aerospace Medicine programs to include: aerospace, operational, occupational, deployment, disaster, and preventive medicine; human factors; human performance enhancement and sustainment; disease surveillance and prevention; occupational, operational, and environmental health risk assessment and risk communication; PRP; and the application of medical standards.

1.4.15.5.2. Serve as a member of the medical treatment facility Executive Committee as the 3-letter functional manager.

1.4.15.5.3. Serve as the installation PHEO IAW AFI 10-2603, *Emergency Health Powers on Air Force Installations*. A qualified Public Health Officer can be designated as the alternate.

1.4.15.6. Provide AME support to designated GSU and MUNSS sites when designated by the MAJCOM/SG.

1.4.15.7. Provide Aerospace Medicine career guidance for all physicians with primary or secondary 48XX designations as appropriate. The SGP will coordinate with the MTF/CC and appropriate Sq/CC to involve FS not currently assigned to the Flight Medicine Clinic in the base AME to maintain their proficiency in Aerospace Medicine.

1.4.16. Limited Scope Medical Treatment Facilities or Medical Aid Station Officer in Charge (OIC).

1.4.16.1. Execute the AME in conjunction with personnel from the supporting MTF.

1.4.16.2. Ensure that assigned medical personnel fulfill their programmatic obligations in support of the AME.

1.4.16.3. Coordinate with local LAF/CCs and supervisors to ensure obligations, requirements, and responsibilities as part of the AME are met in a timely and professional manner.

1.4.16.4. Specific responsibilities for the supported and supporting medical units are contained in the functional AFI's for each program.

1.5. AME Organization and Management at Unit Level.

1.5.1. The AME shall be organizationally aligned IAW AFI 38-101, *Air Force Organization*, and the current MDG guidance within whatever construct is utilized at an installation, (*e.g.* Aerospace Medicine Squadron, Aeromedical-Dental Squadron or Medical Operations Squadron.)

1.5.2. Units may combine or divide programs based on their unique circumstances to achieve maximum efficiency and effectiveness in accomplishing the AME objectives.

1.6. Aerospace Medicine Program Leadership Forums.

1.6.1. Aerospace Medicine Council (AMC)

1.6.1.1. The AMC is a collaborative decision making body chaired by the SGP responsible for the functional oversight of the AME and is directly accountable to the MDG/CC. The AMC is the reviewing/approval authority for the OEHWG, the FOMWG, and the DAWG minutes.

1.6.1.2. The AMC shall convene on a monthly basis, but not less than quarterly. The minutes will be reviewed/approved by the MDG executive committee. The AMC exists as a separate meeting from squadron staff meetings dealing with leadership and management issues. For a sample agenda see attachment 2.

1.6.1.3. The AMC membership, at a minimum, will include the SGP, OICs and/or NCOICs of AOP, BE, FOM, Optometry, PH, Medical Standards Management Element (MSME), and all assigned FS (SMEs included). Attendance by both OICs and NCOICs of each TA functional area is recommended.

1.6.1.3.1. The SGP may invite the Operations Group /CC and Wing Safety to send a representative to the AMC.

1.6.1.4. Key functions of the AMC will include:

1.6.1.4.1. For each Aerospace Medicine program:

1.6.1.4.1.1. Review the program objectives and desired mission effects. (What are we trying to accomplish?)

1.6.1.4.1.2. Review program activities and indicators to measure success. (How are we doing in accomplishing the objectives and desired mission effects?)

1.6.1.4.1.3. Assess whether to continue present activities or to make adjustments to program plans. (Do we need to change anything?)

1.6.1.4.2. The AMC will review, evaluate, solve, or up-channel problems or current issues within the AME or issues that have been referred from other committees.

1.6.1.4.2.1. When issues discussed at the AMC cannot be resolved without change(s) in AF level doctrine, tactics, guidance or instructions, they will be elevated to the MAJCOM/SGP.

1.6.2. The OEHWG is a collaborative decision making body chaired by the SGP or Occupational Medicine Physician and is responsible for providing guidance and establishing medical surveillance requirements for the installation Occupational and Environmental Health Program. It is directly accountable to the MDG/CC through the AMC. Key functions of the OEHWG are detailed in AFI 48-145, *Occupational and Environmental Health Program.*

1.6.3. The DAWG is a cross functional tracking and decision making body chaired by the SGP with the purpose of administratively managing the medical cases of all personnel identified as having a deployment-limiting medical condition. It is directly accountable to the MDG/CC through the AMC. Key functions of the DAWG are detailed in AFI 10-203, *Duty Limiting Conditions.*

1.6.4. The FOMWG is a forum chaired by the SGP for administratively managing and tracking all flying and special duty personnel medical actions. It is directly accountable to the MDG/CC through the AMC. Key functions of the FOMWG are detailed in AFI 48-149.

1.6.5. The PHEWG is a wing level, cross functional working group chaired by the PHEO charged with overseeing the planning and management of public health emergency preparedness and response activities for the installation. The PHEWG is a sub-group of a wing emergency management program body chaired by the installation commander, usually

the Emergency Management Working Group. Key functions of the PHEWG are detailed in AFI 10-2603.

1.6.6. TA members will attend other meetings that directly support the Aerospace Medicine Programs.

1.6.6.1. Medical Group Executive Committee

1.6.6.1.1. The Sq/CC with direct oversight of Aerospace Medicine functions will attend as responsible agent for all squadron activities and programs.

1.6.6.1.2. The SGP will attend as the 3-letter functional.

1.6.6.2. Environment, Safety, and Occupational Health (ESOH) Council

1.6.6.2.1. The OEHWG Chair will attend or ensure representation to provide professional expertise regarding occupational and environmental health issues.

1.6.6.2.2. A BE representative will attend to present metrics detailing occupational and environmental health surveillance and as subject matter expert on recognition, evaluation, and control of occupational and environmental hazards to include related risk management/risk communication.

1.6.6.2.3. A PH representative will attend to present metrics detailing occupational health medical exam compliance rates and address issues relevant to this program.

1.6.6.3. Threat Working Group. BE and/or PH should attend regularly. The PHEO or alternate will attend as needed. See AFI 10-245 *Antiterrorism (AT)* and 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* for specific information.

1.6.6.4. Force Protection Working Group. BE and/or PH should attend regularly. The PHEO of alternate will attend as needed. See AFI 10-245 and 10-2501 for specific responsibilities.

1.6.6.5. Medical Readiness Committee.

1.6.6.5.1. The Sq/CC will attend as the responsible agent for squadron readiness activities and requirements.

1.6.6.5.2. The SGP (or designee if he or she is not available) will attend as the appointed consultant for professional oversight issues related to the AME.

1.6.6.5.3. The PH or Non-Commissioned Officer (NCO) will attend to provide and receive medical intelligence information.

1.6.6.5.4. The BE Officer or NCO will attend to provide and receive CBRNE information.

1.6.6.6. Wing/Squadron Flight Safety Meetings. FS and AOP physiologists will attend and each will periodically brief topics of aeromedical relevance for the flying community.

1.6.6.7. Population Health Working Group

1.6.6.7.1. PH will attend as the epidemiology consultant to help formulate questions regarding population health issues and provide meaningful analysis of resulting data.

1.6.6.8. Installation Restoration Program Advisory Board. The SGP and BE personnel should attend as needed to address community concerns associated with installation restoration and clean-up programs.

1.6.6.9. Operations Group Executive Staff Meeting. The SGP should request permission to attend in order to interface with the wing flying leadership regarding medical support to the flying and operational mission.

1.6.6.10. Wing Deployment Process Working Group (DPWG). A PH representative attends as needed.

1.6.6.11. Wing Emergency Management Working Group. Meeting chaired by the Mission Support Group Commander and attended by the PH, BE, and PHEO. See AFI 10-245 and 10-2501 for specific information.

Chapter 2

FLYING, OPERATIONAL, AND SPECIAL DUTY PROGRAM

2.1. Objectives.

2.1.1. The purpose of the Flying, Operational, and Special Duty Personnel Program is to optimize the health and sustain the performance of aviation (manned and unmanned), missile, nuclear, select combat mission ready cyberspace, weapon system operators, and special duty personnel in support of the operational mission of the Air Force.

2.2. Key Team Aerospace Players: AOP, FOM, Optometry, and PH.

2.3. Desired Effects.

2.3.1. Medically ready aircrew, missile and special duty personnel

2.3.2. Trusted rapport with LAF leadership, and flying, missile and special duty personnel enabling effective assessment of health and safety threats and involvement in operational planning.

2.3.3. Aircrew, missile, and special duty personnel confident that their families' healthcare requirements are being met.

2.3.4. FOM personnel appropriately and constructively engaged in all aspects of the unit operational and flying mission.

2.4. Indicators.

2.4.1. Aircrew Duties not to Include Flying (DNIF) rate tracked and reported to flying squadron and group commanders.

2.4.2. Prioritized installation specific FS Mission Essential Task List (METL) developed, or validated annually.

2.4.3. Annual plan for completion of installation specific FS METLs approved by SGP with copy provided to MAJCOM/SGP.

2.4.4. Compliance with SGP approved plan for METLs completion >90%.

2.4.5. FS Mission Qualification Training (MQT) status. All FS assigned to FOM (MTF and SME) obtain and maintain MQT status within 6-months of operational assignment. See AFI 48-149 for MQT criteria.

2.4.6. Aerospace Medical Service technician(4N0X1), and nurse (46NX) assigned to FOM attend centrally provided advanced FOM training within 6-months of assignment to the FOM clinic.

2.5. Leadership Forums.

2.5.1. FOMWG.

2.5.2. Wing/Squadron Flight Safety Meeting.

2.5.3. AMC.

2.5.4. OG Executive Staff Meeting.

2.6. Reporting.

2.6.1. Flight and Operational Medicine program review will occur at the AMC at a periodicity determined by the SGP.

2.6.2. Flight and Operational Medicine indicators will be briefed at least quarterly to the MDG Executive Committee.

2.6.3. The SGP may present some or all of the Flight and Operational Medicine indicators at the OG staff meeting (after coordination with the OG).

2.7. Flight and Operational Medicine Program Management.

2.7.1. The following AFI's define the roles and responsibilities of TA members in the Flight and Operational Medicine Program: AFI 48-149, AFI 48-123, *Medical Examinations and Standards*, AFI 10-203, AFI 11-202V1 *Aircrew Training*, AFI 11-202V2 *Aircrew Standardization/Evaluation Program*, AFI 11-202V3 *General Flight Rules*, AFI 11-401 *Aviation Management*, AFI 11-402 *Aviation and Parachutist Service, Aeronautical Ratings and Badges*, AFI 11-403 *Aerospace Physiological Training Program*, AFI 11-405 *The Pilot-Physician Program*, AFI 11-412 *Aircrew Management*, AFI 11-421 *Aviation Resource Management*, AFI AFI 13-204V3, *Airfield Operations Procedures and Programs*, DOD5210.42-R_AFMAN 10-3902 *Nuclear Weapon Personnel Reliability Program (PRP)*, AFI 91-204 *Safety Investigations and Reports.*

Chapter 3

OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) PROGRAM

3.1. Objectives

3.1.1. The purpose of the AF OEH program is to protect military and civilian employee health while enhancing combat and operational capabilities.

3.2. Key Team Aerospace Players: AOP, BE, FOM, and PH

3.3. Desired Effects

3.3.1. All OEH hazards and associated risks identified.

3.3.2. All known risks mitigated through engineering and administrative controls or personal protective equipment.

3.3.3. All OEH hazards and risks communicated effectively to workplace employees.

3.3.4. All personnel potentially exposed to OEH hazards surveyed for occupational and environmental health effects as determined by the Installation Occupational & Environmental Medicine Consultant (IOEMC) and in accordance with Occupational Safety and Health Administration (OSHA) and AF Occupational Safety and Health (AFOSH) standards.

3.4. Indicators.

3.4.1. Occupational and Environmental Health Medical Examination (OEHME) completion rate tracked and reported to wing leadership.

3.4.2. OEH Site Assessment (OEHSA) completed and QA-approved annually by BE.

3.4.3. Performed routine high- and medium-risk health risk assessments within established timeframes (≥ 90% current).

3.4.4. Percentage of open special assessments (sampling tasks in Workplace Monitoring Plan) trending downward (target is reducing open plans/projects to zero).

3.4.5. FS Category 1 annual workplace shop visit rate greater than 90%

3.4.6. Workplace assessment completion rate for Fetal Protection Program within 5 days of referral with workplace specific guidance provided within 15 days, greater than 90%.

3.4.7. MAJCOMs and installations may also develop their own installation-specific performance measures to assess objectives for location-unique programs.

3.5. Leadership Forums.

3.5.1. OEHWG.

3.5.2. AMC.

3.5.3. Wing Environment, Safety and Occupational Health (ESOH) Council

3.6. Reporting.

3.6.1. OEH program review will occur at the AMC at a periodicity determined by the SGP.

3.6.2. OEH program indicators will be briefed at least quarterly to the MDG Executive Committee.

3.6.3. OEH program indicators will be briefed at the wing ESOH Council meeting.

3.7. OEH program management.

3.7.1. AFI 48-145, defines the roles and responsibilities of TA members in the OEH program. AFMAN 48-146, *Occupational & Environmental Health Program Management*, provides more comprehensive guidance on overall OEH program management.

Chapter 4

FORCE HEALTH READINESS PROGRAM

4.1. Objectives.

4.1.1. The purpose of the Force Health Readiness Program is to ensure a healthy and fit force and to maximize operational readiness and performance.

4.2. Key Team Aerospace Players: AOP, BE, FOM, Optometry, and PH.

4.3. Desired Effects.

4.3.1. Periodic Health Assessments are completed at the required interval and Individual Medical Readiness (IMR) currency is maintained for all assigned AF service members.

4.3.2. Profiles are completed in a timely manner and effectively communicate work and mobility restrictions to commanders to facilitate operational readiness.

4.3.3. Deployment limiting conditions (DLC's) are accurate and reported in a timely manner.

4.3.4. Medical Evaluation Boards (MEB) are completed in a timely and appropriate manner.

4.3.5. Deployment processing is comprehensive and efficient, meeting DoD and AF standards.

4.4. Indicators.

4.4.1. Fully ready IMR rate tracked and reported to wing leadership.

4.4.2. Pre and post deployment assessments compliance tracked and reported to wing leadership for:

4.4.2.1. Deployment Resiliency Assessment (DRA) #1 and DD Form 2795, *Pre-Deployment Health Assessment.*

4.4.2.2. DD Form 2796, *Post Deployment Health Assessment.*

4.4.2.3. DRA #2 and DD Form 2900, *Post Deployment Health Reassessment (PDHRA).*

4.4.2.4. DRA #3

4.4.2.5. DRA #4

4.4.3. DAWG required metrics IAW AFI 10-203.

4.5. Leadership Forums.

4.5.1. DAWG.

4.5.2. AMC.

4.5.3. Medical Readiness Committee

4.5.4. DPWG

4.5.5. Wing Force Protection Working Group.

4.6. Reporting.

4.6.1. Force Health Readiness program review will occur at the AMC at a periodicity determined by the SGP.

4.6.2. Force Health Readiness program indicators will be briefed monthly to the MDG Executive Committee.

4.6.3. Force Health Readiness Program indicators (IMR) will be briefed or presented to squadron, group, and wing leadership on a monthly basis.

4.7. Force Health Readiness Program management.

4.7.1. The following AFI's define the roles and responsibilities of TA members in the Force Health Readiness Program: AFI 48-120, *Deployment Health Surveillance*, AFI 10-203, AFI 48-123, , AFI 44-170, *Preventive Health Assessment*, AFI 10-250, *Individual Medical Readiness,* AFI 10-246, *Food and Water Protection Program,* AFJI 48-110, *Immunizations and Chemoprophylaxis,* AFI 10-403, *Deployment Planning and Execution*, DoDD 6490.02E, *Comprehensive Health Surveillance*, DoDD 6200.04, *Force Health Protection*, and DoDI 6490.03, *Deployment Health.*

Chapter 5

COMMUNITY HEALTH PROGRAM

5.1. Objectives.

5.1.1. The purpose of the Community Health Program is to protect the military, dependents and beneficiary civilian populations from infectious and communicable diseases, food borne illnesses, and environmental hazards that may adversely impact the health of the community and degrade operational performance.

5.2. Key Team Aerospace Players:

AOP, BE, FOM, and PH.

5.3. Desired Effects.

5.3.1. Base population educated on and protected from infectious and communicable diseases, environmental hazards, and food, water, and vector borne illnesses.

5.3.2. Prevent and/or control the spread of communicable diseases in the community, schools and childcare programs, food facilities and within the Medical Treatment Facility.

5.3.3. Individuals with communicable diseases are appropriately treated and managed.

5.3.4. Appropriate surveillance programs in place to identify, describe, and report disease and conditions of public health significance.

5.3.5. Plans and assets in place to identify, describe, respond to, and control outbreaks and events of public health concern.

5.4. Indicators.

5.4.1. Identification, tracking, and appropriate management of all latent Tuberculosis infection (LTBI) cases and reportable medical events completed as defined by the current Tri-Service Reportable Medical Events Guide.

5.4.2. Medical employee health program compliance of 95% or greater.

5.4.3. Food and facility inspections completed at frequency determined by the AMC.

5.4.4. Surveillance programs to identify, describe, and report disease and conditions of public health significance conducted and reviewed at frequency determined by AMC.

5.4.5. Other indicators based on local threats.

5.5. Leadership Forums.

5.5.1. AMC

5.5.2. Infection Control Committee

5.5.3. PHEWG.

5.6. Reporting.

5.6.1. Community Health Program review will occur at the AMC at a periodicity determined by the SGP.

5.6.2. Community Health Program indicators will be briefed as needed to the MDG Executive Committee.

5.7. Community Health Program management.

5.7.1. The following AFI's define the roles and responsibilities of TA members in the Community Health Program: AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Importance,* AFI 10-2603, AFI 10-2604, *Disease Containment Planning Guidance,* AFI 48-116, *Food Safety Program,* AFI 48-144, *Drinking Water Surveillance Program,* AFMAN 48-138, *Sanitary Control and Surveillance of Field Water Supplies,* AFI 48-117, *Public Facility Sanitation,* AFJI 48-104, *Quarantine Regulations of the Armed Forces,* AFJI 48-110, *Immunizations and Chemoprophylaxis,* AFI 34-248, *Child Development Centers,* and AFI 34-276, *Family Child Care Programs.*

Chapter 6

HUMAN PERFORMANCE SUSTAINMENT PROGRAM

6.1. Definitions of Human Performance terms.

6.1.1. Personnel are the most important and valuable resource for the AF. The Airman is a "human weapon system" requiring "total life-cycle support and maintenance". This line of reasoning leads to three interrelated human performance areas.

6.1.1.1. Human Performance Sustainment covers accession through separation/retirement with the goal of maintaining target performance levels throughout an Airman's career while minimizing adverse health effects. Preventive medicine is a major contributor to performance sustainment because physical and mental health is a necessary precursor for performance. Accordingly, performance sustainment encompasses health service support functions.

6.1.1.2. Human Performance Optimization seeks to achieve the most efficient use of limited human resources by comprehensively integrating Airmen with organizational and technical systems. It goes well beyond human-machine interface design and involves deliberate planning to efficiently leverage Airmen through the process of HSI. This area aligns both line and medical resources and objectives.

6.1.1.3. Human Performance Enhancement enables Airmen to operate beyond currently achievable and sustainable performance thresholds. It is chiefly accomplished through science and technology initiatives that range across the spectrum from intra-human (e.g., biotechnology and pharmacology) to extra-human (e.g., hardware and software).

6.2. Objectives.

6.2.1. The purpose of the Human Performance Sustainment Program is to sustain the performance of Airmen, whether in the face of enemy conflict, environmental threats and stressors, or advancing age. AME personnel provide feedback and lessons learned on human performance shortfalls and/or emerging threats to those organizations and agencies responsible for Human Performance Optimization and Enhancement.

6.2.2. Physical, mental and emotional health as well as physical fitness are necessary precursors to human performance. As such, any activity that supports or encourages improvement in health or fitness contributes to sustaining baseline human performance. Therefore, the other 5 AME programs described in this Instruction each contribute to human performance sustainment and their indicators can be classified as human performance sustainment indicators. This program, while looking at all AME programs and indicators, will also focus base-wide on the threats that are specific to subordinate unit and/or locations. The AMC will consult with operational line leadership and develop a prioritized list of local human performance sustainment threats. The AMC/line leadership team will develop interventions and indicators to measure implementation effectiveness. Examples of human performance sustainment threats are: fatigue, degraded visual acuity, inappropriate shift work cycles, weather extremes (cold and heat), spatial disorientation, hazardous noise, G-induced loss of consciousness (GLOC), inadequate manpower for task, air sickness, vibration, inadequate diet and hydration, hypoxia, etc.

6.3. Key Team Aerospace Players: AOP, BE, FOM, Optometry, and PH.

6.4. Desired Effects.

6.4.1. Successful accomplishment of the AF mission with minimal risk to personnel.

6.4.2. Airmen available for and capable of deployment and/or employment to successfully accomplish assigned missions with minimized assumed risk.

6.4.3. Operational commanders' decision-making and risk management processes are informed by consideration of mission-specific human performance capabilities, limitations, and requirements and associated full spectrum threats.

6.4.4. Threats to human performance are proactively mitigated (i.e., primary prevention), negative human performance trends are quickly identified and corrected (i.e., secondary prevention), and processes to minimize the impact of the adverse effects of human performance failures are in place (i.e., tertiary prevention).

6.4.5. Organizations and agencies responsible for Human Performance Optimization are aware of human performance shortfalls or emerging full spectrum threats.

6.4.6. Organizations and agencies responsible for Human Performance Enhancement are aware of the need for potential new human performance capabilities (i.e., capabilities that cannot be achieved with or derived from current programs and/or systems).

6.5. Indicators.

6.5.1. An AMC validated prioritized list of local human performance sustainment threats developed.

6.5.2. A plan in place for mitigating or minimizing the adverse effects of each major threat as determined by the SGP.

6.5.3. Indicators to measure mitigation strategy effectiveness developed and utilized for each identified major threat as stated in 6.6.1. and 6.6.2.

6.6. Leadership Forums.

6.6.1. FOMWG.

6.6.2. OEHWG.

6.6.3. Wing and Squadron Flight and Ground Safety Meetings.

6.6.4. AMC.

6.7. Reporting.

6.7.1. Human Performance Sustainment Program review will occur at the AMC at a periodicity determined by the SGP.

6.7.2. Human Performance Sustainment Program indicators will be briefed as needed to the MDG Executive Committee.

6.7.3. The SGP may present some or all of the Human Performance Sustainment Program indicators at the OG staff meeting (after coordination with the OG).

6.8. Human Performance Program Management.

6.8.1. The following AFI's define the roles and responsibilities of TA members in the Human Performance Program: AFI 11-202V1, *Aircrew Training*; AFMAN 11-210, *Instrument Refresher Course (IRC) Program*; AFI 11-290, *Cockpit/Crew Resource Management Training Program*; respective 11-2 mission design series (MDS) describing various responsibilities (e.g. anti-G straining maneuver (AGSM) review, night vision goggle training, endurance management, airsickness management); AFI 11-301V1, *Aircrew Flight Equipment Program*; AFI 11-403, *Aerospace Physiological Training Program*; AFI 11-404, *Centrifuge Training For High-G Aircrew*; AFI 11-409, *High Altitude Airdrop Mission Support Program*; AFI 11-410, *Personnel Parachute Operations*, AFI 21-101, *Aircraft and Equipment Maintenance Management*; AFI 48-149, AFI 63-101, Acquisition and Sustainment Life Cycle Management, AFI 91-204, *Safety Investigations and Reports;* AFI 91-223, *Aviation Safety Investigations and Reports*

Chapter 7

TA EMERGENCY RESPONSE / DISASTER MANAGEMENT PROGRAM

7.1. Objectives.

7.1.1. The purpose of the Emergency Response and Disaster Management program is the timely and professional emergency response to aviation, operational, mass casualty, and CBRN events to minimize adverse health consequences and preserve operational capabilities.

7.2. Key Team Aerospace Players: BE, FOM, PH and PHEO.

7.3. Desired Effects.

7.3.1. Aerospace Medicine personnel fully trained and proficient in emergency response skills, roles, and responsibilities based on the principles of the Air Force Incident Management System (AFIMS) IAW AFI 10-2501 and AFI 41-106.

7.3.2. Local emergency response plans, exercises and execution seamlessly integrated with Medical Readiness Office and wing emergency response agencies.

7.3.3. Development of local emergency response priorities in coordination with Medical Readiness Office based on local threat analysis.

7.3.4. Local Disease Containment Plan exercised, validated, and fully integrated with wing response agencies.

7.4. Indicators.

7.4.1. Each TA AFSC trained IAW respective directives and identified vulnerabilities/threats and planned responses.

7.4.2. Completion of all required exercises for TA personnel as specified in AFI 10-403, *Deployment Planning and Execution*, AFI 10- 2501, *Air Force Emergency Management Program Planning and Operations***,** AFI 10- 2603, and AFI 10- 2604, *Disease Containment Planning Guidance*, and as directed by SGP to meet local training requirements.

7.4.3. TA personnel fully trained IAW AFI 10-2501.

7.5. Leadership Forums.

7.5.1. FOMWG.

7.5.2. AMC.

7.5.3. Medical Readiness Committee.

7.5.4. PHEWG.

7.5.5. Wing Emergency Management Working Group

7.5.6. Wing Integrated Base Defense Council

7.5.7. Force Protection Working Group

7.5.8. Threat Working Group

7.6. Reporting.

7.6.1. TA Emergency Response and Disaster Management program review will occur at the AMC at a periodicity determined by the SGP.

7.7. TA Emergency Response & Disaster Management Program management.

7.7.1. The following AFI's define the roles and responsibilities of TA members in the Emergency Response & Disaster Management Program: AFI 48-149, *Flight and Operational Medicine Operations*, AFI 91-204 *Safety Investigations and Reports*, AFI 10-2603 AFI 41-106 *Unit Level Management of Medical Readiness Programs*, AFI 10-2501, *Air Force Emergency Management Program Planning and Operations*, AFI 10-403, *Deployment Planning and Execution.*

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFI 10-246, *Food and Water Protection Program,* December 4, 2004.

AFI 10-250, *Individual Medical Readiness,* March 9, 2007.

AFI 10-403, *Deployment Planning and Execution,* January 13, 2008.

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AFI 44-170, *Preventive Health Assessment,* December 10, 2009.

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AFMAN 48-138_IP, *Sanitary Control and Surveillance of Field Water Supplies,* May 1, 2010.

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Abbreviations and Acronyms

AE—Air Evacuation

AFIMS—Air Force Incident Management System

AFMS—Air Force Medical Service

AFRC—Air Reserve Command

AFRL—Air Force Research Laboratory

AGSM—Anti-G Straining Maneuver

AMC—Aerospace Medicine Council

AME—Aerospace Medicine Enterprise

ANG—Air National Guard

AO—Aerospace Operations Panel

AOP—Aerospace and Operational Physiology

BE—Bioenvironmental Engineering

CBRNE—Chemical, Biological, Radiological, Nuclear, and Explosive

CMA—Competent Medical Authority for the Personnel Reliability Program

CRRA—Capabilities Review and Risk Assessment

DAWG—Deployment Availability Working Group

DHP—Defense Health Program

DLC—Deployment Limiting Condition

DNIF—Duties Not To Include Flying

DoD—Department of Defense

DRA—Deployment Resilience Assessment

DRU—Direct Reporting Unit

ESOH—Environment, Safety, and Occupational Health

ESOHC—Environmental, Safety, and Occupational Health Council

FHP—Force Health Protection

FOM—Flight and Operational Medicine

FOMWG—Flight and Operational Medicine Working Group

FS—Flight Surgeon

GDF—Guide for the Development of Forces

GLOC—G-induced Loss of Consciousness

GSU—Geographically Separated Unit

HP—Human Performance

HPW—Human Performance Wing

HSI—Human Systems Integration

HTSA—Host-Tennant Support Agreement

IMR—Individual Medical Readiness

IOEMC—Installation Occupational and Environmental Medicine Consultant

LSMTF—Limited Scope Medical Treatment Facility

LTBI—Latent Tuberculosis Infection

MAS—Medical Aid Station

MDG—Medical Group

MDGI—Medical Group Instructions

MDS—Mission Design Series

MEB—Medical Evaluation Board

METL—Mission Essential Task List

MOU—Memorandum of Understanding

MPPG—Medical Planning and Programming Guidance

MQT—Mission Qualification Training

MTA—Major Thrust Areas

MTF—Medical Treatment Facility

MUNSS—Munitions Support Squadron Site

NAF—Numbered Air Force

NVG—Night Vision Goggles

OEH—Occupational and Environmental Health

OEHME—Occupational and Environmental Health Medical Examination

OEHSA—Occupational and Environmental Health Site Assessment

OEHT—Occupational and Environmental Health Team

OEHWG—Occupational and Environmental Health Working Group

OM—Occupational Medicine

PH—Public Health

PHEO—Public Health Emergency Officer

PHEWG—Public Health Emergency Working Group

POC—Point of Contact

PRP—Personnel Reliability Program

RAM—Graduate of the Residency in Aerospace Medicine

RD&A—Research, Development, and Acquisition

SA—Support Agreement

SG—Surgeon General

SGP—Chief of Aerospace Medicine

SME—Squadron Medical Element

SPO—Senior Profile Officer

TA—Team Aerospace

USAFSAM—United States Air Force School of Aerospace Medicine

Attachment 2

EXAMPLE TEMPLATE: AMC MEETING AGENDA

A2.1. Date, time, and location of meeting.

A2.2. Attendance.

A2.3. Review of previous minutes.

A2.3.1. Previous AMC minutes

A2.3.2. DAWG minutes

A2.3.3. OEHWG minutes

A2.3.4. FOMWG abbreviated minutes (no HIPAA information)

NOTE: the SGP will determine the frequency that program metrics are briefed and reviewed to ensure the AME is achieving the stated objectives.

The purpose of the AMC is to:

(1) Review of the program objectives and desired mission effects. (What are we trying to accomplish?)

(2) Review of program activities, indicators and measures of success. (How are we doing in accomplishing the objectives and desired mission effects?)

(3) Assess whether to continue present activities or to make adjustments to program plans. (Do we need to change anything?)

A2.4. Flying and Special Duty Program.

A2.4.1. Aircrew Mission Ready Rate or Aircrew DNIF rate

A2.4.2. FS installation METL plan developed, approved and complied >90%.

A2.4.3. FS Mission Qualification Training status rate.

A2.4.4. 4N0X / 46N completion of advanced Flight Medicine training.

A2.4.5. Other emphasis areas may be added as determined locally, such as:

A2.4.5.1. Flyer dental readiness

A2.4.5.2. Clinic access (customer satisfaction)

A2.4.5.3. PRP program compliance

A2.4.5.4. Soft Contact Lens Program

A2.4.5.5. Ground testing

A2.4.5.6. Air evacuation

A2.5. Occupational and Environmental Health Program.

A2.5.1. OEHME completion rate

A2.5.2. OEH Site assessments

A2.5.3. High and medium risk health risk assessments

A2.5.4. Flight Surgeon category 1 annual workplace shop visit rate

A2.5.5. Open special assessments

A2.5.6. Workplace assessment rate for Fetal Protection Program

A2.5.7. Other emphasis areas may be added as determined locally, such as:

A2.5.7.1. Industrial mask fit testing

A2.5.7.2. Confined space permits

A2.5.7.3. QNFT mask fit testing

A2.5.7.4. Occupational illness and injury rates

A2.5.7.5. Industrial ventilation program

A2.5.7.6. Thermoluminescent Dosimetry Program

A2.5.7.7. Radioactive materials permits

A2.5.7.8. HAZMAT authorization report

A2.5.7.9. Initial threshold shift rate

A2.5.7.10. Permanent threshold shift rate

A2.6. Force Health Readiness Program.

A2.6.1. IMR rate tracked and reported

A2.6.2. Pre and post deployment processing tracked and reported

A2.6.3. DAWG required metrics

A2.6.4. Other emphasis areas may be added as determined locally, such as profiling report.

A2.7. Community Health Program.

A2.7.1. Management of LTBI

A2.7.2. Medical employee health program compliance

A2.7.3. Food and facility inspection rate

A2.7.4. Surveillance

A2.7.5. Other emphasis areas may be added as determined locally:

A2.7.5.1. Water vulnerability assessment

A2.7.5.2. Food safety assessment

A2.7.5.3. Immunization rate in DoDDs teachers and daycare providers

A2.7.5.4. Communicable disease report

A2.7.5.5. Child lead screening

A2.7.5.6. Mosquito surveillance

A2.7.5.7. Environmental sampling (potable water, swimming pools, etc)

A2.7.5.8. Animal bite protocol compliance

A2.8. Human Performance Program.

A2.8.1. An AMC validated prioritized list of local human performance sustainment threats developed.

A2.8.2. A plan in place for mitigating or minimizing the adverse effects of each local threat.

A2.8.3. Indicators to measure mitigation strategy effectiveness developed and utilized for each identified local threat as stated in 6.6.1.

A2.9. Emergency Response and Disaster Management Program.

A2.9.1. AFSC trained rate

A2.9.2. TA required exercise completion rate/status. (Focus on AME specific exercises as directed by SGP to meet local training requirements.)

A2.9.3. TA personnel fully trained IAW AFI 10-2501.

A2.10. Review of any new HHQ AFIs, policies, or taskings.

A2.11. Status of MDGI and OIs for currency/review/revision.

A2.12. Old Business.

A2.13. New Business.

A2.14. Subjects/items referred to/from other committees.

A2.15. Adjournment.

A2.16. Date/time/location of next meeting.