THE UNOFFICIAL HANDBOOK FOR AIR FORCE PHYSICIAN ASSISTANTS

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Preface to the 5th edition (2017)

It's been ten years since the first edition of The Unofficial Handbook for Air Force Physician Assistants (then the Physician Assistant Almanac) was published. It was admittedly biased and based on my real life lessons learned in going from Airman Basic to Colonel. It was exactly what I had wished someone had given me the day I was commissioned. I'm happy to say that the flavor hasn't changed. It's still opinionated and, although the information has been proofread and validated by Air Force leaders, there is good reason that it will stay an informal reference.

My goal is not to lay out all the answers to every situation but instead to lay out principles of success from the perspective of a BSC officer and, more specifically, a PA. BSC officers can be promoted following any of the three Corps career paths: Specialty (e.g. clinical), Command, or Research, Development and Acquisition (RD&A). If you do your military Developmental Education (i.e. SOS, ACSC, AWC) as soon as eligible and avoid any disciplinary action, I don't believe there are any other absolute blocks to promotion through 0-6. For example, I followed first the Specialty and then the RD&A tracks and now am proof you can be promoted to Colonel on those paths without ever having been a Squadron or Group commander. (However, I think all agree that the easiest way to get there is via the command path and, if you want to be a flag officer you must have held command…in addition to excelling in your specialty and learning some RD&A). One of my biggest career surprises was discovering that it was more important to be available to new assignments and opportunities, bringing sensible perspective with you, than to be technically expert in the new field (at least at first). I've been fortunate to be able to lean on and learn from many good mentors, coworkers and peers.

None of us are successful without the trailblazing and investments of those who went before us and then shared their experiences and counsel. This book is meant to add to your mentoring armamentarium. Use it, grow, and if you profit, pass it on.

--Col John Bullock

PREFACE

(to the First Edition, 2007)

Look on this compendium as a toolbox. Its contents come from many sources, some official, most not. Like a tool box it may look like a jumble or, at first glance, it may seem that what you're looking for is missing. However if you take the time to familiarize yourself with what's here and then, with some situational awareness and creativity, start to work I'm convinced you'll find the means to effectively deal with almost any situation facing you as an Air Force Physician Assistant.

It's important that you know how you fit into the big organization because then you know not only what's important but how and where you can meaningfully contribute. As in any organization with its own rules and culture you need to know your way around to be both effective and respected. As the journalist Martha Gellhorn wrote in 1984, "People often say with pride, 'I'm not interested in politics.' They might as well say, 'I'm not interested in my standard of living, my health, my job, my rights, my freedoms, my future, or any future.'…If we mean to keep any control over our world and lives, we must be interested in politics." Understanding your world teaches you how to best use the tools you have and it delivers you from helplessness. Beyond that, however, the real foundation of Success is doing the job that's in front of you today well and not being resentful that you've not been entrusted with something "more important". I've found that people who are always worried about the next move in the chess game of their life never quite get at that move. Avoid that thinking. If you're always worrying about the next step it will compromise your ability to do your current job well. You don't have to do this alone. There are many experienced PAs willing to help you if asked. The Consultant is always open for questions, counsel and rumor control. Feel free to contact him. He's there for you (but attempt the homework before you go to the teacher!).

Above all, I've found that the big difference-maker is attitude, both yours about yourself and the one you project to others. Understand the goals of the Air Force and how it works and you can speak up with confidence when you see things getting out of line. If you are collegially proactive and constructively assertive you will be listened to. Your clinical expertise and experience in the Air Force are valuable and, you'll find, unique.

So, this compendium is the book I wish I'd had; my brain dump for you of answers to frequently asked questions, of resources I've found essential in answering those questions, and a miscellany of other items that I've found helpful in my career. It is opinionated, biased and unofficial. Use it and enjoy it.

Col John W. Bullock
August 2007

Few things in life are sweeter than investing in the lives of others and then watching them grow and succeed as a result of your efforts.

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Integrity first
Service before self
Excellence in all we do



"If a man does not have an ideal and try to live up to it, then he becomes a mean, base and sordid creature, no matter how successful."

- Letter to his son Kermit in 1915, quoted in Theodore Roosevelt by Joseph Bucklin Bishop



USAF Posture Statement
Fiscal Year 2018

USAF Posture Statement Fiscal Year 2018

DEPARTMENT OF THE AIR FORCE
PRESENTATION TO THE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

UNITED STATES SENATE



STATEMENT OF:
THE HONORABLE HEATHER A. WILSON
SECRETARY OF THE AIR FORCE

GENERAL DAVID L. GOLDFEIN
CHIEF OF STAFF, UNITED STATES AIR FORCE

JUNE 21, 2017

The Future of Air and Space Power Air Force Posture Statement Fiscal Year 2018 President's Budget Request

Air and space power are vital to our nation's security. Any objective evaluation of today's U.S. Air Force reaches stark conclusions.

- First, the Air Force is too small for the missions demanded of it and it is unlikely that the need for air and space power will diminish significantly in the coming decade.
- Second, potential adversaries are modernizing and innovating faster than we are, putting at risk America's technological advantage in air and space.

The resources provided in Fiscal Year 2017 have begun to arrest the readiness decline. The Fiscal Year 2018 President's Budget request begins to restore readiness and increase the lethality of the force. Future budgets must focus on modernization and continued readiness recovery so that we can defend the homeland, own the high ground, and project power in conjunction with allies.

An Air Force in Demand

Today's Air Force is growing after a period of significant decline and we must continue to increase the size of the force. Currently, the Air Force includes 660,000 active, guard, reserve and civilian Airmen, compared to 946,000 just 26 years ago when we fought in Operation Desert Storm -- a 30% reduction.

The Air Force also reduced its aircraft inventory over this same period from 8,600 to 5,500 aircraft. We have 55 combat-coded fighter squadrons across the active duty, guard, and reserve, compared to 134 squadrons during Desert Storm.

Before 1991, the Air Force bought approximately 510 aircraft per year. In the past 20 years, we have averaged only 96 per year. Today, the average age of our aircraft is over 27 years. And, unlike during the Cold War, Air Force aircraft have been flying in combat for 26 straight years. When the Islamic State of Iraq and Syria (ISIS) sought to consolidate power in Syria and northern Iraq in 2014, the U.S. Air Force surged to the fight. Since then, Airmen have executed over 70 sorties daily against ISIS targets. Coalition air forces have put over 80,000 weapons against enemy targets in over 26,000 airstrikes in Iraq and Syria since the campaign began. Over 70% of those strikes have been conducted by the U.S. Air Force.

Last year alone, MQ-1 and MQ-9 remotely piloted aircraft crews flew more than 351,000 hours and employed more than 3,000 weapons, removing thousands of enemy combatants from the battlefield and protecting U.S. and coalition forces.

Air Force intelligence, surveillance and reconnaissance provides warfighters over 6,000 intelligence products per day that are used to identify enemy targets and initiate 70% of Special Operations Forces assaults on terrorists. Air Force-operated space-based sensors provide around-the-clock global coverage for missile warning, nuclear detonations and other threats.

And Air Force cyber operators blocked more than 1.3 billion malicious connections in 2016 alone, an average of more than 40 malicious connections per second.

While we continue to extend the life of old aircraft, materials suffer fatigue and maintaining old equipment is time consuming and expensive.

We are short of maintainers and pilots. While flying hours to defeat ISIS overseas is a priority, training to confront near peer adversaries has suffered. We are at our lowest state of full spectrum readiness in our history. Only 50% of our squadrons are ready to conduct all of the missions assigned to them.

The decisive warfighting advantages we hold over our near peer adversaries are diminishing.

Air and space superiority -- owning the high ground -- is not America's ordained right. We cannot take it for granted. We must plan for it, equip for it, train for it and fight for it.

The Changing Security Environment

Adversaries are rapidly developing new capabilities to control air and space. They seek to undermine the credibility of our alliances, contest our freedom of maneuver, and neutralize our ability to project power. Over the past several years, their targeted investments in critical capabilities have outpaced our own.

Russia continues its aggression and malign influence in Ukraine and Syria while seeking to return to great power parity with the U.S. by modernizing its military.

China is fielding new defense platforms at a startling pace and continues to expand its regional influence in the East and South China Seas.

North Korea is accelerating nuclear and missile testing. Their actions in the Pacific increase risk of miscalculation and threaten the security of our allies and the homeland.

Iran continues to support international terrorist organizations and extend its negative influence throughout the Middle East while modernizing an array of military capabilities.

Each of these state actors possesses or is pursuing advanced long-range capabilities with the potential to strike American soil.

At the same time, violent extremist organizations and individuals inspired by them are threatening America and our allies.

Potential adversaries are quickly closing the gap in the decisive warfighting advantages we have held for decades. As their capabilities become stronger, the international order will grow more unstable and the strategic risks to American security and our global interests will increase. Staying ahead of these trends will require a concerted, coordinated effort.

Stopping the Decline

The Consolidated Appropriations Act of 2017 begins to arrest the decline and focuses on starting to restore the readiness of the force. The funds for Fiscal Year 2017 address critical capability shortfalls, and enable us to start to address delayed procurement and modernization of our force. This is a critical first step in restoring the Air Force's capabilities to meet future threats. We must have stable, predictable budgets that include strategy-driven funding. We also add our voice to the chorus of concern that budget instability is itself a significant problem. Continuing resolutions, or worse, sequestration, puts at risk our ability to successfully accomplish what our nation asks of us. A failure to provide relief from the current Budget Control Act caps would cut $15 billion from the Air Force budget – a reduction that would further hollow out the force and set us back years.

Restoring the Force

Looking ahead, we are focused on restoring readiness, cost-effective modernization, innovation for the future, and developing exceptional leaders. These areas of focus will allow us to defend the homeland, own the high ground, and project power in concert with our allies.

Of course, there is an assumption behind our plans. As a nation, since the end of World War II, America has chosen to be a global power, capable not only of defending the homeland, but gaining and maintaining dominance over areas of operation abroad. We have an Air Force that provides global mobility, global intelligence surveillance and reconnaissance, global strike, and global command and control to protect our vital national interests in concert with allies.

Threat drives strategy; strategy drives force posture. America's national security interests continue to be global in scope, requiring an Air Force which goes beyond homeland defense or regional power projection.

Restoring Readiness

The Air Force budget recognizes that we cannot restore our readiness in a single year. When we lose an F-22 avionics specialist with 10 years of experience, we cannot hire another person with 10 years of experience on the F-22. We have to recruit them, train them, mentor them and, most importantly, retain them.

For the Air Force, readiness is first and foremost about people.

Personnel – Restoring Readiness

The Fiscal Year 2017 budget increased active duty manpower to 321,000 Airmen. The Fiscal Year 2018 President's Budget request continues to rebuild the force to 325,100 active duty Airmen, while also adding 800 reservists, 900 guardsmen, and 3,000 civilians. The Total Force will increase to 669,611 people from 660,707 in Fiscal Year 2017. The additional personnel are focused on increasing maintainers—particularly for the F-16 and F-35A, increasing remotely piloted aircraft crews, and increasing pilot training capacity by adding two new F-16 formal training squadrons. It also allows us to reduce critical gaps in our space, nuclear, cyber, and intelligence career fields. Pilot retention continues to be a significant concern. We project a deficit of approximately 1,500 total active, guard, and reserve pilots at the end of Fiscal Year 2017 and trending further negative in the near term. Our fighter pilot shortage has already reached crisis levels and we will be approximately 1,300 Total Force fighter pilots below the requirement at the end of this fiscal year. There will be no single solution and no quick fix for the pilot shortage. This budget expands pilot training, continues incentive pay and bonuses, increases administrative support at the squadron level, improves readiness, and funds flying hours.

This budget request also includes 1,168 military and civilian positions to support squadron commanders so that "additional duties," which were shifted to operators, aircrew, and maintainers over years of personnel cuts and most recently in the wake of sequestration and the Budget Control Act, can be performed by dedicated support staff.

Squadrons are where readiness is generated and sustained, and where Airmen and families thrive. It is also where leadership matters the most. We are working to revitalize squadrons as the most essential level of command and the heart of our Air Force. Over the coming year, the Air Force will be reviewing leadership development, particularly at the squadron level.

In order to restore readiness, the budget request includes $6.2 billion to fund flying hours at maximum executable levels and $11.9B to fund weapons system sustainment (parts, maintenance and logistics support) to near the maximum executable level. While the budget for flying hours decreases slightly from Fiscal Year 2017, this reduction is largely because of a decline in fuel costs.

Further, the Fiscal Year 2018 President's Budget request funds a continuation of 641 active, guard, reserve, and civilian positions dedicated to Sexual Assault Prevention and Response (SAPR).

Finally, this budget request is vital for the quality of life for our Airmen and their families – funding a 2.1% increase in military pay, a 3.2% increase in basic allowance for housing, and a 3.4% increase in subsistence.

Munitions – Restoring Readiness

In addition to adding people and training, this budget request also addresses munitions. In the fight against ISIS in Iraq and Syria, the Air Force has delivered more than 56,000 direct attack munitions from the air. That is more than we used in all of Operation Iraqi Freedom.

Our use of munitions in operations is out-pacing production. Working with industry, the Fiscal Year 2018 President's Budget request funds maximum factory production of the most critical munitions, including the Joint Direct Attack Munition, the Hellfire missile, and the Small Diameter Bomb.

Cost-Effective Modernization

While restoring readiness is primarily about the size of the force, quality training, and munitions, for the long term the Air Force must modernize its weapon systems and equipment to defeat emerging threats.

The Fiscal Year 2018 President's Budget request budget prioritizes our top three acquisition programs to modernize the force: the F-35A fighter, the KC-46 tanker, and the B-21 bomber.

The F-35A is essential to our national security — a stealthy multi-role fighter needed to own the high ground and project power against increasingly capable adversaries. This budget request funds the purchase of the next 46 F-35A fighters with a goal of reaching 60 per year in the future. The budget also focuses on restoring readiness and modernizing our 55 combat-coded fighter squadrons.

We have enhanced our air refueling capability by entering initial production of the KC-46 Pegasus tanker. The KC-46 program modernizes our aerial refueling fleet, providing global mobility for the joint force and our allies. The Fiscal Year 2018 President's Budget request buys 15 more KC-46 aircraft. The Air Force expects to sustain steady state production of 15 KC-46 aircraft a year throughout the Future Years Defense Program (FYDP).

We are rapidly developing the B-21 Raider long-range strike bomber. The B-21 will form the backbone of our future bomber force, ensuring the ability of our nation's leaders to hold targets at risk around the world with both conventional and nuclear weapons.

While the F-35 fighter, the KC-46 tanker and the B-21 bomber are our top modernization priorities, there are a number of other modernization efforts supported in the Fiscal Year 2018 President's Budget request. These include the modernization of F-22A, F-15, and F-16 aircraft so that they remain viable, along with B-52, B-1, and B-2 bombers for strategic delivery of advanced munitions.

In the realm of intelligence, surveillance and reconnaissance, the Air Force continues to support the MQ-9 Reaper, RQ-4 Global Hawk, and RC-135 Rivet Joint upgrade strategies.

The Fiscal Year 2018 President's Budget request supports special operations and combat search and rescue with the purchase of two HC-130J and five MC-130J aircraft. We also sustain our commitment to command and control by funding several upgrades to the E-3 Airborne Warning and Control System (AWACS).

Modernizing the Nuclear Deterrent

All legs of our nuclear triad need to be modernized. The last major recapitalization of U.S. nuclear forces occurred in the 1980s. In the case of the Air Force, maintaining our aging nuclear weapons systems remains critical but is becoming more expensive and less practical.

Nuclear deterrence underpins national security for the United States and our allies. The Air Force stewards two legs of the nation's strategic nuclear deterrent and operates 75% of the nuclear command, control, and communications for the President and the military chain of command. Additionally, forward-based nuclear capable aircraft are a key component of the U.S. commitment to deter attacks on our allies.

The intercontinental ballistic missile (ICBM) force represents the most responsive leg of the nuclear triad. The dispersed basing of our land-based deterrent enhances strategic stability by creating an extraordinarily high threshold for a large-scale conventional or nuclear attack on the U.S. homeland. The air-delivered leg of the triad and dual-capable fighters provide a recallable, and highly visible force to extend deterrence, demonstrate resolve, and signal U.S. strategic commitment to our allies. In addition to the B-21 bomber, the Air Force is committed to modernizing the nuclear enterprise by replacing Air-Launched Cruise Missiles with the Long Range Stand-Off cruise missiles, modernizing ICBMs with the Ground Based Strategic Deterrent (GBSD), replacing the UH-1N helicopter, and making targeted investments in nuclear command, control and communication.

Meeting the Space Threat

For decades, the United States enjoyed unimpeded freedom of action in space. This benign environment allowed us to operate satellites for intelligence collection, missile warning, weather monitoring, communications, and precision positioning, navigation, and timing without considering how to protect these systems. That environment no longer exists. Our adversaries understand the advantages we derive from space and are actively pursuing capabilities to diminish them. In future conflict, space will be contested.

The Air Force has been the leading military service responsible for space systems for 54 years, and the Secretary of the Air Force is the principal advisor to the Secretary of Defense on space.

Over the last several years, the U.S. Air Force has been developing operational concepts to ensure freedom of action in space, changing the way we train our space force, and integrating space with the joint force.

The Fiscal Year 2018 President's Budget request increases the Air Force's space investment funding from $6.5 billion in Fiscal Year 2017 to $7.8 billion, a 20% increase. This increase represents a 27% increase in research, development, testing and evaluation (RDT&E) for space systems and a 12% increase in space procurement.

The budget request includes a fixed price block buy of Space Based Infrared Systems (SBIRS) 5 and 6 satellites. The budget funds purchase of terminals, ground control systems, and related communications security for satellites and funds three launches as part of the Evolved Expendable Launch Vehicles (EELV) program.

To fill a gap in weather coverage, the budget request funds a weather satellite through the Operationally Responsive Space (ORS) office.

While our existing Global Positioning System (GPS) satellites remain healthy, we face increasing risk from potential adversary advances, and will improve anti-jamming and secure access to military GPS.

The Air Force budget also funds the continuation of the Space Security and Defense Program and the National Space Defense Center where we are experimenting with concepts to ensure freedom of action in space and resilience in an integrated center that includes all sister-services, as well as the intelligence community. It also funds improvements in space situational awareness, which is foundational for space control, integrated ground systems and improved training of space forces.

Our budget supports the continued integration and normalization of space in the joint warfighting environment and places a high priority on space to ensure that our space systems continue to operate in a contested environment. We would prefer that war not extend into the space domain, but must be prepared to win if it does.

Modernizing Cyber

The Fiscal Year 2018 President's Budget request funds 39 offensive and defensive cyber teams that are on track to be fully operational in Fiscal Year 2018. The budget anticipates an increased reliance on contractors for basic information technology and cloud services so that military members can focus on advanced threats and warfighter missions as part of the joint force.

Innovation for the Future

Research, development, test and evaluation are critically important for a technically oriented service. The Fiscal Year 2018 President's Budget request includes a significant increase in funding for systems development and testing for the B-21, the Global Positioning System Operational Control System (OCX) and the Long Range Stand-Off cruise missile. Funding is also included for engineering and risk reduction for the Presidential Aircraft (PAR), Joint Surveillance and Target Attack Radar System (JSTARS) replacement, and the new Combat Rescue Helicopter.

Funding for basic and applied research related to longer-term national security challenges remains flat in this budget request, although funding for long term research on air dominance is increased significantly. Over the next several years, the Air Force will seek to increase basic and applied research in areas where we must maintain the competitive advantage over potential adversaries, including game-changing technologies like hypersonic vehicles, directedenergy, unmanned and autonomous systems, and nanotechnology.

Accelerating Procurement

To prevail against a rapidly innovating adversary, the Air Force must get capability from the lab bench to the warfighter faster than ever before.

In the Fiscal Year 2017 National Defense Authorization Act, Congress expanded acquisition authorities for the services. Taking advantage of this flexibility, the Air Force is sponsoring an experiment in August 2017 to evaluate

low-cost, permissive environment attack aircraft. While this is an experiment, not a procurement, the project has gone from approval by the Chief of Staff of the Air Force to an operational capabilities assessment in five short months.

The Air Force is also testing new procurement methods with early stage, highly innovative companies who do not normally do business with the Department of Defense. If successful, we will seek to replicate this approach. While not appropriate for large system development, these kinds of projects can open the pathway to rapid innovation for air and space dominance.

Infrastructure and Military Construction

Constrained by the Budget Control Act, the Air Force has prioritized combat and not infrastructure. The Fiscal Year 2018 President's Budget request includes $2 billion for military construction. The beddown of new missions, combatant commander needs, and strengthening the nuclear security enterprise have been given priority for the limited funding available.

In addition, the Fiscal Year 2018 President's Budget request funds construction of improved ranges at the Utah Test and Training Range and Red Flag in Nevada so that we can train using the full range of capabilities available to our aircrews in the F-35A. The budget also funds additional virtual and constructive, or "synthetic", Operational Training Infrastructure (OTI). Synthetic capability provides opportunities to test and train against the world's most significant threats at reduced cost.

The Air Force supports the Department of Defense request for authorization to conduct a Base Realignment and Closure (BRAC) round in Fiscal Year 2021. Completing the more detailed analysis once a BRAC is authorized will have value, and may highlight opportunities for some savings. Enduring savings from BRAC recommendations will leave more DoD resources available for future force structure or readiness requirements. BRAC also allows us, if the analysis supports it, to reposition forces or station new forces in locations that optimize their military value.

Conclusion

The Fiscal Year 2018 President's Budget request begins to restore Air Force readiness with a focus on people, high quality training, squadron support, and critical munitions.

The budget request also invests in top priority procurement to increase the lethality of the force with the F-35A fighter, KC-46 tanker, and the B-21 bomber while also making significant investments in space, the nuclear deterrent, and special operations.

As we enter our 70th year as a separate service and our 26th year of continuous combat operations, we have presented a budget that starts to turn the corner by building on the FY17 budget that arrested years of decline.

As important as program funding is, we also need budget certainty. A return to the current Budget Control Act caps will pose unmanageable -- and unacceptable -- risks to our ability to protect America's vital national interests.

We request that Congress support this budget and provide fiscal predictability for the Air Force so that we can support the National Military Strategy by defending the homeland, owning the high ground, and projecting power in conjunction with allies.

Understanding Airmen: A Primer for Soldiers

Major General Charles J. Dunlap Jr., U.S. Air Force



THE EXTREMELY DIFFICULT QUEST for victory in Iraq is putting enormous stress on the entire U.S. military establishment. As is predictable in such situations, one way the stress manifests itself is in a rising tide of interservice antagonism as the warfighting debate becomes more passionate.

This rivalry often seems more intense between the Army and the Air Force. Soldiers suffer most of the casualties in Iraq and are rightly concerned about the support they receive. Unfortunately, some soldiers question the Air Force's role or denigrate it. Many soldiers appear to believe that the Air Force is filled with people who, as the former chief of staff of the Army put it, are obsessed with "things that go fast, make noise, and look shiny."[1]

If you don't love Soldiers, you have no place in my Air Force. - General Hal Hornburg

Major General Charles J. Dunlap Jr., U.S. Air Force, is the Deputy Judge Advocate General of the Air Force. He earned a bachelor's degree from St. Joseph University, a J.D. from Villanova University, and is a graduate of the Armed Forces Staff College and the National War College. Dunlap has been deployed to support various operations in the Middle East and Africa, including Provide Relief, Restore Hope, Vigilant Warrior, Desert Fox, Bright Star, and Enduring Freedom. These are his personal views.

PHOTO: Maintainers finish working on F-16 Fighting Falcons, 6 June 2007, at a base in Southwest Asia. F-16s flew six close- air- support missions on that day in support of Operation Iraqi Freedom. (U.S. Air Force photo)

Airmen, however, see themselves as part of a service that has been at war in the Middle East for 16 years, was key in defeating Iraq's conventional forces in Operation Iraqi Freedom, and is very much in today's counterinsurgency fight. Despite this, Airmen feel that the Army under-appreciates and misunderstands them. Many Airmen are concerned, for example, that the Army's new Field Manual (FM) 3-24, *Counterinsurgency*, trivializes airpower's role by confining it to a 5-page annex in a 282-page text.

Honest disagreements as to how to address the greatest threats of the 21st century are the premise for some of the contentiousness. Sure, some of it is sheer service parochialism on both sides, but much of it is simply a mutual lack of knowledge. Much of that is, in turn, the fault of the Air Force, which often does a poor job of explaining itself.

Airmen–rather naively–believe that the Air Force's spectacular successes speak for themselves. Because the Air Force does so many things so efficiently—from air defense to airlift to precision attack to reconnaissance to operating and controlling the Global Positioning system (GPS) satellites—it might appear to the Army (and everyone else) that all this is "easy" to do.

Airmen do see their service as unique. While it is certainly true that America's "airpower" includes the vitally important air arms of the other services, it is an article of faith among Airmen that the united states has only one Air Force—one service that focuses on maximizing options for decision-makers by optimizing airpower. To an Airman, airpower includes air, space, and cyberspace power in all its many dimensions

Airmen contend that airpower's flexibility, range, and payload make it capable of applying force at tactical, operational, and strategic levels across the entire spectrum of conflict. Of course, the Army and the other services can do so as well. However, Airmen believe that what makes airpower different from land and sea power is the fact that it can assert U.S. military muscle literally anywhere in the world with a *velocity* that none can equal. To an Airman, the ability to act quickly is the coin of the realm in the 21st century, as is airpower's ability to apply combat power in a way that puts relatively few Americans at risk.

Scarcely anyone disputes the supremacy that U.S. airpower now enjoys in the dimensions in which it operates. To achieve that dominance, the Air Force is vastly more technology-dependent than the other services need to be, and that fact greatly influences Air Force culture and thinking. Obviously, the Air Force operates in environments that are only accessible by mastering technology, but it is really more than that.

The sheer sophistication of the technology counts a lot, perhaps even as much as the skill of the Airman wielding it. For example, from the first moment jet aircraft appeared in World War ii, they had an immediate and radical impact. By comparison, when mechanized units first appeared on the battlefield in World War I, they had little effect on the war. it took decades for mechanization to evolve into the decisive force it became. No aviator—however skilled and courageous—can consistently overcome an opponent who deftly operates technologically superior equipment.

As a result, Airmen, aware of the long lead-time needed to develop complicated aircraft, always press to acquire the most advanced systems far ahead of potential adversaries. This can be a source of irritation to the other services where technological advantage changes the calculus of battles more slowly.

This scientific orientation is one reason the Air Force considers itself, rather immodestly, to be the most forward-thinking of the services. There are many consequences to that self-assessment. The Air Force identifies the past with obsolescence, and for the air weapon, obsolescence equates to defeat. This is why, for example, FM 3-24's heavy reliance on experiences in long-past counterinsurgency efforts does not always resonate with Airmen the same way it does with Soldiers

…the Air Force considers itself, rather immodestly, to be the most forward-thinking of the services.

Examining the past for "lessons learned" is certainly something Airmen value, but they know today's capabilities easily dwarf yesterday's technological limit. Historical models are of limited value in an Airman's mind because the nature of the air weapon gives him a keen appreciation of how quickly technological change can alter the warfighting equation.

Airmen may also not read FM 3-24's slogan of "learn and adapt" as the unqualified good the manual touts it to be. While "adaptability" is certainly an important military virtue, when we juxtapose it with "learn," it strikes Airmen as too defensive and reactive. To Airmen, this sounds a lot like absorbing the first blow and then bending to the enemy by trying to figure out how to fight him on his terms (just do so "better"). That is not the Air Force "way." In air warfare, the first blow can be fatal to relatively fragile aircraft. This makes Airmen extremely offensive-minded, and they are more inclined to take an "anticipate and shape" approach than a "learn and adapt" process. An Airman likes to seize the initiative and force the adversary to fight on his terms—terms in which he believes his superior technology and training will give him the advantage.

This leads to another distinguishing aspect of Air Force culture. The other services proudly trace their heritage to ancient warriors and foreign armies and navies. The Air Force unapologetically revels in its status as the youngest service, uninhibited by thinking derived from the days before man conquered the air.

Although some criticize it for doing so, the Air Force admires much in the efficient and creative culture of civilian enterprises. The service recognizes that private enterprise played, and continues to play, an irreplaceable role in making and sustaining the United States as the world's foremost aviation nation. Given the many synergies and analogs that can exist with commercial aviation, it follows that

Air Force culture is more open to adopting the ways of business than are, perhaps, the cultures of the other services.

Airmen are proud of the warfighting success U.S. air and space supremacy produces. Serbs, Taliban, Al-Qaeda, and Saddam Hussein's forces as well as today's Iraqi insurgents have all undergone what not a single American soldier or Marine has suffered since the Korean War—the sheer torment and terror of death from hostile air attack. Because high-technology airpower can deliver persisting precision attacks in any weather, day or night, the effect is devastating. There is no escaping U.S. airpower.

Airmen believe that the precision revolution, along with air dominance, now produces an unprecedented ability to inflict a sense of helplessness that unhinges adversaries. Opponents who are slow to realize America's asymmetrical advantage in airpower suffer accordingly. A bitter Republican Guard colonel who survived America's air assault in 2003 castigated his leaders in *Time* magazine: "They forgot that we are missing air power. That was a big mistake. U.S. military technology is beyond belief."[2] Today, no military formation in the world can survive American-style air assault.

Yet, it is also true that Airmen's technological focus helps breed a culture of "assertive individualism" that is rather unusual in the armed services. Indeed, in the joint environment—especially with soldiers—some view this trait as being unhelpful or even insolent. Why are Airmen this way? Some of this goes to the earliest history of flight: those who first stepped into flying machines were doing so against conventional scientific—and practical—wisdom. With that heritage, it is not surprising that an Airman's "DNA" inclines him or her to not accept the status quo and to ask "why" or, often, "why not?"

Moreover, as Airmen began to envision the military potential of flying machines, they ran into powerful bureaucratic and parochial resistance within the Armed Forces. The Airman's response was to question authority. Billy Mitchell is the obvious example, but there are many others. Hap Arnold, Claire Chennault, and Curtis LeMay, to name just a few, set a tone for the Airman's attitude that still resounds today.

Another element of Air Force culture that some Soldiers may find disquieting is its egalitarianism. Air Force officers have never needed the formal social "distance" from its enlisted force that is common in the other services. Although the paradigm is changing, for most of its history, the Air Force, completely unlike its sister services, has been an organization in which mostly its *officers* fought, not its enlisted force. When the enlisted force did go into harm's way, such as members of crewed aircraft, the close comradeship of shared risk in tight quarters created traditions that shaped a somewhat different kind of officer/enlisted relationship than exists elsewhere in the U.S. military.

... for most of its history, the Air Force... unlike its sister services, has been an organization in which mostly its officers fought, not its enlisted force.

Some critics imply that the Air Force's egalitarianism and other aspects of its culture make it undisciplined and the least "martial" of the services. The facts show, however, that Air Force culture does not equate to any deficiency in martial qualities when it really counts—in combat. Clearly, Airmen have paid the price in blood. For example, during World War II, more Airmen died in the European Theater of Operations than did Marines in all theaters of that conflict.

Admittedly, Air Force culture can be perplexing to outsiders. Rick Newman and Don Shepperd's recent book about Airmen during the Vietnam War, *Bury Us Upside Down: The Misty Pilots and the Secret Battle for the Ho Chi Minh Trail*, provides great insight. Although the Airmen the book describes plainly had what we might charitably call a casual approach to military etiquette and behavior, there is no question that in probing the Ho Chi Minh Trail they magnificently executed a mission that was among the most dangerous and demanding of any performed by any service during the entire war.

In the current conflict in Iraq, Airmen have demonstrated courage equal to that of the other services—and not just in the air. For example,



U.S. Air Force, TSGT Brian Davidson

Airman 1st Class James Blair coordinates air cover for Army 10th Mountain Division light-infantry Soldiers during operations in the Sroghar Mountains, Afghanistan, 2003.

The technological emphasis in the Air Force does, however, create a heavy demand for personnel who are extremely tech-savvy. This can produce challenges because the Air Force often competes directly with private industry for the same high-quality people. As a group, Airmen have ready options in civilian life. Fortunately, so far the Air Force has been very effective in recruiting and

How does the Air Force do it? Actually, the answer has much to do with another misunderstood feature of Air Force culture, the emphasis on quality of life. All services recognize the importance of their people, but in the Air Force there is special deference to the axiom “recruit the individual, retain the family.” Specifically, the Air Force does not want to place its Airmen in the position of having to choose between the quality of life they could easily acquire for their families in the civilian world and what is available to them in the service

For that reason, the Air Force is unapologetic about having the finest, most family-friendly bases in the Armed Forces. To fill its ranks, the Air

Airmen in truck companies have proudly driven more than 7.6 million miles in over 1,100 convoys into Iraq without refusing any mission.[3] in addition, Airmen were principally responsible for Operation Safeside, a highly successful “outside the wire” ground combat mission that “mounted 338 combat patrols [and] bagged 17 ‘high value’” insurgents while simultaneously suppressing attacks on Balad
Air Base, Iraq.[4]

Nor is the Air Force undisciplined, as some seem to think. In fact, Airmen have, by far, the lowest rates of alcohol and drug abuse of any of the services, and their rate of disciplinary actions is much lower than those of the other services.[5] Airmen also perform well under stress. After improper activities among guards at Abu Ghraib imploded into sadistic abuse, hundreds of Airmen later took up the difficult duties without further incident. Let me be clear. I note these matters not to embarrass any other service, but only to demonstrate that the Air Force is a highly disciplined military force of warfighters. 72

retaining the right people. of

their country.

Force believes putting resources into quality of life improvements is more cost-effective than spending dollars on recruiting. Consequently, the Air Force spends the least on recruiting, yet has not been obliged to lower standards.

The technological orientation of Airmen that makes them so attractive to private industry also creates a perspective about warfighting that often differs from that of others in the Armed Forces. Airmen are the leading proponents of a way of war that seeks to benefit from technological advantage by substituting it for manpower in achieving victory. Although no Airman relishes the notion of killing another human being, when required to do so, Airmen do not seek the “fair fight” or the glory of close combat.

Rather, Airmen shamelessly seek to destroy adversaries with as little risk to themselves or friendly forces as possible. They always look for ways to subject the enemy to the impersonal machine against which the human cannot stand, however determined. In short, Airmen are disciples of George s. Patton Jr.’s view that the object of war is to get the other guy “to die for his country.” Airmen are proud of the fact that, for example, the

Serbs were forced from Kosovo during Operation Allied Force without the need to put a single American soldier in harm's way.[6]

Still, few issues more frustrate Airmen than the apparently intractable belief among some soldiers that the Air Force is wedded to a notion of "strategic bombing" at the expense of ground forces. It seems that no amount of data shakes that belief. Forgotten, it appears, are events such as 1968's Operation Niagara where B-52s poured 60,000 tons of high explosives on North Vietnamese troops, shattering their siege of the Marines at Khe Sanh. More recently, the statistics from Operation Iraqi Freedom show that over three-fourths of the strike sorties were in kill boxes or were otherwise close air support efforts.[7]

Providing support to U.S. troops on the ground is relentlessly imprinted on Airmen. As General Hal Hornburg, one of the Air Force's most distinguished combat veterans and the former commander of the Air combat command, put it, "if you don't love soldiers, you have no place in my Air Force." Today's Airmen do "get it"—yet, sadly, the myth of Air Force indifference to soldiers seems to persist.

All of this said, it is quite true that Airmen do not do enough to understand the cultures of their sister services. That deficiency is one the Air Force is attempting to address through better training. Thousands of Airmen are also achieving a greater appreciation of the Army by working with soldiers as augmentees or "in lieu of" forces at various forward locations in Iraq and Afghanistan.

Regardless, no real Airman will ever suggest that there is a better army than the U.S. Army. Our Army is the finest ever seen in the history of warfare, not just because of the quality of its training and equipment but because of the valor and patriotism of its soldiers. Those qualities are above any debate, and Airmen are honored to serve beside their brothers and sisters in green.
MR

NOTES

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The Airman's Creed

I am an American Airman.
I am a Warrior.
I have answered my Nation's call.

I am an American Airman.
My mission is to Fly, Fight, and Win.
I am faithful to a Proud Heritage,
A Tradition of Honor,
And a Legacy of Valor.

I am an American Airman.
Guardian of Freedom and Justice, My
Nation's Sword and Shield, Its Sentry
and Avenger.
I defend my Country with my Life.

I am an American Airman.
Wingman, Leader, Warrior.
I will never leave an Airman behind,

I will never falter,
And I will not fail.

History of the Airman's Creed

The Airman's Creed was introduced in April 2007 by Air Force Chief of Staff Gen. T. Michael Moseley and replaced all existing Air Force-related creeds. Its memorable and hard-hitting lines articulate fundamental beliefs and capture the essence of our warfighting ethos. The Air Force is not a support Service to the other Services. It is, in itself, an essential combatant organization.

The Airman's Creed reflects pride in the role of air, space and cyberspace power and the Air Force's commitment to supporting and defending the nation. The creed is fueled by the Air Force's heritage and a warfighting ethos that exists in all Airmen.

General Moseley said having an Airman's Creed is like a blinding flash of the obvious. The creed simply and concisely puts into the words the warfighting spirit that exists in Airmen past and present. "Every single Airman, every person who walks across the parade deck at Lackland (Air Force Base, Texas), and every person who is commissioned is a combatant. "That is our culture," General Moseley said. "We're a combatant Air Force; our mission is to fly, fight and win our nation's wars. We should embrace the notion that the Air Force is a combatant organization."

"The contribution of every Airman brings American military might to bear with the least possible loss of friendly lives and the maximum possible loss of hostile lives. That is an inherent good. That is the benefit of the American airpower that goes back to when Billy Mitchell said the same things in the 1920s," General Moseley said.

It's the rich heritage of airpower and the missions Airmen carry out around the world every day that give Airmen their warfighting ethos and bring about the reason to have an Airman's Creed -- an Airmen first mentality.

"This (Airman's Creed) is wrapping ourselves in who we are and in our culture," General Moseley said. "It matters in everything we do from the organizational structure of a wing to our acquisition systems and from how we train to how we deploy. Everything about us is wrapped around our notion of American airpower. The warfighting ethos is a mind set."

The Airman's Creed derived from a collaborative effort and feedback from Airmen throughout the Air Force. General Moseley said the Airman's Creed is designed to resonate with Airmen past, present and future.

"This is about our people and an Air Force that is fundamentally different than any other service," he said. "This is about where we've been and where we're going as an Air Force."

"We're attempting to give credit to 700,000 Airmen -- Active, Guard, Reserve and civilians -- who fight our nation's wars and give them the sense of ownership of a combatant organization, whether it is through changes at BMT, Airman battle uniform, the new service uniform or a focus on warfighting skills," he said. "This is to recognize who we are and the contributions we have made and make and to set the course for the future with a refined, reemphasized and remilitarized Air Force."

The Military Health System

On the battlefield, every element of the Military Health System (MHS) comes together to make the difference between life and death. Army, Navy and Air Force medical professionals help ensure those in uniform are medically ready to deploy anywhere around the globe on a moment's notice. And these medical professionals are also ready to go with them. There isn't another military medical force like it in the world—with the expertise, the assets and the global reach of our health system.

The MHS provides health care to over 9.7 million beneficiaries worldwide using a direct care system of military hospitals and clinics and a contracted network of private sector providers. In addition, the MHS provides coordinated activities and specifically directed to the care of our Nation's warfighters – in and out of designated combat areas. This unique system is currently managed through a policy and oversight function at the level of the Office of the Secretary of Defense (OSD), three Service-led medical departments, and a field activity centered on the TRICARE health care plan.

The MHS is dedicated to improving the health of the population is serves, along with the quality and outcomes of the health care is provides. In 2009, the MHS adopted overall system performance aims of force readiness, population health, quality health care, and cost management. This Quadruple Aim, represented in Figure 1, is our strategic performance measurement and framework to measure and improve the value that the MHS creates for its customers and various stakeholders.

"**Quadruple Aim**"
The Model for the MHS

The "Quadruple Aim" was introduced to the Military Health System (MHS) at the 2010 MHS conference by RADM Christine Hunter, the deputy director of TRICARE Management Activity. It is based on the civilian "Triple Aim" model but expanded to fit the special requirements of the MHS. To understand the concept more clearly it's helpful to look at the tenets of the original "Triple Aim" first:

The "Triple Aim" is a healthcare management model promoted by the Institute for Healthcare Improvement (IHI) as a strategy to simultaneously pursue the three general imperatives it identified as necessary for excellence in management and delivery of healthcare: 1) excellent population health, 2) ideal care (a positive patient experience) and 3) controlled cost. The Triple Aim was intended to show the kind of results that could be achieved when all the elements of a true health care system worked together to serve the needs of a population.

The MHS took this "Triple Aim" health care paradigm and added a necessary fourth target – readiness – in order to adapt it to MHS use. The MHS includes 55 hospitals and 279 clinics. The

average weekly statistics include 20,000 inpatient admissions, 1.9 million outpatient visits, and 177,000 emergency room visits.

Because TRICARE is so large and handles such a vast array of needs in the military medical community, its ability to achieve the four goals of the "Quadruple Aim" is foundational for it to remain on target in keeping the U.S. Armed Forces fit to fight. Here are the four tenets of the Quadruple Aim that have since evolved from the 2010 "Quadruple Aim" and have represented the MHS top priorities since 2014. The Air Force Medical Service (AFMS) has also adopted these as AFMS strategic goals. Additionally, the Air Force



Figure 1. The MHS Quadruple Aim

The MHS Quadruple Aim

1. **Full Spectrum Readiness** – Maintain medically ready Airmen; ensure well-trained, well equipped, and current medics to deliver "Trusted Care, Anywhere" in support of the full spectrum of military operations.

2. **Better Care** – Provide reliable access to safe, quality care for all that we serve, promoting positive patient experiences and outcomes.

3. **Better Health** – Better Health is measured by Health Related Quality of Life (HRQOL), a 4-item measure of health that predicts mortality, morbidity, and health care utilization.

4. **Best Value** – Improve AFMS outcomes through investments in evidence-based approaches that eliminate harm, remove waste and variation, and improve enterprise-wide management.

Defense Health Agency

In 2011, the Deputy Secretary of Defense convened a task force to look at options for the long-term governance of the Military Health System. The lessons from 10 years of war combined with the fiscal realities of American healthcare established the value of a more integrated approach of operational forces. On March 2, 2012, the Deputy Secretary of Defense issued a memorandum calling for the creation of the Defense Health Agency (DHA), a Combat Support Agency (CSA)

that would effectively assume responsibility for shared services, functions and activities of MHS. On September 30, 2013, the Department of Defense issued a directive in accordance with the Deputy Secretary of Defense memorandum, formally establishing the Agency. The DHA's overarching mission is to support a medically ready force and ready medical force at all times, supporting a better, stronger and more agile MHS.

In late 2015, two years after establishment, the DHA achieved full operating capability. This was a milestone in the delivery of high-quality, accessible healthcare, which serves as the foundation of a ready force and a lifesaving combat ability in a deployed environment.

"By working directly with the Combatant Commands and the Joint Staff Surgeon, we've identified readiness challenges that the DHA is uniquely situated to address."

Vice Admiral Raquel Bono, Director of DHA

In November 2015, Vice Admiral (VADM) Raquel Bono assumed responsibility as Director, DHA from the Agency's first Director, Lieutenant General Douglas Robb. In this role, VADM Bono worked to improve the Agency's collective performance as a joint, integrated, premier system of health that supports those who serve in the defense of the United States. She emphasized the servant-leader model of leadership to promote collaboration, accountability, and a joint perspective. This approach is the foundation of the Agency's three long-term goals.

- Fortify our relationship with the services: Deliver results that help Service Medical Departments achieve their performance goals.
- Strengthen our role as a CSA: Reinforce focus on military readiness in the DHA and successfully accomplish agency mission essential tasks lists.
- Optimize DHA operations: Continuously improve operations across the DHA and demonstrate measurable improvement in effectiveness and efficiency.

The DHA executes the above goals and supports the delivery of integrated, affordable, and high quality health services to MHS beneficiaries and is responsible for driving greater integration of clinical and business processes across the MHS by:

- Implementing shared services with common measurement of outcomes;
- Enabling rapid adoption of proven practices, helping reduce unwanted variation, and improving coordination of care across time and treatment venues;
- Exercising management responsibility for joint shared services and the TRICARE Health Plan; and
- Acting as the market manager for the National Capital Region (NCR) enhanced Multi-service Market, which includes Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH).

DHA also manages ten Enterprise Support Activities (ESA) that serve the entire MHS, including administering the TRICARE health benefit. The ten ESAs are a set of support functions that

serves the entire MHS. These services highlight the diverse and complex responsibilities of military medicine:

- Pharmacy Programs
- TRICARE Health Plan
- Health Information Technology (HIT)
- Budget and Resource Management
- Medical Logistics
- Facilities
- Contracting/Procurement
- Research, Development and Acquisition
- Public Health
- Education and Training Directorate

DHA exists to support the warfighter, and they accomplish that through a system that ensures our men and women in uniform are medically ready. DHA sustains their health through a ready medical team of physicians, nurses, other health professionals and an enlisted force that is better trained and prepared than any in the world. DHA strives to enable and better support the Services in this shared mission.

Relationships with the AFMS

The AFMS works with its partners in Army Medicine, Navy Medicine, and the DHA to primarily support the missions, Airmen, Soldiers, Sailors, and Marines serving our nation and their families. The DHA and its partners exist to support the services to include the AFMS however command and control of Military Treatment Facilities (MTFs) within the AFMS belongs to Line Wing Commanders as reflected below in Figure 2. AFMS Relationships.

This is important to understand as the MTF Commander reports to and supports the Wing leadership and his or her priorities and mission. The priorities of the Line Wing Commander drive the priorities and mission of the MTF. This relationship is important to grasp as this is not the same structure within the other services. Within the Army and Navy, the Surgeon General has command and control of medical assets. The MHS desire is for command and control of medical assets and mission to be standardized so change is likely forecasted for either the AFMS or Army and Navy Medicine. Additionally, the DHA will likely take on a larger role within the MHS in the next several years. The upcoming changes in these models of those relationships has not been well defined, is an issue of significant debate and will likely be clearer in the coming two to four years. In the meantime, Figure 2 reflects the current AFMS relationships.

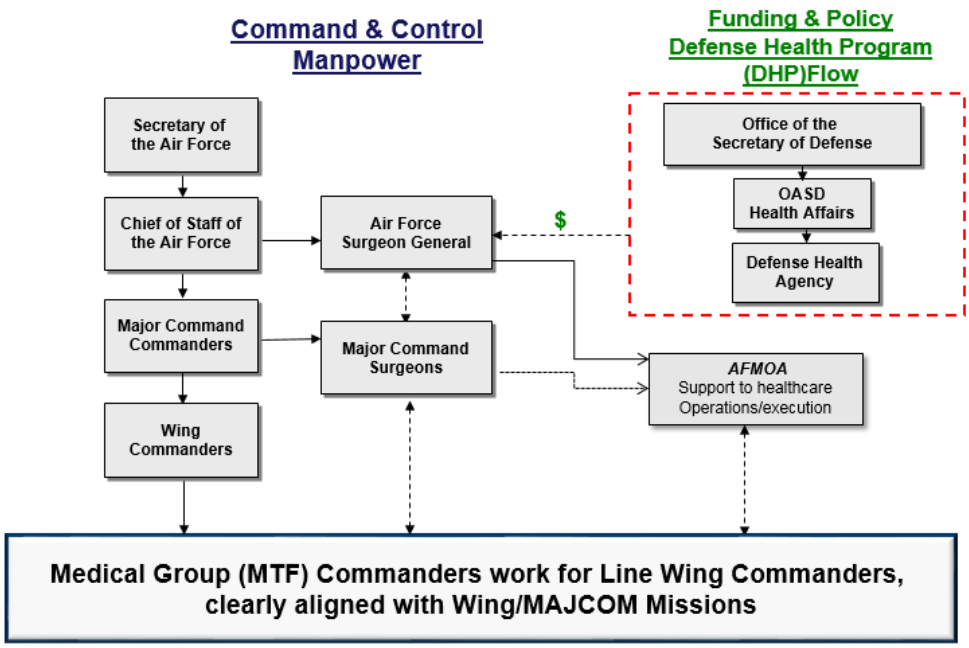


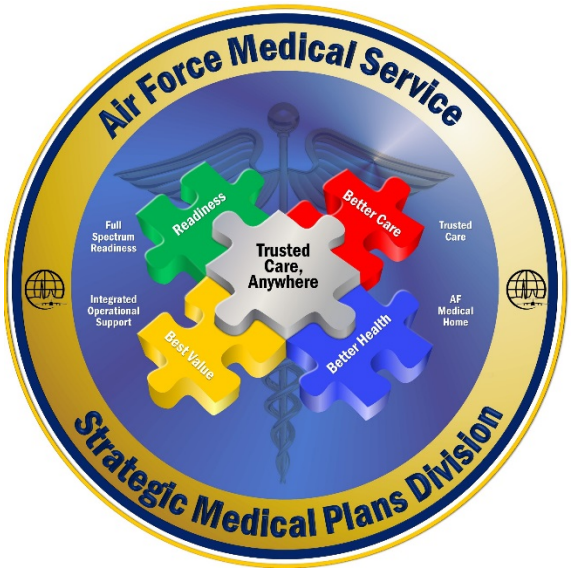
Figure 2. AFMS Relationships

The Air Force and Its Medical Service

The mission of the Air Force Medical Service (AFMS) is *"Ensure medically fit forces, provide expeditionary medics, and improve the health of all we serve to meet our Nation's needs."*

As Airmen in the AMFS, we have the honor and privilege of providing medical care to some of our country's finest Americans. Every Tuesday, parents across the country embrace and bid farewell amidst tears in their eyes to their children as their children embark on a nine and half week journey through the United Sates Air Force Basic Military Training at Lackland Air Force Base, San Antonio. These young men and women emerge from this course as Airmen ready to put themselves in harm's way as they are now warfighters. What allows these parents to rest a little easier and relinquish their loved ones to sacrifice so much for their country? What provides the parents of these young men and women comfort at night, knowing that their loved ones could be called on to go to war? It is our role, as United States Air Force officers and physician assistants (PA's) to provide that comfort and trust by ensuring that the lives of their loved ones are in the best trained, safest and ready capable force in the world. It is an honor to serve as a United States Air Force officer but it is an even deeper commitment to ensure our Active Duty Airmen and their families receive the best and safest care we can provide.

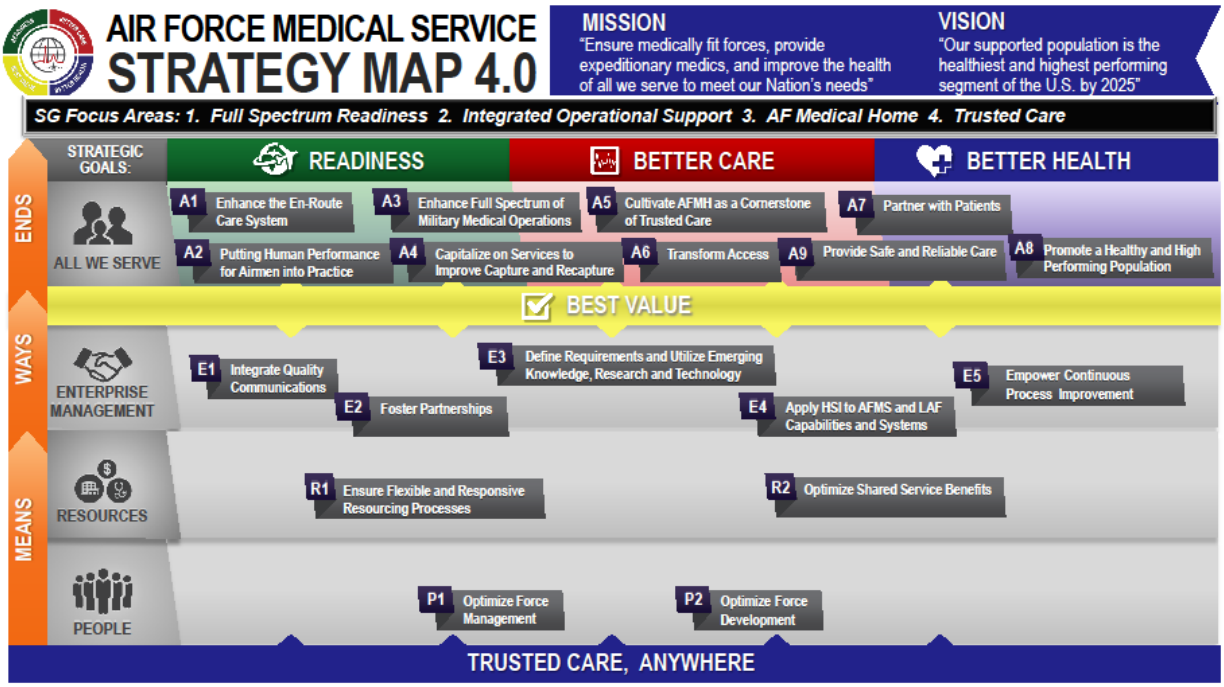
As previously outlined, the MHS quadruple aim has translated into the AFMS Strategic Goals; Readiness, Better Care, Better Health, and Best Value. In addition, our Air Force Surgeon General (SG), Lt Gen Mark A. Ediger has four complimentary focus areas of high interest; Full Spectrum Readiness, Integrated Operational Support, Air Force Medical Home, and Trusted Care.



To further outline and support these goals and focus areas, the AFMS Strategy Map was developed. This was last updated March 2017 and reflects the Objectives that support these key intentions. It is important to understand these priorities as it helps to define your role within the AFMS as a PA and how you can support these priorities as you progress in your career as a leader.

The SG owns the overall AFMS strategy, however, the SG's primary focus is on the Mission, Vision, and Surgeon General's Statement of Intent. The SG's role in strategy management is to oversee the overall management and execution of the AFMS strategy to include:

- Lead the development of the strategic components
- Review the progress and performance of the high-level strategic components (e.g., Mission, Vision, SG Statement of Intent)
- Assign Objective owners
- Hold Objective owners accountable for results through strategy review sessions.



Trusted Care, Anywhere

"In the AFMS, our dedicated professionals have proven their commitment to those we serve and their commitment to our mission. 'Trusted Care, Anywhere' is core to Air Force Medicine as it speaks to our medical support in every domain and our unfailing commitment to those we serve."
Lt Gen Mark A. Ediger, USAF Surgeon General

Prior to attending PA school, consider the last time you went to your provider. Did you question your provider regarding the safety of your care? Did you question your provider if he or she washed their hands? Did you question your provider if he or she prescribed you the correct medication? Of course not because you, like most people, trusted that your provider had your best interests in mind, safe care being paramount. Should we be afraid of our healthcare providers and staff? Do we have cause to worry when we or our loved ones are patients?

Consider that if medical error was a disease, it would be the 3rd leading cause of death in the U.S. Medication error alone causes 1.3 million injuries each year and 1 death every day. Rarely do we question the safety of our care however increasingly adverse medical events are driving attention towards the processes that lend bias towards error. As such, the AFMS has adopted principles that have been established by both the nuclear and flying communities in an effort to prevent and decrease adverse medical events. Such organizations that adopt these principles are known in the civilian community has "High Reliability Organizations". The AFMS has embraced similar principles in its journey to become a 'Zero Harm' organization and adopted the term "Trusted Care" as the title of its HRO transformation efforts.

Trusted Care Principles

- Sensitivity to Operations
- Resistance to Simplify
- Preoccupation with Failure
- Deference to Expertise
- Commitment to Resilience

The key elements of Trusted Care originated from an event in the spring of 2015. At that time, the Department of the Veterans Affairs (VA) came under fire for poor access to care and for unethical leadership practices that tied executive bonuses to inflated access metrics. The resulting resignation of the VA Secretary, along with media articles focusing on medical care provided in the MHS, led then-Secretary of Defense Chuck Hagel to initiate an unprecedented 90-day review of MHS quality, safety, and access to care. The MHS Review, directed on 28 May and concluded 29 August 2014, drove an exhaustive performance against selected national benchmark healthcare systems. As the MHS Review kicked off, AFMS leadership proactively contracted an external reviewer to conduct a gap analysis on the AFMS and a comparative analysis with leading healthcare systems in the domains of leadership, safety and reliability.

The DoD released the MHS Review Final Report to the Services in September 2014. It highlighted six overarching recommendations that focused on patient safety, transparency of information, and the development of the data infrastructure necessary to support effective quality and performance management. It also included 77 specific recommendations in support of these overarching goals, along with 82 action items intended to move the MHS toward becoming a top-performing healthcare system. Of the recommendations and action items given MHS-wide, AFMS leadership were particularly interested in improving AFMS performance to reduce patient harm, maximize access to care, and develop necessary performance management infrastructure needed to improve care quality. AFMS leadership convened at the first ever "AFMS High Reliability Summit" in February 2015. Based on the gap analysis, five gaps were identified at the summit as being key to achieving consistent safe and reliable care:

- Leadership Engagement: More direct leadership is critical to improving the culture of safety and reducing patient harm in the MHS.
- IT and data resources: Improved IT tools and real-time data availability are needed to aid leader decision-making
- Safety focus: Gaps in the AFMS patient safety reporting tool and culture of safety limit the active reporting, investigation, and effective prevention of patient harm events.
- Process improvement: The AFMS needs more data-driven process improvement activity and leadership engagement in process improvement, along with fostering problem solving in its Airmen.
- Quality and safety integration: The AFMS needs to integrate quality and safety programs better to improve the delivery of safe, high-quality patient care.

These gaps served as the foundation for the focus areas for AFMS Trusted Care referred to as the Trusted Care Domains. The Air Force Deputy Surgeon General, Major General Dorothy Hogg, is the Senior Sponsor for Trusted Care and has appointed several AMFS leaders as Trusted Care Domain Champions. These Champions develop, encourage, support and work with MTFs to foster programs that are shared AFMS-wide.

Trusted Care Domains

- Patient Centeredness
- Leadership Engagement
- Continuous Process Improvement
- Culture of Safety

Lt Gen Ediger has recognized that some of the best Trusted Care initiatives however come from our very own Airmen, from the bottom to the top, and therefore encourages "Every Airmen to be a Problem Solver". By encouraging both bottom to top and top to bottom collaboration on patient safety, the AFMS is able to effectively strive towards Zero Harm.

"The AFMS is extensively experienced in deployed medical support and en route care. Through the dedication and professionalism of the men and women of the AFMS, the Air Force contributions have been considerable to a joint effort that has produced impressive results on a large scale. Those results are reflected in facts such as the lowest "died of wounds" rate in the history of warfare, aeromedical evacuation of over 85,000 patients since 2001, and long-range critical care movements often within 24 hours of wounding. Additionally, the AFMS has supported the health and performance of remarkable Airmen performing across dynamic domains of air, space, and cyber operations. We are continuously striving to advance AFMS capabilities. Through research and innovation, our deployable capabilities are continuously evolving to adapt to changing operational circumstances and to bring innovative techniques and technology into the operational environment to improve outcomes.

Why, then, Trusted Care? Simply put, because those we serve deserve the very best. They deserve the very best across all the domains in which our unique system provides medical support. As military medical professionals, we have a tradition of commitment to excellence, as stated in the Air Force Core Values. Trusted Care is our concept for applying our commitment in a new way—by applying principles known to lead to high reliability. The principles are adapted from aviation and nuclear power experts and from the Air Force Safety Center—all deeply experienced in reduction of operational risk in sensitive missions. Trusted Care will be a sustained and substantive change in our approach to our mission.

While our processes for providing care and our programs for improving quality meet industry standards, we must sustain a critical and vigilant eye towards our own processes and performance to ensure an indefatigable effort to improve. Our steadfast goal is to eliminate harm to our patients by identifying and eliminating risk before it becomes a harmful error.
Our goal is Zero Harm.

To succeed, every medical Airman must understand and apply the principles in our daily duties. Every Airman must be a problem-solver, every day. I am certain we will be successful. In the AFMS, our dedicated professionals have proven their commitment to those we serve and their commitment to our mission. "Trusted Care, Anywhere" is core to Air Force Medicine as it speaks to our medical support in every domain and our unfailing commitment to those we serve."

Lt Gen Mark A. Ediger, USAF Surgeon General

The AFMS Physician Assistant

What does this mean to me?
As a physician assistant, Trusted Care means operating at your best within your environment whether that is within a Family Health Clinic, in the fields of the deployed environment, or within a staff or leadership positon. This means not only possessing and continually sharpening your clinical knowledge and skills but willing to be open to innovation. In a resource constrained environment it is of the utmost importance that patient safety be at the forefront of your practice. Cutting corners and creating work arounds are no longer safe practices and put both your patients, your staff, your Airmen and yourself at risk.

As an officer, Trusted Care means being a servant leader to your patients, your staff and your Airmen. This means being willing to listen to your Airmen when they recognize patient safety concerns and it means being open to them when they have solutions to offer. As a leader, you should encourage your Airmen to exercise their duty to speak up as well as exercise your deference to expertise when the answer is not clear. The AFMS is looking to you as a provider and an officer to be the expert, champion and innovator for Trusted Care because our patients deserve safe care.

Although single saves in the clinic will always be applauded, your influence to address and correct the processes that influence mass saves in the clinic will be what the AFMS is hoping you can bring to the mission towards Zero Harm. PA's are positioned uniquely for this new Trusted Care culture. We serve at the frontlines of care and therefore have sensitivity to operations. However, we are also Air Force officers and therefore can be agents of change and influence. We work with our patients directly but we also engage on a routine basis with our leadership. Air Force PA's have the ability to recognize patient safety issues and solve them but also have the voice to elevate issues, if needed. Going forward, PA's will play a significant role in the quest for Zero Harm.

The honor of serving some of the country's finest Americans…
What makes the AFMS PA unique? Some might say it is the deployment experience. Some might say it is the training we receive. Some might say it is the uniform, customs and courtesies or the chain of command we follow. These are valid differences but the true identity of an AFMS PA is so much more. We are charged with not only being excellent providers with keen clinical knowledge and skills but we are charged with being officers. We are officers first and always. We are charged with leading the Airmen, junior officers, and the staff we work with. This goes beyond management principles but obligates us to mentor, inspire, make tough decisions with, celebrate with and cry with those we lead. It is an honor to serve our Airmen as leaders and as providers. We serve them in both capacities as providers and as officers on their very best days and on their very worst days. It is an honor to serve some of our country's finest Americans both in the exam room, on the battlefield, and on our own teams.

U.S. AIR FORCE

Forward Operating Locations & Overseas Military Treatment Facilities



AFMS Operates 12 Military Treatment Facilities In 7 Countries (blue)
1,362 AF Medics Deployed In 30 Countries in 49 Different Locations
>92K Patients Moved From CENTCOM Since 10 Oct 2001

Integrity - Service - Excellence

BIOMEDICAL SCIENCES CORPS (BSC)

HISTORY

When the original Medical Service Corps was formed in July 1949 for the two-year old Air Force, it represented a blending of two types of officers in one corps: administrators/logisticians and scientific/allied technical specialists.

Over time, the demands of allied health care grew in leaps and bounds, while hospital operations and medical logistics became more complex, requiring a higher degree of understanding in business management and administration.

These specialized diversities between the two professional career tracks created many personnel problems in officer utilization, career progression, retention, promotion and training. It was eventually determined that a separate management oversight of the scientific and engineering elements within the MSC was necessary.

As a result, Secretary of the Air Force Eugene M. Zuckert in December 1964 sanctioned the establishment of a separate Biomedical Sciences Corps. On Jan. 28, 1965, Department of the Air Force Special Order CA-5 established a BSC category with its own separate Regular Air Force promotion list.

The BSC's roots began in the Army on May 18, 1917 during World War I, when Congress established the Army Sanitary Corps to combat infectious diseases.

The Sanitary Corps was a Reserve component composed of over 3,000 officers, with ranks filled primarily with scientific and health-related specialties (i.e., sanitary engineering, industrial hygiene, clinical laboratory, and entomology).

-- On June 4, 1920, the Army Medical Administrative Corps (MAC) was established. It incorporated administrative functions as well as medical specialties previously assigned to the Sanitary Corps.

-- In 1936, MAC's operational mission rapidly expanded and pharmacy officers were incorporated into its ranks.

-- With the onset of World War II in 1941, the Army Sanitary Corps was once again formed as a separate corps. It consisted of scientific medical specialists, including sanitary engineers, bacteriologist, biochemists, physiologists, entomologists, and other scientific personnel

-- By 1943 the medical demand for Army dietitians grew dramatically, resulting in Army Dietetics Corps being established. During this same time period, MAC's pharmacy

mission had grown in such scope and complexity it resulted in the formation of a separate Army Pharmacy Corps.

-- In 1945, the Women's Medical Specialists Corps (WMSpC) was created to consolidate the management oversight of all Army occupational and physical therapists. Shortly after WMSpC's inception, the Army Dietetics Corps lost its corps status and was fully integrated into WMSpC's infrastructure as another health discipline.

-- With the passing of the National Security Act in 1947 the Army Medical service Corps was created and consolidated biomedical scientists from the WMSpC, MAC, Army Pharmacy Corps, Army Veterinary Corps, and the Army Sanitary Corps.

-- The 1947 National Security Act was also the legislative catalyst to create the United States Air Force as a separate service. Also, the Army was mandated to provide all health care services for the Air Force.

-- On April 12, 1949 Air Force Secretary Stuart Symington and Army Secretary Kenneth Royal signed a joint agreement supporting separate Army and Air Force medical services.

-- On May 12, 1949 Secretary of Defense Louis Johnson authorized the formation of the Air Force Medical Service (AFMS).

-- On July 1, 1949, the AFMS was officially established and Maj Gen. Malcolm C. Grow was the first surgeon general. As a result, more than 3,700 officers and 1,400 enlisted personnel were transferred from the Army, many from the newly established Army Medical Service Corps.

The new AFMS was composed of six major corps: Medical Corps, Dental Corps, Nurse Corps, Veterinary Corps, Medical Service Corps, and Women's Medical Specialist Corps

The Medical Service Corps contained the majority of the scientific/technical specialists within the AFMS.

When the MSC was formed in July 1949, it represented a blending of two types of officers in one Corps, i.e., administrators/logisticians and scientific/allied technical specialists.

-- Based on a concept developed by Col. Alvin F. Meyer Jr., a bioenvironmental engineer, several independent studies confirmed his theory for separate management oversight of the scientific and engineering elements. As a result, in December 1964, Secretary of the Air Force Eugene M. Zuckert sanctioned the establishment of a separate Biomedical Sciences Corps.

On Jan. 28, 1965, by Department of the Air Force Special Order CA-5, a Biomedical Sciences Corps category was established with its own separate Regular Air Force promotion list

-- On March 15, 1965, the Biomedical Sciences Corps was officially created as a separate entity from the MSC, with Meyer as the first appointed corps chief.

As the BSC Corps became a reality, its officer infrastructure was formed primarily from MSC Corps and from the formal merger with the Medical Specialist Corps (700 scientific positions/214 dietitians and physical/occupational therapists).

-- On July 7, 1971, the first Air Force training class of physician assistants started at the School of Health Care Sciences at Sheppard AFB, Texas. Course graduates were limited to enlisted status only.

-- In 1978 PAs' professional capabilities were recognized, and more than 300 PAs were formally commissioned into the Air Force and assigned to the BSC.

-- On March 31, 1980, the Air Force Veterinary Corps was disbanded and its 272 veterinarians were transferred to the BSC.

-- By fiscal year 1983, the veterinary career field was officially eliminated from the Air Force and the remaining veterinarians who elected to stay BSC, transitioned to the new and dynamic specialty of Environmental Health.

Today, the Biomedical Sciences Corps – with around 2,400 people -- is the third largest element of the AFMS. The strength of the BSC is based in its diversity. The BSC is a corps of 17 distinct specialties (see list below) all working together to provide a broad base of clinical and scientific expertise for the Air Force Medical Service.

While the vast majority of BSCs practice their chosen specialties in hospitals and clinics, many of these multi-talented officers have held a wide variety of key positions: squadron and hospital commanders, MAJCOM and Air Staff positions, Battlefield Airmen, Special Operations, training, medical intelligence, research, development and acquisitions, and health promotions.



CHIEFS OF THE BIOMEDICAL SCIENCES CORPS
(1965 – Present)

1965-69	Col Alvin F. Meyer, Jr.	Bioenvironmental Engineer
1969-70	Col Frances G. Ballantine	Dietician
1970-72	Col Floyd M. Morris	Optometrist
1972-78	Col Thomas L. Cocheres	Psychologist
1978-81	Col Herbert E. Bell	Bioenvironmental Engineer
1981-84	Col Nicholas C. Nicholas	Aerospace Physiologist
1984-88	Col Phillip E. Smead	Bioenvironmental Engineer
1988-91	Col D. Dean Falconer	Dietician
1991-95	Col Jerry W. Davis	Public Health Officer
1995-98	Col Jerry W. Ross	Pharmacist
1998-00	Col Charles A. Watkins, III	Biomedical Laboratory Officer
2000-02	Col R. David Hindelang	Clinical Psychologist
2002-04	Col James H. Young	Pharmacist
2004-06	Col Jeffrey C. Sventek	Aerospace Physiologist
2006-09	Brig Gen Theresa M. Casey	Public Health Officer
2009-14	Brig Gen James J. Carroll	Aerospace Physiologist
2014-16	Brig Gen James E. McClain	Aerospace Physiologist
2016-present	Brig Gen James H. Dienst	Optometrist

HISTORY OF THE USAF PA

1971

- July 1971 - First PA class ("Towner's Boys"). School of Health Care Sciences, Sheppard AFB, TX`
- AFSC established for PAs (917X0) with rank of MSgt recommended for graduates

1972

- AF PA program begins affiliation with University of Nebraska
- August - Lt Gen Alonzo Towner retires 1973
- First PA class graduates
- RAND begins in-depth study of PA program for the Air Force
- First AAPA conference, "Annual Conference on New Health Practitioners", held at School of Health Care Sciences, Sheppard AFB

1974

- April 74 - Society of Air Force PAs (SAFPA) established in April. Larry Russell was the first President 1975
- OSD/H&E study indicated "evidence suggests AF will experience very low retention rates as a result of PA enlisted policy."
- SAFPA established as an AAPA Constituent Chapter 1976
- Jan 1976 - AF/SG (Lt Gen George Schafer) discussed PA issue with AF/CC to gain greater PA recognition (Warrant Rank).
- AF/SG letter to AF/DP addressing issue of increased rank for PAs (Warrant Officer) Mar 1976 - AF personnel community recommends commissioning of PAs because warrant officer grades are not commensurate with PA duties and responsibilities
- Jun 1976 - Air Staff review resulted in PA commissioning proposal
- Aug 1976 - GAO investigation into feasibility of a Tri-Service PA program began Aug 1976 – First PA in the AF Reserve, SSgt David Mittman (predated official AFRES authorization) 1977
- Oct 77 - USAF PA program affiliation changes to University of Oklahoma. Graduates earn a Bachelor of Science as Physician Associate
- Nov 77 - First AF PA assigned to White House (George McCullough)

1978

- Jan 78 - First SAFPA Newsletter
- Feb 78 - PA Commissioning Program implemented
- Apr 78 - First PAs Commissioned into BSC Corps
- First PA appointed Associate Chief BSC Corps
- PA school closed after class 780607 (believed that need could be met through recruiting)
- Jul 78 - SAFPA Newsletter renamed Towner-Shafer Report
- Sep 78 - Commissioning Moratorium enacted, then lifted
- Oct 78 - First PA Consultant to USAF Surgeon General appointed
- Alonzo Towner Society becomes SAFPA's student member arm

1979

- Mar 79 - AF PA school reopens with class 790312. (recruiting hadn't worked)
- Apr 79 - First SAFPA member of the year award presented to Ernest Riggs

- Sep 79 - First Annual BSC seminar for PAs 1980
- BSC Seminar and SAFPA Annual Conference merge
- Aug 1980 - First PA promoted to rank of Major (Chuck Egerton)
- May 80 - Jerrold L Wheaton award first presented (to Dr Wheaton)
- Specialty PAs (orthopedics, otolaryngology and general surgery) begin

1981

- Defense Officer Personnel Management Act (DOPMA) passed. Removed 0-4 grade ceiling and allowed Regular commission status for PAs

1984

- Associate Corps Chief/Consultant position de-linked from Air Staff; does not follow from Brooks AFB to DC. Consultant is an additional duty to regular clinic assignment.
- Paul W. Myers award started for "Outstanding Physician Preceptor of the Year"
- Full commissioning for AF Reserve PAs

1985

- PA school is placed on standby status with the graduation of class 840611 from Phase I
- First PA selected for Lt Col (Chuck Egerton) 1989
- PA school reopens at Sheppard AFB. Affiliated with University of Nebraska Medical Center
- Navy and Public Health Service PAs commissioned 1991
- First Emergency Medicine PA (42G3E) fellowship starts at Los Angeles County Emergency Department

1992

- Army and Coast Guard PAs commissioned 1995
- First PA placed on AFSOC operational aeromedical status (Maj Jackson R. "Trashman" Dobbins)

1996

- The Interservice Physician Assistant Program (IPAP) opens at Ft Sam Houston, TX with Army, Navy, Air Force, Coast Guard, Bureau of Prisons and University of Texas students
- The Air Force school at Sheppard closes to merge into the IPAP 1998
- May - First class graduates from IPAP
- Lt Col Jackson Dobbins becomes the first PA to serve as Combined Special Operations Task Force Surgeon (SWA): Operation DESERT THUNDER

2000

- Jan - Elvin E. ("Ed") Maxwell became the first PA in DoD to attain the grade of 0-6
- Col Maxwell is appointed the first AF Program Director of IPAP

2003

- Jan - IPAP becomes a Masters-level education program. Still affiliated with University of Nebraska
- Last 42G3B (ENT) authorization eliminated Nellis AFB
- Four ENT PAs remain on AD

2005

- First class of Masters-level PAs graduates from IPAP

- Because of two years constructive credit for the new MPAS degree ("entry level" for civilian PAs entering the AF remains at Bachelor level) the new graduates are commissioned as First Lieutenants

2006

- PA Associate Corps Chief/Consultant position is created as a permanent 0-6 authorization at Air Staff
- PAs are first assigned to 365-day deployments in Iraq and Afghanistan First PA Medical Group Commander: Col Jackson Dobbins, Hanscom AFB 2007
- Col Dobbins became first PA selected as Expeditionary Medical Group Commander, (SWA), Operation IRAQI FREEDOM
- Aug - ***PA Almanac*** published (later becoming the "Unofficial Handbook for AF PAs"). Printed copies distributed at annual San Antonio PA Refresher Course (*Fiesta CME*)
- Dec – Authorization to restart the General Surgery PA (42G3C) career field with six to start training in Jul 08 2008
- Jan - AFSCs 42GXD (Perfusionist) and 42GXF (Oncology/Bone Marrow Transplant) are officially mothballed (codes no longer used but could be restored if needed)
- PA Handbook 3.1 commercially printed; posted on Air Force Knowledge Exchange

2009

- AF PAs work at all levels of DoD, MTF, MAJCOM, Air Staff (AF/SG), Assistant Secretary of Defense (Health Affairs) office, Defense Medical Research & Development Office, Defense Medical Materiel Program Office and Joint Staff, Pentagon (medical J4).
- Col Cheryl Gregorio (Altus MDG/CC) is AAPA's Federal Services PAragon Award winner 2009
- Specific expeditionary UTC taskings created for Orthopedic, General Surgery and Emergency Medicine PAs
- Authorization to restart the ENT PA career field (42G3B) with three projected to graduate from fellowship in 2012
- Col John Bullock is AAPA's Federal Services PAragon Award winner
- Col John Chitwood becomes the second AF Program Director for IPAP
- Dec – First class start as IPAP lengthens from 24 to 29 months (14 months Phase I; 15 months Phase II)

2011

- June – 1st class of USAF Emergency Medicine PAs enters in and integrate the USA-Baylor EMPA Doctoral residency at San Antonio Military Medical Center.
- Colonel Doug Hodge is named AAPA's Federal Services PA of the Year

2012

- Lt Col Pamela Lucas is named AAPA's Federal Services PA of the Year
- Dec – 1st class of 4 USAF Emergency Medicine PAs graduate with Doctorate of Science
- Dec – Maj T.J. Bonjour becomes the 1st Army/Air Force integrated EMPA Program Director

2014

- Lt Col Melanie Ellis is named AAPA's Federal Services PA of the Year

2015

- May – Major T.J. Bonjour named AAPA's Military PA of the Year
- June – 1st class of USAF General Surgery PAs enter the USA-Baylor General Surgery Doctoral residency at San Antonio Military Medical Center

2016

- May – Colonel Rene Chadwell named AAPA's Military PA of the Year
- Dec – 1st class of USAF General Surgery PAs graduate with Doctorate of Science

2017

- June – 1st class of USAF Orthopaedic Surgery PAs enter the USA-Baylor Orthopaedic Surgery Doctoral residency at San Antonio Military Medical Center

BSC Badges

(Aeronautical, Duty and Occupational Badges)
AFI 36-2903, (18 July 2011), Dress and Personal Appearance of Air Force Personnel, para 10.4.2 (p 138)

- Formal application/approval no longer required
- Wear Basic badge after graduating from PA school (or when fully qualified in specialty)
- Wear Senior after 7 years in specialty
- Wear Master after 15 years in specialty
- Time in specialty includes any constructive service credit awarded at time of appointment


BASIC


SENIOR


MASTER

"Associate Corps Chief, Biomedical Sciences Corps" and "Chief Military Consultant to the AF Surgeon General for Physician Assistants" What is the Difference?

"Associate Corps Chief" and "Chief Consultant". Each of these is a different duty with a distinct title and (theoretically) can be separate people but BSC policy is to have them held by the same person. Until 2006 both were assigned as additional duties to whatever the person's primary (MTF, MAJCOM, Air Staff) AF job was. In 2006 a position was created at Air Staff specifically for the PA Consultant, the first dedicated O-6 PA authorization in the Air Force.

The Chief Consultant is appointed, based on rank, clinical expertise and experience, by the AF Surgeon General to advise them and their staff on physician assistant issues and utilization.

The Associate Chief, Biomedical Sciences Corps is appointed by the BSC Corps Chief to advise on PA issues within the Corps and to sit on the BSC Development Team (DT) to provide career vectors for the Corps.

The Scope of the Job:

Provides liaison between the field and the SG (and vice versa). They are the subject matter expert on all aspects of PA utilization in the AF. Works with the other SG Consultants on issues such as Clinical Practice Optimization and Consultant Balanced Deployments. Sits on the AF-level Medical Practice Review Board for malpractice or adverse action issues involving PAs AF-wide. Sits on the PA Selection Board for IPAP (if a Col, they will chair the board). Sits on the Health Professions Education Review Board (HPERB) where they screen and vet all BSC fellowship and AFIT advanced academic degree requests. Oversees equitable distribution of AFIT short course authorizations. Coordinates with AFPC for all assignments (0-5 and below).

So What Difference Does That Make for Me?

The Chief Consultant is the AFSC-specific bridge between the Surgeon General and the field. They are not in your chain of command so they should be looked on as a low threat asset that is accessible to every member of the career field. They have the rank and experience to be effective but the currency they deal in is information. They are open to gripes, ideas for improvement, mentoring questions, counseling, rumor control, career broadening requests, etc. Ultimately it's their job to make AF PAs as effective as possible wherever they

are and to have job satisfaction however they are asked to serve. Therefore, let them know your plans and desires early on. Chances are your application (or a request to vouch for you) will flow through them anyway before approval.

Associate Chiefs of the BSC and Chief Consultants to the Surgeon General for Physician Assistants
1976-Present

1976-1978	**CMSgt George D. McCullough***	**Class #711006**
1978-1981	**Capt David H. Gwinn**	**Class #720308**
1981-1986	**Capt Lawrence Russell**	**Class #710707**
1986-1991	**Maj Thomas J. Lemley**	**Class #740703**
1991-1994	**Maj Coy L. Barfield**	**Class #760609**
1994-1996	**Lt Col William J. Curran**	**Class #731107**
1996-2002	**Col Elvin E. "Ed" Maxwell****	**Class #750618**
2002-2008	**Col John W. Bullock**	**Class #790702**
2008-2010	**Col John L. Chitwood**	**Class #840211**
2010-2012	**Col Cheryl E. Gregorio**	**Class #800227**
2012-2016	**Col Rene Chadwell**	**Civilian Accession**
2016-present	**Col Terry R. Mathews**	**Class #022090**

*CMSgt McCullough was the first PA to be commissioned (as a Capt 1 Apr 1978) and the first PA assigned to the White House (Nov 1977)

**Col Maxwell was the first PA to attain the rank of Colonel

Personnel Management

Managing Your AFSC

The Air Force Officer Classification Directory (AFOCD) provides the following information foll all Air Force Officer AFSCs: duties and responsibilities, specialty qualifications, and specialty shredouts. It is updated bi-annually (Apr, Oct) and can be found through the MyPers website under the Classification section.

Prefixes:

An "**M**" prefix indicates Board (NCCPA) Certification (Although there has been a mistaken belief that this is somehow related to a Masters degree). Everyone should have an "M" prefix. Per the AF Officer Classification Directory (AFOCD), Section 1:

> Prefix "M" identifies officers certified by an appropriate American Specialty Board or other board acceptable to the Air Force Surgeon General. See AFI 41-104, *Professional Board and National Certification Examinations*, for a list of approved boards and certification procedures for award of prefix M.

To make an administrative change in your AFSC you apply on an AF 2096. For an "M" prefix you should attach a copy of your NCCPA certificate. It cannot be applied to your DAFSC, only to your primary, secondary or tertiary AFSC.

> An "**H**" prefix identifies officers selected by the Air Force Surgeon General's Officer Classification Board as having achieved consultant status in a particular medical service or physiological support specialty. Does not attach to the DAFSC.

A "**T**" prefix may be used on your DAFSC only if you're currently in a teaching position. Add it if you've earned it. It may be retained on your primary, secondary or tertiary AFSC after you leave the teaching position but must be removed from the DAFSC.

Core AFSC:

A new PA is a 42G1. After you have six months of providing primary medical care in the AF AND NCCPA certification you should upgrade to a 42G3. You have to initiate this. It won't happen automatically. There are too many Captains and above whose records still say "42G1"!

Suffixes (shredouts):

A suffix is authorized upon completion of an additional residency or fellowship program related to the suffix and acceptable to the AF Surgeon General. The PA specialty fellowships fulfill those. All specialty PAs who have completed an AF fellowship should have their PAFSC

show the appropriate shredout suffix. Their 2AFSC should remain 42G3. PAs assigned to specialty positions (e.g. emergency department) but who have not had the specified formal training are not eligible for the identifier.

Authorized PA Shredouts:

A	Orthopedics
B	Otolaryngology
C	General Surgery
D	Cardiac Perfusionist (deleted 1 Jan 2008)
E	Emergency Medicine
F	Oncology/Bone Marrow Transplant (deleted 1 Jan 2008)

Why is all this important? Not only does it keep assignments and deployments straight but the accuracy of the information can be used as a tiebreaker on selection boards as a reflection of how well you manage the details of your life. Fair? I can't say but it's a fairly easy thing to fix. Your SURF is the only available representation of you in many situations. The information on your SURF is the same information that will be on your officer service brief (OSB) for your promotion boards. Getting it right is worth the effort.

ASSIGNMENTS

HQ AFPC/DP2NW

This section provides helpful information for understanding the Air Force Assignment System (AFAS). The official AFAS timeline can be found on the MyPers website. AFI 36-2110, *Assignments*, can be found on the AF Forms and Pubs website that can accessed through the AF Portal. The below table provides general timelines for the match cycles. **Specific dates are released annually.**

ASSIGNMENT CYCLE TIMELINES					
CYCLE	**VML (Initial)**	**PRD (Vacancies)**	**ADP DUE**	**MATCHES MADE**	**RNLTD**
Spring	Jul	Aug-Sep	Sep	Sep-Oct	Feb-May
Summer	Nov	Dec-Jan	Jan	Jan-Mar	Jun-Sep
Fall	Apr	May-Jun	Jun	Jun-Jul	Oct-Jan

- **Initial VML:** The initial vulnerable to move list (VML) is released to squadron commanders. This normally lists officers projected to have at least 36 months time on station (TOS) during their projected departure date (PDD) for their next assignment. Also included on the VML are AFIT graduates, graduating squadron commanders and officers with a DEROS during the assignment cycle.

- **Reclama:** This allows commanders to request that an officer not be moved during the cycle. They have approximately two weeks to file a reclama and justification must include a significant mission impact. If a reclama is denied at AFPC, this does NOT guarantee that the officer will move. It provides the flexibility to move the officer in order to meet mission requirements. The reclama window is also the time for officers who are OCONUS to request a DEROS extension.

- **Final VML / Last day to submit requisitions**: This is an established deadline after which commanders will be unable to submit requisitions in AMS. Requisitions are advertised on AMS as potential job vacancies, and are visible during the PRD (Personnel Requirements Display) visibility window. Commanders should submit a requisition so that positions may be advertised for a fill.

- **PRD Visibility Window: It is the officer's responsibility to view the available job openings during the visibility window**. The jobs advertised on the PRD reflect what has been submitted by the commanders before the suspense date, and may not be an exhaustive list of what will be available as the cycle progresses. The system does not receive real-time updates, so jobs will not fall off the PRD as they are filled. Commanders submit requisitions for all officers on the VML. Therefore, there will be circumstances when an officer does not

PCS, and that position will not require a fill. When checking requisitions, search for your own grade, but also search for one-grade up and one-grade down.

Note: Authorizations = total list of positions, regardless of whether available for fill
Requirements = anticipated openings during the cycle

- **ADP (formerly known as the T-ODP) due: The ADP is critical in making assignments for officers from 2Lt through Lt Col**. The ADP was designed to be a "one size fits all" developmental game plan and a specific job preference request. The ADP must be routed through your reviewer (SQ/CC or equivalent) and forwarded to AFPC by this date. It is imperative that your ADP status says, **"Development Plan at AFPC".** If it does not show this as the status, AFPC will NOT be able to view your ADP. Please make certain you have filled in the location selections and your comments section. Your assignments officer personally reads every ADP and takes into consideration your comments, your reviewer's comments and the Development Team's comments. Assignment officers use the ADP to generate volunteer lists, particularly for OCONUS locations. If officers do not complete an ADP they will miss out on the first round of matching. **You may still be matched to an assignment or location not on your ADP in order to meet the needs of the Air Force.**

- **AFPC Matches:** The 42G assignments officer, currently Maj Connie Converse who is an audiologist, manages four other BSC specialties in addition to the 42G. She works closely with the PA Associate Corps Chief and generally works through the list in this order:

    1) OCONUS backfills (particularly Korea, then all other OCONUS)
    2) PRP and Flight Medicine
    3) Special programs
    4) Remaining clinical billets

  42G Assignment Officer, Maj Connie Converse's contact info: DSN 665-3821/1665 or Commercial 210-565-3821/1665, Email: connie.converse.1@us.af.mil

- **General Tips:**

- **If you are interested in a special assignment such as MAJCOM, staff, training director, etc., please make comments on your ADP, but also contact the PA Associate Corps Chief.** AFPC works closely with them to place the right officers at the right time into these positions.

- If you are on the VML, coordinate with your Flt/CC or Sq/CC to ensure your position is advertised with a requisition. Help your leadership by developing a solid job description. This ensures that the position is advertised, and also helps other officers know what the expectations are for the positions for which they may be volunteering. **Remember, if a requisition is not submitted, the position may not be advertised.** It is important for requisitions to be visible so officers may list suitable locations on the ADP.

- Review the **43B/49X** (43B is BSC-specific, 49 is multi-corps) positions. Health of the career field is a major factor in whether you can be released for these positions. Please let both the PA Associate Corps Chief and the assignments officer know if you are interested in these jobs, and remember **you must be released by your Associate Corps Chief and AFPC before you may compete**. Also, look at the comments on these jobs, some positions restrict the AFSCs that are eligible to apply.

- If you are planning on **separating or retiring from the Air Force**, you remain eligible to receive an assignment until a DOS (Date of Separation) has been established in the system. Formal separation requests must be made through the virtual MPF at least six months prior to your intended separation. The Air Force is currently in the process of releasing a new retirement system. You are highly encouraged to go on the MyPers website to educate yourself on this new system.

- **ADP tips:**

    - List your background and experience
    - List your "dream" assignment even if you don't think it will be open; certain situations may arise (humanitarian reassignment, join spouse, etc) that can create last minute vacancies
    - Focus on career progression -- types of jobs as well as specific jobs you're interested
    - Explain unique situations involving family, timing, school, etc.
    - Consecutive overseas tours are the exception rather than the rule. Exceptions may include the use of your specialized training that may be specific to OS bases, locations that may be less popular, or being the only volunteer for that particular location.
    - List locations that you prefer. If you list a particular location, don't be surprised if you get matched there. We highly recommend that family discussions take place prior to filling out your preferences.
    - Don't give only one preference or repeat the same preferences
    - Ultimately the needs of the AF must be met. **You may be matched to a location that is not on your ADP.**
    - Utilize the "Search Authorizations" function in AMS to find out where positions are authorized for your AFSC at a particular location. The authorizations menu is always available.
    - **Do not leave the comments section blank**

The majority of PCS moves occur in the summer assignment cycle. Therefore, the match period Jan-Apr is the AFPC BSC Utilization and Education Branch's busiest time of the year. Once you are matched to an assignment, you will receive an official email notification directing you to complete your initial assignment briefing in the virtual MPF. You will also appear your squadron commander's outbound roster. AFPC runs daily assignment batch uploads to MilPDS,(AF military personnel system).

Retirement

Resources: MyPers website > Retirements, AFI 36-3203, *Service Retirements*, AFI 36-3003, *Military Leave Program*

As required by Title 5, USC 8301, all non-disability service retirements must occur on the first day of the month; therefore, you may request to retire on the first day of the month after reaching retirement eligibility. The Blended Retirement System (BRS) will be implemented on 1 January 2018. Airmen entering the service 1 January 2018 and later will automatically be enrolled in the new retirement system. Airmen entering the service prior to 1 January 2018, will be grandfathered under their current Legacy retirement system; however, service members with less than 12 years of service as of 31 December 2017 will have the option to elect the BRS if they desire. Modernizing the current retirement system into the BRS will not only ensure that the vast majority of all uniformed members receive a portable retirement benefit, but it will also help make Uniformed Service a more attractive option for those who would like to serve but do not plan to stay for an entire career.

Applications for retirement may be submitted no earlier than 12 months and no later than 120 days before your requested retirement effective date. If you request a retirement date with less than the required 120 days notification, a waiver will be required and must include full justification and your commander's recommendation. In certain circumstances, applications may be submitted outside these parameters if you are applying in conjunction with 7-day or 3-day option programs or when authorized under specific Force Management programs offered by the Secretary of the Air Force.

The Retirement Personnel Processing Application (PPA) can be located on the vMPF through AFPC Secure.

1.Input Common Accesss Card (CAC) PIN or enter Air Force Personnel Center (AFPC) Secure User ID and Password and click on Secure Login
2.Click on vMPF
3.Click on Self Service Actions
4.Click on Retirements
5.Click on Request Retirement

You can review information on retirement eligibility by selecting the Eligibility link. Select the Restrictions link to review tables that contain information regarding conditions that preclude the submission or processing of your retirement application, and conditions/restrictions that may be waived in the Best interest of the Air Force or for Hardship not common to other Air Force members. Select the Entitlements Counseling link for information on basic entitlements involved with retirements. It is recommended that you review these areas before applying for retirement.

After reviewing this information, click on the Check Retirement Eligibility link to submit your request. The Total Force Service Center-San Antonio Retirements Section will review your record and respond via email within 5 duty days of receipt. If you are found eligible to request retirement, you may initiate a retirement application using the following procedures:

Step 1: Submit Pre-Application Checklist. After AFPC notifies you via email that you are eligible to apply for retirement, access the Retirements area of the vMPF Self-Service actions again. Click on the Request Retirement link and the Pre-Application Checklist will open. Read and complete each item on the checklist and click the submit button.

Step 2: Submit Retirement Application. Once you have submitted your Pre-Application Checklist, the system will open the Retirement Application. Complete and submit your retirement application. If AFPC identified that you need to request a waiver of a retirement restriction or condition, attach all required supporting documents to your retirement application at the time of submission. You must also have your unit commander's email address available and include it in your request. After you submit your request, the system will forward it to your commander for a recommendation.

AFPC Retirements Branch application process

Colonels are forwarded to the Colonels' Group for approval/disapproval; estimated processing time is four to six weeks.

Lt Cols and below are processed by AFPC within four to six weeks. NOTE: Applications requiring Secretary of the Air Force Personnel Council coordination may take longer than four to six weeks to process.

NOTE All processing time is calculated from the date a complete and correct application is received from the Unit Commander or designated representative.

When a decision has been made on your application you will receive an email notifying you of the approval or disapproval.

For problems logging into AFPC Secure, please call the A1 Service Desk, Commercial 210-565-5004, DSN 665-5004, or 1-800-525-0102, option 8.

For problems in navigating through the web application, please call the myPers-Total Force Service Center (myPers-TFSC).

Commanders may approve up to 20 days PTDY for CONUS-based member and up to 30 days PTDY for members stationed overseas. The amount of terminal leave the commander can approve is limited to the members' leave balance. However, commanders have the authority to disapprove PTDY and/or terminal leave if it interferes with the military mission.

Retirement in Enlisted Grade

The procedure for retiring with 20 years time in Service but with less than ten years commissioned is outlined in AFI 36-3203, *Service Retirements,* paragraph 3.6. Apart from special times of force reduction this action is granted only under extreme hardship or in response to a date of separation endorsed at the Secretary of the AF level. Since this has been a scenario considered by PAs in the past, because of sometimes significant enlisted prior service time, here is the answer from AFI 36-3203:

> **3.6. Officers Desiring Active Duty Retirement in Enlisted Status .** Only when documented hardship situations exist, when the SecAF or designee establishes a mandatory DOS, or when the SecAF or designee approves retirement or transfer to the retired reserve in lieu of involuntary separation, court-martial, or a court-martial sentence (See Table 2.2), can officers with 20 years TAFMS request to retire before completing 10 years of TAFCS. (NOTE: When allowed by law, the SAF may elect to waive TAFCS to 8 years under an existing Force Management program.) The officer must first request the delegated authority's approval of resignation or release from active duty according to AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers. The appropriate authority must authorize enlistment in the Active Component for the purpose of retirement.
>
> 3.6.1. For commissioned officers to be eligible for retirement under 10 USC §8911 they must not only have 20 years of active service but also a minimum of 10 years of active commissioned service to retire as an officer (10 years commissioned service is not a requirement for officers retiring under 10 USC §12731). Without meeting both of these requirements, they are ineligible for retirement as an officer regardless of TAFMS. When allowed by law, the SecAF may elect to waive TAFCS to 8 years under an existing Force Management program. Title 10 USC §8914 allows for enlisted members to retire, but specifically requires an eligible member to be an enlisted member. Because there are no actual provisions of law that would allow an officer to retire as an enlisted member, the following procedure has been developed. This strict procedure involves a number of AFPC/ARPC offices to process a retirement of an officer in enlisted status. To retire as an enlisted member, the officer must first apply for separation. After applying for separation, the officer must then apply to be enlisted and accessed back as an enlisted member.
>
> 3.6.1.1. If the member is allowed to enlist, they must then apply for retirement in that enlisted status. To effect an enlisted retirement, officers will not fill enlisted accession billets; rather, they will typically only hold their enlisted status for one day and then retire the next. Officers desiring to retire as enlisted members are required to be in enlisted status upon retirement to meet the requirements of 10 USC §8914 as stated above, but they may not fill a slot or remain on active duty in this status for any longer than required. A Regular officer may not apply for retirement in enlisted status until they first attain enlisted status on active duty prior to completing/submitting a retirement application in

their new enlisted grade. To accomplish this type of retirement, the officer will not be able to take PTDY or terminal leave in enlisted status in conjunction with retirement. Approval of the retirement request and inability to use either permissive TDY or terminal leave may not be construed as a denial of entitlement(s).

3.6.1.2. Refer to the Retirements PSD Guide on retirement processing procedures

3.6.2. Accrued leave: If an officer separated for the purpose of reentering active duty in enlisted status, then 37 USC §501 and DoDFMR, Vol 7A, Chapter 35, Table 35-2, Rule 2 prohibits payment of accrued leave. If the AF separates an officer for failure of selection to a higher grade and he/she immediately reenters the active component in an enlisted status, then finance regulations allow payment of accrued leave. Officers who, after notification of an impending discharge, resign for the purpose of continuing a military career cannot receive payment for accrued leave (37 USC §501 and DoDFMR 7000.14-R, Vol 7A, Chapter 35, Table 35-2, Rule 4 and Note 1).

3.6.2.1. The officer is not able to take terminal leave, but may, as an exception to policy, request PTDY and ordinary leave in their officer status. If approved, they may take the PTDY and ordinary leave prior to their separation as an officer. Members must have retirement orders in hand before they can out-process and retire. Because orders under paragraph 3.6 are not published before the date of enlistment, it is imperative that officers return to their unit following PTDY and ordinary leave for final out-processing.

3.6.3. When the member in paragraph 3.6.2.1 accumulates 30 years of active duty plus service on the retired list, the member will be advanced to the highest grade held satisfactorily on active duty as determined by the SecAF, see paragraph 7.5. If there is doubt the officer serves satisfactorily in the officer grade, the RAA must initiate an Officer Grade Determination for the SecAF to consider when deciding whether or not to advance the member at 30 years see paragraph 7.6.

3.6.4. In rare cases, the officer's advanced grade may equate to a lower rate of retired pay than the enlisted retired pay. Title 10 USC §8965 allows the member 3 months to turn down the advancement. Example: a MSgt advanced to 2Lt may receive lower retired pay when advanced to 2Lt. To turn down the advancement, the member should contact the RAA for instructions.

NOTE:
The above is an extract from the AFI. If this area is important to you, read the entire section in the current AFI, which elaborates on the significant loss of benefits one incurs by following this course.

At this time, waiver requests to AFPC for BSC early retirements are being denied by policy

42G SPECIAL PAYS

*Please note that special pays are briefly discussed to ensure you are aware that they exist. It is strongly recommended that you go to the Medical Special Pays website on MyPers and familiarize yourself with the USAF FY17 BSC Special Pay Plan (FY18 pay plan has not been released yet).

Starting in FY16 the USAF began converting from Legacy Special Pays to Consolidated Special Pays (CSP). Full information and eligibility criteria on Medical Special Pays can be found on the MyPers website > Medical Special Pays
at: https://mypers.af.mil/app/answers/detail/a_id/29350/kw/medical%20special%20pays/p/9

Contact information:
AFPC/Medical Special Pays Branch
550 C Street West Ste 27
JBSA-Randolph TX 78150-4729
DSN 665-0102/Comm (210) 565-0102 Toll Free: 1-800-525-0102
AFPC Medical Special Pays Branch
afpc.dp2ssm.medicalspecialpay@us.af.mil

Air Force Medical Service (AFMS) Special and Incentive (S&I) Pays is the Air Force's primary health professions program for incentive and retention. Special pay for medical personnel is intended to narrow the gap between military and civilian salaries for medical professionals and provide a means to attract and retain them beyond initial obligation. All medical pays are taxable.

There are four main types of contractual medical special pays (distinct from other special pays for which PAs may be eligible, such as hazardous duty pay):

- **Accession bonus** For any new accession to the Air Force
  - Requires a three or four year contract commitment
  - Paid in annual lump sums

- **Incentive Pay**
  - A method of increasing compensation to help retain select professions
  - Must meet requirements of "Fully Qualified" as an AF PA-C
  - Requires a 12-month contract commitment
  - Paid in equal monthly disbursements

- **Retention Bonus**

- o A method of increasing compensation to help retain select professions o Must meet requirements of “Fully Qualified” as an AF Physician Assistant o Requires a 24, 36, or 48-month contract commitment
- o Provides bonus pay in addition to Incentive Pay to ensure additional obligation o Paid in annual lump sums

- **Board Certification Pay**
  - o Eligibility for PAs: NCCPA certification and an advanced academic degree in the specialty-copy of diploma required
  - o Paid in equal monthly disbursements (identified as “Save Pay” on Leave and Earnings Statement)
  - o Officers should work with their Commanders Support Staff or Military Personnel Sections via AF 2096, to have the “M” prefix added to their AFSC

Consolidation of Special Pays for Physician Assistants

42G PHYSICIAN ASSISTANT	1 Year	2 Year	3 Year	4 Year
AB -Accession Bonus/yr	N/A	N/A	$12,500	$20,000
IP -Incentive Pay/yr	$5,000	$5,000	$5,000	$5,000
RB -Retention Bonus/yr	N/A	$10,000	$15,000	$20,000
BCP -Board Certification Pay	$6,000	$6,000	$6,000	$6,000

AB and RB amounts are paid as annual equal lump sum payments on initial contract execution and on anniversary date of the multiyear contracts. IP and BCP are paid in equal monthly installments for the life of the contracts. BCP is an entitlement and incurs no obligation.** ***AB and RB are mutually exclusive and personnel eligible for either cannot receive both. **No contract can be voluntarily terminated early.**

Professional Career, Courtesy and Conduct

"Fully Qualified" Criteria for PAs: Certification & Licensure

Physician Assistants are accessed into the Air Force only when "fully qualified". The requirements to be "fully qualified" can be found in the AF Officer Classification Directory (AFOCD) in MyPers. For civilian accessions (whether by scholarship or direct) that means they must be a graduate of a program accredited by Accreditation Review Commission for Physician Assistant Education, Inc. (ARCPA) or its predecessors, and acceptable to the HQ USAF/SG and have successfully passed the PANCE and be currently certified by NCCPA at the time of entry to AD or ARC duty. IPAP graduates must be certified within 12 months of graduation. PAs are required to maintain NCCPA certification. (See AFI 41-104, *Professional Board and National Certification Examinations,* for reimbursement rules for certification maintenance). AFI 44-119, *Medical Quality Operations,* para 4.6 provides direction for "Failure to Obtain or Maintain a License, Certification, or Registration".

Current certification/recertification requirements are at the NCCPA website: http://www.nccpa.net

LICENSURE:

Physician Assistants are in a unique position relative to other AFMS providers in that, based on an Assistant Secretary of Defense/Health Affairs waiver, we are allowed to practice within the DoD without a State license. The following is from AFI 44-119, para 4.1.1.2:

> Physician Assistants (PAs) must possess and maintain an active, current, valid, and unrestricted nationally recognized certification. In addition, non-personal service contract PAs are required to be licensed in the state of practice.
>
> PAs (other than non-personal services contract PAs) are exempt from the licensure requirement due to the fact that most states have very specific supervision requirements that are impractical, if not impossible, to meet given the diverse and mobile population in DoD medical operations. In response, Assistant Secretary of Defense for Health Affairs has exercised the authority to waive the license requirement as long as the PA has successfully met the criteria reviewed when privileges are initially granted or renewed. Therefore, PAs who have been granted privileges within the MHS by an authorized

privileging authority will be automatically granted a waiver. This waiver is automated and the information is pre-populated in CCQAS under the licensure tab. The waiver date matches the date privileges were granted and expires with privileges or the expiration date of the National Certification, whichever comes first. The waiver is automatically reissued based on renewal of privileges and/or national certification. Monitoring for compliance will be accomplished by the Standard Unlicensed Provider Report in CCQAS.

Waiver for licensure is not applicable to PAs who are non-personal services contractors.

Career Broadening

The subject of career broadening carries mixed messages in the AFMS. Most senior leaders assert that some career broadening is needed to create a well-rounded officer as well as for reliable promotions beyond Major (O-4). The tension is that PAs are so valuable in the clinic that any significant career broadening often comes at a painful cost to the unit. Good commanders develop their people. Poor commanders see only the near-term cost to their production.

Career broadening is successful only if you have a solid foundation in your core competency. My experience has been that if you excel in your core job you will be asked to do more (like supervise, teach, sit on committees, write articles, etc.). The official position is that you can stay 100% clinical and get promoted to Lt Col. That's true only if some broadening has happened clinically. For example one PA spent several years in family practice then did a specialty fellowship and ultimately became the program director at one of the fellowship sites, where he was promoted to Lt Col. He remained clinically focused even though he broadened. Bottom line, if you stay 100% in primary care seeing patients eight hours a day you'll be very fortunate to make it past Major.

There are main ways for a PA to broaden *clinically* (specialty fellowships, joining the faculty at IPAP, clinical research, clinic flight command) or *operationally* (White House PA, International Health Specialist, 820 SFG, Battlefield Airmen, AFSOC, etc.). Also, there are opportunities for career broadening in 43B positions (generally any BSC AFSC can fill these positions). On the AF Knowledge Exchange (Kx) > AF BSC Utilization page (https://kx2.afms.mil/kj/kx4/AFBSCUtilization/Pages/home.aspx) you will find a section dedicated to advertising vacant/projected vacant BSC Career Broadening/43B opportunities (maintained by AFPC BSC Assignment Officers). Also, AFMS multi-corps job opportunities will be advertised via MyPers messages. If you would like to compete for any of these 43B or AFMS mult-corps positions, you will need to be released by the PA Associate Corps Chief (Col Mathews) and your Assignment Officer (Maj Converse).

My advice has consistently been if you have any desire to apply to any of these broadening jobs, apply and don't be held back by any sense of inadequacy! You're supposed to feel stretched a little. Most of these require interviews thus if you are selected for the job you have already been judged by experts as able to succeed in the job. They all provide training. Don't self-eliminate prematurely. These are all highly rewarding and highly satisfying jobs where you can know you make a difference.

The Path to Senior Leadership in the USAF Medical Service

Lt Gen Charles Roadman

There is no specific sequence of jobs required for an officer in the Air Force Medical Service (AFMS) to achieve senior rank. However, the hallmark of the exceptionally successful military medical career is a solid foundation built upon a diversity of assignments that fully develop the officer's technical, staff, and leadership skills.

An officer's early career should focus on building technical expertise, to include achieving board certification. Whether working as a generalist or a specialist, timely and frequent movement to positions with increasingly complex mission support responsibilities provide the officer with a broad base of solid operational expertise.

The need for a stable staff in research and academic organizations requires long-term assignments. Officers choosing careers in these areas are generally less competitive for promotion beyond the grade of colonel.

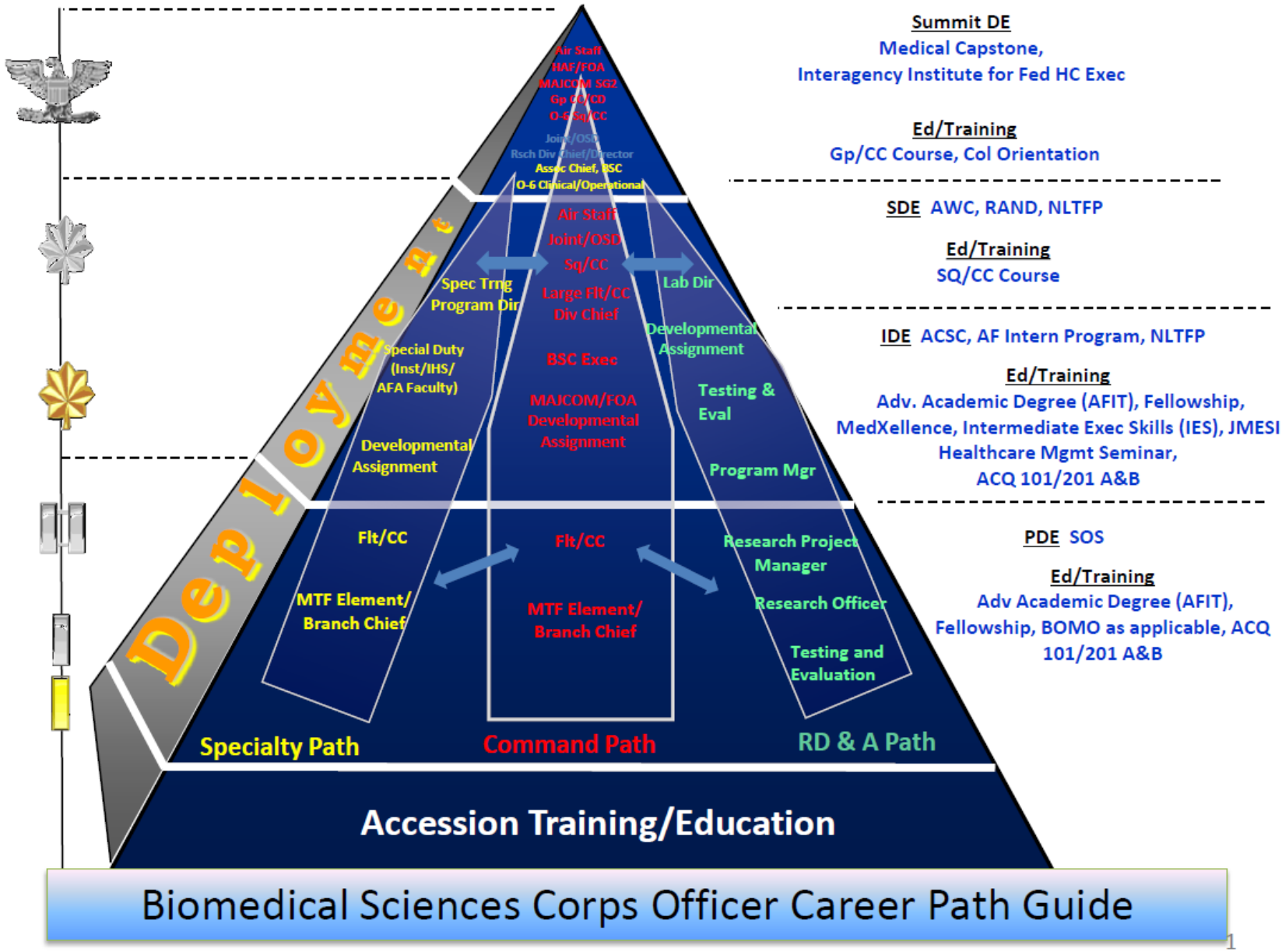
Professional Military Education (PME) provides officers with the academic background in military subjects necessary to understand the working environment. Lieutenant colonels are expected to have completed Intermediate Service School, and colonels are expected to have completed Senior Service School, by either correspondence or seminar if not selected for inresidence training. Opportunities for AFMS officers to attend PME in-residence are extremely limited; therefore, selection is a superb discriminator of future leadership potential. Being selected as a distinguished graduate from among peers from all competitive categories at an inresidence PME course is an especially good indicator of leadership potential.

Staff assignments at headquarters level organizations provide officers with an enterprise-wide vision of the mission. Examples of staff assignments include the Office of the Inspector General, Major Air Command, DoD or Headquarters Air Force. Officers in staff positions hone decision-making skills, and gain extensive experience in learning to "pull it all together" as they develop, implement and improve programs that turn concepts into operational capability.

Abundant leadership opportunities exist in the areas of research/academics, clinical specialization and staff assignments. However, the key prerequisite for leadership at the most senior levels is command. Officers who prepare themselves by effectively performing in progressively tougher roles as Flight Commander, Squadron Commander, and Group
Commander are generally considered to be the ones who have best demonstrated those attributes required of officers in the Air Force's most senior leadership positions.

--Lt Gen Roadman was AF SG (1996-1999). This is a 1998 response to Congress

BSC Career Paths



Biomedical Sciences Corps Officer Career Path Guide

Peculiarities of the Pathways

Until around 2007 there were only two proven career pathways for BSC officers, Specialty and Command. But in August 2006 the AF gained its first BSC Brigadier General, Brig Gen Theresa Casey. At the same time Lt Gen James Roudebush, who had just become Surgeon General, gave the Biomedical Sciences Corps responsibility commensurate with having a flag officer; it was given responsibility for all AFMS medical research, development and acquisition (RD&A). The MSC logisticians remained responsible for all buying of final products but the BSC as a Corps had gained a new core competency requirement as research, development, operational testing and evaluation (RDT&E) experts using the overarching principles of DoD acquisition.

RD&A: To meet the need, Gen Casey created the BSC RD&A career pathway to develop officers with the needed skills in an officially-endorsed track yet still maintain equitable promotion opportunity. The difficulty was that the career track was created before there was a clear assignment progression. The work was there but there wasn't always a position. The jobs were sometimes unfamiliar to medical promotion boards and therefore harder to compare to more traditional job descriptions. Although officers in this track are essential to the BSC meeting its mission it is more difficult to be promoted beyond Lt Col unless clear leadership and AF-level or Joint impact appear prominently in the CV.

SPECIALTY: All BSC officers, whether they are "BSC Clinicians" (42X) or "BSC Specialists" (43X) must become fully proficient and experienced in their primary AFSC before launching out on any of the career paths. Those choosing the Specialty career path opt to stay, further develop skills and become leaders in their core specialty or a subspecialty. Becoming an educator or chief consultant is consistent with this track. Promotion to 0-6 is likely only if your record documents significant MAJCOM and/or AF-level service.

COMMAND: All BSC officers should welcome leadership opportunities. **Records that do not show leadership are not selected for promotion**. Leadership opportunities exist on all the career paths at both home station and deployed locations. The Command pathway, though, is made up of a series of command assignments, usually formally applied for, selectively chosen and carrying UCMJ authority ("G-series" orders). Assignments include Squadron and Group command or AFELM CC. Since successful leadership proves you can lead, **the Command pathway is the surest route to higher rank.**

None of the Pathways are stovepipes. At times it may be necessary (or just good tactics) to move from one pathway to another. For example, a successful assignment as a commander improves your chances for promotion on any of the career tracks. Or, an initial assignment in RD&A may need to be followed by a specialty assignment back at an MTF to better prepare for a squadron command assignment before returning back to RD&A.

Opportunity for promotion to senior rank is possible, but not equal, on any of the pathways. It is easiest on the Command path. Whatever your choice, get advice from senior leaders, listen to

your mentors, embrace new opportunities and new skills, and excel in your current job. **In my experience officers do the best and are most fulfilled when their work is in harmony with their passions. Pursuing rank alone is ultimately an unhappy choice.**

42G Career Planning Matrix

	Core Assignments	Core Experiences	Education	Training
Tactical (Lt – Maj)	Primary Care PA Specialty PA Readiness Officer Flight Commander Instructor --Phase II Coordinator --ACLS Executive Officer Deployments	NCCPA Certification Readiness UTC team Credentials Officer JC/HSI/AAAHC expectations Health Promotions Member, Grp-level committees	BDE Masters/Education	Biennial CME Clinical Specialty Fellowships C-4 Expert Field Medical Badge RSV Courses Readiness Courses (OEMS, TCCC, etc.)
Operational (Mid-Capt – Lt Col)	MAJCOM Staff Officer White House PA Air Staff/Operations AFIA Inspector IPAP Instructor Joint Medical Planning AFMS Tactical Doctrine Special Operations Squadron Command AFMSA AFPC AFRS AFRL	MAJCOM Consultant Specialty PA Consultant Malpractice Expert Reviewer PA Mentor Readiness Plans/Ops Information Technology/ Management Group BSC Executive (SGB)	IDE PhD/Education MPH	Intermediate Executive Skills Course International Health Specialist Fellowship Squadron CC Course Acquisition Certification BSC Force Management Fellowship Research & Development Fellowship Medical Acquisition Fellowship
Strategic (Lt Col – Col)	Group Command Air Staff/Policy Medical Doctrine Joint/OSD Staff MAJCOM SG	AF SG Consultant Associate Chief, BSC BSC Corps Chief Director/Division Chief	SDE	Interagency Executive Management Course Group CC Course

White House Physician Assistants

White House physician assistants assist the White House physicians in providing comprehensive health care to the President, Vice President and their families. They plan, coordinate and direct emergency action plans for medical contingencies including both on-site and remote assessment of medical capabilities at White House travel destinations worldwide. They also provide acute care to military personnel assigned to the White House and occupational health services to members of the White House staff. They stand independent watch as the on-site medical response officer for the President and Vice President. These officers represent military medicine to the nation's senior leaders on an international stage. The following Air Force PAs have served in the White House:

George McCullough (1977-84)
David Gwinn (1981-86)
Dallas Diederich (1986-91)
Gary Dunham (1991-93)
Ed Luminati (1994-96)
John Chitwood (1996-99)
Pat Grimm (1997-99)
Carol Forrest (1999-00)
Daniel King (1999-01)
Marc Boyer (1999-02)
Brian Moore (2001-03)
Tom Waters (2001-04)
Robert O'Sullivan (2004-08)
Ken Baron (2005-09)
Joseph Uzpen (2008-13)
L. David Carnes (2009-12)
Trevor Ambrose (2012-2015)
Chuck Henderson (2012-2015)
Justin Wright (2013-2016)
Jimmy Lam (2015)
Justin Kandle (2015-
Nathan Ley (2016-
Benjamin McGarvey (2016-
Juan Garcia (Projected 2018)

Awards and Recognition

Besides MTF and base-level awards, several national groups actively solicit AF PAs to apply for their organization's recognition. These are all worth applying for as it is another marker that can distinguish you from your peers.

Air Force Medical Service (AFMS), see AFI 36-2856, *Medical Service Awards*

- In 2011, the AFMS discontinued the David Gwinn USAF Field Grade Physician Assistant of the Year and the Jesse Edwards USAF Company Grade Physician Assistant of the Year annual awards.

PAST AFMS PA OF THE YEAR AWARD WINNERS		
Year	**Jesse Edwards Company Grade PA of the Year**	**David Gwinn Field Grade PA of the Year**
1998	Robert R. Young	Jackson R. "Randy" Dobbins
1999	Herve Poulard	Raymond E. "Rick" Farrell
2000	Brian E. Moore	Anne P. Heinly
2001	Lee E. Ackley	John W. Bullock
2002	Timothy D. Howerton	Anne P. Heinly
2003	David Eaton	Richard W. Farnum
2004	Eric F. Severson	Michael E. Shipman
2005	Michael B. Smith	Gordon H. Campbell Jr.
2006	Hector R. Stephenson	Stephen G. Griep
2007	Jamie A. Barnes	Brian L. Costello
2008	Kevin L. Kubly	Alvin F. Barber
2009	Jon M. Farley	Brian E. Moore
2010	Richard A. Waggoner	Errill C. Avecilla

- PAs now compete in USAF Biomedical Clinician (Category I, II or III) Officer of the Year in either the Company Grade or Field Grade Officer categories. Additional guidance can be found on the AFMS Awards Program page on the Kx website. https://kx2.afms.mil/kj/kx3/AFMSAwards/Pages/home.aspx.

American Academy of Physician Assistants (AAPA) **(**see https://www.aapa.org/about/aapa-awards/)

- "AAPA Federal Service PA of the Year Award". The PA must be nominated by the board of directors of your federal constituent chapter, in our case the Society of AF PAs.

Numerous USAF PAs have been recognized for their significant impact and contributions to military medicine. The following Air Force PAs have been recipients of this national award.

Major Ann Heinly (2007)
Lieutenant Colonel David H. "Bubba" Gwinn (2008)
Colonel Cheryl E. Gregorio (2009)
Colonel John W. Bullock (2010)
Colonel Doug "Boots" Hodge (2011)
Lieutenant Colonel Pamela M. Lucas (2012)
Lieutenant Colonel Melanie J. Ellis (2014)
Major Timothy (T.J.) Bonjour (2015)
Colonel Rene M. Chadwell (2016)

AAPA Veterans' Caucus (see http://www.veteranscaucus.org)

- "Military Physician Assistant of the Year"

Association of Military Surgeons of the United States (AMSUS) (see http://www.amsus.org/)

- "Andrew Craige Allied Health Professional Award"
- Other (e.g. various functional mission Awards)

Society of Air Force Physician Assistants (SAFPA) (see http://safpa.org)

Paul W. Myers Award
Named after former surgeon general, Lieutenant General (Dr.) Paul W. Myers, this award honors an outstanding PA educator (MD, DO, NP, or PA) who distinguished themselves by enhancing the clinical learning of PAs.

Douglas W. Webb Excellence Award
This award honors a recipient with up to 4 years of experience as an Air Force PA, who has demonstrated exemplary service to the Air Force PA profession. This service may be exhibited through leadership, quality patient care, community service and commitment to advancement of the PA profession.

Jerrold L. Wheaton Award
This award honors a recipient with greater than 4 years of experience as an Air Force PA, who has demonstrated outstanding service to the Air Force PA profession. This service may include accomplishments in mentorship, leadership, quality patient care, community and volunteer service, education and commitment to the advancement of the PA profession.

Tony DiTommaso Clinical Publishing Award
Named after Tony DiTommaso, a steadfast advocate for the Society of Air Force PAs, this award honors the PA author who has published an exceptional clinical or research article within the previous calendar year, contributing to the education and advancement of the PA profession. Authors who have contributed to the Towner-Schafer Report are included as automatic nominees for this award.

The Paradox of Self-Nomination

(or, In the Blur of AF Life, How Do I Get Seen?)

In an organization that holds the credo of "service before self", where does the idea of self-nomination for awards or recognition have a place? In most of us there is something deep down that balks at the prospect of self-promotion. After all, even the Bible says "Let another man praise you, and not your own mouth; a stranger, and not your own lips." (Proverbs 27:2). However in the Air Force, to be successful, we are told, "look out for your own career", "write OPR-ready bullets for your supervisor" and "get recognized for what you do". Is this advice just a moral Catch-22 or is there ethical and practical sense to it all?

My opinion of this subject has changed as I've risen higher in rank and had more chances to see behind the scenes at the "hows" and "whys" of awards and other recognition. I used to be convinced that my responsibility was to do the best job I could and wait to be noticed for it by my perceptive and appropriately appreciative boss. If I measured up I'd be recognized. Anything else would be self-promotion and therefore would be contrary to the AF Core Value of "Service Before Self". Besides, if my work was so uninspiring that I would have to beg someone to nominate me and even have to "sweeten the pot" by offering to write the words for the nomination myself, the award would be tainted, the process manipulated and I still wouldn't be convinced of my value! Fortunately these perceptions are not the truth.

Good leaders recognize and reward their people. It's foundational to effective leadership. However, because they are successful, good leaders are loaded with more and more to do. The urgent problems have some success in crowding out the merely important. Simple procrastination is the biggest killer of recognition ("Well, I'm really busy right now. I'll submit Capt Smith to be the CGO of NEXT quarter…there'll be another chance"). But, it's your job to help your boss be successful. If you are qualified they will welcome the opportunity to endorse you, especially if you make it easy for them. You are facilitating meeting one of their core responsibilities.

People tend to forget that when they suggest themselves for an honor they are not selecting themselves. When you go to your supervisor or commander and say "Would you consider submitting my name for…", that person has the option of saying "No". Once they say "Yes" to you there is no obligation to use either your package or your words. Your responsibility for the outcome is over. You haven't manipulated anything.

The system left to itself is neither efficient nor always fair in this area. Therefore those officers who do a great job and actively encourage proper recognition don't compromise, but instead improve, the process. It's one of the few areas where you can directly help a commander excel in their career and contribute to unit morale. And, if you'd really like to impress someone and improve morale, nominate one of your co-workers! Make it easy for your organization to recognize its most deserving people.

How to Write an AF Award Nomination

(from AFI 36-2856, *Medical Services Awards*)

Written nominations must be submitted on a one-page AF Form 1206 (front only), using the most current IMT version of the form found at **http://www.e-publishing.af.mil/** Packages should be in standard bullet format.

Individual nominations must include specific facts that clearly distinguish the nominee from their peers citing examples that occurred during the specified nomination period. Nomination packages are graded on the following:

- **Leadership and Job Performance**: describe significant leadership accomplishments and how well the member performed assigned primary and additional duties. Define the scope and level of responsibilities and the impact on the mission and unit. Include any new initiatives or techniques developed by the member that positively impacted the unit and/or the mission during the award period.

- **Significant Self-Improvement and Base/Community Involvement**: show how the member developed or improved skills related to primary duties; e.g., achievements in professional societies or associations, off-duty education related to primary duties, formal training, Career Development Course enrollment or completion, on-the-job training, certifications, etc. Include completion of any Developmental Education (DE) as well as awards earned during in-residence attendance. Include any off-duty education not directly related to primary duties, e.g., class, course, degree enrollment and/or completion and grade point average. Cite any other relevant training or activity that significantly enhanced the member's value as a military member during the nomination period. Define the scope and impact of the member's positive leadership and involvement in both the military and civilian communities. Include leadership, membership or participation in unit advisory councils, professional military organizations, associations, and events; e.g., President of Company Grade Officer's Council, President of Top Three, unit dining-out committee, member of Air Force Association, Sunday school teacher, and so forth.

BSC Clinical Fellowship & AFIT Advanced Academic Degree Selection Process

(or "How do I get selected for a fellowship?")

Before talking about how the selection process works, there are a few things you should consider and do now if you want to get chosen for an AFIT Advanced Academic Degree (AAD) or clinical fellowship (e.g. orthopedics, general surgery, otolaryngology or emergency medicine).

1. Take the required Graduate Record Exam (only for AAD applications)
2. Make sure you understand what you're applying for (shadow!)
3. Complete developmental education (PME) appropriate to your rank
4. Update your ADP to show your desires and your Commander's support
5. Contact the specialty PA Consultant
6. Consider 43B fellowships (BSC Force Management, AFPC, BSC Project Management Acquisition Fellowship, MSHS in Healthcare Quality…)

Each year each specialty in the AFMS evaluates its training needs for the future. Training needs are based on authorizations, projected attrition, and changing missions within the AFMS. After validation by the Corps, all the training requests are submitted to the Health Professions Education Review Board (HPERB) which first validates or invalidates the requests then prioritizes the validated requests based on the needs of the AFMS. Each Corps is allotted a certain number of training years. Thus the BSC goes down its prioritized list and matches man-years to training needs. Invariably it runs out of available man-years before it runs out of validated needs. A line is drawn on the list where the man-years run out. Those training opportunities above the line are "approved and funded"; those below the line are "approved but unfunded". Applicants are solicited for ALL the approved positions, both funded and unfunded because as man-years become available (from other Corps or because we can't get qualified applicants for some "approved and funded" positions) we will be putting some people in the previously unfunded training positions.

When the call for applicants goes out (approx. June of each year) and the time comes to actually apply, follow the directions **(found on the AF Knowledge Exchange…BSC Education page)** https://kx2.afms.mil/kj/kx3/AFBSCEducation/Pages/home.aspx

The original application goes directly to AFPC while a copy goes to the PA Associate Corps Chief for their endorsement. The Associate Corps Chief writes an endorsement letter to the selection board (BSC Fall DT) for each applicant applying from their career field. They will give their recommendation or non-recommendation along with their reasons. The Associate Corps Chief will also prioritize (stratify) those recommended. The BSC DT will make the final selection. The Associate Corps Chief cannot prevent anyone from meeting the board and the board has no obligation to follow their advice.

There BSC AFIT selection board consists of the BSC Chief (BG James Dienst), BSC Director (Col Therese Bohusch), BSC Utilization and Education Branch Chief (Col Melanie Ellis), AFMOA SGB (Col Peter Breed), Associate Corps Chiefs from all 14 different BSC core IDs, AF Reserve/Guard 0-6 representative and 1-2 BSC 0-6 guest members (usually sitting MDG/CCs). Their first evaluation action is the "quality cut". The AFIT selection board scores all the records,

disregarding both AFSC and program, ranking them for quality on a 6.0 – 10.0 scale, 10 being outstanding. Those below the quality cut line (generally 7.0-7.5) are immediately disqualified and ineligible for any program. Those remaining are matched against the programs they chose. Those with higher scores have priority over those with lower scores. For example, if someone applied for more than one program and stated that "Program A" was his first preference (over "Program B"), they would get that program if his score was higher than anyone else applying. However, if someone else applied for Program A and scored higher, they would be selected and the first applicant would be considered for "Program B" and ranked against all other "Program B" applicants.

Candidates are selected for all programs, both funded and unfunded. Those selected for funded programs are notified right away while those selected for unfunded programs wait to see if fallout funding appears.

Bottom line, if you want to apply, start preparing. If you want to apply for more than one program, go for it! It does not count against you. Just make sure you prioritize and clearly communicate your desires. OPR for BSCs applying for AFIT is the AFPC BSC Education and Utilization Branch, Ms. Michelle Cardassi, DSN: 665-2775/1821,
Email: afpc.dp2nw.workflow@us.af.mil

Writing Your "Why I Want to Do This" Letter

For AFIT programs, you will be selected by a board that will require a formal application, including a personal one-page letter stating the program(s) you wish to apply, career goals and reasons for applying. There are some good ways to do this and, unfortunately, there are some bad approaches that are used far too often. I'm not going to give you a three-paragraph outline of what to say. The best letters are professional yet uniquely personal. Say your message the way you say it best. Here are some basic principles to follow to write an impressive but accurate letter.

1. Write from the BSC DT AFIT Board's point of view. They have a job that needs to be done and are looking for someone to fill it. They are not there to give your career a boost or to fulfill your lifelong desires. Too many letters start out saying "I've always wanted to do this" or "This will be a great career-enhancing job for me". It always comes across as "I'm concerned with myself first but I'll be happy to help you with my skills along the way". Reread your letter as if you were a Board member. Better, get someone else to do it. Best, get someone not your friend to do it.
2. Your priorities in the letter must be the organization's priorities. For example, you don't apply for a specialty fellowship because you want to get out of family practice. You don't apply to the White House for an exciting lifestyle and world travel. They have higher priorities and are hoping you do too.
3. Document previous interest, experience and success in the general area for which you're applying. Some of the worst letters start, "As soon as I saw the ad I knew I wanted to do this". Boards prefer to see evidence of a longer history of interest.
4. Understand the job for which you're applying. Understand it well enough (do the research; talk to people in the job) to know how you would fit in and contribute. The focus of your letter should be how you, in particular, have the skills, experience and

aptitude to do that job, with all its unique peculiarities, well. Working well with others is a key skill you shouldn't forget.

5. Include a positive and personal quote of endorsement from someone credible in the field, if possible. This is especially important if you can't have a full letter of endorsement from outside your chain.
6. Service before Self. Document your excellence but always remember your letter is an application to serve. Serve well and the recognition will come, but if the recognition is your goal, don't apply.
7. No BS. No faking. No embellishment. If you're a valid candidate it's likely that someone on the board already knows of you. Even if not, your letter will be compared to your other documentation. Nothing will turn a board off faster than discovering an applicant is inflating his package.

Continuing Medical Education & AFIT Short Courses

A limited number of AFIT-funded TDYs are available each year to attend Cat I CME-granting courses. Quotas are awarded based on projected end strength for the PAs for that fiscal year. Generally, members are eligible to use this funding no more often than every other year.

DEPARTMENT OF THE AIR FORCE
AIR FORCE MEDICAL OPERATIONS AGENCY
JOINT BASE SAN ANTONIO LACKLAND TEXAS

28 November 2017

MEMORANDUM FOR RECORD

FROM: TERRY R. MATHEWS, Col, USAF, BSC
BSC Associate Corps Chief and AF/SG Consultant

SUBJECT: Air Force Physician Assistant Refresher Course (PARC) Central Funding Guidance

1. The PARC covers all Comprehensive Medical Readiness Program training requirements and reviews core PA medical skills and knowledge on an annual basis. Central funding has been approved for 75 active duty Air Force PAs to attend the 2018 conference, currently located at the La Quinta Inn and Suites in San Antonio, TX from 19-22 February.

2. Central funding requests will be solicited through email and sent to all active duty Air Force PAs by December 1st of each year. The PA Consultant's Ops Officer will be responsible for the email distribution and collection of all applicants. Basic selection requirements include:

a. The applicant has current board certification through the National Commission on Certification of Physician Assistants and is in good standing with their current medical organization.

b. The applicant has completed the PA Ramp-Up program and 3-level skill upgrade.

c. The applicant graduated more than 1 year prior to attending course.

d. The applicant has the required service retainability (1 year) to receive funding.

3. Priority will be given to all OCONUS PAs, conference presenters, and IPAP Phase 2 Coordinators and Junior Advisory Board members (when possible).

4. Factors making applicants ineligible to apply include CONUS PACB members, current specialty fellows (Ortho, EM, Gen Surgery, ENT), PAs stationed in local San Antonio area, and PAs who received central funding for the previous year's course. CONUS FGOs will also have a lower likelihood of being selected.

5. PAs will be selected for funding at a minimum of every 48 months to maintain current CMRP performance requirements.

TERRY R. MATHEWS, Col, USAF, BSC, MPAS, PA-C
BSC Associate Corps Chief and AF/SG Consultant for PAs

Uniform Wear Policy at Meetings and Conferences

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

21 January 2010

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Wear of the Uniform at Military and Civilian Meetings (supersedes SG Policy Letter #07-0017, 17 Sep 07)

As members of the Air Force Medical Service (AFMS), we represent the Air Force when we attend meetings and conferences. The Air Force Chief of Staff has provided guidelines on the wear of the blue uniform, and its role in our Service's traditions and image (see Atch 1).

If you are attending a civilian-hosted conference where business formal is the attire, wear our service dress uniform. If you are attending a civilian-hosted conference where civilians are wearing business casual, wear any authorized combination of our blue uniform. It is not appropriate to wear our utility uniforms in these settings.

When the military is hosting and the host does not specify a uniform, wear our ABU, BDU or green flight suit. Civilian attire should not be worn for official government-sponsored meetings and training unless there are obvious security threats, safety, or practicality issues. The sponsors should include these threats in normal operational risk management assessment of the event.

I expect each AFMS member to present a sharp and professional military image, regardless of forum or setting. If you have any questions concerning this policy, please contact my executive staff at 703-588-7222 or DSN 425-7222.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment:
CSAF Memorandum, 4 Sep 08

SG Doc 10-0001

Officership

"Officership" is a term that's been described by many different authors. What follows is my perspective as a senior Air Force physician assistant (PA) specifically applied to physician assistants . For some PAs, talk of officership and military developmental education has been an ongoing nuisance that interferes with their "real" work of patient care. One PA told me several times that because he was the best AF PA in his clinical specialty he shouldn't have to do any professional military education to get promoted. Well…he wasn't promoted. He shouldn't have been. Although he retired at Major, he had never really joined the Air Force.

The concept of "officership" is a particularly problematic issue for PAs in the Air Force. Like the rest of the AFMS we are not first identified as "officers" but as "medical officers"…a modifier. But, beyond that, PAs additionally struggle with the tension between our professional name of "assistant" (not a leader) and our military rank (which implies leadership ability). The name is a misnomer that has always been awkward to explain and, being repeatedly put into the position of having to explain it tends to throw our competency (and potential) as officers into question.

However, I believe we hinder ourselves and unnecessarily heighten that awkwardness by wrongly believing there's a sharp distinction between the two roles. Living dual identities, sometimes as a medical and sometimes as a military professional, leads to dysfunctional choices and, I believe, contributes to the common complaint I hear from PAs that they are somehow considered inferior or disadvantaged compared to other AFMS officers. **How we see ourselves influences how we act. How we act influences others' opinions of us and their interactions with us.**

Being an Air Force officer is not a secondary job and the subtle pressures we face every day to view it that way are to our detriment. We are told the Air Force wants us because we are expert and valued medical professionals. That's true, but then, almost as an afterthought, we are told we are also professional military officers. For example, Basic Officer Training (BOT), where the Line trains 2nd Lts, is 12 weeks long. In contrast, Commissioned Officer Training (COT) is an abbreviated 4 ½ week course for direct commissioned officers (medical, legal and chaplain) who are coming in with an advanced rank. The rationale is that because of their professional education, projected utilization and generally older age, less training is necessary for the direct comissionees. Unfortunately the discrepancy sends the message (by award of advanced rank and a shorter military training requirement) that our medical skills are more valued than our potential military contribution. After all, one invests the most in the areas one values most. Right?

Most AF PAs are prior enlisted. After almost 2.5 years of intense clinical schooling they receive a Masters degree and are commissioned as 1st Lts. Their first job is to pass the national certification exam (PANCE) to become certified as physician assistants. Their first assignment is to a non-leadership clinical position. Thus, having very little training as military officers they are most likely to view themselves as professionals in the *medical* field and less likely as military professionals. With new rank and authority as a military officer but with little experience, most will fall back on their professional skill as a PA (or skills learned as a junior NCO) when acting as managers, leaders, and professional officers.

Here's a test: If you had been asked yesterday (before you read this) how you viewed yourself, whether an officer first or as a PA, what would you say? Most would say "PA" because that's

what's emphasized as a company grade officer and that's where we've invested most of our self improvement. Again, which do you see as most important, professional medical society membership or military society membership? We create a professionalism conflict when we make a hard distinction between the standards of the military profession and the standards of the medical profession. A classic example is M.A.S.H. where Hawkeye and Trapper almost invariably chose to be physicians rather than military officers. The two standards need not be mutually exclusive. (COL Potter more successfully blended the two). For those of us in the medical field, we are called to be both military and medical professionals. We are military medical professional officers.

General Bennie L. Davis, past commander in chief of the Strategic Air Command, **defined officership as a blend of leadership, management and professionalism.** Although there are certainly complexities, this definition captures the basic ingredients.

LEADERSHIP

Leadership is probably the first thing to come to mind with the word "officership". It is certainly the most glamorous. It is assumed that great officers are, first of all, great leaders. Because leadership and officership are so closely related it's easy to blur the distinction.

> The statement is sometimes made that an officer is a leader. A more exact statement is that an officer is a potential leader. He was selected for a commission because he demonstrated the potential for leadership. However, since leadership is a demonstrated behavior, an officer cannot be a leader until he performs leadership tasks.
>
> --BG S.L.A. Marshall in <u>The Officer as a Leader</u>, 1966

A short definition of leadership could be "the ability to influence and direct the behavior of others." I like that definition because it presupposes the presence of winning personal qualities like charisma, courage, integrity, honesty and common sense. The best leaders are exemplars themselves, who inspire others to do and be their best.

MANAGEMENT

Management is the most underappreciated of the three sides of officership. If great leadership inspires us with visions of great battles and triumphs, management bores us with images of green eyeshades and metrics. A better way to look at it is that leadership is the great heart of officership but management is the mind. Management is an essential element of officership that complements leadership skills. From Commanders down to my job as Associate Corps Chief, the job of management is to make sure workers have the tools, the information, and the understanding they need to do the job. Management is a step removed from the action but a successful manager must be a leader.

> Military officers must be concerned with both people and mission-related areas through the concept of the organization. After all, the organization is a group of people with a mission to perform. The mission is the justification for the people and the people, ultimately, are the only means to carry out the mission. Thus, the officer's leadership role is to infuse his organization with loyalty, cohesion and discipline, while his management role is to wisely use this motivated organization to accomplish the mission.

--Maj James McDermott, "Leadership and Management: A Balanced Model of Officership". ACSC, 1982

PROFESSIONALISM

If leadership is the heart of a good officer and management is the mind, then professionalism is the soul. It is the tradition-produced moral ethic of officership.

As PAs we easily see ourselves as medical professionals. We are in an occupation that requires considerable training and specialized study to enter. Our practice must meet defined professional standards. We are governed by a professional code of ethics. There is a collegial relationship amongst those of us practicing medicine. We are encouraged to join PA professional societies and when asked to identify our occupation we will usually answer "PA". Indeed, because it seems like we became officers *because* we were PAs, our officership tends to stay subservient to our professional medical identity. We forget that for military-trained PAs our potential for officership was part of the selection process for PA school. For us PAs in the AF it is not a question of which profession should have priority but rather of how to meld the two professions together in ourselves so that we are effective military medical officers.

Samuel Huntington in <u>The Soldier and the State</u> identifies three defining characteristics of a profession: Expertise, Responsibility and a Sense of Identification ("corporativeness"). These apply equally to the military and the medical professions.

- **Expertise** is the ability to act within the standards of your profession. For the medical professional it means you must have the medical knowledge, judgment and procedural skills that are expected of members of your profession. For the military professional it means having a knowledge of military history, military structure/organization and rules, the judgment of how to apply those rules, and facility in the specific skills that may be required of your position.
- **Responsibility** is more than simply good judgment and accountability. Judgment means that when faced with alternatives you choose wisely. Responsibility is broader and deeper. It is demonstrated when:
    - You make positive actions to ensure you fulfill your obligations o You step back from the pressures of the moment and work towards the larger interests of the profession itself
    - You take initiative to look at the system and try to improve it
    - You are aware of how your image and actions reflect upon your profession and take steps to promote that image. Avoid the appearance of impropriety. Our actions reflect on the profession as a whole.
    - You take opportunities to mentor those around you so they can step into your shoes and improve things further when you leave
    - You have a commitment to stay "state of the art", to keep up with the literature and even taking the opportunity to contribute to that literature
    - You don't play "tit for tat" and blame others for your actions (e.g. "I'm not going to his promotion ceremony because he criticized my briefing"). "The best person does the right thing first."
    - You uphold the highest ethical standards even when that may mean inconvenience, embarrassment or other personal loss
- **Sense of Identification** is when one's primary motivation is for the "good of the profession". This "higher ideal" motivation may be the most important characteristic of

> professionalism. Without it an individual is just doing a job, and when that happens the motivating factors become money, prestige, fame or other secondary benefits. The professional feels these motivations as well but they are not the primary motivation. Instead, the professional is motivated by the feeling that his own self-worth is linked to their actions as a member of his profession.

When did you join the Air Force? Somewhere along the line we all joined the AF. For me it was when I was still enlisted and decided I wanted to be a PA and do it in the AF. Some PAs haven't joined yet. Some have retired but never did really join the AF. There's a difference between being in the Air Force and joining the Air Force.

As Air Force physician assistants, we have dual professionalism. We serve both our country and our patients. Instead of being a mutually exclusive conflict of professional loyalties, there is clear agreement between the expectations of the two professions. Medical values such as patient autonomy, the primacy of patient interests and social justice are mirrored in the Air Force core values of integrity first, service before self, and excellence in all we do.

The American Board of Internal Medicine Foundation Charter on Medical Professionalism created a list of professional responsibilities. It corresponds very well with the AF Core Values.

Professional Responsibilities	
Medical	**Air Force**
Commitment to competence	Excellence
Commitment to honesty	Integrity
Patient confidentiality	Service and Integrity
Appropriate patient relations	Service before self
Improving quality of care	Excellence
Improving access to care	Excellence
Just distribution of care	Integrity
Scientific advancement	Excellence
Self-regulation	Integrity

Look at this concordance between military and medical professional responsibilities:

- Knowledge of history, regulations, structures
- Organizational expertise
- Judgment
- Technologic expertise
- Ability to plan and adapt
- Mentoring
- Loyalty to the organization and profession
- Responsibility to the nation's ideals and morals

But what about medicine's Prime Directive, "Primum non nocere" (First, do no harm) allegedly handed down from Galen in 170 AD? We're in the military and, as Dr James Toner put it,

> "What finally segregates you [the military professional] from so many others with whom, in many other ways, you might share high values is precisely this: you guard our country

> and our way of life, and you are prepared to die in our defense. But more--in guarding our country and our way of life, you are also prepared, either directly or indirectly, to kill in our defense. Yours is a contract conceivably involving death--either yours or our country's enemies'. Your contract thus contains…the "clause of unlimited liability." That, simply put, is your ethic, the military ethic, the profession of arms.
>
> (*Airpower Journal*, Summer 1996)

The people we serve use violence to further national ends. Obviously the roles of the military professional and the medical professional, unless balanced, do have the power to conflict. The key is in understanding both roles.

The Geneva Conventions and other laws of armed conflict define appropriate professional conduct and separate the roles of medical provider and military officer in conflict. In the midst of battle, the medical officer is not obligated to rush to aid the enemy wounded and may defend himself. Conversely, once the wounded is a patient he is no longer an enemy target. In this environment failure to distinguish either principle leads to unprofessional conduct on one side or the other. Laws of armed conflict chart the moral high road and are necessary to follow, even when the enemy does not.

Officership is taught. Those of us who are senior must mentor the junior and promote true professionalism in both our military and medical roles. For example, there was an AF physician who was consistently lauded as an outstanding go-getter. He was always the first one in in the morning and the last one out at night. He never said no to an additional duty. Shouldn't he be admired and promoted?

No. That officer was subsequently divorced and lost custody of his children. He entered mental health treatment for depression and has separated from the military. Over-identifying with your job and taking your self-worth from it is not professionalism. It leads to a loss of balance and detracts from other areas of life. Rather than being a reason to live it becomes an excuse from living. Part of professionalism must be balance—knowing how to do well at the job without it consuming you. Ultimately, failure to recognize this can lead to the inability to do the job, or live life, well at all.

But who teaches this when the opposite seems the way to promotion? Who is there to show that the above thinking is an excuse *from* real living and not healthy, wholesome and ultimately rewardable? The more senior of us are in a position to mentor, educate and influence our younger officers. Our medical education was not left to chance. Too often our military and professional development is.

Officership is more than receiving a commission and assuming officer rank. Officership, to be ideal, must blend together the essential elements: leadership, management and, most importantly (and the essence of officership)--professionalism. Professionalism must be taught, nurtured and encouraged within both our military and medical roles. But how?

Here are some suggested steps for professional development:

> **Set expectations**. To adhere to the expectations of a profession, its members must be taught what those expectations are. This can take the form of written charters, oaths, core

values, or academic papers. These are important for clarification. However, unwritten expectations are just as important. The old saw that what is important to a group depends on what its leaders pay attention to is still very true. We need to be very careful to pay attention to those aspects of professional behavior that we want to shape. The staff member who doesn't complete his paperwork tells the junior staff that this is not a priority. The PA that focuses on paperwork but doesn't stop to really listen to his patients passes on that message. Everything we do in our professional role sends a message, which is why the professional must fully incorporate the habits of professionalism.

Provide experiences. These can include formal ethics courses, less formal talks, staff "lessons learned" of their experiences or curricula that place the student into situations where various aspects of professional behavior are demonstrated, such as serving underserved communities, international settings, wartime ethics, etc. But just as the most important expectations may be the unwritten ones, **the most important experience is the role model. Seeing a mentor behaving professionally will have a far greater impact than all the lectures in the world.**

Evaluate outcomes. This can take the form of standardized interpersonal interviews, video-taped "practice sessions", peer review or full "360" evaluation in which peers, other staff (nursing, tech, admin), and even patients and their families are queried after an encounter. While time-consuming, judicious use of this technique can give great insight into the variety of factors that make up professional behavior. Some of our sites are now attempting to use this technique.

So, have you joined the Air Force? Are you a "military medical professional" or just an officer? We must establish, nurture and maintain such a culture of excellence in both fields that we all are proud to identify ourselves as members.

ACKNOWLEDGEMENTS

Maj Gen Thomas Loftus, "Professionalism in Your AF Medical Practice", CSPAR Brief, Dec 06 Lt
Col Gary McCoy, "Developing Officership: It Starts at the Top". AWC paper, 1996.
Maj James McDermott, "Leadership and Management, a balanced model of officership".
Air University Review, Sep-Oct 1983.
Maj Terry Wyrick, "Officership and Direct Commissioning Programs", ACSC 1983

Mentoring

A mentor is defined as "a trusted counselor or guide." Mentoring, therefore, is a relationship in which a person with greater experience and wisdom guides another person to develop both personally and professionally.

AFMAN 36-2643 describes the Air Force mentoring program. In the program "the immediate supervisor or rater is designated as the primary mentor for each of his or her subordinates". The scope and goals of this program are excellent and chart a course for effective counseling and professional development advice for every Air Force officer. Mentoring helps

prepare officers for the increased responsibilities they will assume during their careers. It is not a promotion enhancement program, it is a professional and personal development program with rich rewards.

However, as the Instruction acknowledges, the mentor the AF assigns you may not be a person you would choose yourself. Conversely, for a number of reasons, your supervisor may have no special passion about investing time in you, either.

People who successfully rise to the top of an organization often have sought mentors along the way. These mentors are special people who you can relate to and learn from--people who guide, teach and inspire. Great mentors guide but rarely direct because, normally, they're not in a supervisory relationship. Don't expect them to track you down and make you their protégé. It's up to you to initiate it, but the rewards are worth it. Here's one way to start a successful mentoring relationship

 Look for someone you respect, admire, and trust

Look for someone with whom you already feel a connection—someone you can look up to. You're not looking for a friend, although friendship can develop. You want someone who can teach you about success in life and, specifically, life in the Air Force. If you can see in that person the kind of person you'd like to be, then you have the foundation for a successful mentoring relationship.

 Contact that person

Once you've decided upon a potential mentor (and there may be several) start spending time together. Get to know them as a person and not just a professional. However, don't be overeager and say, "I'm here. Will you be my mentor?" Inspiration and commitment can't be forced. It's better to proceed slowly and let the relationship grow. You can't force someone to take you on as a protégé. Both parties have to be interested in fostering the relationship and must make efforts towards that end. This takes time. You want someone who will be honest with you. They may not have the desire or skill to mentor.

 Ask questions relevant to your mentor's life, not yours

Allow the person to talk about his own experiences while you learn through osmosis. You can ask, "Did you ever have a problem like …?" Then listen, listen, listen! Allow your mentor to talk and you will be led into new ways of thinking.

 Feed the relationship

Make regular contact. People like knowing that they matter and that they can influence another's life for good.

 Know when to move on

Generally, people grow out of their mentors and need new ones. In the best relationships this time is recognized on both sides and the special relationship is ended gracefully. You're still friends. Because of the relationship you've developed this is never a "use 'em and lose 'em" maneuver--it's just that you've learned as much as you can from this person in this level of relationship and need to move on to someone with new insights. In the AF this often happens with a PCS or major job change.

Take some time and look over AFMAN 36-2643. Mentoring is not only a benefit you receive, mentoring is a fundamental responsibility of all AF officers. If you're senior, take a willing junior PA under your wing. Get to know them, open their eyes to their potential and wisely guide them in professional development. Both of you will be rewarded.

Developmental Education

(Professional Military Education)

If you want to be competitive for promotion, **Just Do It!**

Air University weblink: http://www.airuniversity.af.mil/

PRIMARY DEVELOPMENTAL EDUCATION (PDE): SQUADRON OFFICER COLLEGE

- For Captains
- 100% opportunity to attend in-residence
- BSC officers eligible for distance learning at 2 years time-in-grade
- SOS in-residence program is a 6.5 week educational experience for USAF captains. The purpose of the program is to help develop solution-minded, bold and courageous Airmen ready to overcome today's and tomorrow's challenges. In order to accomplish this task, the course is structured around four primary areas (1) leadership, (2) building highly-effective teams, (3) logical and ethical reasoning in decision making, and (4) multi-domain joint warfare. Students will engage in classroom and hands-on application events that will challenge their individual leadership awareness, foster innovative thinking, provide effective methods for conflict resolution, and collaboratively solve problems.

INTERMEDIATE DEVELOPMENTAL EDUCATION (IDE): AIR COMMAND & STAFF COLLEGE

- For Major and Major-selects
- 2-4 BSC officers selected to attend in-residence each year
    - ACSC resident curriculum is a rigorous 10-month graduate-level program taught through intensive seminars and engaging lectures. Courses cover topics that include the profession of arms, leadership and ethics, joint operations, airpower, and the international environment. Additionally, students have the opportunity to conduct research and participate in elective courses that explore topics of varying interests. Success at ACSC is wholly dependent on student engagement and ability students should arrive eager and prepared to critically write, read, and think at an advanced level of mastery. Students who successfully complete the ACSC Resident Program are awarded Joint Professional Military Education I credit as adjudicated by the Joint Chiefs of Staff. The school is further accredited by the Southern Association of Colleges and Schools Commission on Colleges. As such, Air University through ACSC awards the Masters of Military Operational Art and Science Degree to qualified students who meet all curriculum and criteria requirements.
- Distance Learning non-Masters option (the most probable for PAs)
    - The curriculum consists of 7 courses and 4 applied session, to be completed in the following order: Leadership and Command, Applied, National Security, Applied,

Warfare Studies, Airpower Studies, Applied, Joint Forces, Joint Planning, Joint Air Operations, Applied

- Online Master's Program option
  - Estimated completion time 2-5 years
  - Requires 10-15 hrs of work per week
  - In addition to DL curriculum, there are 4 additional concentrations: Joint Warfare, Leadership, Operational Warfare and Nuclear Weapons.

SENIOR DEVELOPMENTAL EDUCATION (SDE): AIR WAR COLLEGE

- For Lt Col selects and above
- 2-3 BSC officers selected to attend in-residence each year
  - In-residence AWC is a Joint PME II equivalent
  - Encompasses seven program standards and seven learning areas taught by the college faculty throughout the academic year and is the second of three elements required to become a joint specialty officer. The joint specialty rating indicates an officer who is experienced and knowledgeable in working with other military services in the warfighting environment
  - All students within the regular curriculum must complete six semester hours in the electives program
  - Also requirement for professional studies paper, international fellows field studies and regional/cultural studies.
- Distance Learning (the most probable for PAs)I
  - Curriculum is based on the five core areas central to all levels of professional military education—leadership, profession of arms, warfighting, national/international security, and communication studies. The program provides a strategic, "air-minded" curriculum that prepares graduates to provide strategic leadership, appropriate expertise and critical thinking in support of national security objectives.

Air Force 101

- Know who your boss is
- Your boss's priorities are your priorities
- Given direction, follow it
- Answer direct questions with direct answers
- Know what your job is
- Do what it takes to get the job done right
- Do not assume anything
- Give your people direction
- Do not tolerate substandard performance
- Accept responsibility for your actions
- Do not blame others for your mistakes
- Take credit for only what you do
- Do not fall in love with yourself
- The Air Force is not a democracy
- The Air Force is a profession

Promotions

AFI 36-2501, Officer Promotions and Selective Continuation, and the promotion section of myPers https://mypers.af.mil/app/categories/c/656/p/9 provide policy and guidance for promotions.

Per AFI 36-2501, “A promotion is not a reward for past service; it is an advancement to a higher grade based on past performance and future potential.”

Verifying Your Records is Vital to Career Progression

Successful career progression for Airmen requires hard work, planning and dedication, but even more importantly, an accurate personnel record. Missing or inaccurate information can affect promotion scores and Developmental Team vectors. The following records make up your promotion selection record: officer selection brief, promotion recommendation form, OPRs, training reports, citation(s) for approved decorations, optional letter to board, if applicable court martial/article 15/LOR/UIF.

You can review your records on the Personnel Records Display Application (PRDA) which can be found on the AF Portal and AFPC Secure application. For errors not correctable on-line, local CSS, or local military personnel section, consider contacting the Total Force Service Center, DSN: 665-0102, Commercial: (210) 565-0102, Toll-Free: 1-800-525-0102 or email via myPers: https://mypers.af.mil/app/ask .

Principles of Promotion Preparation (Are You Ready?)

- "As an executive reaches middle-management and beyond, the primary criteria for advancement are communication and motivation skills rather than basic job performance." *--Bottom Line Personal*

- The highest level of rank at which you regularly need to do business collegially indicates the rank for which you’re next best suited. *--Bullock’s Principle*

- “If you don’t decide what you want from your career, the people around you will make that decision for you”

  --Harry Joiner (executive recruiter)

Officer Performance Reports

The OPR (Lt thru Col utilizes AF Form 707) is the official record of an officer's performance and provides information used for school selection, promotion, assignment, separation, and other management actions. It provides a cumulative permanent record of an officer's professional development and is the primary way of identifying outstanding performers within the officer force.

Several sections compose the OPR, each of which provides information on a different facet of the officer's performance. The OPR contains many sections, including a duty title and job description, performance factors, and the rater and additional rater assessments.

The governing directive for the OES is AFI 36-2406, Officer and Enlisted Evaluation Systems. Refer to the AFI for more detailed guidance on feedback, preparing evaluation reports and the promotion recommendation process.

The most important ingredient of your successful OPR is your performance. A pig dressed up doesn't fool anyone but significant accomplishments can go unnoticed if they're not presented well. You've worked hard and providing quality performance feedback and accurately documenting performance are two of the most important responsibilities of your supervisor. Each of those few lines has to count! Here's how to help others fully appreciate the significance of what you've done.

OPRs are used to provide a record of your performance in the context of your unit's mission. On the front page of the AF707 the bullets of Section II lay out the scope of your job. Section III documents whether or not you met expected standards of professionalism, leadership, fitness, etc. The back side of the form (Section IX) is used only if you do not meet standards.

Sections IV and V are used for your raters to give their evaluation (backed up by specific examples) of your character, decision-making, and leadership potential. This is the real meat that's used to evaluate whether or not you are someone the AF needs at a higher level of leadership and influence. This is where selection boards will spend most of their time. Your performance is viewed from incrementally higher perspectives (from rater to additional rater to reviewer) with the goal of documenting not only your performance but what that performance might promise. Using specific numbers, attributing quotes, and defining the level of impact are all essential to making the raters' assessments credible.

The BSC page of the AF KX (Knowledge Exchange) provides briefings/information on OPR and bullet writing. https://kx2.afms.mil/kj/kx1/BiomedicalSciencesCorps/Pages/AF-Writing.aspx

Stratification

The last line in each of the assessment sections is crucial and in most successful evaluations it takes the form of a "push statement". The three parts of an effective push statement are:

1) Stratification
2) Push for the next job
3) Push for school (rank-appropriate developmental education)

Stratification is the least well understood of these three although when it's used judiciously and honestly it's by far the most powerful.

The number one rule for an effective statement is: "***Every stratification needs a denominator***". Without a denominator the statement lacks meaning and will not be taken seriously. The following is from a briefing slide presented in at AFPC to BSC leaders on the importance of stratification in BSC OPRs.

Stratification is key

- My best XXX in 25 years – weak
- Top 2% I've ever known -- weak
- My #2 of 200 XXX in 25 years – great
- #1/50 CGO/FGOs – great
- #1/15 Flt/CCs-great

o Ways to stratify

- Within single grade (just among Lt or Capt or Maj or Lt Col)
- Within single AFSC
- Organizational level (SQ, Grp, Wing, MAJCOM, FOA, AF)
- Multiple grades (CGO, FGO)
- Multiple AFSCs (just BSC or all corps?)
- Over time (# of years)
- Location (Base, Wing, etc.)
- Within additional duties (my #1 of 20 EET members)

Col Danny Glover (past Chief of BSC Utilization at AFPC and the officer at AFPC who does promotion non-select counseling for passed-over BSC officers) noted that the absence of a stratification statement is as damaging as the lack of a recommendation for developmental education or future job.

The caveat is honesty. Stratify only what you know to be true and verifiable. And if your rater cannot rank you high in comparison with your peers, don't force a statement that's not there.

Here is AFPC's guidance on stratification (Apr 10 memo to the field):

Officer Stratification Clarification Guidance

Stratification in performance reports remains an integral tool in the evaluation process. This message (151445Z Apr 10) clarifies AFI 36-2406, Officer and Enlisted Evaluation Systems, and

provides specific guidance on authorized stratification remarks. This message replaces previous clarification messages and is effective immediately

- STRATIFICATION BASED ON PEER COMPARISONS: Stratification remarks can be made among: Peers (#1/10 Majors or #1/5 Captains); Peer groups (#1/10 FGOs or #1/10 CGOs); Duty Positions (#1/7 Action Officers, #1/7 Squadron Commanders); Aggregate Groups (#1/50 Officers in my Group; #1 of 50 majors in my 20 years of service); Additional Qualifiers (#1/4 Force Support CGOs; Best Major in my 32 years); and recognition level (Wing CGO/yr, #1/200). Stratification that is vague or lacks a qualified peer reference group is prohibited. (Example, although not inclusive, would be: "#1/5", "#1/50 officers", or "#1/200 personnel", as these do not identify a specific peer group).

- STRATIFICATION WITHIN A RATER'S AUTHORITY: Senior raters may stratify within their rating chain. For example, the Air Force Chief of Staff (CSAF) could say "#1 of 500 Majors in HAF" or major command (MAJCOM) commander may state "#1 of 500 Majors in the command." Stratification outside the scope of the rater's chain of command, despite functional authority or responsibility, will remain prohibited (except for quoting from deployed evaluations). Example: a MAJCOM/A1 may not stratify an officer as "#1/75 38F FGOs in this MAJCOM."

- STRATIFICATION QUOTES FROM SENIOR LEADERS: Raters can reference stratification by senior leaders in the chain of command. Subordinate raters may quote reviewer's stratification; provided the reviewer is a signatory on the OPR (a squadron or group commander could say "Wg/CC's #1 of 50 Majors"). Stratification quotes outside the ratee's chain of command will remain prohibited (except for quoting from deployed evaluations). Example: a MSG/CC may not state "OG/CC lauds as #1 LRO in my Group." In addition, if a Gp/CC is not a signatory on the OPR, a Gp/CC stratification is not authorized (unless supported by an award, "CGO Qtr").

- STRATIFICATION IN DEPLOYED LETTER OF EVALUATIONS: Stratification, assignment, command, and developmental education (DE) push statements in deployed letter of evaluations are authorized. Deployed stratifications and push statements may be quoted in future officer performance reports (OPRs) (as long as the stratification is not previously documented in the permanent record) and promotion recommendation forms (PRFs).

- STRATIFICATION ON PRFs: Statements that imply stratification of an officer's standing at a Management Level Review (MLR), such as "#1 of 22 DPs awarded at the MLR," or "If the MLR had one more DP, she would get it," remain prohibited.

- STRATIFICATION STATEMENTS WITHIN DECORATION CITATIONS. The use of stratification remarks in decorations is prohibited.

Left-hand Writing

The following is more advice from Col Glover based on his personal experience, feedback from selection boards, and analysis of BSC records of selects vs. non-selects. Although based on the old OPR form the principles are still relevant.

"I learned this from my group commander about a year and a half ago….he learned it from his wing commander (General Officer) a year or so before teaching me. Basically, a promotion board starts at the bottom of pg 2. After glancing at the reviewer, they go to Blk VII, and look at the last line, then the first line. After reading these 2 lines, they scan lines 2-4, but if the bullet begins with subjective words (the same ones that they have already read in 95% of the records) they will get no farther than 4 or 5 words then their eyes will jump back to the beginning of the next bullet. If it doesn't grab their attention, they will likely never see the last half of it before jumping back to the 4th bullet. Left hand writing is simply beginning a bullet with the impact rather than ending it with the impact. If we bury the impact at the end of the line, the board may never get to it. Let me show you the difference:

Lines from an OPR before:

- Totally revamped exposure response protocol--ensured 100% of workers/patients tested within two hours
- Ensured safe prep of 30K+ meals per day to 35K+ base personnel by enforcement of strict hygiene standards
- Aggressive leadership averted life-threatening "flesh-eating" Group A Streptococcal outbreak among 6K trainees

Same OPR after the Group CC applied left hand writing:

- 100% of patients tested within two hours of accidental exposure; new response protocol ensures protection
- 30,000 meals per day safely prepared and served to over 35,000 personnel; strict hygiene standards enforced
- 5,900 military trainees saved by thwarting Group A Streptococcus outbreak through aggressive prophylaxis

After looking at the PRFs of six recent BPZ promotees, as well as the records of some of the promotees, it is obvious the board preferred "objective data" rather than "subjective descriptions".

Placing that objective data at the beginning of the bullet merely ensures the board members will not miss it.

Speeding

Finally, and above all, protect your and your rater's integrity. The board makes an opinion about both of you. Despite the temptation, avoid speeding! For example, a PA volunteers to help with school physicals and participates in a team that sees over 1300 kids. A speeding bullet looks like this:

> Was instrumental in performing 1,300 school physicals saving the AF over $30,000 in eight hours

The bullet is unbelievable, you'll get caught for obviously exaggerating and your record will likely get pulled over…and you'll be stopped.

Promotion Recommendation Form (PRF)

The PRF (AF Form 709) is key to assisting the promotion board in deciding who among the eligible officers is best qualified for promotion. The purpose of a PRF is to communicate the Senior Rater's promotion recommendation directly to the promotion board and to explain why an officer should or should not be promoted. The senior rater makes one of three promotion recommendations, "Definitely Promote" (DP), "Promote" (P), or "Do Not Promote" (DNP). The PRF is an executive summary of your career and highlights items in your OPRs, training reports, awards, decorations.

PRF Tips:
-be cautious of career field jargon as it may be meaningless to the LAF officers on the board
-highlight strats, awards, leadership/levels of responsibility, significant impact on mission
-everything must be previously documented in the record
-cover the entire career, not just the current job
-review Maj Gen Zadalis' PRF slides/presentation located on the KX https://kx2.afms.mil/kj/kx1/BiomedicalSciencesCorps/Documents/Forms/HideFolders.aspx?FilterField1=Classification&FilterValue1=PRF

What If I'm Not Selected For Promotion?

Some things to check for if you're mysteriously passed over for promotion:

- Take advantage of AFPC's non-select counseling (done by the AFPC BSC Utilization and Education Branch, DSN 665-3821)
- Was grade-appropriate Developmental Education (PME) completed before the Board date? Do you records show it?
- Was your officer preselection brief correct? Did you check your records before the board? Is your SURF completely correct? Are you a 42G3 and not a 42G1?
- Are you performing expertly in your current job?
- Do you have an advanced academic degree? Do your records show it?
- Do your OPRs fully reflect what you do and its impact? Did you provide input? Did your PRF and/or OPRs have a stratification statement? (#/# is preferable to %) Did your OPRs have recommendations for next job and school? (i.e. DE/PME, command, etc)?
- If you have deployed is it reflected in your record? Bullets in your OPR? Did you show leadership?
- Have you won any awards? Met any boards? Anything to distinguish you from your peers?
- Have you held office in professional societies? National organizations? Are you a member? (Start with SAFPA).
- At what level do you influence? Only in the clinic? Hospital committees? Base or community service? National? Rule: The level at which you regularly interact professionally is the level at which we need your grade to be.
- Knowing that promotion is not a reward but instead a giving to you the tools you need to do the next job the AF needs you to do (and which you've already shown yourself prepared to do), can you justify why the AF should promote you?
- If you're going for field grade you should have already been out of your comfort zone a few times and succeeded
- Have you made it a point to broaden your leadership experiences?
    - As Captain show at least Wing-wide impact
    - As Major at least MAJCOM; AF-wide impact is even better
    - As Lt Col show AF-wide impact; DoD-wide is even better
- Put together a package and get nominated for AFMS BSC Clinician of the Year. Any level you win at (base, MAJCOM, AF) will be noticed favorably at the next board.

Top Ten Ethics Rules

(A simplified distillation of major federal laws and regulations)

1. Do not work on a matter for the Government that will affect your financial interests—or the financial interests of someone whose interests are imputed to you, such as your spouse, your dependent child, your general partner, or an organization you serve as a fiduciary.

2. Do not work on a matter for the Government in which your former employer is a party or represents a party

3. Do not accept a gift from someone who does business with your agency or is seeking to do business with your agency. Do not accept a gift from your subordinate or someone who earns less pay than you do.

4. Do not engage in outside activities that conflict with your Government position.

5. Do not represent third parties back to the Government

6. Do not misuse your Government position or resources

7. Do not seek employment with an organization that you can affect by performing your Government job—unless and until you have disqualified yourself from taking actions that will affect that prospective employer

8. After you leave the Government, do not represent third parties back to the Government on any matter that you worked on personally and substantially for the Government, or that fell under your official responsibility during the last one year of your Government employment

9. If you worked on a procurement valued at ten million dollars or more do not go to work for the contractor awarded that contract—unless and until it has been one year since your role on that contract ended.

10. Whenever you have an ethics question, or even suspect you have an ethics question, contact the ethics counselor assigned to your unit. Normally it will be someone from the legal (JA) office.

Planning Calendar for PAs

JANUARY	FEBRUARY
IPAP applications due Summer cycle assignment matching begins	Annual AF PA Refresher Course
MARCH	APRIL
PA Selection Board (IPAP) Summer cycle assignment matching ends	
MAY	JUNE
BSC Spring Development Team Health Professions Education Review Board (HPERB) AAPA Conference Fall cycle assignment matching begins	Fall cycle assignment matching ends
JULY	AUGUST
	AFIT applications due to AFPC
SEPTEMBER	OCTOBER
BSC Fall Development Team AFIT AAD and Fellowships Board Spring cycle assignment matching begins	AFMS Senior Leadership Symposium (Leesburg) AFMS Award nominations due to MAJCOMs Spring cycle assignment matching ends
NOVEMBER	DECEMBER
AMSUS	Complete your ADP in preparation for summer assignment cycle!

Demystifying MEPRS & DMHRSi

Time is Money…Getting MAXIMUM Credit for Your Work!

Excerpts originally written by Darrell D. Dorrian, Former Air Force MEPRS Program Dir
Edits by Maj(s) Stephen A. Smith, DSc, GSPA-C, reviewed by Mr. Keith R. Andre, Current MEPRS Program Dir

If you are anything like me, you have most likely coasted through your AF time trying to waste as little time as possible on DMHRSi… like **30 seconds** on a Friday evening at 1830 after your 20+ AHLTA notes and 3,000th T-CON! (…amiright?) Well, I certainly can't fault you for the frustration because it is just ONE MORE thing that you "have to do" in a never-ending sea of PCM responsibilities. However, like it or not, DMHRSi is NEVER going away so you better have at least a minimum understanding of what it is and why it matters.

What is MEPRS? The Medical Expense and Performance Reporting System (MEPRS) is a uniform reporting methodology designed to provide consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense (financial), manpower (personnel), and performance (workload) data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment format. (The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.)

What is DMHRSi? Air Force SG has directed the use of the Defense Medical Human Resource System, internet (DMHRSi) to report all personnel time. All timesheets are due by close of business on the first Monday after the end of the pay period… i.e. every 2 weeks like clockwork!

- ➔ *MEPRS is the expense allocation piece and DMHRSi is how we account for personnel hours worked.*
- ➔ *Simply put, this is the ONLY way we have to accurately provide visibility, document, and track medical resources across the MHS—and **ultimately guide corporate/financial decision making** on military health care.*

Why it is FRUSTRATING? First and foremost, **it takes precious time** to accurately report hours (got it, no getting around this). I recommend jotting down your various hours every day on a calendar or sticky note then you can simply input the data at the end of the 2-week period—literally takes <60 sec baring any system issues which leads me to the next point. The system has historically been **highly unreliable** going "down" FREQUENTLY. New hardware, servers, and upgraded technology have been put in place which has provided better reliability as of late.

- ➔ *You will likely never DIRECTLY "see or feel" the **benefit** or **damage** caused by inaccurate reporting but make NO mistake, it affects BIG AF and the DoD! (Imagine Pres. Trump saying "billions and billions and billions…")*

Why it MATTERS?
- Timecard accuracy influences our Medicare-Eligible, Retiree Health Care Fund (MERHCF) annual reimbursement.
- The MERHCF reimbursement is driven by cost of providing Medicare-eligible patients healthcare services in the MTF.
- The "cost of labor" (i.e. "provider time" in DMHRSi) is a **primary driver** of the cost of services.
- Healthcare salaries make up 70% of the overall MTF operating costs.
- A recent AF-wide audit showed only **56%** of **850** providers across 12 MTFs documented time accurately.

- ➔ *When timecards don't accurately show time spent caring for patients, **the cost of services is under-represented and BOTTOM LINE the AF gets less overall reimbursement.** It quite literally is critical to keeping the MTF "door's open for business."*

How can you HELP?
STEP #1 = **Do it!** Get obsessive about reporting your hours **accurately, every time**… make it a habit and encourage your colleagues to do the same. Don't get influenced by the crusty MD/PA who just puts in 8 hours across the board! You put in the hard work and the LATE nights… make sure you, the MTF, and the AF get the credit. Ultimately, it's to your advantage to see that the time reported for you reflects reality accurately.

- ➔ Report clinic production time under your clinic code. For example, in Family Practice (**BGAA**), production time is your **"seeing patients" time** as well as anything you do that **directly supports your clinic's work** (e.g. completing charts after hours, setting up for the next day, etc.).

- ➔ If you are **NOT** in a production mode, you need to report your time in an appropriate **"non-clinic"** code. The key is to move that time to anything under **"Available Hours Worked."** ***Avoid*** using **"Mil Other**" or other **"Non-available Time**" which would be charged back to the assigned work center as non-productive time, causing your "cost per unit" of service to go up.

- ➔ If you're not working, don't claim the time under a workplace code where clinical production is expected. Failure to properly annotate readiness or other **"non-clinic activities"** on your timesheet will result in an increase in the **"cost per unit"** of your services. Thus, when your Resource Management Office (RMO) costs them out, you (or your FTE slot) will come across as **"expensive"** and therefore a target for elimination. Your commander does NOT have the luxury of carrying inefficiency.

- ➔ Therefore, even if your facility has tried to increase efficiency by **"relieving you"** of MEPRS reporting duties it is in your best interest to find out what is being reported and, if necessary, take the job back. First check with your group practice manager. If he/she can't help, go to your RMO office and ask to see your MEPRS report for the previous month. Make sure all your non-clinic time is accounted for in the correct category.

+++ Addt'l info: There is a slightly longer and more complicated explanation as to the various MEPRS codes and the expense allocation system they represent in conjunction with the personnel "full-time equivalent (FTE)" piece if you are so inclined *(see figures 1-3 below if you dare…)*

STEP #2 = **Get hot on coding**! Accurate coding means accurate clinical workload, and increasingly, REAL DOLLARS. The AFMS tracks not only MEPRS data (time data) and DRGs ("Diagnosis-Related groups"—the institutional charges) but also professional services (workload data). ***Coding must be a "Life Skill" for providers.*** AHLTA has most diagnosis/procedure codes built in and should be a time saver.

- ➔ Find a coder. Be their best friend. **Actively** seek their review of your charts with coding feedback where you screwed up (which you will…). This is particularly important when **procedures** are involved!! They are out there, trust me.

- ➔ Better coding = better RVU generation = more $$$ for the MTF and can be an easy way to "rack and stack" you against your MD/PA-C/NP peers and show continued/consistent production on OPRs/DECs/PRFs/etc. PLUS, how do you think you are going to afford your new boat when you separate/retire and snatch that sweet sweet dermatology PA gig --> #**CODING!!**

STEP #3 = **Be proactive** in efforts to optimize business practices in your clinic, from scheduling to case management. The more processes we optimize, the more money we can make. It is that simple in concept. It will be only those functions that **produce a return on investment** or have a **non-negotiable expeditionary requirement** that will be retained in the MTF. In other words, keeps you gainfully employed whether you continue in the AF or get out into the civ world!

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This next section, from the Air Force MEPRS Program Manager, has guidance on how to correctly account for your hours in more detail. For specific questions, go to your facility's MEPRS manager (in the RMO) and get a list of available category codes while you're there. I recommend doing this at LEAST annually when the FY switches over.

Anatomy of a MEPRS Code

FIRST LETTER	SECOND LETTER	THIRD LETTER	FOURTH LETTER
Functional Categories *(DoD Standard)*	Summary Accounts within the functional categories *(DoD Standard)*	Specific work centers within the summary accounts *(DoD Standard)*	Identifies specific types of costs and workload *(MTF-unique)*
Examples: **A** = Inpatient **B** = Outpatient **C** = Dental **D** = Ancillary **E** = Support (Overhead) **F** = Special Programs **G** = Readiness	*Examples:* **A** = Medical Care **B** = Surgical Care **C** = Ob//Gyn Care **D** = Pediatric Care **E** = Orthopedic Care **F** = Mental Health Care **G** = Family Practice **H** = Primary Care **I** = Emergency Med **J** = Flight Medicine **K** = Undersea Medicine Care **L** = Rehabilitative Ambulatory Svs	*Examples:* **B** = Outpatient Care **BA** = Medical Care **BAA** = Internal Med **BAB** = Cardiology **BAD** = Dermatology **BAE** = Endocrinology **BAF** = Gastroenterology **BAG** = Hematology	Can distinguish between different teams within the Family Practice clinic, like **BGAA** and **BGAB**, or *"Family Practice without GME" (BGA[A-F]) and "Family Practice with GME" (BGA[H-L])* Note that "BHA" (Primary Care) has been replaced by BGA (FP) in the AF

Accounting for Hours in MEPRS

There are a few rumors and misconceptions that need to be **busted** in reporting MEPRS data…

If you take work home you **can** count that as work time, I will stress only the time you were working, not the time you *intended* to work, but got hooked on the football game.

If you are on call you **can't** count the time you are just watching TV, but you **can** count anytime you are on the phone with a call. If you bring work home to do (since you realize you will unproductive while tied to the phone at the office) you can count that time. You can only count the **actual time**. No one is monitoring, but we should all be truthful enough to report only what we did, not inflate to what we intended to do. *(Integrity FIRST!)*

Now, if you are required to stay in the facility while on call you should report **idle time** to **EBAA;** but if you go to your office to do specific tasks, that should go back to your assigned clinic code or other appropriate code. For example, if you review/complete patient records the time gets credited to your regular clinic code. If you catch up on EPRs/OPRs use **EBCL**. If you get pulled to the Emergency Room to help take care of patients then that time needs to go to the ER--**BIAA**. But, if you go to the commander's office for a nap or to the **chow hall** for Breakfast/Lunch/Dinner/Midnight Chow, that time is **not countable**.

If you are on a base detail such as Security Forces augmentee, base beautification or just helping in the Wing Commander's office you should count that time as **FCGA**--Support to a Non-MEPRS Reporting activity.

If you are attending a Wing Meeting under your specialty you should use your own assigned MEPRS Code. If you go representing your Commander, use the Commander's code. These scenarios fall under your duty responsibility as a representative of the Medical Group.

Wing Commanders Call - **FCGA**
Group Commander's Call falls under **EBBA** - Commanders Special Staff.
Squadron Commander's Call falls under the appropriate squadron.

If you go downtown to round on patients - **FCA** - Support to Beneficiary (unless you have an External Resource Sharing Agreement, in this case you would report time and workload under the appropriate 54**/A*** or B*** Code for services provided. Contact your local MEPRS Data Quality Manager for specific instructions).

If you go to the VA to round on your patients - **FCE** - Support to the VA (unless you have a Resource Sharing Agreement, in this case you would report time and workload under the appropriate 56**/A*** or B*** Code for services provided. Contact your local MEPRS Data Quality Manager for specific instructions).

If you are loaned to another Military Treatment Facility you have to report to your home unit under FCD, but you also have to report your hours to that other facility in the appropriate clinic or service you worked. DMHRSi makes this process much easier, if you report your time to another MTF's Project Number, the system automatically populates your timesheet with the appropriate FCD* Time.

If you are deployed for the entire month there is no need to report more than 168 hours (168 hrs = 1 FTE); time reports only allocate salary to the appropriate areas. Only if you are deployed for part of the month does the allocation of expenses become a concern.

Only Chartered Committees can be counted in **EBCC.** If a committee is under the purview of a specific MEPRS Area then all members of that Committee would count their time under that specific MEPRS Code (example: Information Management/Information Technology (IM/IT) would be under Systems **EBJA**)

Unit PT or sanctioned exercise during duty time would be under **GFAA**

In-Residence PME, both Officer and Enlisted, would be **GBAA.** If you are just doing your book work after duty hours it cannot be counted, it is personal upgrade training. Required Flying Time is also **GBAA**.

Most all class attendance would be considered **FAL** from the time you are taken out to the parking lot to learn how to put out a trash can fire to your annual training requirement to keep up your medical proficiency. This doesn't include GME Classes they are under an **FA?** Code (refer to 6010.13 for specific codes relating to your program).

Goal Days or "Family days" would be considered **Military Other** for Military, and either **Leave** or alternate duty for civilians, based on Civilian Personnel Office guidance.

If a civilian is granted alternate duty location, for a family day that time would have to be reported as actual work time to the assigned work center, but if an official down day was granted then they would be considered on Admin Leave and it would be counted as **Leave**.

Contractors and Volunteers only report time they are working. We do not capture **"non-available"** time, such as time they're on vacation, at appointments, or sick. We only capture the time they are actually working for us.

During PCS and Retirements people have to report time to **FDGA** up to the RNLTD or the actual retirement day.

+++ MEPRS is actually important three-part expense allocation system (i.e. it identifies which people and what activities are expensing the money) for MTFs. It looks at three major areas: financial, personnel, and workload. The three slides which follow give a clear snapshot of the personnel piece. For MEPRS purposes personnel expenses have a monthly rate for each grade, which includes both pay and benefits. One FTE (full-time equivalent) is 168 hours.

Figure 1

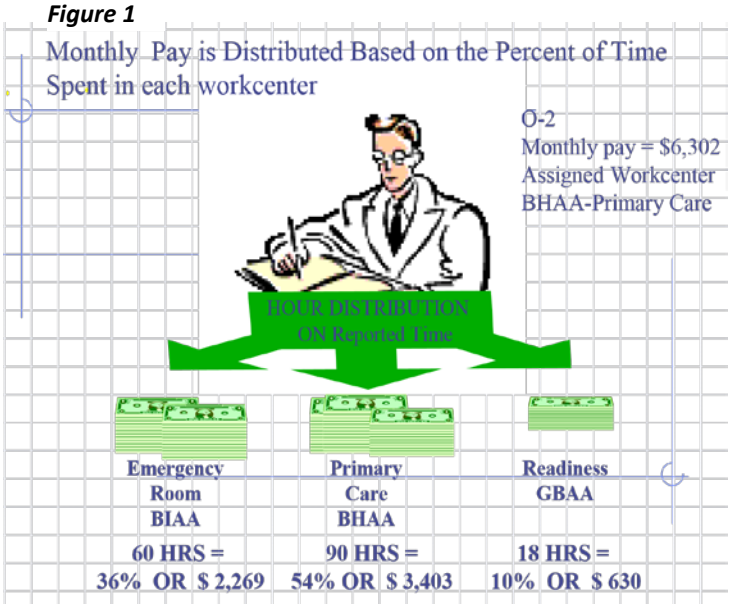
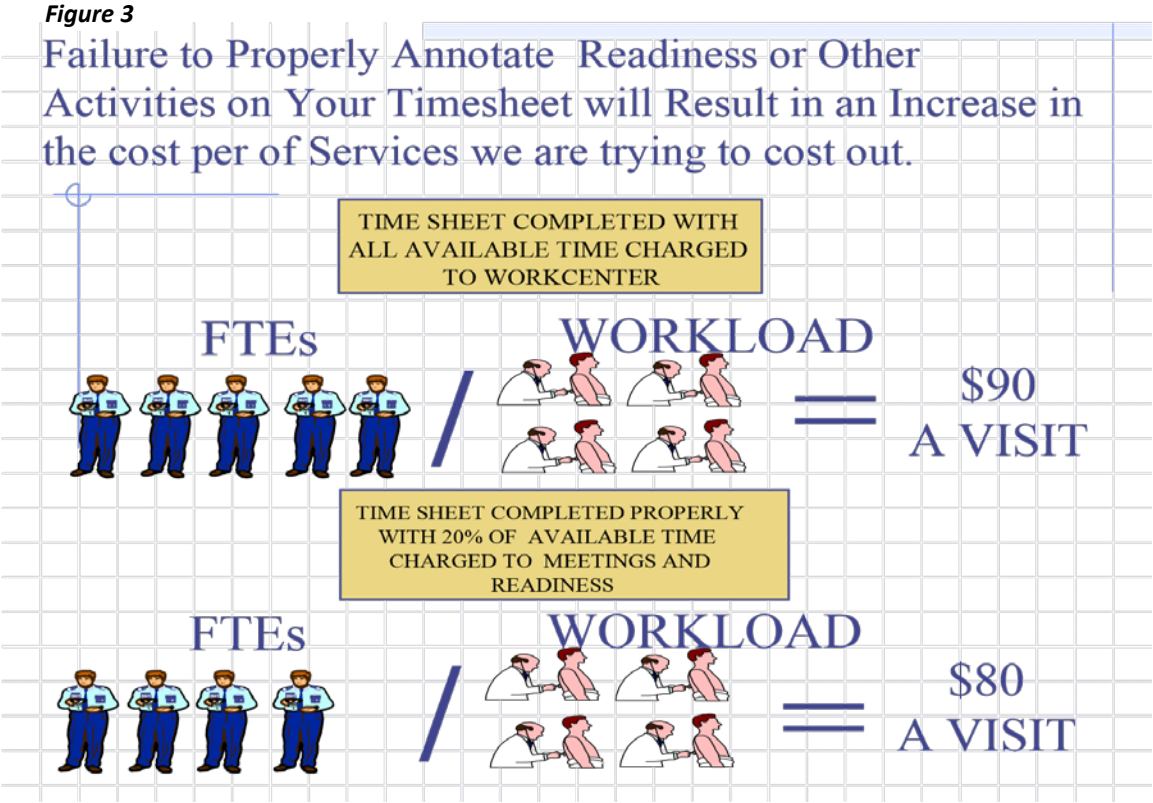


Figure 2

Figure 3



The following is the "Medical Staff Quick Reference Guide" to MEPRS codes. It's a valuable resource that changes each year so check with your local MEPRS manager to make sure you're using the latest. Print it out and keep it handy.

Medical Staff Quick Reference Guide

Medical Expense Performance Reporting System (MEPRS)

Matrix for Time Reporting

A = Inpatient Services; report all time associated with inpatient care that directly or indirectly affects production of Relative Weighted Products (RWPs) and Diagnosis Related Groups (DRG)

B = Outpatient Services ; report all time associated with outpatient care that directly or indirectly affects production of Relative Value Units (RVUs)

C = Dental Services; report all time associated with dental care that affects the production of Dental Weighted Values (DWVs) or Composite Lab Values (CLVs). Assigned dental providers who generate non-DWVs and who produce RWP/DRG or RVU based production must report their time to the appropriate A (e.g. Oral Surgery ABFA) or B (Plastic Surgery- BBGA) account

D = Ancillary Services; report all time associated and performed in an ancillary setting--generally reported by pharmacy, laboratory, and radiology. This can also include time performing EKGs, EEGs, EMG, etc., to include time in anesthesia not in the outpatient clinic.

E = Support Services (Administrative overhead); Logistics, Resource Management, TRICARE Operations and Patient Administration, Command Support Staff, Committees, and Group and Squadron Command, EPRs, OPRs, Decorations, etc ---- Non-Clinical Time

F = Special Programs; most comprehensive as this category includes over 70 different subcategories. Contact MTF MEPRS Program Managers for entire list and explanation of each.

G = Readiness; report time for activities supporting Readiness Training, Exercises, Mobility Processing Lines, Fitness, and Deployments.

NOTE: There are a few exceptions to the use of primary MEPRS codes. Contact MTF MEPRS Manager when any doubt surfaces as to the proper code to use when reporting time

MEPRS Codes (* denotes wildcard)	RWP/RVU Production Activities		RWP/RVU non-Production Activities	
A* -Inpatient Care (RWPs/DRGs)**				
A* Inpatient Services - RWPs DRGs**	**Inpatient Production for "A" MEPRS**	**RWP/DRGs**	**Inpatient non-Production for "A" MEPRS**	**No RWPs**
	DRG = RWP (Bundled Care)	A***	Case Management (Particular to single episode of care)	A***
	In-house Direct Patient Care	A***	Inpatient Care **NOT** the discharge service	A***
	Inpatient Care (Rounds)	A***	Non-Codable events	A***
	Downtown Rounds/Surgery (Admitted Patient)	A*** (Civ DMIS ID 54##)	Inpatient Consult: No "B***" Encounter, no ADM; provider only sees patient, writes note in chart	A***
B* - Ambulatory Care (RVUs)**				
B* Outpatient Services - RVUs**	**Outpatient Production for "B" MEPRS - earns RVUs**	**RVUs**	**Outpatient non-Production for "B" MEPRS**	**No RVUs**
	Ambulatory Care (Outpatient Clinic not APU)	B***	Nurse Triage	B***
Note: B**P and B**W have been removed for FY10 Processing.	Ambulatory Procedure Care (Outpatient Clinic APU) (Slated for removal in FY11)	B**5	On Call at home - Pt calls-NOT SOAP documented; No CHCS ADM	B***
	Observation (slated for removal in FY11)	B**0	Group Appt **without** individual Provider contact/SOAP note	B***
	MEB/PRP/PHA w/Pt present (Coded)	B***	Consult-No associated appt. in CHCS	D***
	Group Appt **with** individual Provider contact/SOAP note	D***	Peer Reviews	**EBDA**
	Inpatient and Outpatient Consult-has an associated appt. in CHCS	B***	On Call at home - (not-idle) Pt phone call-SOAP documented	B***
Note: BGAZ will be used for Non-FHI Related functions such as Clinical Pharmacy Services and Behavioral Health Services.	Downtown APV, Encounter (Patient Not Admitted)	B*** (Civ DMIS ID 54##)	On Call at home - Idle Time	Not Reported
	ER Consult: May "virtually" walk Pt. Consult into home MEPRS clinic, and code as InPt or OutPt consult, as appropriate	B***	ER Consult: No "B***" Encounter, no ADM; provider only sees patient, writes note in chart	BIA*
C* - Dental Services are only used for generating DWV or CLVs**				
D* Ancillary Services**				
D* Related Production for Ancillary Care**	**Technician, Laboratory "work"--"D***" Codes, Potential "Lost" RVUs; Ancillary procedures should be coded for RVU production**			
	EKGs, PFTs, Audiograms: Potentially lost RVUs; can "capture" Provider "work RVU" if one walks-in to a non-count appt (99499) and records the CPT on the ADM. This includes PHAs, pre-op studies, etc. (Shared Machines)	DD**		
E* Support Services (Overhead)**				
E* Clinical Meetings**	**Most Clinically Associated Meetings "E***" Codes**		On Call in MTF - idle time (MOD, AOD, NCOD)	**EBCL**
	Military Personnel Supervision (OPRs/EPRs/Décor/Civilian Appraisals)	**EBCL**	Dental Squadron Commander's Call & Support (Not Aero-Dental)	EBCD
	SQN, SGC, SGA, Credentialing, JCAHO Coordinator	EBBA	Outpatient Coder/Auditor	EKAA
	Personal Reliability Program	EKAC	Inpatient Coder/Auditor	EJAA
	Medical Provider Teaching Time (GME)	EBEA	Support Squadron Commander's Call & Support	EBCE
	Medical Group Commander's Call	EBAA	Aerospace Squadron Commander's Call & Support (Aero-Dental)	EBCF
	Clinical Management (e.g. Peer Reviews)	EBDA	Operations Squadron Commander's Call & Support	EBCH
	Committee Meetings (see Atch 5 in AFI41-102	EBCC	Diagnostic & Therapeutic Squadron Commander's Call & Support	EBCJ
	Special Staff (QA/RM, Chaplain, Infection Control, Med Law)	EBBA	Surgical Squadron Commander's Call & Support	EBCK
	ACLS, PALS, CPR, Patient Safety Training (Instructor)	EBFA	Inpatient Squadron Commander's Call & Support	EBCI
	In-service for another clinic (instructor)	EBFA	Graduate Dental Education (GDE) Instructors & Support	EBIA
There is no code for Admin time (Record Documentation, CHCS/AHLTA entry, etc.) This is "B" Clinic Time	Group Practice Manager (Assigned Only) Available time should be reported to the individual clinics benefiting from service	EBDA	Commander Directed Details (Cash Count, Drug Inventory, Report of Survey, Classified Material Destruction, Casualty Assistance, etc.)	**EBCL**
	HIPAA Program Management and Instruction	ELAH	Health Care Integrator	EBDA
	Case Management	ELAN	Graduate Medical Education (GME) Instructors & Support	EBEA
			Representing Group/Squadron CC at Official Functions	EBA/EBC*
F* Special Programs**				
Military Related F* Codes**	**Military Related "F***" Codes**		**Military Related "F***" Codes**	
	TDY Manning/Staffing assist at a MTF other than where you are assigned. **Note:** Report time (same time) in the appropriate MEPRS Code for work at the TDY Location.	FCDA	VA Care (MTF provider seeing patient in a VA facility) This also can be reported under the VA DMIS ID and Product line scenario (56** A***/B***)	FCE*
	PCS/ETS Time (Terminal Leave/PCS Leave/House hunting)	FDGA	MTF/Base Orientation	FAL*
	GME Intern/Resident Expenses	FAMA	Wing/Base Details/Commander's Call (Honor Guard)	FCGA
	GDE Intern/Resident Expenses	FANA	Clinical Investigations (Validated Projects Only)	FAHA
	GME Fellowship Research Expenses	FAPA	In/Out processing	FCGA
	GDE Fellowship Research Expenses	FAQA	Continuing Education (CE)	FAL*
	Non-GME/GDE Student Expease (Skill Level 2-5)	FAKA	Medical Board Processing/Medical Clearances	FEDA
	GME Full Time Research	FAOA	In-Services	FAL*
	Mental Health Outreach/Education (Briefings not Pt Care-Briefer only)	FAZY	Medical Support to Federal Agencies (Non-DoD)	FCEA
	Special Needs Identification & Assignment Coordination (SNIAC)	FAZN	ADAPT (Non-Clinical)	FAZS
	Family Advocacy (Non-DHP)	FAZF	Starting Up/Closing Down Clinical Functions	FDZC
G* Readiness Codes**				
G* Readiness Codes**	**Readiness Training "G***" Codes**		**Deployment Related "G***" Codes**	
	Readiness Office	GABA		
	Readiness Training - PME, RSVP, UCI Preparation	GBAA	Deployment	GDAA
	Peace time Disaster - Actual	GGAA	Deployment Planning	GAAA
	Flying Time	GBAA	Deployment Preparation (Shots, Special Uniforms, Legal, Financial)	GAAA
	Force Protection Response (Security)	GGAA	PHA Records Review (Pt Not Present)	GAAA
	PT - during duty hours	GFAA	Clinician Working Deployment Line	GAAA
	PT - on personal time; not captured	Not reported	WRM	GEAA

Non - Available Time	
Leave	**MILITARY LEAVE** (Count normal duty hours, Holidays - **DO NOT COUNT Weekends or regular Scheduled days off)** **CIVILIAN Non-Available time** ANNUAL LEAVE and civilian's Holiday time or any administrative time (Snow Days), Authorized Fitness Time, EMERGENCY LEAVE **Note:** Contractors Do Not Report Non-Available Time.
Hosp/Sick Leave/Medical Appointments	MEDICAL/DENTAL APPOINTMENTS, CONVALESCENT LEAVE, CIVILIAN SICK LEAVE, QUARTERS, PROFILE OR REDUCED WORK SCHEDULE (COUNT SCHEDULED DUTY TIME, **DO NOT COUNT WEEKENDS OR REGULAR SCHEDULED DAYS OFF.)**
Military Other	Down Days, Personal Military Matters (MPF, Finance, Permissive TDY); **Civilians and contractors can not use Military Other**

POC: AFMSA/SG8YR - Mr. Darrell D. Dorrian DSN 425-6456 (Comm 703-588-6456) - E-Mail: Darrell.Dorrian@Pentagon.af.mil

INTERSERVICE PHYSICIAN ASSISTANT PROGRAM

Overview

Mission: To provide the uniformed services with highly competent, compassionate physician assistants who model integrity, strive for leadership excellence, and are committed to lifelong learning.

History:

In 1996 the US Department of Defense combined the Air Force, Navy and Army Physician Assistant Programs into one program and named it the Interservice Physician Assistant Program (IPAP). The program was integrated into the Army's Academy of Health Sciences, at Fort Sam Houston, Texas.

At that time the University of Nebraska Medical Center (UNMC) entered into a contract with the United States Army which specified that the UNMC be the affiliated academic institution for the IPAP. UNMC agreed to provide administrative support to the IPAP and award academic credit to students completing the IPAP curriculum. Students who successfully complete the IPAP Program are granted a Bachelors of Science and a Master of Physician Assistant Studies (MPAS) degree from the University of Nebraska.

IPAP is located at the Academy of Health Sciences (AHS), Army Medical Department Center and School (AMEDD C & S) on Fort Sam Houston, San Antonio, Texas. The program mission is to educate and train physician assistants for the uniformed services (Army, Air Force, Navy, and Coast Guard). Applicants need to be commissioned or non-commissioned officers in the uniformed services

The IPAP students complete their first phase of study (academic) at Fort Sam Houston, Texas. The second phase of study (medical/surgical clerkships) is completed at various military installations throughout the United States.

Students entering the IPAP prior to January 1, 2003 were awarded a Bachelor of Science degree upon successful completion of the program. In January 2003 the IPAP converted to a graduate level physician assistant program. Based on the revised, more intense curriculum IPAP students entering and successfully completing the IPAP after January 1, 2003 were awarded a Master of Physician Assistant Studies (MPAS) degree by the University of Nebraska.

Starting with the December 2010 class the length of the program was expanded to 29 months of training. Phase I at Ft Sam Houston is 14 months. Phase II is 15 months.

IPAP is accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

Applying

AIR FORCE APPLICATION FOR THE

INTERSERVICE PHYSICIAN ASSISTANT PROGRAM

The Air Force is accepting applications for the Fiscal Year 2019 (FY19) Interservice Physician Assistant Program (IPAP). This advanced medical training program in a unique, multi-service opportunity available to both **enlisted** and **officer** applicants from **any career field**. IPAP offers an accelerated path towards earning a Master of Physician Assistant Studies (MPAS) degree from the program underwriter, the University of Nebraska Medical Center (UNMC).

IPAP is a 29 month program conducted in two phases. Phase 1 is a 16 month period of intense classroom and hands-on instruction conducted at Joint Base San Antonio, Fort Sam Houston. Phase 2 is a 13 month period of various clinical rotations at a large military hospital.

Enlisted members are commissioned upon program completion as a First Lieutenant (1Lt/O-2E). IPAP (enlisted and officer) graduates are inducted into the Air Force Medical Service (AFMS) as a Physician Assistant (PA) in the Biomedical Sciences Corps (BSC).

1. KEY DATES:

A. Applications will be accepted from **01 Sep 2017** through **26 Jan 2018**. Applicants are responsible for preparing and submitting the required documents through the UNMC IPAP Centralized Application Service (UNICAS). (See UNICAS information in section 10.)

B. Instructions for video interview will be released on or before **01 Dec 2017** with a submission suspense **of 25 Feb 2018.**

C. IPAP selection board will convene in **March 2018**. Incomplete applications will NOT be reviewed by the selection board.

D. IPAP Phase 1 classes convene in December, April and August of each fiscal year.

2. CHANGES for FISCAL YEAR 2019 (FY19) APPLICATIONS:

A. Revision of the academic requirements with clarification of acceptable on-line, College Level Examination Program (CLEP), or Defense Activity for Non-Traditional Education Support (DANTES) credits.

B. Deletion of the Armed Service Vocational Aptitude Battery (ASVAB) and Scholastic Assessment Test (SAT) requirements.

C. Deletion of the Academic Worksheet requirement.

3. WAIVERS:

A. Waivers are allowed on a case-by-case basis for exceptional applicants with high academic achievements, significant awards, outstanding conduct and superior performance evaluations. Requests for waivers will

be evaluated by HQ AFPC/DP2NW and/or the IPAP Administrative Support team. (See contact information in section 11.)

B. Applicants may request waivers for some military eligibility criteria (age, retention, etc.) and/or academic requirements (grades, time of courses, etc.).

i. Applicants are allowed to have one prerequisite course pending at the application deadline. Waiver of two pending course may be considered for rare circumstances such as deployments or short-notice assignments. Course waivers are granted to allow application during the current year instead of waiting until the following year's cycle.

ii. Applicants selected to attend IPAP with course waivers will be assigned a specified date for completion. Failure to meet the required completion date will result in forfeiture of the member's IPAP training authorization.

4. MILITARY ELIGIBILITY:

A. ENLISTED:

i. GRADE: Must be in grades E-3 through E-8 as of 01 Aug 2018.

ii. TIME IN SERVICE (TIS): Must have a minimum 2 years or up to a maximum 14 years of service as of 01 Aug 2018.

iii. AGE: Must be less than 39 ½ years old as of 01 Aug 2018.

iv. RETENTION: Must be eligible to obtain 5 years of retainability prior to the training start date. High Year of Tenure (HYT) and other retention waivers are allowed for the purpose of obtaining a commission IAW AFI 36-2606, *Reenlistment in the United States Air Force*, para 5.13. Members will subsequently incur a 5 year Active Duty Service Commitment (ADSC) upon graduation from IPAP. The training ADSC will override existing enlistments/extensions in effect at the time of graduation

v. CONDUCT: Must be of high moral character and personal qualifications. Must NOT have received a courts-martial conviction at any time. Article 15 Non-Judicial punishments must be evaluated by the HQ AFPC/DP2NW and/or IPAP Administrative Support teams prior to beginning the application process.

vi. MEDICAL: Must be medically qualified, or acceptable with waiver, for a commission IAW AFI 48-123, *Medical Examination and Standards*.

vii. SECURITY CLEARANCE: Must have evidence of an Entrance National Agency Check (ENTNAC) or National Agency Check (NAC). Most members have this clearance conducted upon initial entrance into the military and renewed every ten years of service.

viii. CITIZENSHIP: Must be a United States (US) citizen. Citizenship verification will be conducted IAW AFI 31-501, *Personnel Security Program Management*.

ix. COMMISSIONING: Must meet commissioning requirements as specified in AFI 36-2005, *Appointment in Commissioned Grades*, for appointment as an officer in the Biomedical Sciences Corps (BSC).

B. OFFICERS, ACADEMY & ROTC CADETS:

i. GRADE: Must be in grades O-1 through O-4 as of 01 Aug 2018.

ii. TIME IN SERVICE (TIS): Must have less than a maximum 8 years of service as of 01 Aug 2018.

iii. AGE: Not Applicable.

iv. RETENTION: Not Applicable

v. CONDUCT: Must be of high moral character and personal qualifications. Must NOT have received a courts-martial conviction at any time. Must NOT have received an Article 15 Non-Judicial punishment at any time as an officer.

vi. MEDICAL: Must be physically qualified for worldwide duty with no history of emotional instability.

vii. SECURITY CLEARANCE: Must have evidence of an Entrance National Agency Check (ENTNAC) or National Agency Check (NAC). Most members have this clearance conducted upon initial entrance into the military and renewed every ten years of service.

viii. CITIZENSHIP: Must be a United States (US) citizen. Citizenship verification will be conducted IAW AFI 31-501, *Personnel Security Program Management*.

C. GUARD and RESERVE: Guard and Reserve members must meet all of the military eligibility and academic requirements outlined in this document. Guard and Reserve applicants must also coordinate specific funding support and/or release from their component headquarters.

5. ACADEMIC REQUIREMENTS:

A. OVERVIEW:

i. ACADEMIC EVALUATION: Must submit official transcripts for upload into UNICAS. E-script may also be submitted. The evaluation process is essential for credit acceptance and transfer during IPAP enrollment.

a) After identifying the college/university within UNICAS, applicants will request the transcript be sent to the IPAP Transcript Processing Center. (See instructions in section 10. B)

b) Credential Solutions may also be used for transcripts. For a list of member institutions, visit http://www.credentialssolutions.net/links-for-students-alumni .

ii. TOTAL COLLEGE CREDITS: Must have a minimum 60 semester hours of transferable credits.

a) Earning the majority of credits within the past 5 years is highly recommended to better prepare students for the rigors of a fast paced program.

b) May earn up to 30 semester hours from one or more of the following non-traditional sources: DANTES, CLEP, end-of-course or subject examinations, correspondence

courses, off-campus classroom study, or resident/intern programs conducted by an accredited college/university.

c) Community College of the Air Force (CCAF) credits are acceptable.

iii. GRADE POINT AVERAGE (GPA):

a) Cumulative GPA: Must have a minimum 2.5 GPA or better on a 4.0 scale for the applicant's entire academic history. Repeated courses are included in the cumulative GPA calculation.

b) Math and Science GPA: Must have a minimum 3.0 GPA or better on a 4.0 scale for the required Math/Science courses (A&P, Chemistry, and Algebra). The most recent or recently repeated Math/Science course(s) will be used to compute the Math/Science GPA. Must have completed the Math/Science requirements within the past 10 years.

B. SPECIFIC PREREQUISITE COURSES:

i. MANDATORY

a) ANATOMY & PHYSIOLOGY (A&P): 6 semester hours required (recommend 8 hours w/labs). May not CLEP this requirement. On-line courses acceptable but not recommended. "Introductory" or "Intro" courses are not acceptable.

b) GENERAL CHEMISTRY: 6 semester hours required (recommend 8 hours w/labs). May not CLEP this requirement. On-line courses acceptable but not recommended. "Introductory" or "Intro" courses are not acceptable.

c) MEDICAL TERMINOLOGY: 2 semester hours required. CLEP or on-line courses acceptable. A no-cost, on-line course is available via the Army Knowledge Exchange (AKO) by requesting access from the IPAP Admin Support team.

d) ALGEBRA: 3 semester hours required. May not CLEP this requirement. On-line courses acceptable.

e) ENGLISH: 6 semester hours required (3 of the 6 hours must have been earned from an English Composition course). May not CLEP this requirement. On-line courses acceptable.

f) PSYCHOLOGY: 3 semester hours required. May not CLEP this requirement. On-line courses acceptable.

g) SOCIAL SCIENCES & HUMANITIES: 6 semester hours required. CLEP or on-line courses acceptable.

ii. HIGHLY RECOMMENDED:

a) BIOLOGY & MICROBIOLOGY: No specific requirement (highly recommended with labs).

b) ORGANIC CHEMISTRY & BIOCHEMISTRY: No specific requirement (highly recommended).

c) SOCIOLOGY: No specific requirement (recommend 3 semester hours). CLEP or on-line courses acceptable.

6. LETTERS OF RECOMMENDATION:

A. PERSONAL LETTER or 'STATEMENT OF PURPOSE': Must submit a typed essay revealing the applicant's desire to become a Physician Assistant. This essay is also known as the "Why I want to be a PA" letter. Must be 250 words or less and must be signed by the applicant.

B. LETTERS OF RECOMMENDATION:

i. MANDATORY LETTERS:

a. Air Force Physician Assistant (active duty or retired) with a minimum of two years clinical experience. A recommendation from an IPAP graduate is preferred.

i. The letter must include a summary of the personal interview.

ii. The author my incorporate feedback from other providers if the applicant has shadowed multiple providers.

iii. Must confirm a minimum of 40 hours of shadowing. There is no maximum hour limitation. Shadowing is defined as interaction, with the provider and patient, throughout the encounter and participation in case discussions. Simply assisting with clinic functions or performing patient check-ins and/or intake exams does NOT qualify as shadowing.

b. Physician familiar with the role of a Physician Assistant. If available, a recommendation from a Family Practice physician more closely reflects the focus of IPAP training.

c. Immediate supervisor or rating official

d. Immediate Unit or Squadron Commander

ii. OPTIONAL LETTERS: Applicant may submit up to two additional 'Letters of Recommendation' from anyone who may attest to the applicant's suitability.

C. SUBMISSION INSTRUCTIONS: Applicants must input the email address for the author of each letter into UNICAS. The authors will submit the signed/dated letters directly into UNICAS. Letters must bear either an ink signature or an electronic signature from a validated source, such as a military Common Access Card (CAC).

7. VIDEO INTERVIEW:

A. Projected Release of interview questions is on or before **01 Dec 2017** with a submission suspense of **25 Feb 2018.**

B. Interview questions will be provided to applicants with a current UNICAS application as of the projected release date.

i. Must submit an approximately 2 minute video of the applicant answering the interview questions.

ii. Must NOT contain special effects; NOT include other individuals; and NOT show the applicant in a clinic setting or with patients.

C. Videos may be submitted electronically to AFPC. In rare circumstances, videos may be recorded on a compact disc and mailed to AFPC. Definitive instructions will be provided with the release of the interview questions.

8. ADDITIONAL REQUIREMENTS:

A. MEDICAL CLEARANCE:

i. Must submit an AF Form 422, *Notification of Air Force Member's Qualification Status*, more commonly known as a 'Physical Profile' form.

ii. The AF Form 422 must be coordinated by a medical representative and include the following statement:

"*Based upon review of the applicant's medical records, I certify the applicant is fully qualified for worldwide duty IAW AFI 48-123, (Examination & Standards) and is not medically restricted under assignment limitation code C2 or C3.*"

B. CAREER BRIEF: Must submit an electronic or scanned version of applicant's Career Brief, also known as a 'SURF', available via AF Portal; AFPC Secure; Assignment Management System; Personnel Information; My Career Brief.

C. PERFORMANCE REPORTS: Must submit the last 5 Enlisted or Officer Performance Reports (EPRs/OPRs) to include any Training Reports or formal Letters of Evaluation. Inclusive timeframe will generally span a 5 year period. Non-consecutive, missing or significant reporting gaps must be explained in a separate personal memorandum uploaded into UNICAS.

D. FITNESS REPORT: Must submit a Member Individual Fitness Report, also known as a Fitness Tracker Report, from the Air Force Fitness Management System II available via the AF Portal. The fitness report must be a complete report containing all available fitness assessments. Significant fitness exemptions or failures must be explained in a separate personal memorandum uploaded into UNICAS.

E. OFFICER TRAINING DISENROLLMENT RECORD: If applicable, must submit a DD Form 785, *Record of Disenrollment from Officer Candidate Training for Airmen*, or an AETC Form 125A, *Record of Administrative Training Action.* Applicable only if the applicant attended but did not complete a previous officer commissioning program.

9. PERSONNELL ACTIONS FOR APPLICANTS AND SELECTS:

A. OCONUS APPLICANTS: Overseas members should have a Date Eligible for Return from Overseas (DEROS) on or before 31 Aug 2018. Applicants selected to attend IPAP may have some return date adjustments as coordinated by HQ AFPC/DP2NW and the member's respective career field manager (CFM) and/or assignment team.

B. ENLISTED:

i. After confirmation of application eligibility, HQ AFPC/DP2NW will defer further assignment actions by placing an Assignment Availability Code (AAC) of 05 in the member's record IAW AFI 36-2110, *Assignments*, para 2.15, Table 2.1, Rule 2.

iii. Applicants already selected for a Permanent Change of Station (PCS) prior to application for a commissioning program may be ineligible for deferment.

iv. Enlisted selects will be assigned one of the three class start dates in coordination with the member's respective career field manager (CFM) and/or assignment team.

a) Enlisted selects entering IPAP will have a promotion status similar to Officer Training School (OTS).

b) Enlisted selects in the grade of Senior Airmen (SrA/E-4) and below who have obtained the required service retainability will be promoted to Staff Sergeant (SSgt/E-5) not earlier than the eleventh (11) day prior to the IPAP report date

c) Enlisted selects in the grade of Staff Sergeant (SSgt/E-5) or higher will maintain their current pay grade during the training program.

d) Enlisted selects with a Promotion Sequence Number (PSN) will promote (pin-on) when incremented regardless of whether it occurs before or after the member enters a commissioning program IAW AFI 36-2502, *Enlisted Airman Promotion/Demotion Programs*, para 4.1.

e) Enlisted selects entering a commissioning program on or before the Promotion Eligibility Cut-Off Date (PECD) are ineligible for promotion consideration for that cycle and subsequent cycles throughout the training program IAW AFI 36-2502, *Enlisted Airman Promotion/Demotion Programs*, para 4.1.

F. OFFICER and ACADEMY/ROTC CADETS:

i. HQ AFPC/DP2NW will coordinate with the member's respective Officer Assignment Team (OAT) to confirm a career field release for advanced education.

ii. Academy/ROTC Cadets must have their Detachment Commander contact AFPC/DP2LT (Officer Accession Branch) for release confirmation. Academy Cadets must also coordinate approval from the Health Professions Advisory Committee (HPAC) to compete for the MPAS degree through IPAP.

iii. Officer/Cadet selects will be assigned to the earliest August class start date. Funding sources require officers/cadets to begin advanced educational programs within the same fiscal year as selected. (March 2018 selection requires a FY18 start date.)

iv. Officer selects entering IPAP will maintain their current grade, will be eligible for promotion consideration, and will promote (pin-on) when incremented while attending IPAP. Academy/ROTC Cadet selects are promoted to Second Lieutenant (2Lt) at the culmination of their cadet programs and prior to beginning IPAP.

10. UNMC IPAP CENTRALIZED APPLICATION SERVICE (UNICAS):

A. On-line registration is MANDATORY for all applicants at https://ipap.liaisoncas.com

i. UNICAS does NOT require .mil domain access.

ii. Applicants must complete all questionnaires within UNICAS.

iii. **Redact all but the last 4 of the SSAN before uploading document into UNICAS.**

iv. HQ AFPC/DP2NW and UNMC will have simultaneous visibility of submissions and uploads throughout the application process.

B. A registered UNICAS ID is required for transcript requests. After identifying the college/university within UNICAS, select the 'Download Transcript Matching Form' link next to the institution's name for the IPAP Transcript Processing Center address.

Send transcripts to:	FedEx Address:
IPAP Transcript Processing Center	**IPAP Transcript Processing Center**
P.O. Box 9140	**311 Arsenal Street, Suite #15**
Watertown, MA 02471	**Watertown, MA 02472**

11. POINTS of CONTACT:

Please review the Frequently Asked Questions (FAQs) section on the AF Medical Services Knowledge Exchange Website https://kx2.afms.mil/kj/kx3/afbsceducation for common inquiries. The Knowledge Exchange is a .mil domain access website. Cadets or remote site applicants may request this information directly from HQ AFPC/DP2NW.

A. Inquires PRIOR to application submission will go to the IPAP Administrative Support Team:

Interservice PA Program
Graduate School, Academy of Health Sciences
3599 Scott Road, Bldg 2841
JBSA Fort Sam Houston, TX 78234-6130
DSN: 471-7796
COM: (210) 221-7796
Email: usaf.jbsa.59-trg.list.59-trg-academic-support@mail.mil

B. Inquires AFTER beginning application submission will go to HQ AFPC/DP2NW:

HQ AFPC/DP2NW
550 C STREET WEST
JBSA-RANDOLPH TX 78150-4729
DSN: 665-2775
COM: (210) 565-2775
Email: AFPC.DP2NW.WORKFLOW@US.AF.MIL

Application requirements are subject to change. Always check the current requirements on the Knowledge Exchange (KX), BSC Education page: https://kx2.afms.mil/kj/kx3/AFBSCEducation/Pages/home.aspx

Interviewing and Endorsing Applicants

The applicant's interview/shadowing time with you is to determine the applicant's motivation for applying, their understanding of the career and likelihood of success in the program, based on personality, academics and service record (military and community). Here are some guidelines.

1. Never give your letter to the applicant. You have no obligation to show it to the applicant or even tell them what you said. As stated in the above guidance, you will upload your letter directly into the UNICAS system. This gives you the freedom to be honest in your assessment.
2. Be honest and say it plainly. Don't depend on the board to recognize that you didn't write as strongly as you're capable of. If indicated, say things like:
    a. Should get more experience and reapply next year
    b. Doesn't understand what a PA really does
    c. Thier first goal is to get commissioned
    d. They really want to go to medical school but…
    e. They're a wonderful person but probably will have trouble academically
3. Use your unit letterhead. Use a two-line signature block
4. If you're writing more than one letter, stratify (e.g. "My #1 of 3"). To stratify, you need to have done all your interviews before you write the letters.
5. The person should have a good idea of what they're really applying for (the pressure, the difficult patients, etc). The ideal candidate will do significant shadowing.
6. You need to see their whole application before you interview them and write the letter. This is a good time to tell them what areas they can strengthen or change.
7. If they'll let you, critique their letter. If they have difficulty accepting constructive criticism they will have trouble as a PA. The letter should answer both "Why I want to be a PA" and "What I have demonstrated that shows the AF I would be a good choice".
8. The most important parts of the application (and close to this order) are
    a. Applicant's letter
    b. GPA
    c. Interviewing PA's letter (yours)
    d. EPRs
9. How credibly a recommender knows the applicant and the PA career field is much more important than the rank or title of the writer. That said, Lieutenants should not write the letters if a more senior PA is available.
10. **If you cannot recommend someone DO NOT turf the job off onto someone else who is more likely to write a recommendation. Say "do not recommend selection at this board". You are the first gatekeeper of the profession.**
11. Be honest. Recommend enthusiastically when warranted. Recommend with reservations noted if needed, and be willing to actively withhold your endorsement whenever it's the right thing to do—for the mismotivated, the self-serving and the unqualified.

FOR QUESTIONS, CALL THE AFPC IPAP POC:

Ms. Michelle Cardassi **HQ AFPC/DP2NW** **550 C Street West, Suite 27** **Randolph AFB, TX 78150-4729**	**DSN 665-2775 COM (210) 565-2775** **E-MAIL: michelle.cardassi.2@us.af.mil**

BANDING and TEMPO

In summer 2008, the CSAF directed that all Air Force directorates begin a change to the "AEF Deployment Construct", designed to better define, posture, employ and sustain Air Force capabilities. This Air and Space Expeditionary Force (AEF) construct included posturing capabilities/UTCs in tempo bands that reflect both the Combatant Commander (CCDR) requirements and the availability of corresponding resources in our forces. Within the medical community, "low supply/high demand AFSCs (such as 42G Physician Assistant) were placed in tempo bands to more effectively source the capability from across the entire AFMS. In short, the higher the demand and the less available the resource, the lower the tempo band will be and the greater the risk to our ability to support additional contingency operations. Using the following deploy-to-dwell ratios (i.e. the ratio of time deployed versus the time in a "dwell" state at home), AFMS planners, Consultants and Career Field Managers aligned medical capabilities according to our ability to fill requirements and sustain forces.

a. Tempo Band A: Deploy-to-dwell ratio 1:4; standard 120 day AEF structure
b. Tempo Band B: Deploy-to-dwell ratio 1:4; 179 day Tour Length; low risk
c. Tempo Band C: Deploy-to-dwell ratio 1:3; 179 day Tour Length; moderate risk
d. Tempo Band D: Deploy-to-dwell ratio 1:2; 179 day Tour Length; significant risk
e. Tempo Band E: Deploy-to-dwell ratio 1:1; 179 day Tour Length; high risk

It's critical to note that a 1:2 deploy-to-dwell ratio does not always mean a single individual will automatically deploy every third rotation. SG Consultants are able to manage individual deployments to maximize operational participation across the AFMS, limiting repeat deployments to the greatest extent possible.

Advantages of Banding:

- Although single deployments may be longer, the number of times an individual will deploy during an assignment should be fewer, resulting in less time away from home
- Enhances the predictability for our personnel and maintains team integrity
- Early engagement of Consultants ensures the right people are deployed at the right time—a critical factor when assigning taskings to one Service over another

What PAs Need to Know:

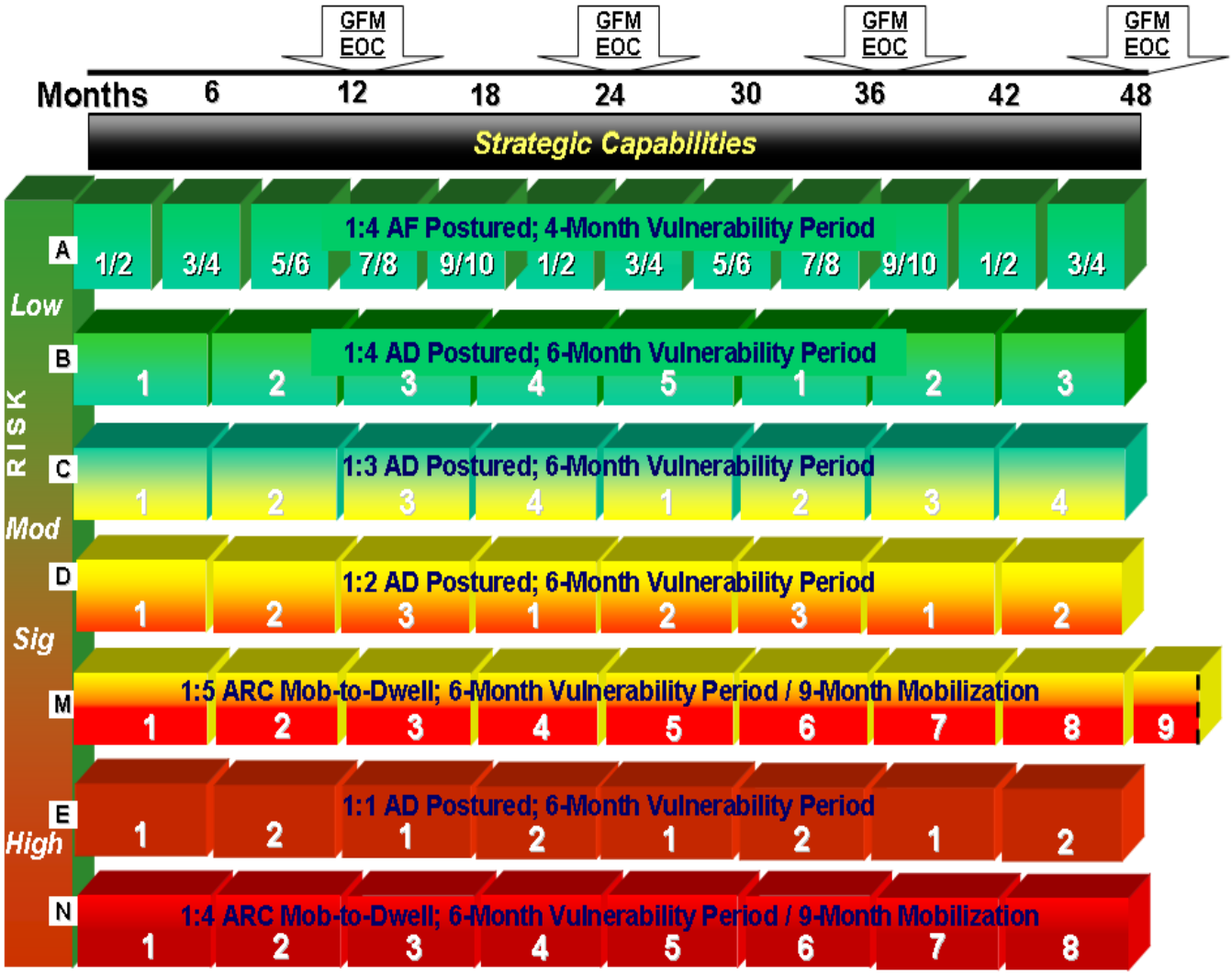
Tempo band calculations are periodically recalculated for all AFMS Unit Type Codes (UTCs) as any of the five AEF blocks may become unbalanced over time for several reasons: PCS, retirements/separations, new graduates and other taskings. Therefore you, as a PA, need to:

- Ensure your DAFSC/shred/AEFI (block) are correct in the three tracking systems:
  Virtual Military Personnel Flight (VMPF) - can check via "AFPC Secure"
  Military Personnel Data System (MILPDS) - controlled by your Command Support Staff
  MRDSS (controlled by your readiness office)
- Create an AEF Online account with your CAC using the following link: https://aef.afpc.randolph.af.mil/. The website provides a single access point for all AEF-related issues to include reporting instructions, tempo banding, training requirements, functional area posturing and sequencing guidance

Accurate and even distribution of PAs across the bands is extremely important since specialty PAs are deployed separately from Family Medicine PAs. This is to ensure there are enough specialty PAs to cover all the specialty UTCs (and not use them in their 2AFSC of Family Medicine until all specialty obligations are filled).

To volunteer outside of your block, you need to fill out the correct form letter from your Readiness Office and have your Command's approval.

AEF SCHEDULE



AFI 10-401, *Air Force Operations Planning and Execution*, dated 7 Dec 06, Figure 2.2, outlines the AEF schedule which operates on a 24-month life cycle, divided into five Active Duty (AD) tempo bands (A through E). This AEF cycle includes periods of normal training, preparation, and deployment vulnerability.

Under normal AEF rules certain members of low supply/high demand UTCs (usually those members at larger facilities) are at increased risk of deploying disproportionately more often than other AFMS specialties. The Consultant Balanced Deployment (CBD) concept incorporates recommendations from the Chief Consultant for an affected AFSC in an attempt to best manage the deployment load in that specialty.

CBD ensures AEF deployment requirements are met using the most qualified individuals from across the AFMS. This approach limits disruptions to home station health care and maximizes individual career development and growth. Critical AFMS UTCs and their correlating AFSCs will be managed according to the following CBD principles.

How it works:

- Consultants and Career Field Managers of primary AFSCs associated with identified low supply/high demand UTCs will review personnel UTC assignments
- Based on that review they will recommend reassignment of personnel within the constraints of the AEF construct
- Must maximize the use of personnel from the same facility to fill UTCs and provide team integrity
- When necessary they can recommend individuals from other MAJCOMs to complete the UTC for an AEF rotation
- After AFMS and MAJCOM coordination the recommendations are sent to AFPC prior to sourcing

PHYSICIAN ASSISTANT (42G3) UTCs

A UTC is a potential capability for accomplishing a specific mission that the military service provides. A list of the 42G UTCs in MRDSS is provided below for your information:

42G UTCs

UTC	REQUIREMENT	MISCAPS (Mission Capabilities
81STG SPECIAL TACTICS GROUP HQ	**42G3**	DEPLOYABLE TO BB WITH BOS PROVIDED. PROVIDES COMMAND OPERATIONS MANAGEMENT, ST INTEL SUPPORT, ST MEDICAL M PLANNING & FORCE MGMNT OF DEPLOYED SPECIAL TACTICS FOR DEPLOYED WHEN TWO OR MORE SPECIAL TACTICS UNITS ARE DE THEATER & WILL BE RESPONSIBLE TO THE JSOAC/CJSOAC FOR AL TO SPECIAL TACTICS OPERATIONS. CAPABLE OF 24 HOUR OPERAT DAYS WITHOUT RESUPPLY. REQUIRES UTC: AVIATION RESOURCE XFPRM. WHEN LOGISTICS PLANS (2G071) SUPPORT IS REQUIRED XFHB7. WHEN KNOWLEDGE OPS SUPPORT IS REQUIRED (3D0X1) 3D1X1 CAN BE SUBSTITUTED WITH AFSC 3D0X1. AFSC'S 013C AN INTERCHANGEABLE. AFSC'S 1N0X1 & 014N3B CAN BE SUBSTITUE REQUIREMENTS DICTATE. AFSC 042G3 CAN BE SUBSTITUTED WIT AFSC'S 1C2X1 & X1T2X1 ARE INTERCHANGEABLE TO MEET MISSI AFSC 1C2X1 CAN BE SUBSTITUTED WITH 1C4X1 AND AFSC 1T2X1 SUBSTITUTED WITH 1T0X1 AS MISSION REQUIREMENTS DICTATE DSN 579-7810. REVIEWED FEB 14.
FFDCL DEPLOYED CLINIC AUGMENTATION TEAM	**42G3**	PROVIDES ADDITIONAL MEDICAL PERSONNEL FOR ENDURING OP ESTABLISHED DEPLOYED STAND-ALONE OUTPATIENT CLINIC.CAN OR EQUIVALENT DEPLOYED MTF. PROVIDES CARE FOR PATIENTS URGENT MEDICAL CONDITIONS. AUGMENTS UTC FFPCM (MED P WHEN ENHANCED OUTPATIENT CLINIC CAPABILITY IS REQUIRED. CAPABILITY REQUIRES DEPLOYMENT WITH UTC FFLGE (AIR TRAN CAPABILITY INCLUDES INITIAL TRAUMA RESPONSE AND STABILIZ TRAUMA PATIENTS CAN BE HELD FOR UP TO 12 HRS. NON-TRAU HELD FOR UP TO 48 HRS. ASSUMESHOSPITAL OR AE IS READILY A FOR AFSC 042G3 IS 046Y3H. OTHER AFSC SUBS AUTH IAW WMP- SUPPLEMENT. SKILL LEVEL SUBS AUTH IAW AFI 10-403. DEPLOYS REQUIRED. MAJCOM POC: ACC/SGXM, DSN: 575-0785. REVIEWE

FFEDP EMER MED PA AUGMENTATION	**42G3E** Emergency Medicine PA	PROVIDES EMERGENCY MEDICINE PHYSICIAN ASST AND MEDICAL AUGMENT EMERGENCY MEDICINE CAPABILITY FOR ENDURINGOF ESTABLISHED AFTH OR EQUIVALENT DEPLOYED MTF. PROVIDES RESUSCITATIVE AND EMERGENCY MEDICAL SUPPORT, TRAUMA S ADVANCED TRAUMA LIFE SUPPORT. SHOULD DEPLOY WITH FFED MEDICINE TM). 042G3E MUST HAVE 12 MONTHS EMER MED EXP EMERGENCYMEDICINE FELLOWSHIP TRAINING. 4N051 SHOULD H EMERMED EXPERIENCE (12 MTHS IN THE LAST 36 MTHS). AFSC SU AUTHORIZED. SKILL LEVEL SUBSTITUTIONS AUTHORIZED IAW AFI TO MOB. ECS/BOS REQUIRED. PILOT UNIT/MAJCOM OPR: HQ A AFB VA (JBLE) DSN 575-0783. REVIEWED MAR 15.
FFEP4 EMEDS AFTH 25 BED PERSONNEL AUGMENTATION	42G3 PAs and P-APNs are **authorized substitutes** for 44F3 (Family Practice Physician)	PROVIDES SUPPORT PERSONNEL TO ESTABLISH 24-HR SICK CALL A MEDICAL CARE FOR DEPLOYED AEROSPACE EXPEDITIONARY FORC AUGMENTS EXPEDITIONARY MED SUPPORT (EMEDS) HRT AND +1 DEPLOYS IN CONJUNCTION WITH UTC FFEE2/3/4/5/6, FFEP2/3/4/ 2, FFPCM OR FFDAB, FFP01/E, FFHR1, FFPM1/2/3/4/5 TO COMPR OF EMEDS. 25-BED EMEDS PROVIDES ACLS/ATLS EMER SVCS, LIM IN/OUTPATIENT CAPABILITY, LAB, PHARMACY, X-RAY, DENTAL SV THERAPY, PLANNING ADMIN, AND LOGISTIC SUPPORT TO 5,000-6 7 DAYS W/O RESUPPLY IN LOW CBRN THREAT. EMEDS+25 PROVI INFRASTRUCTURE FOR LATER ADDITION OF SPECIALTY UTC'S, AN AND MED LOG/EQUIP MAINT. AFSC 046A3 MUST BE 05 OR HIGH ADMINISTRATOR SHOULD COMPLETE PATIENT SAFETY MANAGER DEPLOYERS IAWGUIDANCE IN THE AF DEPLOYED PATIENT SAFETY PRIOR TO DEPLOYMENT. AT LEAST ONE 046N AFSC MUST BE 04 O 042G3 OR 044F3 MAY SUBSTITUTE FOR 046Y3H. ALL OTHER AFSC IAW WMP 1, AFMS SUPPLEMENT. SKILL-LEVEL SUBS AUTHORIZED DEPLOYS TO MOB, AOB, FOB, AND BB. ECS/BOS REQUIRED. PILOT LANGLEY-EUSTIS VA. MAJCOM POC: ACC/SGX, DSN: 575-0783. RE
FFGK1 ANG MEDICAL SPT PERSONNEL 750	**PRIMARY** (***ANG only***) 42G3	PROVIDES MEDICAL SUPPORT OF THE OPERATIONAL MISSION AT GUARD (ANG) INSTALLATIONS, WORKLOAD FACTOR OF LESS THA SUPPORT INCLUDES PREVENTIVE HEALTH ASSESSMENTS, LIMITED MEDICINE, DEPLOYMENT PROCESSING, IMMUNIZATIONS, DENTA HAS THE CAPABILITY TO GENERATE IN-PLACE WITH LIMITED SUPP PARENT ORGANIZATION. WHEN USED IN CONJUNCTION WITH TH MEDICAL ELEMENT (SME), CAN PROVIDE BASIC SUPPORT TO IN-P MISSION. SUBSTITUTES AUTHORIZED AS DIRECTED BY NGB/SG.B SOURCE: ANG. PILOT UNIT: HQ ANG/SGASX, DSN 612-8515. MRA ACC/SGX, DSN 575-0783. REVIEWED JAN 16.

FFGLB PATIENT DECON TEAM--PDT	**42G3** (42G3 is Team Chief)	PROVIDES SUPPORT PERSONNEL TO REMOVE OR NEUTRA EXTENT POSSIBLE, CBRN AGENTS ON WARTIME CASUALTI ADMITTED TO AN MTF. PROVIDES LIFE-SUSTAINING INTEF DURING AND AFTER THE DECONTAMINATION (DECON) PF EQUIPMENT IS IN UTC FFGLC. TWO TEAMS (FFGLB) & ONE (FFGLC) SHOULD BE PROVIDED FOR EACH MTF WHERE A C EXISTS. USED IN SUPPORT OF EMEDS/AFTHS IN A CBRN TH ENVIRONMENT. ALL POSITIONS MAY BE SUBSTITUTED WI EXCEPT 4N071 AND 042G3 (WHERE AVAILABLE). THE 042C SUBSTITUTED WITH 046Y3H OR 4N071. THE 042G3 (OR SU TEAM CHIEF. AFSC 4N0X1 POSITIONS REQUIRE NATIONAL CERTIFICATION. TEAM CHIEF MUST ENSURE PERSONNEL A UTC ARE OF SUFFICIENT STATUREAND PHYSICAL CONDITI FREQUENT LITTER CARRIES AND STRENUOUS MANUAL LA ENSEMBLE. DEPLOYS TO AOB, MOB, FOB, AND BB. ECS/BC MAJCOM POC: ACC/SGX, DSN: 575-0785. REVIEWED JUL 1
FFPPS **ERPSS PROVIDER**	42G3	PROVIDES CLINICAL PROVIDERS, ADDITIONAL NURSING ST LOGISTICS SUPPORT TO ENHANCE THE CLINICAL CAPABILI PATIENT(PT)STAGING UTC. SERVES AS A CLINICAL PROVID CAPABILITY BETWEEN FORWARD MEDICAL CARE AND THE INITAL CONTINGENCY OPERATIONS, INITAL STATESOF MA AND HUMANITARIAN ASSISTANCE/DISASTER RESPONSE, I DEFENSE SUPPORT TO CIVIL AUTHORITIES EVENTS. THE AI UTC ENHANCES THE INITAL STAGING CAPABILITY WITH TH EXTRA CLINICAL AND LOGISTICS STAFF INCREASING ONLY CAPABILITY OF THIS INITIALRESPONSE UTC. NO ADDITION GAINED WITH THESEADDITIONAL PERSONNEL ONLY THE C THE STAGE BY BEING ABLE TO ADJUST/PRESCRIBE MEDICA NECESSARY BY THE PROVIDER STAFF THIS UTC PROVIDES MAY DEPLOY WITH OR AS A FOLLOW ON TO FFEPS. NO AD EQUIPMENT IS REQUIRED IF DEPLOYED WITH UTC FFEPS A EQUIP PKG (FFPS1). COULD DEPLOY INDEPENDENTLY TO S EMEDS/HRT WHERE PT STAGING IS DELIBERATELY PLANN SUBSTITUTION FOR THE 048R3 IS AN 048A3 OR 048G3. SU THE 042G3 IS A 046Y3H. OTHER SUBSTITUTIONS ARE AUT 10-403 AND WMP-1 AFMS SUPPLEMENT. ECS REQUIRED. AOB, BB, FOB OR MOB. SOURCE: AD, AFRC AND ANG. PIL TRAVIS AFB. OPR: HQ AMC/SGXM, DSN 779-6952.REVIEW
FFQE8 SOF MED ELEMENT AUGMENTATION	42G3	PROVIDES PERSONNEL FOR PREVENTIVE MEDICAL SERVIC LOGISTICS, AND LIMITED CASUALTY DECONTAMINATION SPECIAL OPERATIONS ELEMENTS (UTC'S FFQEK OR FFQER EXTENDER SUPPORT FOR CLINICAL MEDICINE ACTIVITIES. CAPABILITY TO PERFORM FOOD AND WATER SAFETY, FIEL HYGIENE/SANITATION, LIMITED NBC DETECTION AND OCCUPATIONAL/ENVIRONMENTAL HEALTH SITE ASSESSM WITH UTC FFQEA, SOF AUGUMENTATION EQUIPMENT. TH SUBSTITUTIONS ARE AUTHORIZED: AFSC 041A3 WITH 4A0 4N051, AFSC 042G3 WITH 048G3, 044F3, 4N071C, AFSC 4 AND AFSC 4E071 WITH 043H3. OTHERWISE ENLISTED PER SKILL UP OR 2 DOWN AND OFFICERS MAY SUB 1 GRADE U REQUIRED. CAPABLE OF OPERATING FROM: MB, LB, SB, B DSN 579-1594. PILOT UNIT: 1 SOSS/OSM. REVIEWEDJAN 1

FFSOR ORTHOPAEDICS AUGMENTATION TEAM	42G3A Orthopedic Physician Assistant	PROVIDES ORTHOPAEDIC MEDICINE PERSONNEL TO SU OPERATIONS AT AN AFTH OR EQUIVALENT DEPLOYED M ON MTF FOR SURGICAL, ANESTHESIA, NURSING, AND A SUPPORTAND IS NOT A STAND-ALONE CAPABILITY. UTC ALTERNATIVELY BE UTILIZED TO PROVIDE PRIMARY MU CARE AND GENERAL SURGERY SUPPORT IN AN EXPEDIT WITH A LOW VOLUME OF ACUTE SURGICAL CARE. AFSC AUTHORIZEDIAW WMP-1, AFMS SUPPLEMENT. SKILL LE SUBSTITUTIONS AUTHORIZED IAW AFI 10-403. DEPLOYS REQUIRED. MAJCOM POC: ACC/SGX, DSN: 575-0783. RE
FFSPH SURGICAL ASST AUGMENTATION	42G3C General Surgery Physician Assistant	PROVIDES GENERAL SURGERY PHYSICIAN ASSISTANT TO GENERAL SURGICAL CAPABILITY DURING OPERATIONS A EQUIVALENT DEPLOYED MTF. MAY BE ALTERNATIVELY PROVIDE GENERAL SURGERY SUPPORT IN AN EXPEDITIO WITHA LOW VOLUME OF ACUTE SURGICAL CARE. MUST GENERAL SURGERY CAPABILITY IS ALREADY ESTABLISHE DEPLOYFIRST TO FORM AFTH/EQUIVALENT. DEPENDEN MEDICAL-SURGICAL NURSING AND ANCILLARY CARE SU A STAND-ALONE CAPABILITY. AFSC SUBSTITUTIONS AUT WMP-1, AFMS SUPPLEMENT. SKILL LEVEL SUBSTITUTIO IAWAFI 10-403. DEPLOYS TO MOB. ECS/BOS REQUIRED ACC/SGX, DSN: 575-0783. REVIEWED MAR 17.

QFFAD AIRBORNE FORCE PROTECTION HQ ADVON	J42G3	UTC PROVIDES AN AIRBORNE QUALIFIED SQ HQS FORC ASSESSMENT/ADVON TEAM. DEPLOYS AS AN ADVANCE QFFPG AND IS DESIGNED TO BE INTEGRATED WITH 9AA 4F9R6, 4F9R7, 4F9R8, 4F9R9, 7E1AM. PERFORMS LIAIS AIRFIELD SEIZURE IN ORDER TO PROVIDE SEAMLESS IN- SEIZURE FORCE. MANAGES EMPLOYMENT OF FOLLOW PROTECTION FORCES WHILE PROVIDING LIMITED ENGI COMMUNICATIONS, AND MEDICAL CAPABILITIES. RESP ACCORDING TO DOC STATEMENT. DEPLOYS TO ALL TYI SUFFICIENT FOR 5 DAYS. MAY REQUIRE QFAAG TO EXP COUNTERINTELLIGENCE CAPABILITY. BASED ON THE M SUBSTITUTIONS ON ARE AUTHORIZED FROM THE AFSC' SKILL-LEVELS THAT ARE CONTAINED WITHIN THE QFFPC AFSFC/SFOC DSN: 945-5121. REVIEWED MAY 14.

QFFSQ INTEGRATED BASE DEFENSE SQ	42G3	PROVIDES PERSONNEL AND INDIVIDUAL EQUIPMENT F DEFENSE SECURITY FORCES SQUADRON RAPIDLY DEPL VARIOUS MISSIONS THROUGHOUT THE SPECTRUM OF ENSURES ASSIGNED LOCATION RESOURCES AND PERSO AFFORDED A SECURE ENVIRONMENT TO OPERATE. TH MULTI-FUNCTIONAL CONTAINING SECURITY FORCES, IN COUNTER INTELLIGENCE, CBRNE/EMERGENCY MANAGI ENGINEERING ASSISTANCE, COMMUNICAITONS, MEDIC ADMINISTRATION PERSONNEL TO OPERATE WITH LIMI FROM OTHER AEF FORCES. THE SQUADRON IS CAPABL AN ADVANCE ECHELON TO PERFORM AIRBORNE INSER OPS AND AIRFIELD SECURITYASSESSMENT. PROVIDES E EXTERNAL MOUNTED AND DISMOUNTED PATROLLING AREA, COUNTER INTELLIGENCE, PATROL/EXPLOSIVE DE & COMMAND & CONTROL OF THE DEFENSE FORCE FOR OR SEVERAL SMALL SITES. ELEMENTS OF THIS UTC MA & AIR ASSAULT CAPABILITIES. INCLUDES INDIVIDUAL W PRECISION ENGAGEMENT CAPABLILITY, NIGHT OBSERV AND LIMITEDLIFE SUPPORT FOR AUSTERE LOCATION FO CAN ESTABLISH BASE DEFENSE/FORCE PROTECTION AT RESPONSE TIME ACCORDING TO DOC STATEMENT. CA INTEGRATED DEFENSE FORCES. MAY BE DEPLOYED WI SF UTCS. COMMUNICATIONS SUPPORT FOR THIS UTC I UTCS QFL2J AND QFL2K. OPR: HQ AFSFC/SFOC DSN: 94 MAR 16.

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COMPREHENSIVE MEDICAL READINESS PROGRAM (formerly READINESS SKILLS VERIFICATION)

The Comprehensive Medical Readiness Program (CMRP) is a continuous learning program designed to ensure you are familiar with the concepts and skills you will need for deployment. Training is documented by your MTF's AFSC Functional Training Manager in the Medical Readiness Decision Support System (MRDSS). For some clinical personnel, daily practice in a peacetime environment provides all the clinical training and expertise required for success in the deployed environment. For others, daily practice does not mirror the trauma skills needed to care for combat casualties. Reserve Component clinicians may be given credit for equivalent training based on their civilian employment experience and when appropriate documentation is provided. If your daily practice provides you ample experience to maintain a particular CMRP skill, you are not required to do additional or redundant training. In those situations, your MTF's AFSC Functional Manager can update your training in MRDSS based on the ongoing clinical experience. The program is governed by AFI 41-106.

Personnel assigned to a standard UTC must complete the CMRP training for their Duty AFSC (DAFSC), usually 42G. In addition, personnel who are used as authorized substitutes on a standard UTC must complete CMRP training for the AFSC for which they are substituting, as well as their own AFSC. ***EXCEPTION:*** For the Patient Decontamination Team, UTC FFGLB, authorized substitutes will complete CMRP training for their own AFSC, not the AFSC they are substituting for.

The listed training sources (unless mandated by AFI 44-102, e.g. ACLS) are only SUGGESTED. If you find an equivalent or better source and get it signed off IAW AFI 41-106 you have met the requirement. The point is not to fill a square but to really have the skills you are likely to need for your next deployment.

The Physician Assistant (42G) CMRP training list can be found on the AFMS KX at:

https://kx2.afms.mil/kj/kx6/PhysicianAssistant/Documents/Readiness%20and%20Training/Physician%20Assistant_CMRP_Checklist_42G%20PA.pdf

The Physician Assistant (42G) CMRP skills checklist was created by the PA Consultant to the Air Force Surgeon General after gathering information from previous deployers and coordination with experts in each functional area. The checklist is reviewed on a periodic basis for appropriateness and currency. These skills checklists were coordinated with and have Air Force Reserve Command and Air National Guard approval. If you have suggestions for changes, contact the PA Consultant.

COMPREHENSIVE MEDICAL READINESS PROGRAM
Physician Assistant - 42GX Checklist (Inc 42GXA/42GXB/42GXC/42GXE)

Category-1 Clinical Currency for Readiness –Fundamental training and skills of an Airman, usually obtained through medical education and in-garrison care, that form a foundation on which to build readiness skills.	**Knowledge/ Performance**	**Frequency**	**Training Sources**	**Trainer Initials**	**Member Initials**	**Date**
1. Advanced Cardiac Life Support (ACLS): Successful completion of an ACLS course. (42G – ALL)	Performance	Q24M	Advanced Cardiac Life Support (ACLS) course completion/references			
2. Urgent Clinical Care: Knowledge of latest developments in the treatment of disease processes of the AD deployed population, specifically as they pertain to the skill set of Physician Assistants. Encouraged for ANG/AFR, however may defer based on funding considerations. (42G – ALL)	Knowledge	Q36M	Physician Assistant Refresher Course attendance			

3. Treats Combat Stress: Performs an initial evaluation of individual who is suffering combat stress to determine if the patient needs referral to Mental Health. Treats those that can be returned to duty without Mental Health evaluation. (42G, 42GXE) (Exception: 42GXA, 42GXB, 42GXC)	Knowledge	Q24M	1) Local brief from Mental Health personnel 2) RSV PTSD Training Powerpoint presentation TBD 3) Review SWANK course 63912 and 66512 or brief from local Mental Health 4) PARC Lecture			
4. Uncommon Disease / Illness: Reviews disease/illnesses uncommon in US practice that may be seen commonly in the deployed environment, to include infectious diarrhea, tuberculosis, malaria, parasitic diseases. This requirement is to be focused on the projected AOR for the member's UTC. (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Knowledge	Q24M	Any of following fulfill requirement: 1) MTF: UTC team training, MURT, Public Health in-services 2) USAMRIID training programs 3) USAFSAM Global Medicine Course 4) Travel Notices and Disease Directory at HYPERLINK "http://www.cdc.gov" www.cdc.gov 5) USAFSAM Aerospace Medicine Primary Course (AMP201) 6) PARC Lecture Travel Prep			
5. Immunizations: One-time training: Familiarity with immunization indications and techniques including smallpox and anthrax programs. (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Knowledge	Once	1) Military Public Health Instruction 2) Immunization Clinic Rotation (1 shift)			
6. Case Log: Surgeons must maintain log of cases by CPT code. Recommended American Board of Surgery Maintenance of Certification is American College of Surgeons website: or equivalent. Surgical OR Software (S3), if available at surgeon's MTF may be used as a backup - TAA cases will still need to be compiled by surgeon. (42GXC – ONLY)	Performance	Q24M	ACS Website: https://www.facs.org/membership/pbls.html			

COMPREHENSIVE MEDICAL READINESS PROGRAM
Physician Assistant - 42GX Checklist (Inc 42GXA/42GXB/42GXC/42GXE)

Category-2 AFSC Skills for Readiness – Skills specific to an AFSC which allow an Airman to perform within the full scope of their AFSC in a deployed environment.	**Knowledge/ Performance**	**Frequency**	**Training Sources**	**Trainer Initials**	**Member Initials**	**Date**
1. Pediatric Advanced Life Support (PALS): Successful completion of a PALS course. (42G – ALL)	Performance	Q24M	Pediatric Advanced Life Support (PALS) course/references			
2. Trauma Life Support: Successful completion of a provider-level trauma care course with concentration on pre-hospital and small-facility emergent stabilization skills. (42G – ALL)	Performance	Q48M	Any support Performance: 1) ED privileges/experience validated by supervisor 2) Emergency Procedures (at military Clinical Investigation Facility course only) 3) PHTLS, TCCC 4) C-STARS			
3. Initial Management of Acute Trauma: Minor surgical techniques, wound closure, injury stabilization including simple reduction, splinting and casting. (42G – ALL)	Performance	Q48M	Any support Performance: 1) Everyday work experience validated by supervisor 2) 1-2 week ER rotation 3) AAFP/USAFP Sports Medicine Symposium 4) Wilderness Medicine Symposium 5) Procedure-based workshops at CME conferences 6) PARC - Battlefield Skills Lab			
4. Dentistry: Performs limited urgent dental care in an austere environment (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Performance	Q48M	Any support Performance: 1) Local dental clinic rotation/in-service. 2) IDMT Medical and Dental Treatment Protocols: HYPERLINK "https://kx2.afms.mil/kj/kx2/IDMTConsultant/Documents/IDMT%20Toolbox/Fixed%20I DMT%20Protocols.pdf" https://kx2.afms.mil/kj/kx2/IDMTConsultant/Documents/IDMT%20Toolbox/Fixed%20I DMT%20Protocols.pdf 3) Book: "Where There is No Dentist" by Murray Dickson			
5. Evaluate and Treat Traumatic Brain Injury (TBI): Performs screening, initial evaluation and treatment of patients with all range of TBI, utilizing current CPGs and/or theater protocols. Determine need for referral of more seriously injured patients. (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Knowledge	Q24M	Any support Performance: 1) Local brief from Mental Health personnel 2) Review Mild TBI and Mod to Severe TBI on CEMM: HYPERLINK "http://www.traumaticbraininjuryatoz.org/Mild-TBI/Mild-TBI-Concussion-Overview" http://www.traumaticbraininjuryatoz.org/Mild-TBI/Mild-TBI-Concussion-Overview and HYPERLINK "http://www.traumaticbraininjuryatoz.org/Moderate-to-Severe-TBI/Moderate-to-Severe-TBI-Overview" http://www.traumaticbraininjuryatoz.org/Moderate-to-Severe-TBI/Moderate-to-Severe-			
6. Advanced Trauma Life Support (ATLS): Successful completion of an ATLS course. (42GXA, 42GXC, 42GXE)	Performance	Q48M	Advanced Trauma Life Support (ATLS) course/references			

7. Dentistry: Performs limited urgent dental care in an austere environment (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Performance	Q48M	Any support Performance: 1) Local dental clinic rotation/in-service. 2) IDMT Medical and Dental Treatment Protocols: HYPERLINK "https://kx2.afms.mil/kj/kx2/IDMTConsultant/Documents/IDMT%20Toolbox/Fixed%20IDMT%20Protocols.pdf" https://kx2.afms.mil/kj/kx2/IDMTConsultant/Documents/IDMT%20Toolbox/Fixed%20IDMT%20Protocols.pdf 3) Book: "Where There is No Dentist" by Murray Dickson 4) Highly recommend refresher rotation in 4-6 month deployment preparation phase.			
8. Humanitarian Assistance and Disaster Relief: Prepare providers to provide medical care to civilian populations of all ages in humanitarian assistance and disaster relief settings. Include review of emergent deliveries. (42G, 42GXE) (Exception: 42GXA, 42GXB, 42GXC)	Knowledge	Q60M	1) DMRTI's Military Medical Humanitarian (MMHAC) Course 2) Pediatric/Women's Health rotations before deployment 3) NRP course 4) NALS course			
9. Patient Movement in Theatre: Knowledge about how to prepare, enter and move patients in an aerovac joint operations environment. The clinician should be able to request air evac, complete appropriate paperwork, communicate urgency/ severity of the condition to air evac personnel. joint-operations environment. (42G, 42GXB, 42GXC, 42GXE) (Exception: 42GXA)	Knowledge	Q24M	1) Familiarization with AE concepts and documents; local MTF ProStaff briefings satisfies, 2) Aerospace Medicine Primary Course 3) Aeromedical Evacuation: HYPERLINK "https://kx2.afms.mil/kj/kx6/PhysicianAssistant/Documents/Readiness%20and%20Training/Aeromedical%20Evacuation.docx" https://kx2.afms.mil/kj/kx6/PhysicianAssistant/Documents/Readiness%20and%20Training/Aeromedical%20Evacuation.docx PARC – Patient Movement			
10. EXTERNAL FIXATOR: Apply external fixator to leg/arm/wrist/pelvis (42GXA - ONLY)	Performance	Q36M	DRC: Disaster Response Course (http://www7.aaos.org/education/courses/course_detail.aspx?ProductId=25128) CESC: Combat Extremity Surgical Course (http://www.wheelessonline.com/ortho/12821) EWS or C-STARS: Emergency War Surgery Course (http://www.dmrti.army.mil/courses.html)			
11. AMPUTATION.: Amputation of an extremity (42GXA - ONLY)	Knowledge	Q36M	Reading Requirement from: DRC: Disaster Response Course (http://www7.aaos.org/education/courses/course_detail.aspx?ProductId=25128) CESC: Combat Extremity Surgical Course (http://www.wheelessonline.com/ortho/12821) EWS or C-STARS: Emergency War Surgery Course (http://www.dmrti.army.mil/courses.html)			
12. REPAIR: Tendon/Nerve Repair (42GXA - ONLY)	Knowledge	Q36M	Reading requirement from: DRC, CESC or EWS; or C-STARS			
13. WOUND DEBRIDEMENT: Debridement of soft tissue wounds and open fractures (42GXA - ONLY)	Knowledge	Q36M	Reading requirement from: DRC, CESC or EWS; or C-STARS			

14. COMPARTMENT PRESSURES: Measures compartment pressures to determine if fasciotomy is indicated (42GXA - ONLY)	Knowledge	Q36M	Reading requirement from: DRC, CESC or EWS; or C-STARS			
15. FASCIOTOMY.: Fasciotomy of leg/arm (42GXA - ONLY)	Knowledge	Q36M	Reading requirement from: DRC, CESC or EWS; or C-STARS			
16. BLAST INJURIES: Understands basics of blast injuries and wound care (42GXA - ONLY)	Knowledge	Q36M	Reading requirement from: DRC, CESC or EWS; or C-STARS			
17. Trauma Management: Deploying surgeons will participate in an active trauma care program for a minimum average of 20 days/year. These trauma call days are considered duty days and appropriate recovery time should be incorporated into the regular work schedule. (42GXC – ONLY)	Performance	Q24M	C-STARS (for exceptions see AFI 41-106 and AFMC C-STARS Waiver and Exemption Policy)			
18. Certifications: ATLS and EWS (or equivalent): Deploying surgeons must participate in a 3-5 day didactic course in military-specific surgical care no more than 24 months prior to start of deployment (42GXC – ONLY)	Performance	Q24M	Emergency War Surgery Course Army/Navy War Surgery Courses may substitute (e.g. JFCTMC)			
19. CRITICAL CARE MANAGEMENT: Initial management of critically ill patients including management of cardiac and pulmonary disorders and the use of vasoactive medications (42GXE – ONLY)	Performance	Q24M	MTF or alternate (TAA, MOU, VA, moonlighting, C-STARS, STARS-P)			
20. ESTABLISHES ADVANCED VENOUS ACCESS: Establishes advanced venous access through percutaneous insertion of a central line catheter into an internal jugular, femoral or subclavian vein. Establishes intraosseous (IO) infusion through percutaneous insertion of an IO needle into the marrow of the sternum, humerus or proximal tibia based on the specifications of the IO device being used. (42GXE – ONLY)	Performance	Q24M	MTF or alternate (TAA, MOU, VA, moonlighting, C-STARS, STARS-P, or Procedure Lab)			

21 PERFORMS THORACOSTOMY: Using appropriate techniques, positions the patient, injects infiltrative anesthesia, and correctly inserts a needle to thoracostomy tube into the patient's chest cavity. Appropriately secures chest tube, applies occlusive dressing, and attaches the tube to one-way valve or water seal. (42GXE – ONLY)	Performance	Q24M	MTF or alternate (TAA, MOU, VA, moonlighting, C-STARS, STARS-P, or Procedure Lab)			
22. PERFORMS CRICOTHYROIDOTOMY: Obtains as necessary supplies, positions patient, performs surgical airway. (42GXE – ONLY)	Performance	Q24M	MTF or alternate (TAA, MOU, VA, moonlighting, C-STARS, STARS-P, or Procedure Lab)			
Category-3 UTC Training – Training specific to a UTC for which an Airman is assigned			Per AFI 41-106, Chapter 5. Auto-populated in MRDSS upon assignment to a UTC.			

For Comprehensive Medical Readiness Program questions, please contact the Air Force Expeditionary Medical Skills Institute (AFEMSI) office at 937-938-2905/3218 DSN: 798-2905/3218 and/or send correspondence to usafsam.ets.rsvm@us.af.mil. For comments or suggestions to the content of the Comprehensive Medical Readiness Skills list, please contact your Surgeon General Consultant or Career Field Manager (CFM) through your MAJCOM. (Consultant and CFM list can be reached through the AF Clinical Quality Website.

Law of Armed Conflict

A (very) Brief Overview

The Law of Armed Conflict A part of public international law, the Law of Armed Conflict (LOAC) regulates the conduct of armed hostilities. It also aims to protect civilians, prisoners of war, the wounded, sick, and shipwrecked. LOAC applies to international armed conflicts and in the conduct of military operations and related activities in armed conflict.

Principles

Three important LOAC principles govern armed conflict—military necessity, distinction, and proportionality.

Military Necessity. Military necessity requires combat forces to engage in only those acts necessary to accomplish a legitimate military objective. In applying military necessity to targeting, the rule generally means the United States Military may target those facilities, equipment, and forces which, if destroyed, would lead as quickly as possible to the enemy's partial or complete submission.

As an example of compliance with the principle of military necessity during Operation Desert Storm, consider our targeting and destruction of Iraqi SCUD missile batteries and of Iraqi Army and Air forces. These actions quickly achieved air superiority and hastened the Iraqi military's defeat.

Military necessity also applies to weapons review. AFI 51-402, Weapons Review, requires the Air Force to perform a legal review of all weapons and weapons systems intended to meet a military requirement. These reviews ensure the United States complies with its international obligations, especially those relating to the LOAC, and it helps military planners ensure military personnel do not use weapons or weapons systems that violate international law. Illegal arms for combat include poison weapons and expanding hollow point bullets in armed conflict. Even lawful weapons may require some restrictions on their use in particular circumstances to increase compliance with the LOAC.

Distinction. Distinction means discriminating between lawful combatant targets and noncombatant targets such as civilians, civilian property, POWs, and wounded personnel who are out of combat. The central idea of distinction is to only engage valid military targets. An indiscriminate attack is one that strikes military objectives and civilians or civilian objects without distinction. Distinction requires defenders to separate military objects from civilian objects to the maximum extent feasible. Therefore, it would be inappropriate to locate a hospital or POW camp next to an ammunition factory.

Proportionality. Proportionality prohibits the use of any kind or degree of force that exceeds that needed to accomplish the military objective. Proportionality compares the military advantage gained to the harm inflicted while gaining this advantage. Proportionality requires a balancing test between the concrete and direct military advantage anticipated by attacking a legitimate

military target and the expected incidental civilian injury or damage. Under this balancing test, excessive incidental losses are prohibited. Proportionality seeks to prevent an attack in situations where civilian casualties would clearly outweigh military gains. This principle encourages combat forces to minimize collateral damage—the incidental, unintended destruction that occurs as a result of a lawful attack against a legitimate military target.

Military members who violate the LOAC are subject to criminal prosecution and punishment. Criminal prosecutions may take place in a national or international forum. In theory, US Armed Forces could be prosecuted by courts-martial under the UCMJ or through an international military tribunal, "I was only following orders," has generally not been accepted by national or international tribunals as a defense in war crime trials. An individual airman/soldier/sailor/marine remains responsible for his or her actions and is expected to comply with the LOAC.

Above information derived from AFPAM36-2241

DEPLOYMENT

Most Air Force Physician Assistants will deploy at least once during their Air Force career. As a clinician, you provide a critical capability in the deployed environment – life-saving combat care. Physician Assistants have proven their wartime value over and over during our recent conflicts in Iraq and Afghanistan and over past few years PAs have been in high demand for deployed Special Operations Forces.

When you are tasked to deploy, your Unit Deployment Manager (UDM) will identify the specific reporting instructions for your deployed location and will include required training and equipment. The instructions are online at https://aef.afpc.randolph.af.mil/AFRIT/Afrit.aspx and are updated routinely to ensure you are issued and bring the most essential items for your specific location and mission. It is important that you personally read the reporting instructions to ensure you arrive prepared. Don't leave your combat preparedness up to your UDM.

The list below are all items that will be useful at most deployed locations. Some of them will be on your required items list and will be issued to you free of charge. Others are worth purchasing at your own expense to make the deployed experience better:

A good reliable flashlight and lots of extra batteries (usually issued)
Spare flashlight, LED Light, Penlight
A headlamp for doing minor procedures (usually issued)
Pen, Pad, and Paper
PT gear
Spare Boots/footwear/Steel toe/ANSI Rated (usually issued)

Personal entertainment device (tablet/smart phone & good headphones)
Sunscreen (usually issued)
Trauma Shears
Sun Glasses (usually issued)
Ballistic Eyewear with Polarized lenses Inserts (usually issued)
Gortex Jacket/Liner (issued depending on the region and time of year)
Poncho Liner (issued depending on the region and time of year)
Work Gloves/Liner (usually issued)
Sand scarf/Balaklava (issued depending on the region and time of year)
Light Tactical Gloves (usually issued)
Ear Plugs (available through your local Public Health)
Knee and Elbow pads (usually issued)
New Model of Kevlar Helmet and body armor (may or may not be issued)
Wristwatch/Watch with analog hands
Camelback (usually issued)
AFolding pocket knife (usually issued)
Lightweight binoculars
Parachute cord (550 cord)
Duct Tape
Karabiners (may or may not be issued)
Stethoscope
Pocket Otoscope / Ophthalmoscope
Multi-tool - Gerber/Leatherman (usually issued)
Sewing kit
Fire Fly Rescue Strobe with Infrared Lens (may or may not be issued)
Batteries (AA, AAA, D, C)

DEPLOYMENT TRAINING

SAs stated previously, there will be instructions for your deployed location designating the specific training required prior to arrival. Some of the training programs below will be required for your deployed location – some will not. When possible, it is always useful to reach out to the person you will replace to find out which courses were most beneficial in preparing for the deployed mission.

Advanced Trauma Life Support (ATLS)
Center for the Sustainment of Trauma and Readiness Skills (CSTARS) Course
dvanced Cardiac Life Support (ACLS)P
Basic Life Support (BLS)
Fieldcraft – Hostile

Fieldcraft – CENTCOM
Air Advisor Academy
Tactical Combat Casualty Care course (TCCC)
Combat Casualty Care Course (C4)
Tactical Critical Care Evacuation Training (TCCET)
Critical Care Air Transport Team (CCATT)
-4 & M9 Training/QualificationL
Public Health Training (Inspections Facilities/Dormitories/Epidemiology/Vector Control)

CUSTOMS AND TRADITION

CHALLENGE COINS

Why should I have a Challenge Coin? What do I do with it?

Military challenge coins are also known as military coins, unit coins, memorial coins, unit challenge coins, or commander's coins. The coin represents affiliation, support or patronage to the organization represented by the coin. In addition to unit or organizational coins, commanders and other senior leaders may present specially minted personalized coins to improve morale, foster unit esprit and honor service members for their hard work. The challenge coin is a treasured and respected representation of the organization or office represented by the coin.

Challenge coin rules only apply to other individuals who also have a challenge coin. As the owner of a challenge coin you may "challenge" any individual who is known to have a coin. A challenge is made by withdrawing your own coin and raising it in the air or by tapping it on a bar or table. The individual who is challenged is required to produce their coin within 60 seconds. If the individual produces the coin, you are obligated to buy them a drink. If the challenged individual fails to produce the coin, they are obligated to buy you the drink. The same rules apply if someone challenges you. The reward does NOT have to be an alcoholic beverage. It can be a soda or any other reward that the two individuals agree on.

Accidentally dropping a challenge coin is considered to be a deliberate challenge to all within hearing distance. Everyone being challenged must immediately produce the coin for their organization and anyone failing to do so must buy a round of drinks for the challenger and everyone else who has their challenge coin. However, should everyone challenged be able to produce their coin, the challenger must buy a round of drinks for the group (provided they have their coin on them of course).

Coin challengers are known to strike anywhere at anytime. They insidiously stalk the challenge, waiting for just the right moment to attack. An innocent bystander may never hear the challenge -- only the challengee's despairing cry, "... Ah ____! I forgot mine!

BSC PAs have several options for the coin we carry. We can use our unit coin, the AFMS coin, the BSC coin, the SAFPA coin, AAPA Veterans Caucus coin (if a member) or the PA Associate Corps Chief coin. The only requirement is that there is a direct military connection between you and the entity represented by the coin. However, regardless of any "coin regulation," most officers prefer to carry their coins, not only to show their pride with their Corps or unit, but also to save money on drinks they may have to buy if caught without it!

Your coin is tangible evidence that you’re part of a very special group. Always carry it as a reminder of your commitment and connection to something bigger in your daily life.

History of the Challenge Coin

During World War I, American volunteers from all parts of the country filled the newly formed flying squadrons. Some were wealthy sons attending colleges such as Yale and Harvard who quit in mid-term to join the war. In one squadron, a wealthy lieutenant ordered medallions struck in solid bronze and presented them to his unit. One young pilot placed the medallion in a small leather pouch that he wore about his neck.

Shortly after acquiring the medallions, the pilot's aircraft was severely damaged by ground fire. He was forced to land behind enemy lines and was immediately captured by a German patrol. In order to discourage his escape, the Germans took all of his personal identification except for the small leather pouch around his neck. In the meantime, he was taken to a small French town near the front. Taking advantage of a bombardment that night, he escaped. However, he was without personal identification.

He succeeded in avoiding German patrols by donning civilian attire and reached the front lines. With great difficulty, he crossed no-man's land. Eventually, he stumbled onto a French outpost. Unfortunately, saboteurs had plagued the French in the sector. They sometimes masqueraded as civilians and wore civilian clothes. Not recognizing the young pilot's American accent, the French thought him to be a saboteur and made ready to execute him. He had no identification to prove his allegiance, but he did have his leather pouch containing the medallion. He showed the medallion to his would-be executioners and one of his French captors recognized the squadron insignia on the medallion. They delayed his execution long enough for him to confirm his identity. Instead of shooting him they gave him a bottle of wine.

Back at his squadron, it became tradition to ensure that all members carried their medallion or coin at all times. This was accomplished through challenge in the following manner - a challenger would ask to see the medallion. If the challenged could not produce a medallion, they were required to buy a drink of choice for the member who challenged them. If the challenged member produced a medallion, then the challenging member was required to pay for the drink. This tradition continued on throughout the war and for many years after the war while surviving members of the squadron were still alive.

CHALLENGE COIN RULES

The "Coin Check"

A "Coin Check" consists of a Challenge and a Response. *Challenge coin rules only apply to other individuals who also have (or should be expected to have) a challenge coin.* Specific rules may vary somewhat between units but the following are standard for the uniformed services and the Veterans Caucus of the AAPA.

1. RULES:

A. The challenge is initiated by drawing out your coin, holding it in the air by whatever means possible and state, shout or otherwise verbally indicate that you are

initiating a coin check (i.e. yell “Coin check!”). Another, but less vocal method is to firmly place (or slam) your coin on the bar, table, or floor producing an audible noise which can be easily heard by those being challenged (but try not to leave a permanent imprint). If you accidentally drop your coin and it makes an audible sound upon impact, then you have just "accidentally" initiated a coin check for everyone in hearing distance. (This is called paying the price for improper care of your coin.)

B. The response consists of all those persons being challenged drawing their coin in a like manner (see above for examples of coins acceptable for AF PAs to use).

C. If you are challenged and are unable to properly respond, you must buy a round of drinks for the challenger and the group being challenged (those that have their coin).

D. If everyone being challenged responds in the correct manner, the challenger must buy a round of drinks for all those people they challenged (who had their coin).

E. Failure to buy a round is a despicable crime and will require that you turn-in your coin to the issuing agency.

2. WHEN - WHERE:

Coin checks are permitted ANY WHERE, ANY TIME, ANY PLACE.

3. EXCEPTIONS:

There are no exceptions to the rules. They apply to those clothed or unclothed. At the time of the challenge you are permitted one step and an arm’s reach. If you still cannot reach it -- SORRY ABOUT THAT!

4. A COIN IS A COIN

They are not belt buckles, key chains or necklaces. Coins worn in a holder around the neck are valid.

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The Military Mess

Formal military dinners are a tradition in all branches of the United States Armed services. In the Air Force and Navy, it is the dining-in; in the Army, the Regimental Dinner; in the Marine Corps and Coast Guard, Mess Night.

As with most ancient traditions, the origin of the dining-in is not clear. Formal dinners are rooted in antiquity. From pre-Christian Roman legions, to second century Viking warlords, to King Arthur's knights in the sixth century, feasts to honor military victories and individual and unit achievements have been a custom.

Some trace the origins of the dining-in to the old English monasteries. The custom was then taken up by the early universities and eventually adopted by the military with the advent of the officers' mess. With the adoption of the dining-in by the military, these dinners became more formalized.

The Air Force dining-in custom probably began in the 1930s with General H. "Hap" Arnold's "wing-dings." The close bonds enjoyed by Air Corps officers and their British colleagues of the Royal Air Force during World War II surely added to the American involvement in the dining-in custom.

The dining-in has served the Air Force well as an occasion for military members to meet socially at a formal military function. It enhances the esprit de corps of units, lightens the load of demanding day-to-day work, gives the commander an opportunity to meet socially with their subordinates and enables military members of all ranks to create bonds of friendship and better working relations through an atmosphere of good fellowship.

The dining-in and dining-out represent the most formal aspects of Air Force social life. The dining-in is the traditional form, and the term will be used throughout this document. However, most of the information applies equally to both dinings-in and dinings-out.

It is important for the success of a dining-in that members enjoy the evening, and that the ceremonies are done in a tasteful, dignified manner. A dining-in should have a theme around which the decorations and ceremony are built.

The purp se of the dining-in is to bring together members of a unit in an atmosphere of camaraderie, good o fellowship, and social rapport. The basic idea is to enjoy yourself and the company. The dining-in is also an excellent means of providing hail and farewell to members of a unit. It is an excellent forum to recognize individual and unit achievements. The dining-in, therefore, is very effective in building high morale and esprit de corps.

Dining-in. The dining-in is a formal dinner for the members of a wing, unit, or organization. Although a dining-in is traditionally a unit function, attendance by other smaller units may be appropriate.

Dining-out. The dining-out is a relatively new custom that includes spouses and guests. It is similar in all other respects to a dining-in. The dining-out is becoming increasingly popular with officers and enlisted members alike.

Combat dining-in. The combat dining-in, the newest of the dining-in traditions, is becoming increasingly popular, especially in operational units. The format and sequence of events is built around the traditional dining-in, however, it's far less formal atmosphere and combat dress requirements (flight-suit, BDUs) have made it very appealing to the masses. There is not a great deal written on the subject and the only limit seems to be that of the imagination of the planning committee.

Dress. Officers wear the mess dress uniform. Retired officers may wear the mess dress or civilian attire. For enlisted members, mess dress or the semi-formal dress uniform is worn. For retired enlisted personnel, the mess dress, semiformal dress, or civilian attire is appropriate. Refer to AFI 36-2903, Dress and Personal Appearance of Air Force Personnel for appropriate wear instructions. Male civilians should wear appropriate black tie dinner dress. The proper dress for civilians should be clearly stated in the invitation.

TABLE OF SERVICE EQUIVALENT UNIFORMS

EVENT WHEN WORN	ARMY	MARINE CORPS	NAVY	AIR FORCE	COAST GUARD	CIVILIAN ATTIRE	
			FORMAL & DINNER DRESS UNIFORMS			Gentle	Ladies men
Official formal evening functions, State occasions	Blue Mess/ Evening Dress	Evening Dress "A"	Formal Dress	Mess Dress	Formal Dress	Tuxedo / White Tie	Evening Gown
Private formal dinners or dinner dances	Blue Mess	Evening Dress "B"	Dinner Dress Blue Jacket	Mess Dress	Dinner Dress Blue Jacket	Tuxedo	Evening Gown
	White Mess	Evening Dress "B"	Dinner Dress White Jacket	Mess Dress	Dinner Dress White Jacket	Tuxedo	Evening Gown
Less formal occasions requiring more formality than service uniforms	Army Blue (bow tie)	Blue Dress "A" or Evening Dress "B"	Dinner Dress Blue Jacket*	Mess Dress	Dinner Dress Blue	Tuxedo	Evening Gown/ Cocktail Dress
	Army White (bow tie)	Blue/White Dress "A" or Evening Dress "B"	Dinner Dress White Jacket*	Mess Dress	Dinner Dress White	Tuxedo	Evening Gown/ Cocktail Dress
			CEREMONIAL UNIFORMS				
Parades, ceremonies and reviews when special honors are being paid, or official visits of or to U.S. or foreign officials	Army Blue	Blue Dress "A"	Full Dress BlueParticipants Service Dress Blue- Attendees	Service Dress	Full Dress Blue	Civilian Informal	Civilian Informal

	Army White	*Blue/White "A"*	*Full Dress White - Participants* *Service Dress Blue-Attendees*	*Service Dress*	*Full Dress White*	*Civilian Informal*	*Civilian Informal*

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SERVICE UNIFORMS							
Business and info mal r social occasions as appropriate to local customs	*Army Green/Class A*	*Service "A"/Blue Dress "B"*	*Service Dress Blue*	*Service Dress*	*Service Dress Blue "A" / "B"*	*Civilian Informal*	*Civilian Informal*
	Army White	*Service "A" or Blue/White "B"*	*Service Dress White*	*Service Dress*	*Service Dress White*	*Civilian Informal*	*Civilian Informal*
	Army Green/Class B	*Service "C"/Blue Dress "D"*	*Service Khaki*	*Blues w/short sleeve shirt (w/or w/out tie/tab)*	*Tropical Blue Long*	*Civilian Informal*	*Civilian Informal*
	Army Green/Class B	*Blue Dress "D"/Service "C"*	*Summer White*	*Blues w/short sleeve shirt (w/or w/out Tie/tab)*	*Tropical Blue Long*	*Civilian Informal*	*Civilian Informal*
	Army Green/Class B	*Service "B"*	*Winter Blue-E6 & below Service KhakiE7 & up*	*Blues w/long sleeve shirt (w/tie/tab)*	*Winter Dress Blue*	*Civilian Informal*	*Civilian Informal*
WORKING UNIFORMS							
Working in field or plant environment where soiling of clothing is expected	*Battle Dress*	*Utility*	*Working Khaki/Aviation Working Green*	*ABU*	*Undress Blue/Working Blue/ODU*	*Civilian Casual*	*Civilian Casual*
	Battle Dress	*Utility*	*Winter Working Blue (E6 & below)/Coveralls*	*ABU*	*Undress Blue/Working Blue/ODU*	*Civilian Casual*	*Civilian Casual*

	Battle Dress	Utility	Utilities/Camoufla ge Utility Working Uniform	ABU	Undress Blue/Working Blue/ODU	Civilian Casual	Civilian Casual

Note: Some uniforms are optional, seasonal or required for specific pay grades only. Check each Service's uniform regulations for specific guidelines.

**** Navy Dinner Dress Blue/White Jacket is prescribable only for O-4 & above and is optional for O-3 & below; O-3 & below equivalent is Dinner Dress Blue/White Attire:***

Civilian Informal: Business Suit for gentlemen; Dress or Suit for ladies

Civilian Casual: Sports Coat open collar for gentlemen; Dress or Suit for ladies

Washington DC Specific Attire:

Civilian Informal: Business Suit for gentlemen; Dress or Suit for ladies. Civilian Casual: Sports Coat & Open Collar for gentlemen; Dress, Pantsuit or Suit for ladies.

Smart Casual: Open Collar with Sports Coat or Jacket for gentlemen; Dress, Pantsuit or Suit for ladies

As of 2 Apr 03; Col Merri Uckert, OCJCS Protocol, DSN 227-6606

SYMBOLS



The U.S. Air Force symbol is based on the original Hap Arnold wings and represents many different aspects of the service's lasting heritage and limitless future.

Air Force guidelines ensure the symbol is used in a consistent manner. While not comprehensive, the guidelines found at http://www.af.mil/library/symbol/guidelines.asp cover many situations.

Department of Defense employees and their immediate families have an implied license to use the Air Force symbol on personal products such as printed materials, literature, briefings, coins, and web sites. These items must be intended for internal use and not for sale, advertising or potential endorsements. Use of the symbol must adhere to guidelines at this site. Designs must still be approved by the Trademark Licensing office.

Commanders may use the symbol on "perishable" products and those involving limited expense, such as printed materials, clothing, coins, etc. Approved guidelines for using the symbol on base gates and water towers is available. The symbol should not be applied at this time to "nonperishable" uses such as Air Force aircraft and vehicles. Commanders retain discretion to decide how the symbol is used in their organizations consistent with these guidelines.



STAFF OF
ASCLEPIUS

WHICH IS CORRECT?



CADUCEUS

Eventually you may have the chance to influence the design of a medical logo. Whether it's your own coin or a unit patch, if you're considering a "snake on a stick" it's important to know that the proper symbol of medical practice (as opposed to medical commerce) is the staff of Asclepius, or the Asklepian, which is a stout club with one snake and no wings.

Unfortunately, the caduceus (with two snakes and two wings) is often incorrectly used as a symbol for medicine or doctors in place of the rod of Asclepius. A 1992 survey of American health organizations found that 62% of professional associations used the rod of Asclepius, whereas in commercial organizations (like pharmaceutical companies or medical equipment manufacturers), 76% used the caduceus.

Early confusion between the symbols almost certainly arose due to the links between alchemy and Hermes, whose symbol is the caduceus. The alchemists adopted the caduceus because Hermes, the god of messengers, was also the patron lord of gamblers, thieves, tricksters and alchemists. By the end of the 16th century, alchemy became widely associated with medicine in some areas, leading to some use of the caduceus as a medical symbol.

In Greek mythology, Asclepius was a half-mortal who had the power to heal the dead. He learned it by seeing a snake he had killed with his staff revived by another snake, which had crammed herbs into its mouth.

Using the same herbs, Asclepius saved a man killed by one of Zeus's thunderbolts. Zeus frowned on that presumption, which also threatened to put his brother Hades, the god of the dead, out of business, so he zapped Asclepius too. Zeus later relented and made Asclepius the god of medicine.

Several historians blame the mix-up on two people, a 19th-century British publisher and an American Army surgeon. The publisher, John Churchill of London, used the caduceus as a printer's mark on popular medical texts he exported because Hermes was the god of commerce. Predictably, the caduceus became mistaken for a medical symbol.

The surgeon, Capt. Frederick Reynolds, lobbied hard in 1902 to have a gold caduceus adopted as the badge of Army physicians. After having the idea rejected several times by the Army Surgeon General, he finally persuaded the new incumbent (WH Forwood) to adopt it. ," Two Australian medical historians, in a 2003 article in The Annals of Internal Medicine state, "From Captain Reynolds's correspondence with the surgeon general's office, it is apparent that he was unaware of the distinction."

Fifteen years later the librarian for a different Surgeon General realized the mistake, but by then it was too late to change. The Army uses the caduceus; the Air Force and Navy use the asklepian.

Physicians who know the classics are particularly offended because Hermes was also the god of thieves and, even more ominously, was charged with leading the souls of the dead to the underworld.

ESSENTIAL REFERENCES

ABBREVIATIONS, ACRONYMS AND GLOSSARY TERMS for the MHS

(http://www.tricare.mil/mhsophsc/mhs_supportcenter/glossary/glossary.htm)

Air Force Physician Assistant AFMS Kx Homepage (https://kx.afms.mil/kj/kx6/PhysicianAssistant/Pages/home.aspx)

PUBLICATIONS: (http://www.e-publishing.af.mil/)

AFI 1-1	**AF Culture (AF Standards)**	
AFH 33-337	**Tongue & Quill**	**Manual for AF Writing**
AFI 10-403	**Deployment Planning and Execution**	
AFI 33-119	**AF Messaging**	**E-mail, signature blocks, etc**
AFI 36-2005	**Commissioning Appointment**	
AFI 36-2030	**Original Appointment of AF Officers**	
AFI 36-2101	**Classifying Military Personnel**	**AFSCs, Skill levels, etc.**
AFI 36-2106	**Competitive Category Transfers**	**Cross-train between Corps**
AFI 36-2107	**Active Duty Service Commitments (ADSC)**	
AFI 36-2110	**Assignments**	**Includes Humanitarian, EFMP rules**
AFI 36-2133	**Specified Period of Time Contracts (SPTC)**	
AFI 36-2107	**Active Duty Service Commitments**	
AFI 36-2401	**Correcting Officer and Enlisted Evaluation Reports**	
AFI 36-2406	**Officer and Enlisted Evaluation System**	**OPRs & PRFs**
AFI 36-2501	**Officer Promotions and Selective Continuation**	**How the board works**
AFI 36-2603	**AF Board for Correction of Military Records**	
AFI 36-2611	**Officer Professional Development**	
AFI 36-2856	**Air Force Medical Service Awards**	
AFI 36-2903	**Dress and Personal Appearance**	
AFI 36-2905	**Fitness Program**	
AFI 36-3003		**Table 4.5: Permissive TDY tables**

AFI 36-3203	**Military Leave Program**	
AFI 36-3208	**Retirements**	
AFI 36-3401	**Administrative Separation of Airmen**	
AFI 38-101	**Air Force Mentoring Program**	**Medical Group Structure**
AFI 41-104	**Air Force Organization**	
AFI 41-105	**Professional Board/National Certification Examination**	
AFI 41-106	**Medical Education and Training Programs**	**Comprehensive Medical Readiness Program**
AFI 41-108	**Medical Readiness and Training Program**	**(CMRP)**
AFI 41-109	**Training Affiliation Agreement Program**	
AFI 41-115	**Special and Incentive Pay**	
AFI 41-117	**Authorized Health Care and Health Care Benefits in the MHS**	
AFI 41-210	**Medical Service Officer Education**	
AFI 44-102	**Tricare Operations and Patient Administration**	
AFI 44-103	**Medical Care Management**	
AFI 44-104	**AF IDMT Program**	
AFI 44-119	**Medical Consultant and CFM Program**	
AFI 44-162	**Medical Quality Operations**	
AFI 44-170	**International Health Specialist (IHS) Program**	**#1 References for PA Practice**
AFI 48-123	**Preventive Health Assessment (PHA)**	
AFI 51-601	**Medical Examinations and Standards**	
AFI 51-604	**Gifts To The Department of The AF**	
AFMAN 10-100	**Appointment To and Assumption of command**	**PRP Program, Competent Medical Authority, etc**
AFMAN 13-501	**Airman's Manual**	
AFMAN 33-236	**(DoD Manual 5210.42) PRP**	
AFMAN 36-2643	**Preparing Official Communications**	
AFPAM 34-1202	**AF Mentoring Program** **Guide to Protocol**	
AFPAM 36-2241	**Professional Development Guide**	
AFPAM 36-2607	**Application's Guide to AF Board For Correction of Military Records**	
AF Handbook 1	**The Airman Handbook**	

CONSULTANT LIST All SG Chief Consultants:
https://kx.afms.mil/kj/kx4/SGConsultants/Pages/home.aspx

OFFICER CLASSIFICATION DIRECTORY (AFOCD). **Go to the MyPers website (https://mypers.af.mil/) and search under "Officer Classification Directory ". The Directory describes all AF officer AFSCs and qualifications. It's updated a couple times a year.**

OTHER UNIFORMED SERVICES:

(http://armypubs.army.mil/)
AR 40-68 : Army Clinical Quality Management
AR 40-501; Army Standards of Medical Fitness

Army PA Practice
Needed if doing MEBs

NAVMED P-117 (MANMED): Manual of the Medical Department (see chap 15):
http://www.med.navy.mil/directives/Pages/NAVMEDP-MANMED.aspx
DA3349: Army Physical Profile form
NAVMED 6111/4: Physical Fitness Assessment Medical Clearance/Waiver

OTHER RESOURCES:

AAPA:	**http://www.aapa.org/**
AAPA "Clinical Practice Toolbox"	**https://www.aapa.org/career-central/practice-resources/**
AF Portal	**https://www.my.af.mil/gcss-af/USAF/ep/home.do**
AF Core Values (The "Little Blue Book")	**http://www.airman.af.mil/Portals/17/001%20Home%20Page/005_The_Little_Blue_Book/Profession%20of%20Arms_Final_For%20Screen.pdf?ver=2015-08-21-135633-620**
AF Language and Culture	http://culture.af.mil/
AFMS Home Page:	**http://www.airforcemedicine.af.mil/**
AFMS CAG (or AFfMS policy, briefings, tools, etc.)	**https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=SGSTRATCOM**
AF Directory Services (Locator, "E-mail for life" etc.)	**https://imp.afds.af.mil/default.aspx**
DoD Global Directory Service:	**https://www.disa.mil/enterprise-services/identity-and-access-management/gds**
AFMS Virtual Library:	**https://kx.afms.mil/kj/kx8/VirtualLibrary/Pages/home.aspx**
Air Force Art (including symbol protocol)	**http://www.af.mil/News/Art.aspx**
American College of Clinicians:	**http://www.amcollege.org/**
Biographies, AF:	**http://www.af.mil/About-Us/Biographies/** **http://www.airforcemedicine.af.mil/About/Leaders/**
BSC Home Page:	**https://kx.afms.mil/kj/kx1/BiomedicalSciencesCorps/Pages/home.aspx**
CMRP AFMS Kx Homepage:	**https://kx.afms.mil/kj/kx9/CMRP/Pages/home.aspx**
USAF IDMT Medical and Dental Treatment Protocols:	https://kx.afms.mil/kj/kx2/IDMTConsultant/Documents/IDMT%20Toolbox/IDMT%20Protocols.pdf

Deployment Resources:

- **AEF Online** — **https://aef.afpc.randolph.af.mil/default.aspx**
- **Language & Culture** — **http://fieldsupport.dliflc.edu/**

Defense Health Agency (DHA) https://health.mil/dha
Military Health System (MHS) website **http://www.health.mil/**

(Professional Development Tools)
Airman Development Plan (ADP) via Air Force Portal **https://www.my.af.mil/**
DoD Website: **http://www.defenselink.mil/**
NCCPA: **http://www.nccpa.net/**
Society of Air Force PAs (SAFPA) website **http://www.safpa.org/**
Profession of Arms Center of Excellence (PACE) **http://www.airman.af.mil/**

APPENDIX

(My lagniappe for you. Miscellaneous quotes that have helped me maintain my perspective)

“A healthy body is the guest-chamber of the soul; a sick body, its prison.”

--Sir Francis Bacon

"Success is not final, failure is not fatal: it is the courage to continue that counts."

--Sir Winston Leonard Spencer Churchill

“Nine tenths of what you see is behind your eyes”

--Various

“God uses crooked sticks to draw straight lines”

-- Ignatius

“Courage is more exhilarating than fear, and in the long run it is easier”

--Eleanor Roosevelt

“If you value the world simply for what you can get out of it, be assured that the world will in turn estimate your value to it by what it can get out of you”

--Arthur Twining Hadley

“We must not, in trying to think about how we can make a big difference, ignore the small daily difference we can make which, over time, add up to big differences that we often cannot foresee.”

--Marian Wright Edelman

“Things turn out the best for people who make the best of the way things turn out”

--Gregg Jacobs

IF.....

IF you can keep your head when all about you
Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowance for their doubting too; If you can wait and not be tired by waiting,

Or being lied about, don't deal in lies, Or being hated, don't give way to hating, And yet don't look too good, nor talk too wise:

If you can dream - and not make dreams your master;
If you can think - and not make thoughts your aim;
If you can meet with Triumph and Disaster
And treat those two impostors just the same;
If you can bear to hear the truth you've spoken
Twisted by knaves to make a trap for fools, Or watch the things you gave your life to, broken,
And stoop and build 'em up with worn-out tools:

If you can make one heap of all your winnings
And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
And never breathe a word about your loss;
If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the Will which says to them: 'Hold on!'

If you can talk with crowds and keep your virtue, ' Or walk with Kings - nor lose the common touch, if neither foes nor loving friends can hurt you,
If all men count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run, Yours is the Earth and everything that's in it, And - which is more - you'll be a Man, my son!

- Rudyard Kipling

“Attitude”

"The longer I live, the more I realize the impact of attitude on life. It is more important than the past, than education, than money, than circumstances, than failures, than successes, than what other people think or say or do. It is more important than appearance, giftedness or skill. It will make or break a company ... a church ... a home.

The remarkable thing is we have a choice every day regarding the attitude we will embrace for that day. We cannot change our past ... we cannot change the fact that people will act in a certain way. We cannot change the inevitable. The only thing we can do is play on the one string we have, and that is our attitude ... I am convinced that life is 10% what happens to me and 90% how I react to it. And so it is with you ... we are in charge of our Attitude."

- Chuck Swindoll

Success is whatever gets you closer to what you believe is important

- Anon

You don't have to like the new bus company owners, or the driver they hired or the route he drives. You have a choice. You can stand on the corner and shake your fist and rant and rave about how things used to be and suck up the fumes as the bus pulls away from the curb. Or you can get on the bus, even if you don't like the new driver or the upholstery on the seats or the re-designed routes and go for the ride. But one way or another, the bus is leaving.

- Brad Sham

"It is not the critic who counts: not the man who points out how the strong man stumbles or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes up short again and again, because there is no effort without error or shortcoming, but who knows the great enthusiasms, the great devotions, who spends himself for a worthy cause; who, at the best, knows, in the end, the triumph of high achievement, and who, at the

worst, if he fails, at least he fails while daring greatly, so that his place shall never be with those cold and timid souls who knew neither victory nor defeat."

Theodore Roosevelt, "Citizenship in a Republic," Speech at the Sorbonne, Paris, April 23, 1910

"In looking for someone to hire, you look for three qualities: integrity, intelligence, and energy. But the most important is integrity, because if they don't have that, the other two qualities, intelligence and energy, are going to kill you."

- Warren Buffett

When the character of a man is not clear to you, look at his friends.

- Japanese Proverb

Even a fool is thought wise if he keeps silent, and discerning if he holds his tongue.

- Proverbs 17:28

“If you could kick the person in the pants responsible for most of your trouble, you wouldn't sit for a month”

-- Theodore Roosevelt

“Leadership is the art of getting someone else to something you want done because he wants to do it.”

Dwight D. Eisenhower

“Opportunity comes from expertise, not just luck, talent, and passion. If you find it impossibly tedious to become an expert about what you think matters to you, then you’re not chasing a dream, you’re just daydreaming” --J. Porras, S. Emery, and M. Thompson *in* *“The Cause has Charisma”*, *Leader to Leader*. 43 (Winter 2007): 26-31.