THE UNOFFICIAL HANDBOOK FOR AIR FORCE PHYSICIAN ASSISTANTS

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Preface to the 4th edition (2010)

It's been three 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.

August 2007
Col John W. Bullock

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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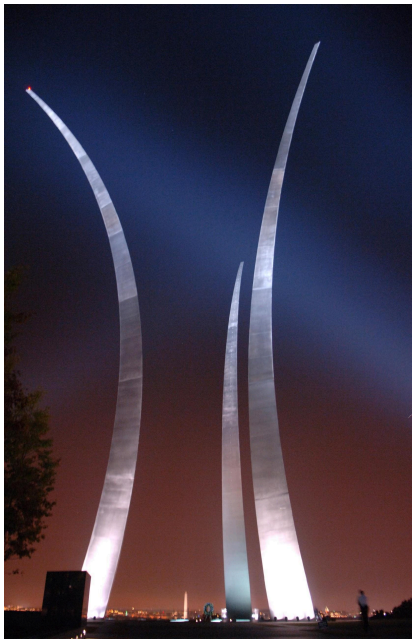
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Integrity first
Service before self
Excellence in all we do



"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

The Air Force:
Its Character and Mission

Understanding the mission of the Air Force, both present and future, and your place in it is essential to your success.

On 29 December 2007 Gen T. Michael Moseley published a White Paper, “The Nations Guardians, America’s 21st Century Air Force”, which laid out the strategic foundations for the Air Force of the future. That paper starts on the next page. As the Chief said in his message to the MAJCOM commanders:

> “This is my definitive guidance to ensure America's Air Force will fly, fight, and win the Nation’s wars in the 21st Century. Implementing this transformational strategy requires all of us to give it our utmost push. We've achieved tremendous progress through the ongoing initiatives. Now all efforts must cascade from this single, unifying strategy.”

Our challenge is to assure that the medical support we provide to our Air Force and Joint warfighters is absolutely coherent with the Chief's strategy in fighting today's, and tomorrow's, fight.

The Air Force must be dominant in three domains: Air, Space, and Cyberspace. "No modern war has been won without air superiority. No future war will be won without air, space and cyberspace superiority."

In recent year the Air Force has allowed to go unchallenged the perception that its role is relatively unimportant compared to the other Services. One of the Chief’s imperatives is that the Air Force must define itself. We cannot allow ourselves to be defined by others. The Air Force is not merely an enabler. The paper indicates that we are no longer using the words "enabling force." The Air Force is fully engaged in today’s fight and is not an enabler but rather a key, decisive part of the joint team.

To help you explain the Air Force mission and culture to members of other Services, I’m including a second article, “Understanding Airmen: A Primer for Soldiers”.

THE NATION'S GUARDIANS

AMERICA'S 21ST CENTURY AIR FORCE



CSAF White Paper

General T. Michael Moseley
18th Chief of Staff
United States Air Force

We better be prepared to dominate the skies above the surface of the earth or be prepared to be buried beneath it.

General Carl A. "Tooey" Spaatz
1st Chief of Staff U.S. Air Force

1. PURPOSE

This White Paper charts U.S. Air Force strategy for the next two decades and defines the Air Force's indispensable role in promoting and defending the national interest. In framing the strategic imperatives that face the United States and its Air Force, the paper lays out the urgent actions required to cope with today's and tomorrow's challenges. Accordingly, this White Paper is a definitive statement of Air Force intent to maintain its role as the guardian of America's freedom, security and prosperity—the Nation's force of first and last resort.

2. AMERICA'S GUARDIANS

Since the Nation's birth, it has been the constitutional duty of our military to ensure national survival, defend lives and property, and promote vital interests at home and abroad. To provide for the common defense, all of America's military Services strive for excellence in how they organize, train, and equip their forces to fight and win the Nation's wars. All are vital, interdependent components of a mighty joint team, united by a tradition of honor, valor, and devotion.

The Air Force exists to fly, fight and win—to achieve strategic, operational and tactical objectives—unhindered by time, distance or geography. The Air Force's mission is to "deliver sovereign options for the defense of the United States of America and its global interests—to fly and fight in Air, Space, and Cyberspace." Thereby, jointly with our brothers and sisters in arms—Soldiers, Sailors, Marines, and Coast Guardsmen—we underwrite the national strategy of defending the Homeland and assuring allies, while dissuading, deterring and defeating enemies.

As the Nation's premier global, multi-dimensional maneuver force, the Air Force safeguards America by dominating the ultimate vantage of air, space and cyberspace. We provide *Global Vigilance, Global Reach and Global Power* in and through these domains.

- ***Global Vigilance*** is the persistent, world-wide capability to keep an unblinking eye on any entity—to provide warning on capabilities and intentions, as well as identify needs and opportunities.
- ***Global Reach*** is the ability to move, supply, or position assets—with unrivaled velocity and precision—anywhere on the planet.
- ***Global Power*** is the ability to hold at risk or strike any target, anywhere in the world, and project swift, decisive, precise effects.

With the oldest inventory in history, battered by 17 years of continuous combat, the Air Force's ability to fulfill its missions is already being tested. This is particularly true in cyberspace, seen by potential adversaries as a relatively inexpensive venue to offset our traditional advantages in air and space. Since the air, space and cyber domains are increasingly interdependent, loss of dominance in any one could lead to loss of control in all. Thus, superiority and freedom of action—the historically proven predicates of all joint operations, in all warfighting domains—cannot be taken for granted.

No modern war has been won without air superiority. No future war will be won without air, space and cyberspace superiority. Accordingly, the Air Force must be better postured to contend with both today's and tomorrow's challenges. To promote and defend America's interests through Global Vigilance, Global Reach and Global Power, the Air Force must attain cross-domain dominance. Cross-domain dominance is the freedom to attack and the freedom from attack in and through the atmosphere, space and the electromagnetic spectrum. It permits rapid and simultaneous, lethal and non-lethal effects in these three domains to attain strategic, operational and tactical objectives in all warfighting domains: land, sea, air, space, and cyberspace. Cross-domain dominance integrates systems, capabilities, operations, and effects in air, space and cyberspace to gain competitive advantage in any and all domains. It transforms our operational concepts to maximize synergy among air, space and cyberspace, thus generating a new array of simultaneous, synchronized effects.

Through cross-domain dominance, the Air Force grants joint freedom of maneuver in all warfighting domains: land, sea, air, space, and cyberspace. This, in turn, allows the Joint Force Commander to achieve desired outcomes across the full range of military operations: from humanitarian relief saving those in need, through preventing war via dissuasion and deterrence, to inflicting strategic paralysis on implacable opponents. Without the Air Force's ability to present this spectrum of capabilities to the joint team in peace, crisis and war, national security would be at risk.

3. THE STRATEGIC IMPERATIVE

History is replete with examples of militaries that failed due to their inability to transform organizations and culture, adopt new operational concepts, or leverage breakthrough technologies. But militaries do not fail by themselves. Failure occurs in the context of an overall, national debacle, caused by systemic problems that fall into three distinct but related categories: failure to anticipate, failure to learn and failure to adapt. In contrast, victory comes to those who foresee, recognize and act on changes in the strategic environment. To succeed—indeed, to avoid catastrophic failure—we must redefine the Air Force for the 21st Century.

In the wake of the Vietnam War, the Goldwater-Nichols DoD Reorganization Act of 1986 and the collapse of the Soviet Union, tectonic shifts in the global security setting prompted extensive changes in Air Force culture and structure. Organizational and technological transformation brought about a quantum leap in airpower's effectiveness—compellingly demonstrated in operations such as: DESERT STORM,

maintaining no-fly zones in Iraq through NORTHERN WATCH and SOUTHERN WATCH, ALLIED FORCE in the Balkans, ENDURING FREEDOM, and IRAQI FREEDOM, as well as in operations providing life-saving relief to victims of tsunamis, famines, earthquakes, and hurricanes. Our transformation objectives were uniquely suited to the strategic context of the time. The U.S. Air Force harnessed space and cyber capabilities as the catalysts of precision, stealth, speed, reach, and persistence that became the hallmarks of late 20th Century warfare. In the process, the entire joint team—indeed, the entire free world—became increasingly dependent on space, electronics and the electromagnetic spectrum as the indispensable pillars of freedom of action. Consequently, 21st Century airpower is not merely the *sum but the product* of air, space and cyberspace superiority. Loss of control in any one of these domains risks across-the-board degradation—if not outright failure.

Today's confluence of global trends already foreshadows significant challenges to our organization, systems, concepts, and doctrine. We are at an historic turning point demanding an equally comprehensive revolution. The future strategic environment will be shaped by the interaction of globalization, economic disparities and competition for resources; diffusion of technology and information networks whose very nature allows unprecedented ability to harm and, potentially, paralyze advanced nations; and systemic upheavals impacting state and non-state actors and, thereby, international institutions and the world order. The following are salient features of this increasingly complex, dynamic, lethal, and uncertain environment:

- Violent extremism and ethnic strife—a global, generational, ideological struggle
- Proliferation of weapons of mass destruction and empowering technologies
- Rising peer competitors with voracious appetites for resources and influence
- Predatory and unpredictable regional actors
- Increasing lethality and risk of intrusion by terrorist and criminal organizations
- Systemic instability in key regions (political, economic, social, ideological)
- Unprecedented velocity of technological change and military adaptation
- Availability of advanced weapons in a burgeoning global marketplace
- Exponential growth in volume, exchange and access to information
- Surging globalization, interconnectivity and competition for scare resources
- Dislocating climate, environmental and demographic trends

4. 21st CENTURY WARFARE

These global dynamics are closely intertwined with the changing character of 21st Century warfare. Having experienced—or vicariously learned—the cost of challenging the U.S. head-on, would-be adversaries are developing asymmetric approaches to attack vital levers of U.S. power. Their strategies seek to circumvent our core advantages, while undermining international support and domestic resolve.

Airpower's unprecedented lethality and effectiveness deter opponents from massing on the battlefield, driving them to adopt distributed and dispersed operations. They find maneuver space and sanctuary in dense urban areas, ungoverned hinterlands and

loosely regulated information and social networks. These enemies pose a significant challenge to our freedom of action and threaten our interests at home and abroad. Their operations are difficult to constrain with traditional force-on-force approaches, compelling all Services to think anew about the challenges of irregular warfare.

Meanwhile, ascendant powers—flush with new wealth and hungry for resources and status—are posturing to contest U.S. superiority. These adaptive competitors are translating lessons from recent conflicts into new warfighting concepts, capabilities and doctrines specifically designed to counter U.S. strengths and exploit vulnerabilities. They are advancing in all domains. For example:

- "Generation 4-plus" fighter aircraft that challenge America's existing "4th Generation" inventory—and, thus, air superiority—with: overwhelming numbers and advanced weaponry; sophisticated integration of electronic attack and advanced avionics; emerging low-observable technologies; and progressive, realistic, networked training
- Increasingly lethal, integrated air defense systems (IADS) that threaten both our Airmen and aircraft, and could negate weapons used to suppress or destroy these systems
- Proliferation of surface-to-surface missiles with growing range, precision, mobility, and maneuverability—capable of delivering both conventional and non-conventional warheads
- Proliferation of unmanned aerial systems (UAS) capable of conducting low observable, persistent, intrusive missions in both lethal and non-lethal modes
- Resurgence of offensive counterspace capabilities
- Increasing ability of even marginal actors to surveil the disposition of U.S. and allied assets through commercially available and widely accessible means
- Attacks through cyberspace are already creating tactical, operational and strategic effects at low cost and with relative impunity

Even if we continue to successfully dissuade and deter major competitors, their advanced equipment is proliferating worldwide. We are bound to confront these weapons systems wherever America engages to promote and defend its interests. We must also be vigilant to adversary breakthroughs in fields such as cybernetics, nanotechnology, biotechnology, electromagnetic spectrum physics, robotics, advanced propulsion, etc. We cannot assume that the next military revolution will originate in the West. Indeed, the hub of innovation in science and engineering education has shifted eastward. Therefore, we must anticipate innovative combinations of traditional and new concepts, doctrines, weapons systems, and disruptive technologies.

5. A STRATEGIC CROSSROADS

As a consequence of these global dynamics and shifts in the character of 21st Century warfare, we are at a strategic crossroads. The Air Force has aggressively pursued air dominance through focused, sizable investment in Airmen, aircraft, weapons, training and essential support structure—to include fundamental and applied

research. The investment has paid off; no U.S. ground forces have been attacked from the air since 1953. The Cold War was won through deterrence, backstopped by America's nuclear might. DESERT STORM is commonly called the "100-hour war"—that's how long the ground campaign lasted—because the preceding 1000-hour air war made it so. After the Iraqi army limped from the battlefield with sufficient capability to attack its own citizens, the Air Force imposed regional containment through Operations NORTHERN WATCH (to protect the Kurds) and SOUTHERN WATCH (to protect the Shia). Operation ALLIED FORCE, which compelled the Belgrade regime to bend to NATO's will and stop the slaughter of innocents, was won through airpower without the need for a costly ground campaign. Brutal dictatorships were toppled in Afghanistan and Iraq in record time, with many of the necessary effects accomplished from the air. However, the advantages that accrue from air dominance can no longer be taken for granted. Consequently, America's freedom of action in all warfighting domains—land, sea, air, space, and cyberspace—is no longer assured.

From this point forward, the Air Force should expect to be challenged not only in the air domain, but in and through space and cyberspace as well. In January 2007, China demonstrated the ability to hold satellites at risk and the willingness to contest the space domain. State and non-state actors are already exploiting cyberspace to gain asymmetric advantage. In April 2007, Estonia was the victim of a well-coordinated, far-reaching cyber attack which brought its technologically sophisticated government to a virtual standstill. Insurgents in Iraq, Afghanistan and elsewhere exploit electronics and the electromagnetic spectrum to kill and maim through improvised explosive devices (IEDs), while propagating their message of hate to the world. Thus, perhaps for the first time in the history of warfare, the ability to inflict damage and cause strategic dislocation is no longer directly proportional to capital investment, superior motivation and training, or technological prowess.

The Global War on Terrorism is a generational struggle we must win. The Air Force will continue to fly and fight in the various theaters of this war. At the same time, we owe the Nation a holistic approach that balances today's exigencies with the far-reaching, long-term implications of looming threats. America's Air Force will succeed in the 21st Century only by developing and resourcing a strategy that closes the gap between ends and means. The window of opportunity is shutting fast. Time is not on our side.

6. REDEFINING THE AIR FORCE FOR THE 21st CENTURY

The Air Force strategy is framed in terms of *ends, means, ways, and risk.* The *ends* are the objectives we must achieve. The *means* are capabilities and resources. The *ways* define how we employ the *means.* The essence of our strategy is to use required *means* in innovative *ways* to attain the desired *ends* with acceptable *risk.*

Ends: Protect Democracy and Guard Freedom

The Air Force's commitment to America's joint team is to provide forces proficient across the range of military operations to protect the United States, its interests,

values and allies; deter conflict and prevent surprise; and, should deterrence fail, prevail against any adversary. Airmen deliver global surveillance, global command and control, and the requisite speed, range, precision, persistence, and payload to strike any target, anywhere, anytime, in any domain—and assess the results. Global Vigilance, Global Reach and Global Power grant Joint and Combined Force Commanders the ability to safeguard the Homeland, assure allies, dissuade opponents, and inflict strategic dislocation and paralysis on adversaries—all while minimizing the loss of life associated with land warfare.

Ways: Global Vigilance, Reach and Power through Cross-Domain Dominance

Innovation, flexibility and integration are the hallmarks of all successful strategies. Airmen must develop creative solutions—*ways*—to gain and maintain superiority in air, space and cyberspace, exploiting the synergies of cross-domain dominance to attain a quantum leap in mission effectiveness. To this end, we must: refocus our organization and culture on the warfighting mission; implement advanced operational concepts to fly, fight and win in all domains; leverage game-changing technologies; and recapitalize our aging equipment.

Any organizational renaissance begins with people. We must prepare our Airmen for a future fraught with challenges, fostering their intellectual curiosity and ability to learn, anticipate and adapt. To this end, we are reinvigorating warrior ethos, revitalizing the world's most advanced training system and expanding 21st Century educational opportunities. Our expeditionary Airmen must be prepared to deploy and ready to fight. While we enrich our Airmen's culture, leadership, training, education, and heritage, we will care for their families and provide for their future.

We are committed to enhance Total Force Integration. We are developing concepts, strategies, force management policies and practices, and legal authorities to access sufficient Air Reserve Component forces without the need for involuntary mobilization. Though the Air Force is already the model for melding its Guard, Reserve and civilians with its active duty elements, we can and will push this synergy to new levels.

We must continue to inject Airman's global, inherently three-dimensional perspective into all levels of planning and execution. We will better prepare our officers for key joint leadership positions by bolstering cultural, language and academic skills—as well as practical experience—to ensure they are articulate airpower advocates, capable of fully integrating and leveraging our distinctive capabilities in joint and coalition arenas.

In an era of intense competition for resources, all Services must avoid unnecessary duplication and overlap in acquisition, procurement, manning, and operations. To this end, we will continue a series of cross-Service initiatives already underway with the aim of generating new joint synergies across all warfighting domains: land, sea, air, space, and cyberspace. We will also work with the rest of DoD to enhance collaboration and interoperability with the Department of Homeland Security, Department of State, the

Intelligence Community, law enforcement agencies, and other interagency partners to facilitate a more effective orchestration of all elements of national power.

America's strategic partnerships are more important than ever. Our Air Force will strengthen and broaden coalitions, capitalizing on the global community of like-minded Airmen, while attending to interoperability between allies and partners. Building these relationships not only expands, extends and strengthens Global Vigilance, Global Reach and Global Power, but also leverages airpower's value as an engine of progress and, thus, as a potent instrument of America's diplomacy in an increasingly interconnected world.

The U.S. Air Force is formulating innovative operational concepts to anticipate, adapt to, and overcome challenges. We are transforming our thinking from considering the space and cyber domains as mere enablers of air operations to a holistic approach that factors in their interdependence and leverages their unique characteristics. We must continue to push this conceptual envelope—and expand the boundaries of existing tactics, techniques and procedures—to fully exploit the synergies of cross-domain dominance.

We will accelerate the deployment of evolutionary and disruptive technologies, as we address the urgent need to recapitalize and modernize. We must bolster our advantage through continued investment in our own science and technology, as well as outreach and integration with industry, academia and think tanks. We will reform our procurement and acquisition system to ensure full transparency, open competition and adherence to operational timelines.

Means: Revitalizing the Air Force

The U.S. Air Force has been in continuous combat since 1990—17 years and counting—taking a toll on our people and rapidly aging equipment. While we remain globally engaged, we recognize the imperative of investing in the future through recapitalization and modernization. We must field flexible systems, capable of providing full-spectrum effects across the entire range of military operations, from a catastrophic attack on the Homeland, through major theater contingencies, to irregular warfare and humanitarian relief.

We must position the Air Force to secure America's superiority in all domains, including: appropriate mixes of stand-off capabilities; penetrating manned aircraft; enhanced cyber capabilities; advanced unmanned combat systems; operationally responsive space; and breakthroughs in fields such as electromagnetic spectrum physics, directed energy, nanotechnology, bioengineering, super-stealth, and hypersonics—all wedded to innovative concepts and superior training.

To meet current and future challenges, we will maintain a credible deterrent that convinces potential adversaries of our unwavering commitment to defend our Nation, its allies and friends. The U.S. nuclear arsenal continues to serve as the ultimate backstop

of our security, dissuading opponents and reassuring allies through extended deterrence.

As the demand for global intelligence, surveillance, reconnaissance, and communications continues to grow, our reliance on assured access to space will increase exponentially. The challenge is to find an affordable pathway to secure space—striking the right balance among hardening, countermeasures and reconstitution. We need to deploy high-altitude, high-speed, air-breathing systems to mitigate risks to space-based capabilities. The Air Force will continue to provide the entire joint team with exacting intelligence, surveillance and reconnaissance in air, space and cyberspace. We will also develop new concepts that merge sensors and shooters into a seamless, ubiquitous force that can permeate adversary defenses.

Throughout history, war-fighters at all levels have operated with limited information and constrained situational awareness. With advances in sensors, information sharing and network-centric systems, our operators are suffering the embarrassment of riches—they are, quite literally, struggling with information delivered at a velocity and volume far exceeding human ability to process and absorb. We must develop and field systems that are not just network-centric, but knowledge-centric. These systems process, filter and integrate data, presenting information in a format that enables quick, logical decisions. To this end, we will develop self-forming, self-healing networks that harness the power of machine-to-machine interfaces, freeing up human resources for activities where intellect and warrior spirit are indispensable.

In September 2007, the Air Force stood up Cyber Command to provide combat-ready forces, trained and equipped to conduct sustained operations in and through the electromagnetic spectrum, fully integrated with air and space operations. We will continue to develop and implement plans for maturing cyber operations as an Air Force core competency. Our objective is to provide flexible options to the decision-makers to deter, deny, disrupt, deceive, dissuade, and defeat adversaries through destructive and non-destructive, lethal and non-lethal means.

Soldiers, Sailors, Marines, and Coast Guardsmen share a sacred bond with Airmen: we will not leave a comrade behind. We are modernizing combat search and rescue forces to fulfill the moral imperative to locate, support and recover our joint warriors. The Air Force is committed to fielding a new combat search and rescue aircraft; advancing our rescue concepts of operation; and enhancing survival, evasion, resistance, and escape (SERE) training—all to ensure that the Air Force remains the premier combat search and rescue force for the entire joint team.

The Global War on Terrorism has highlighted the importance of specialized airpower to meet the requirements of Special Operations Forces. We will continue to provide aircraft, unmanned aerial vehicles, agile combat support, and trained personnel to meet Combatant Commanders' special operations requirements. Air Force Special Operations Command is establishing a new main operating base in New Mexico, with world-class training ranges and facilities to accommodate its growth. In addition, the Air

Force continues to refine tactics, techniques and procedures to enhance the synergies between airpower and Joint Special Operations Forces.

An enduring element of our national security strategy is to engage forward in peace, crisis and war. Accordingly, we must maintain a sufficient rotational base to sustain our forward-deployed and forward-based posture, as well as enhance our ability to project and protect those forces—a moral imperative and a military necessity. The Air Force will work with Combatant Commanders and partner air forces to secure basing and counter potential anti-access strategies. We will continue to develop new ways of projecting power without projecting vulnerabilities and design systems that facilitate reach-back, thus maximizing effects while minimizing forward presence.

Risk: Failure to Anticipate, Learn, Adapt

All strategic planning is based on a set of assumptions. Surprise occurs when core assumptions are proven wrong. To succeed, we must continually validate our strategy across the *ends, means, ways, risk* framework. We should not assume that future conflicts will resemble the current fight in Iraq or Afghanistan—lest we lose the ability to project global power, inflict strategic paralysis, deter nation-states, destroy their fielded forces, and defend our Homeland, its allies and friends.

For a nation whose security is predicated on an enduring strategy of dissuasion and deterrence, the most fundamental risk is failure of deterrence. Deterrence is a function of capability, will and credibility and, thus, exists in the eye of the beholder. Its success—or failure—is measured only in the breech. To mitigate the risk, we must retain a modern, secure and well-trained force and evolve new deterrence concepts. In particular, it behooves us to rethink concepts such as extended deterrence and conceive new ways to deal with actors who might be deemed “undeterrable” in the Cold War construct.

Strategic risk can also mount through the accumulation of shortfalls in recapitalization and modernization, stale operational concepts and failure to revitalize warrior ethos. Recapitalization is about more than replacing aging aircraft; it is about ensuring the combat effectiveness of all air, space and cyberspace forces. The success of the Air Force and the joint team depends upon the ability of our people and organizations to adopt new, relevant operational concepts, suitable to the dynamics of the strategic environment. Cross-domain dominance is essential to victory.

7. FROM HERITAGE TO HORIZON

Billy Mitchell’s appeal for strategic foresight still resonates today: "Nations nearly always go into an armed contest with the equipment and methods of a former war. Victory always comes to that country which has made a proper estimate of the equipment and methods that can be used in modern ways."

Complacency breeds failure. In the 1920s and 1930s, when our political and military leaders assumed the Nation was appropriately postured for the future, we failed to anticipate the coming crucible. Despite the vocal objections of a few, we entered World War II unprepared for the demands of total war. Likewise, we engaged in both Korea and Vietnam unprepared for the challenges of limited war. America paid a heavy price in blood and treasure for this strategic myopia. To cite but one example: on August 1, 1943, American Airmen flew a daring, low-level mission to strike Hitler's largest oil refinery—Ploesti. The target was demolished, but attrition was brutal: 44 of 177 B-24 Liberators were shot down and 540 of 1720 Airmen were lost. Through determination, ingenuity and innovation—as well as our industrial might—we persevered. The Nation and its entire military adapted in the midst of these fights to win decisively in World War II, restore the *status quo* in Korea, terminate the conflict in Southeast Asia, and, having exorcized the ghosts of Vietnam, deliver a swift victory in DESERT STORM.

We must learn from history. Our shared touchstone of warrior virtues and single, unifying purpose remain unchanged: fly, fight, win. We must remain true to the legacy of valor and devotion, so boldly written with contrails and smoke across the skies from Ploesti and Schweinfurt, through MiG Alley and downtown Hanoi, to Kandahar and Baghdad. This legacy defines our role in the American way of war—to risk the lives of Airmen to kick down the opponent's door so thousands need not die.

We will have neither the buffer of time nor the barrier of oceans in future conflicts. The Air Force is smaller in December 2007 than it was in December 1941. The character, tempo and velocity of modern warfare already severely test our ability to adapt. Therefore, redefining the Air Force for the 21st Century is an urgent national security requirement—not a luxury we can defer. If we are to defend America and promote its interests, the Air Force must continue to provide the joint team with prompt, persistent, decisive air, space and cyberspace effects.

The Air Force is often first to the fight and last to leave. We give unique options to all Joint Force Commanders. The Air Force must safeguard our ability to: see anything on the face of the earth; range it; observe or hold it at risk; supply, rescue, support or destroy it; assess the effects; and exercise global command and control of all these activities. Rising to the 21st Century challenge is not a choice. It is our responsibility to bequeath a dominant Air Force to America's joint team that will follow us in service to the Nation.

Understanding Airmen: A Primer for Soldiers

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



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

- General Hal Hornburg

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]

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.

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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 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.

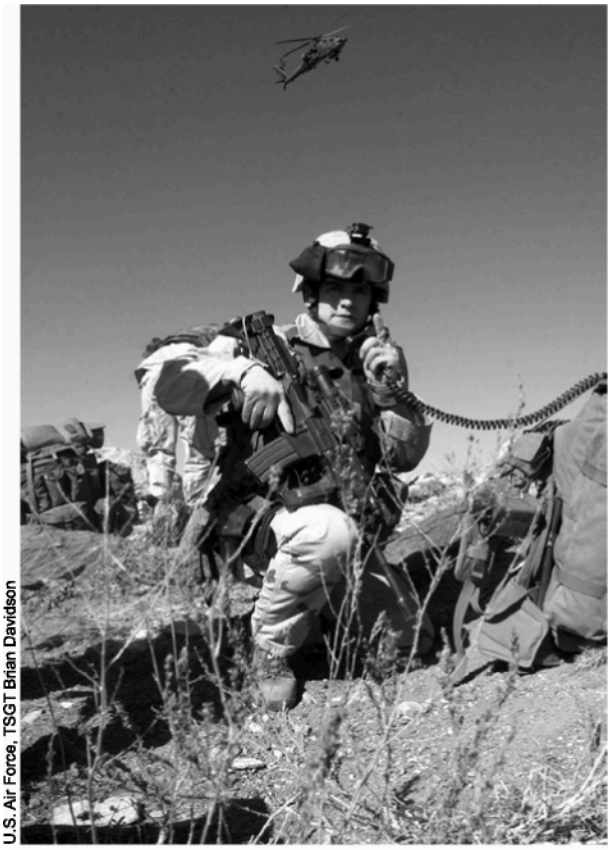
... for most of its history, the Air Force... unlike its sister services, has been an organization in which mostly its officers fought, not its enlisted force.

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.

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.

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 retaining the right people.

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 of their country.

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 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

1. General Peter Schoomaker, "Ground Truth, interview," *Government Executive,* 14 September 2006, <www.govexec.com/features/0906-15/0906-15s1.htm>.
2. Terry McCarthy, "what Ever Happened to the Republican Guard?" *Time,* 4 May 2003, <www.time.com/time/magazine/article/0,9171,449441,00.html>.
3. Compare Gerry J. Gilmore, *Alleged Troop Mutiny was 'Isolated Incident', General Says,* 18 October 2004, American Forces Press Service, < www.defenselink. mil/news/Oct2004/n1 01 82004_2004101 805.html>.
4. See Rebecca Grant, "Safeside in the Desert," *Air Force Magazine* (February 2007) <www.afa.org/magazine/feb2007/0207desert.asp>.
5. See Department of Defense, *Department of Defense Survey of Health Related Behaviors Among Active Duty Personnel, 2005* (December 2006) <www.ha.osd. mil/special_reports/2005_Health_Behaviors_ Survey_1-07.pdf>.
6. See, generally, "Operation Allied Force," *Global Security.org,* 27 April 2005, <www.globalsecurity.org/military/ops/allied_force.htm>.
7. See U.S. Central Air Forces, *Operation Iraqi Freedom—By the Numbers,* April 2003, <www.au.af.mil/au/awc/awcgate/af/oifcentaf.pdf>.

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

The Military Health System (MHS) of the Department of Defense encompasses the entire spectrum of medicine in the military: from basic research to bedside care; from DoD-level health policy through its resourcing and execution by the individual Services. It spans uniformed and civilian; military and private sector. Its base is broad but its mission is focused:

The Military Health System mission is to provide optimal Health Services in support of our nation's military mission—anytime, anywhere.

America's Military Health System (MHS) is a unique partnership of medical educators, medical researchers, and healthcare providers and their support personnel worldwide. This DoD enterprise consists of the Office of the Assistant Secretary of Defense for Health Affairs; the medical departments of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Joint Chiefs of Staff; the Combatant Command surgeons; and TRICARE providers (including private sector healthcare providers, hospitals and pharmacies).
The MHS is prepared to respond anytime, anywhere with comprehensive medical capability to military operations, natural disasters and humanitarian crises around the globe, and to ensure delivery of world-class healthcare to all DoD service members, retirees, and their families. The MHS promotes a fit, healthy and protected force by reducing non-combat losses, optimizing healthy behavior and physical performance, and providing casualty care.
As a source of innovative education, medical training, research, technology and policy, the MHS strives to provide a bridge to peace.



"**Quadruple Aim**"
The New 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. According to IHI, to achieve the Triple Aim, organizations must act as "integrators" focused on achieving high levels of performance across the three objectives. In the process, they must address system components that include:

- **Individuals and families**
  Example: Memory and recognition of individuals anywhere they go in the system
- **Redesign of primary care services and structures**
  Example: Cooperation and coordination with other specialties and hospitals
- **Population health management**
  Example: Use of predictive models to deploy resources to high-risk individuals
- **Cost control platform**
  Example: Yearly initiatives to reduce waste and the associated cost, with all providers involved
- **System integration**
  Example: Execution, including spread, of strategic initiatives

The MHS took this "Triple Aim" health care paradigm and added a necessary fourth target – readiness – in order to adapt it to Military Health System use.

The MHS is a large and complex system of systems. The sheer size of TRICARE's operations alone is daunting: 59 hospitals and medical centers, 364 health clinics and roughly 350,000 individual providers serving a beneficiary population of 9.6 million. There is also a massive number of

processes that are happening on a regular basis: roughly 22,000 inpatients admitted, 2.5 million prescriptions written and 3.5 million claims being processed every week.

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 and the metrics used in 2010 to track each:

The MHS Quadruple Aim

1. **Readiness**
   Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions
   - Observed vs Predicted Survival Rate
   - Battle-Injured Medical Complications Ratio
   - Individual Medical Readiness

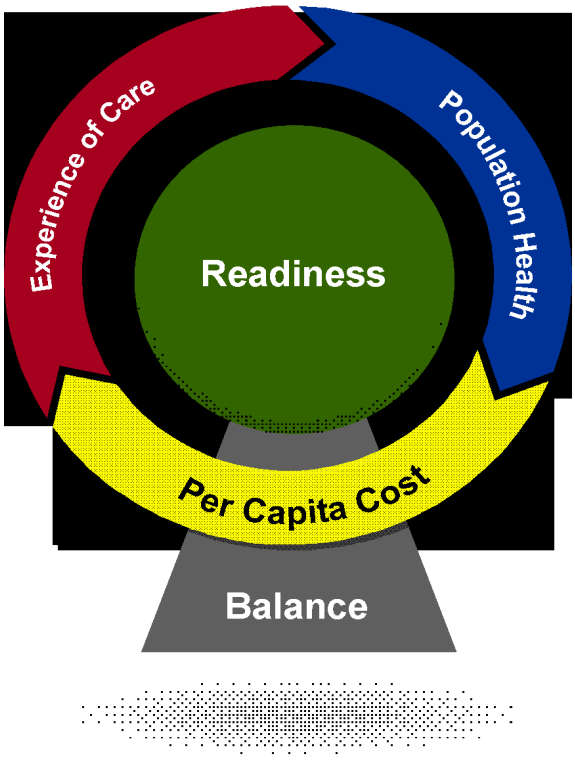
2. **Population Health**
   Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience
   - Active Duty Smoking Rate
   - Body Mass Index Rate
   - Colorectal Cancer Screening Rate
   - Management of Lipids in Diabetics

3. **Experience of Care**
   Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality
   - Satisfaction with Health Plan
   - Satisfaction with Health Care
   - Primary Care Continuity
   - Satisfaction with Provider Communication
   - Overall Satisfaction with Getting Timely Care

4. **Responsibly Managing the Total Health Care Costs**

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual care activity

- Per Member Per Month Expense
- Emergency Room Utilization



Key enablers needed to make this possible are: Retention, Clinical Currency, and Low Personnel Turnover

The Air Force and Its Medical Service

The mission of the Air Force Medical Service (AFMS) is *"To provide seamless health service support to the United States Air Force and Combatant Commanders."*

This is one of the most important sections in this book. I cannot stress enough how important it is for you to read and understand the concepts it describes. In the Air Force we are both physician assistants and Air Force officers and must be excellent in both roles for a satisfying career. You became a good PA through rigorous training, and continuous education (both self and CME). Officership is parallel but different. After the basics of COT, the good officers learn by emulating others, doing military developmental education (DE), and stepping into leadership opportunities as they open. Situational awareness is essential. You must know what is going on in the larger organization outside your MTF. The AFMS Transformation Truck is barreling down the road. You have the choice of sitting in the cab with the driver or being run over without warning. To help you enjoy the ride I give you the following topics.

The first article, by Maj Gen Charles Dunlap and reprinted earlier in this handbook (with permission from Military Review) is "Understanding Airmen". I consider it particularly apropos with the increasing number of Air Force PA joint expeditionary tasking (JET) missions, using airmen to augment ground forces. The DoD is joint, and although the Air Force culture and mission are different from that of the Army, which is different from the Navy, we fight in unity. Our differences are neither a cause for snobbery nor something to apologize for. We are teammates. The second piece, by Lt Gen Green, the current Air Force Surgeon General, provides a broad overview of the state of the AFMS today. The third article, by former Air Force Surgeon General Roudebush provides insight into why the Air Force resists a totally "purple suit" medical service. How the AF fights, where it fights from, and who the AFMS works for is unique. Finally, "AFMS Long View Strategy" outlines the principles by which long term staffing and resourcing decisions are made. The MHS's "Quadruple Aim" model, presented earlier, helps guide the AFMS decisions.

I am frequently asked about increasing the number of PAs or expanding the spectrum of PA specialty practice. Whether the question is about entering new specialties such as aerospace medicine, dermatology, radiology, cardiology, urology, neurosurgery, or occupational medicine, or older established fields like orthopedics, general surgery or emergency medicine, the answer is the same. New authorizations are created (and old ones continue) based on the needs of the AFMS. Those needs are determined by analysis of both manpower and mission.

Around 2001 the AFMS launched the Long View Strategy with a goal to "attain the highest expeditionary capability and the best health status of our people, while managing the overall cost". This strategy clearly places expeditionary capability as top priority. As a previous Surgeon General said, "Without an expeditionary mission there is no need for an AF medical service". Therefore any proposed resourcing action (e.g. new specialties, more people) will first be analyzed for its expeditionary contribution.

Please read the section on the Long View carefully. Understanding these concepts will go far in keeping you oriented in the midst of a rapidly transforming AF Medical Service. To think constructively you need to understand the organizational situation and goals. Only then can you thrive and be an agent for constructive change within the system.

***NOTE**:* Although the "Long View Strategy" by name is now passé, its principles are still a worthwhile guide

Air Force Medical Service—
Trusted Care Anywhere

By Lt Gen (Dr) Charles B Green

"Trusted Care Anywhere" is the Air Force Medical Service's vision for 2010 and beyond. In every domain of Air, Space, and Cyberspace, our medics contribute to the Air Force and joint team with world-class medical capabilities. Our 32,000 active duty medics around the globe are trained and motivated for mission success. Over 1,600 are now deployed to 40 locations in 20 countries, delivering state of the art preventive and life-saving care. From our theater hospitals in Balad and Bagram, to the efforts of our Humanitarian Assistance Rapid Response Teams (HARRT), that recently responded to earthquake-ravaged Indonesia, to the care of our families at home, we put our patients first.

Today's focus is on our missions in Afghanistan and Iraq: stability operations, health care delivery, and preparing for emerging threats. We continue to find ways to quickly adapt our medical systems, and implement organizational change to produce healthier outcomes in those diverse mission areas. While we've earned our nation's trust with our capabilities and the expertise of our people, we constantly seek to do even better! Here are our areas of strategic focus.

Enhance Expeditionary Medicine and Aeromedical Evacuation Capabilities

Our success in battlefield medicine underscores our ability to provide Trusted Care Anywhere. The joint medical team brings a wounded warrior from the battlefield to an operating room within an unprecedented 20 to 40 minutes. That rapid transfer enables our medics to achieve fatality rate under ten percent; the best survival rate ever seen in war. In addition, our aeromedical evacuation system (AE) and critical care air transport teams (CCATT) are world class. We mobilize specially trained flight crews and medical teams on a moment's notice to transport our most critical patients across oceans. Since November 2001, we have transported more than 69,000 patients from Afghanistan and Iraq.

We don't rest on our laurels. Among the innovations we have implemented recently from lessons learned on the battlefield is a device that provides spinal immobilization for AE patients. This device maximizes patient comfort and reduces skin pressure. We are also working towards an improved detection mechanism for compartment syndrome in trauma patients. The early detection and treatment of excess compartment pressure could eliminate irreversible tissue damage. In February 2010, a joint Air Force and Army team began testing packages that will improve ventilation, oxygenation, fluid resuscitation, physiological monitoring, hemodynamic monitoring and intervention, and flexible power utilization in critical care air transport.

Provide Patient-centered Health Care

We are committed to bringing the same high level of trust we've earned in combat to our patients at home through patient-centered care. Our focus is to enhance the health of all our patients with the introduction of our Family Health Initiative (FHI). This initiative mirrors the American Academy of Family Physicians' "Patient Centered Medical Home" concept and is built on care provided by a dedicated team of professionals. The goal of this partnership between our patients and

their health care teams is to increase prevention successes and achieve better health outcomes. Our providers are given full clinical oversight of their care teams and enabled to practice to the full scope of their training. We believe the results will be high quality care and improved professional satisfaction.

Two of our initial FHI bases—Edwards AFB, CA, and Ellsworth AFB, SD— have dramatically improved their national standings in cost containment, patient satisfaction, access to care, and quality of care. Eleven other bases are now organized to implement the FHI for their beneficiaries. In 2010, we will add 20 additional sites. We are particularly encouraged by our patient continuity data for our FHI. Previous metrics showed that our patients only saw their assigned provider approximately 50 percent of the time. At Edwards and Ellsworth, provider continuity is now in the 80-90 percent range.

We still have work to do, such as developing improved decision support tools, strengthening case management support, and refining our FHI training. The challenge of implementing change of this size and scope requires broad commitment. The AF Medical Service has that commitment and we are confident the FHI will deliver exceptional care in the years ahead.

Patient safety is central to everything we do. By learning from mistakes and sharing information, we continually work to enhance the quality of our care. Through alerts and advisories, we share our clinical lessons learned with the DoD Patient Safety Center and sister Services. We integrate clinical scenarios and lessons learned into our simulation training, and we securely share de-identified patient safety information across the Services through DoD's web-based Patient Safety Learning Center.

To optimize our care we also built strong academic partnerships with St. Louis University, Wright State University (Ohio), University of Maryland, University of Mississippi, University of Nebraska--Lincoln, University of California--Davis, and the University of Texas--San Antonio, among others.

Our long history of collaborating with the VA enhances clinical currency for our providers, saves valuable resources and provides a smoother transition for our airmen as they move from active duty to veteran status. The Air Force currently has five joint ventures with the VA, including the most recent at Keesler AFB, MS Additional efforts are underway for Buckley AFB, CO to share space with the Denver VAMC, which is now under construction.

Safeguard the Mental Health of Our Airmen

Trusted care for our patients includes safeguarding their mental health and well-being. To do this, we are engaged in a number of initiatives to improve and optimize mental health access and support.

In addition to constantly looking for ways to improve our existing training material such as the "Leaders' Guide for Managing Personnel in Distress," "Community Suicide and Violence Awareness Briefings," and "Landing Gear Program," we are partnering with the Air Force personnel and logistics communities to develop a comprehensive airman resiliency program that will provide services for targeted high-risk groups. We provide basic resiliency training, psychological screening, and support for all deploying airmen. Additionally, airmen at higher risk for post traumatic stress are closely screened and monitored for psychological concerns post-deployment.

We recently unveiled "Defenders Edge," which is tailored to security forces airmen who conduct missions in or outside the wire. This is intended to improve airmen's mental resiliency to combat-related stressors. Unlike conventional techniques, which adopt a one-on-one approach focusing on emotional vulnerability, DEFED brings the mental health professional into the group environment, assimilating them into the security forces culture.

Increase Focus on Recruiting and Retention Initiatives

To gain and hold the trust of our patients, we must always have highly trained and qualified providers. To have those high quality providers in the future, there are numerous efforts underway to improve recruiting and retention.

We've changed our marketing efforts to better target recruits, such as providing Corps-specific DVDs to recruiters. The Health Profession Scholarship Program remains vital to attracting physicians and dentists, accounting for 75 per-cent of these two Corps' accessions. The AF International Health Specialist program is another successful program, providing AFMS personnel with opportunities to leverage their foreign language and cultural knowledge to effectively execute and lead global health engagements.

For our enlisted personnel, targeted Selective Reenlistment Bonuses, combined with continued emphasis on quality of life, generous benefits, and job satisfaction have positively impacted enlisted recruiting and retention efforts.

Strengthen GME and Officer/ Enlisted Training

We are working to further develop AFMS personnel in a manner that fosters excellence in clinical, operational, and joint roles. We are increasing opportunities for advanced education in general dentistry and establishing a more formalized, tiered approach to Medical Corps faculty development. Senior enlisted collaboration in the National Capital Region and the San Antonio Military Medical Center (SAMMC) is fostering tri-Service collaboration, enlightening the Services to one another's capabilities, and establishing opportunities to collaboratively sharpen readiness skills.

Our Centers for the Sustainment of Trauma and Readiness Skills (CSTARS) at St Louis University, University of Maryland-Baltimore Shock Trauma, and University of Cincinnati College of Medicine remain important and evolving predeployment training platforms for our doctors, nurses, and medical technicians. We recently expanded our St Louis University training to include pediatric trauma. This training came about because, tragically, our deployed medics treat hundreds of children suffering from war-related injuries.

Rebuild Our Hospitals

Our patients appropriately expect our AFMS facilities and equipment will be state-of-the art and our medical teams clinically current. They trust that we will give them the best care possible.

We are engaged in an extensive modernization of Wright-Patterson Air Force Base Medical Center in Ohio, with particular focus on surgical care and mental health services. We are continuing our investment in a state-of-the-art medical campus for SAMMC at Lackland AFB, TX. Our ambulatory care center at Andrews AFB, MD, will provide a key capability for the delivery of world-class health care in the National Capital Region's multi-service market.

In addition to upgrading our medical facilities, we are also increasing our capabilities to give patients more choice and increase provider satisfaction with a more complex case load. In our larger

facilities, we have launched a Surgical Optimization Initiative, which includes process improvement evaluations to improve operating room efficiency, enhance surgical teamwork, and eliminate waste and redundancy. This initiative resulted in a 30 percent increase in operative procedures at Elmendorf AFB, AK, and 118 percent increase in neurosurgery at Travis AFB, CA.

By increasing the volume, complexity, and diversity of care provided in AF hospitals, we not only make more care available to our patients but we provide our clinicians with a robust clinical practice that ensures they are prepared for deployed operations, humanitarian assistance, and disaster response.

Set Clear Research Requirements

Trusted care is not static–we must earn that trust over and over every day. The science of medicine is dynamic and we are always looking toward tomorrow's requirements. We will ensure our patients and war-fighters always benefit from the latest medical technologies and clinical advancements.

We are looking 5 to 10 years ahead to meet the changing needs of our peacetime beneficiaries. More critically, to protect our war-fighters from future threats, we look 20 to 30 years ahead to understand evolving technologies, changing weapon systems, and changes in doctrine and tactics. If injury does occur, we will quickly diagnose and effectively provide cutting edge treatment to our wounded warriors. Our expanding medical research capabilities across the AFMS are focused on identifying and correcting any capability gaps.

Our planning processes ensure that solutions are focused on critical AFMS mission needs. Further, deliberate planning approaches are used to maximize our research and development funding. We have a multi-functional team approach to determine our vital interests. We also compete for additional sources of funding and leverage efforts of sister Services or other federal agencies. By understanding gaps, we determine clear research requirements to make proper resource investments.

Conclusion

As an enterprise, the AFMS is committed to success across the spectrum of operations. Where appropriate, we are increasing clinical capacity and the scope of our practice. We are strengthening our education and training platforms and actively involved in research and development opportunities.

We will continue to improve our facilities and the quality of our health care delivery to ensure the health and wellness of all entrusted to our care. We will do all this in a patient-centric manner; focused on patient safety and sound fiscal stewardship.

In closing, I share a quote from our Air Force Chief of Staff, Gen Norton A Schwartz, who said, "I see evidence every day that the Medical Service is 'All In', faithfully executing its mission in the heat of the fight, in direct support of the war-fighter, and of families back home as well."

"All in" is the right place to be.

Planned AFMS Research Innovations

- Directed energy force protection, which focuses on detection, diagnosis, and treatment of laser threats.
- The Virtual Lifestyle Manager (VLM), a web-based prevention program that provides education, training, and support to diabetics, and at-risk patients.
- Air Force Blue Strategic Plan for Diabetes, geared toward improving diabetes prevention and treatment across DoD.
- Autism research, focused on the diagnosis, causes, and treatment of autism, in support of the Family Health Initiative.

The AFMS Difference

By Lt Gen James G. Roudebush AF/SG (2006-2009)

Quick Overview

The Air Force Medical Service [AFMS] operates with an approximate $7.7 billion annual budget. Our authorized end strength is 39,600 Air Force medics. And please note that when I say medics, I am referring to all Air Force medical personnel…officer, enlisted and civilian. We operate 75 military treatment facilities [MTFs]— 57 clinics, one ambulatory surgery center, 13 hospitals, and four medical centers across the globe.

We have been busy transforming our infrastructure to match changes in population and Air Force missions while ensuring the best quality of care for our beneficiaries. From 1988 to 2013, we have reduced the number of facilities 43 percent, and converted many of our bedded facilities to clinics. This is in large part due to changes in medicine that have driven more outpatient care and higher acuity inpatients. Our small hospitals, similar to rural hospitals around the country, could not expand to meet the needs of higher acuity inpatients. Although our physical footprint has changed, we continue to deliver impeccable care to deployed forces and state-of-art care at home. We continue to provide the best care America can offer to over three million patients annually.

Air Force medicine is structured differently than the medical services in the Army and Navy. Why?

The Air Force mission is doctrinally different than the Army, Navy or Marines. We fight from our bases and build new bases [airfields] when needed. Air Force medics are funded and fielded differently than our Army and Navy counterparts. The AFMS does not have a separate line funded operational medical capability. Our facilities are funded through the Defense Health Program (DHP) but all medical capabilities are under direct operational control of Air Force line commanders at each base.

This close alignment has enabled remarkable transformation. We've transformed from a heavy, forward-based medical force to a light, lean, modular, targeted capability. We are innovators in modular capability and are routinely first tasked and first in place for contingencies due to our modular capabilities and close linkage to airlift. We can go in light because we are always connected via air evacuation to medical facilities worldwide. Our close ties to the Air Force line keeps us highly agile.

Ensuring a fit and healthy force, preventing casualties, restoring health, sustaining human performance and supporting the joint warfight is our mission and our mantra. Our local wing [base] commanders are responsible for their airmen's health; and our medical group commanders have a direct responsibility to the wing commander for the health of each and every airman and their families.

From an interview in *Military Medical/NBC Technology.* Vol 11, No.6. Oct 2007

AFMS Long View Strategy

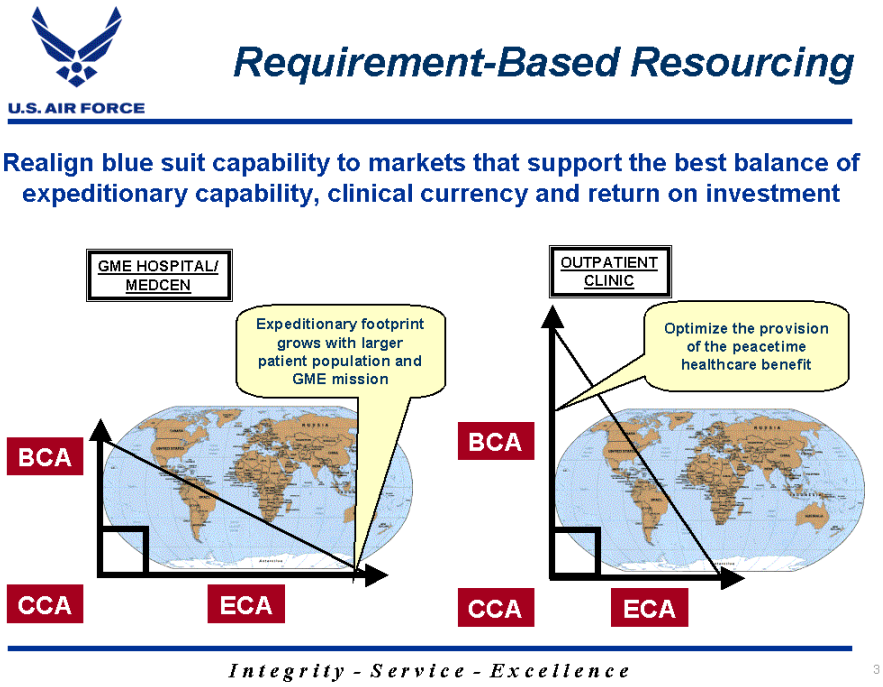
AFMAN 38-208, Volume I states, "Resource requirements reflected in a manpower standard should be based on an organization and process design that most effectively and efficiently accomplishes the mission. Improving mission effectiveness while maintaining or improving efficiency should be the goal of any modification to a function's current organizational or process design. Efficiency does not necessarily mean decreasing resources, but rather improving the return on the resources used." This is the foundation for the Air Force Medical Service's (AFMS) resourcing strategy known as the Long View.

The AFMS Long View strategy employs a requirement-based resourcing approach that seeks to attain the highest expeditionary capability and the best health status of our people, while managing the overall cost. It answers two basic questions:

1. What is the true requirement?
2. How do we resource the true requirement?

Achieving the best balance of expeditionary capability, clinical currency and return on investment is the strategy's goal. Figure 1 graphically depicts the strategy using Expeditionary Capability Analysis (ECA), Currency Case Analysis (CCA), and Business Case Analysis (BCA).

Figure 1.

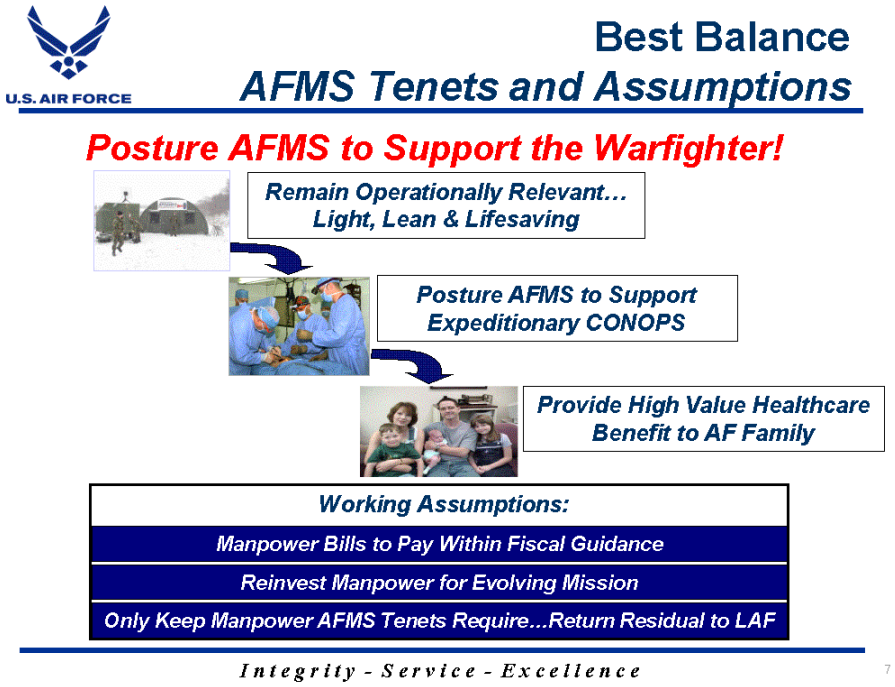


The Long View Strategy is scalable and can be used at all levels and scenarios. It offers full visibility to all stakeholders (AF, MAJCOMs, TMA, Consultants, manpower, finance). It offers standard central programming for local execution.

The Long View strategy embraces three AFMS tenets (see Figure 2)--operational relevance, expeditionary support, and the provision of a high value healthcare benefit. Embedded within

the strategy's tenets are the two key components of the AFMS mission, namely, support of expeditionary air operations at home or abroad, and delivering a high value healthcare benefit to our patient population in the peacetime setting. These two components are not mutually exclusive, but rather, mutually enabling. The "best balance" approach employed by the Long View strategy recognizes this symbiotic relationship and promotes it.

Figure 2.

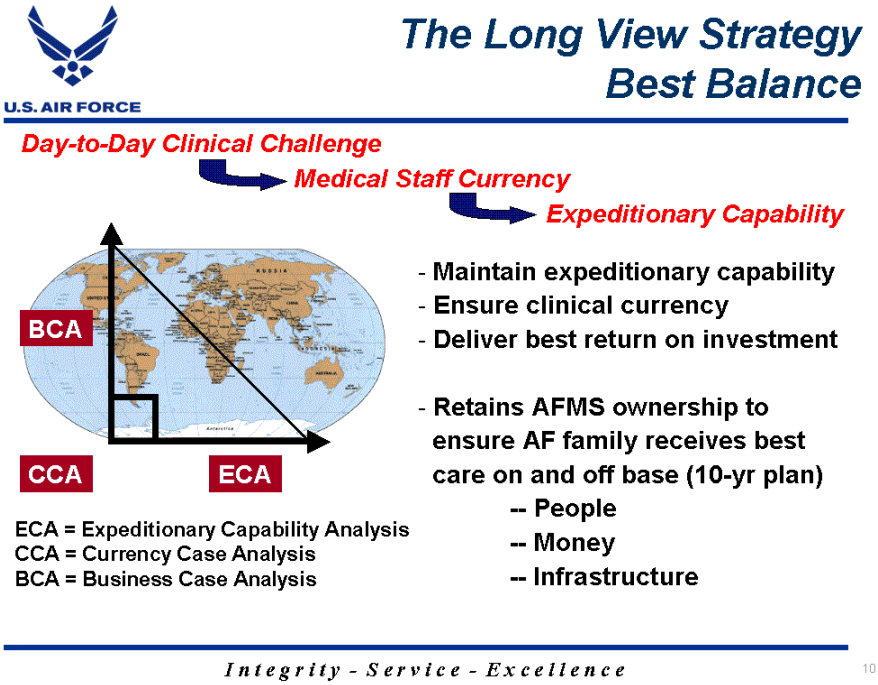


To ensure the benefit of the strategy is not expropriated, the Long View's three working assumptions serve as guideposts for actions taken concerning any manpower gains realized as a result of the strategy. Those three assumptions are: 1) There will be manpower bills to pay under the current Fiscal guidance, 2) Manpower savings shall be reinvested in support of the evolving mission, and, 3) Only that manpower that supports the strategy tenets will be retained, the residual will be returned to the Line of the Air Force.

Ultimately, the strategy's "best balance" approach postures the AFMS in support the warfighter; the first key component of the AFMS mission. In today's high threat environment, the need for readily deployable medical assets is critical, whether the contingency involves overseas AORs or homeland defense. Not only must these medical assets be capable of deploying at a moment's notice, they must be capable of performing medical intervention immediately upon arrival at the contingency location. Weight and cube rule the day in a rapid response, expeditionary setting and medical redundancy in the field is a luxury no longer acceptable. Expeditionary medicine provides one medical team with one chance to get it right. Performing at the "tip of the spear", there is no opportunity to gradually phase into the wartime medical effort. The bottom line is the team that deploys must be a clinically current, full-up round, ready to work independent of any other medical support.

How is this accomplished? The AFMS Long View strategy enhances expeditionary capability through placement of medical personnel at locations where the peacetime mission provides sufficient workload volume and complexity for maintenance of clinical currency for both the provider and their support staff (see Figure 3).

Figure 3.

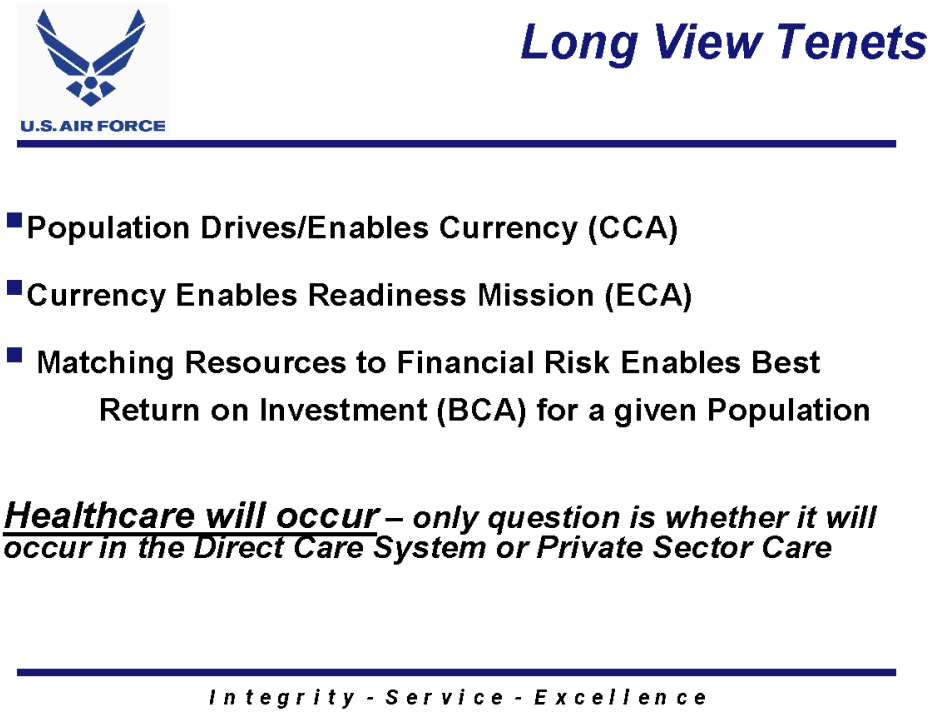


But this clinical currency also pays dividends to the second key component of the AFMS mission, namely, the provision of a high value healthcare benefit to all Military Health System (MHS) eligible beneficiaries seeking care at AF Military Treatment Facilities (MTF). Just as clinical currency promotes expeditionary capability, it also enhances the health status of the peacetime population through placement of medical personnel at locations that afford clinical currency for both the provider and their support staff. Why? Medical staffs that are exercising their clinical acumen on a daily basis provide a higher quality of healthcare benefit to their patients. The Long View strategy embraces this approach to healthcare delivery.

The AFMS mission, like the AF mission, is accomplished with limited resources. The Long View strategy not only places medical personnel at the right locations to ensure clinical currency, it also seeks to achieve the best return on investment by placing the right number, the right specialty mix, and the right "Blue Suit" versus outsourcing mix at each of these location. If placement of an Active Duty provider at a particular location provides no readiness benefit, i.e., no additional wartime requirement exists then a business case analysis can identify the best return on investment for the next clinical currency requirement. Furthermore, if a location lacks clinical currency, or no additional "Blue Suit" assets remain in the inventory, it is the business case that will identify the next best option for meeting the medical needs of the population regarding a particular product line. Under this scenario, outsourcing the service is examined as an alternative to "Blue Suit" manpower. The outsourcing can take on many forms, but principally, the service will be purchased for delivery in the MTF when the business case

supports it, or the service will be purchased downtown for those situations when the business case indicates a greater cost savings potential if the MTF divests the service entirely (see Fig. 4).

Figure 4.



Ultimately, expeditionary capability, clinical currency and business case analysis (return on investment) are inextricably linked and mutually reinforcing. While expeditionary capability is the AFMS' first priority, clinical currency is an integral factor for achieving that capability. Since clinical currency is the integral factor for achieving expeditionary capability, the environment of limited resources demands the AFMS strategically place each finite asset at locations that will provide the best return on investment. The Long View strategy uses each of these factors (ECA, CCA, & BCA) under a best balance approach to accomplish the AFMS mission (see Figure 5). The benefit is an expeditionary capability second to none and the best health status for the population, while managing the limited AFMS resources.

A Word About Optimization: The Family Health Initiative (FHI), as did Clinical Practice Optimization (CPO) and Primary Care Optimization (PCO) before it, reflects the long view. AFMS transformation is not so much downsizing and penny-pinching as it is a redistribution of assets to best meet long view-identified AFMS priorities. If a capability is judged 1) necessary to the AF mission and 2) best provided by AD AF, then that capability should be fully resourced in manpower and materiel (see Figure 6).

Figure 5.

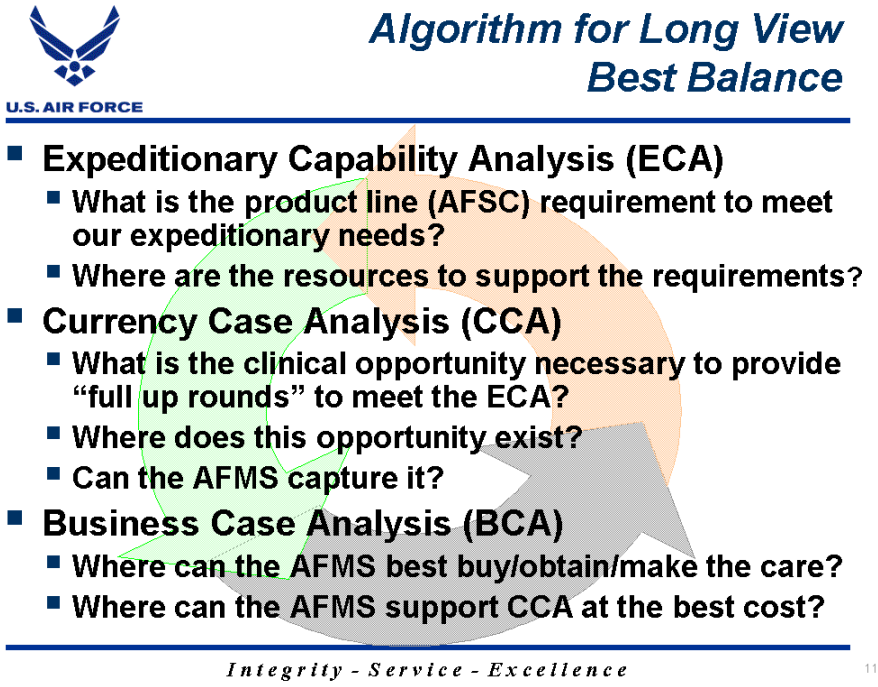
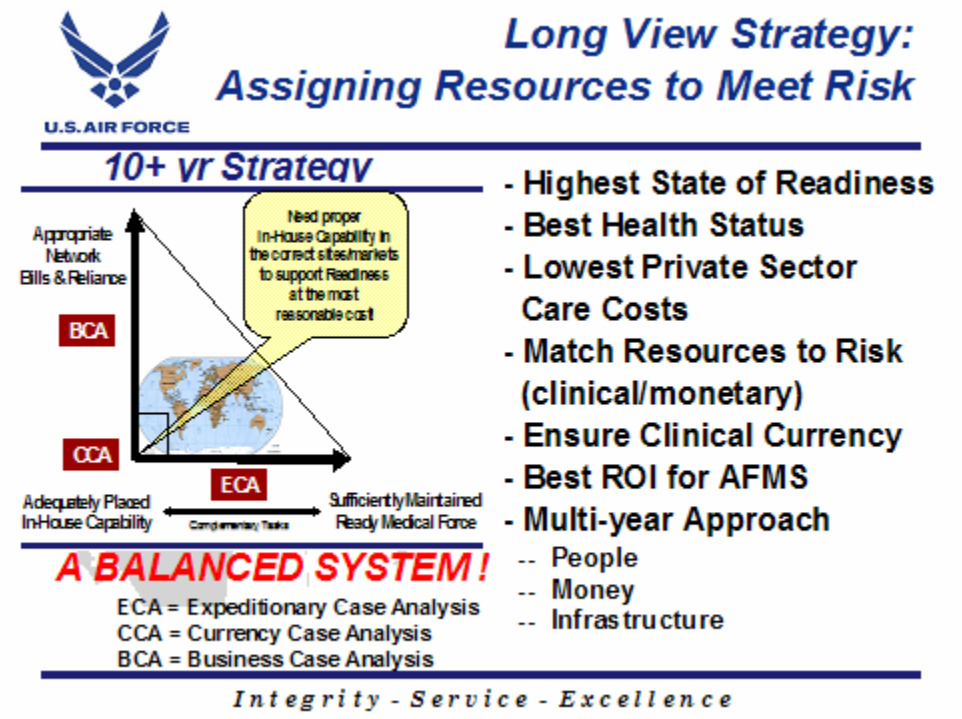
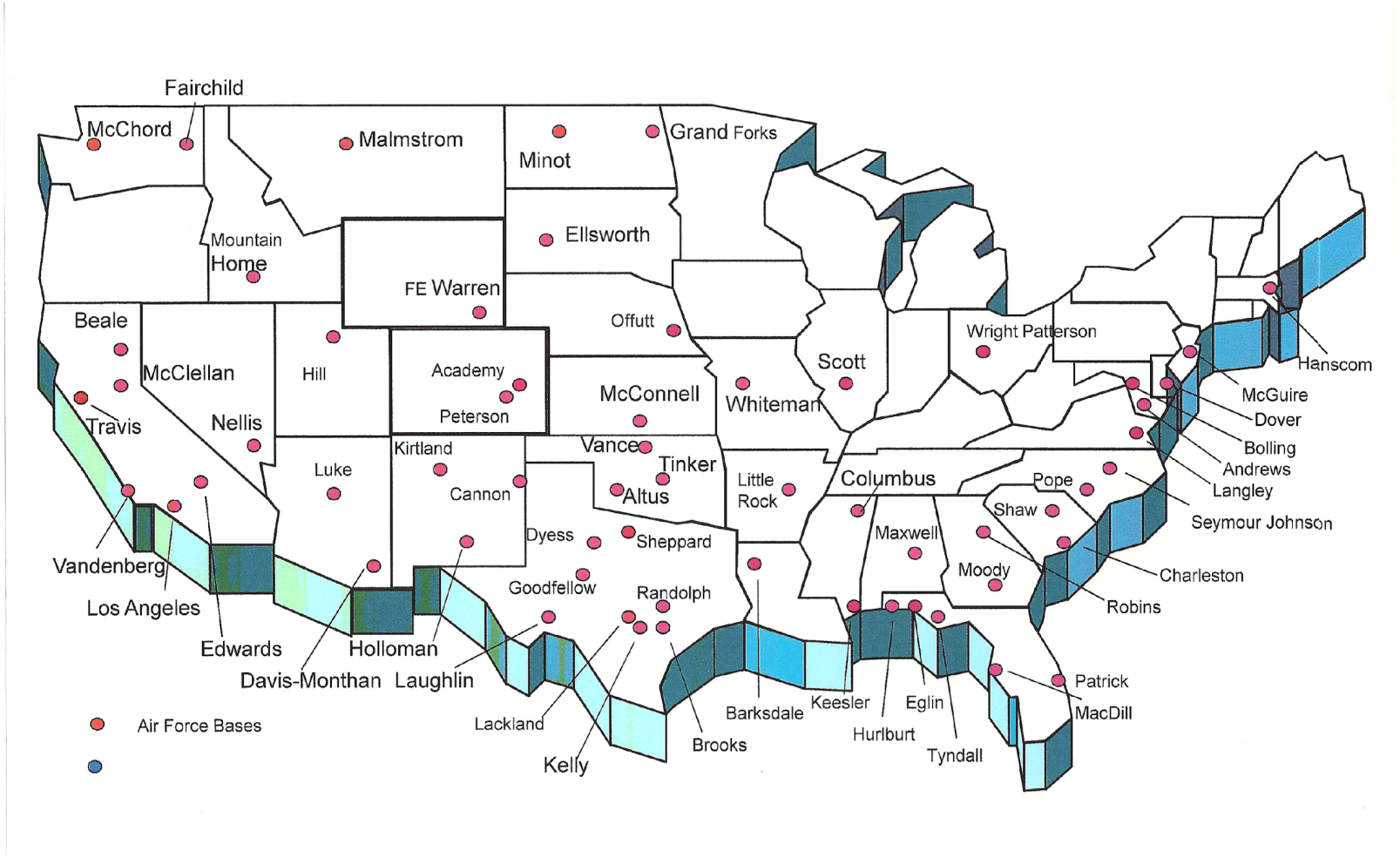
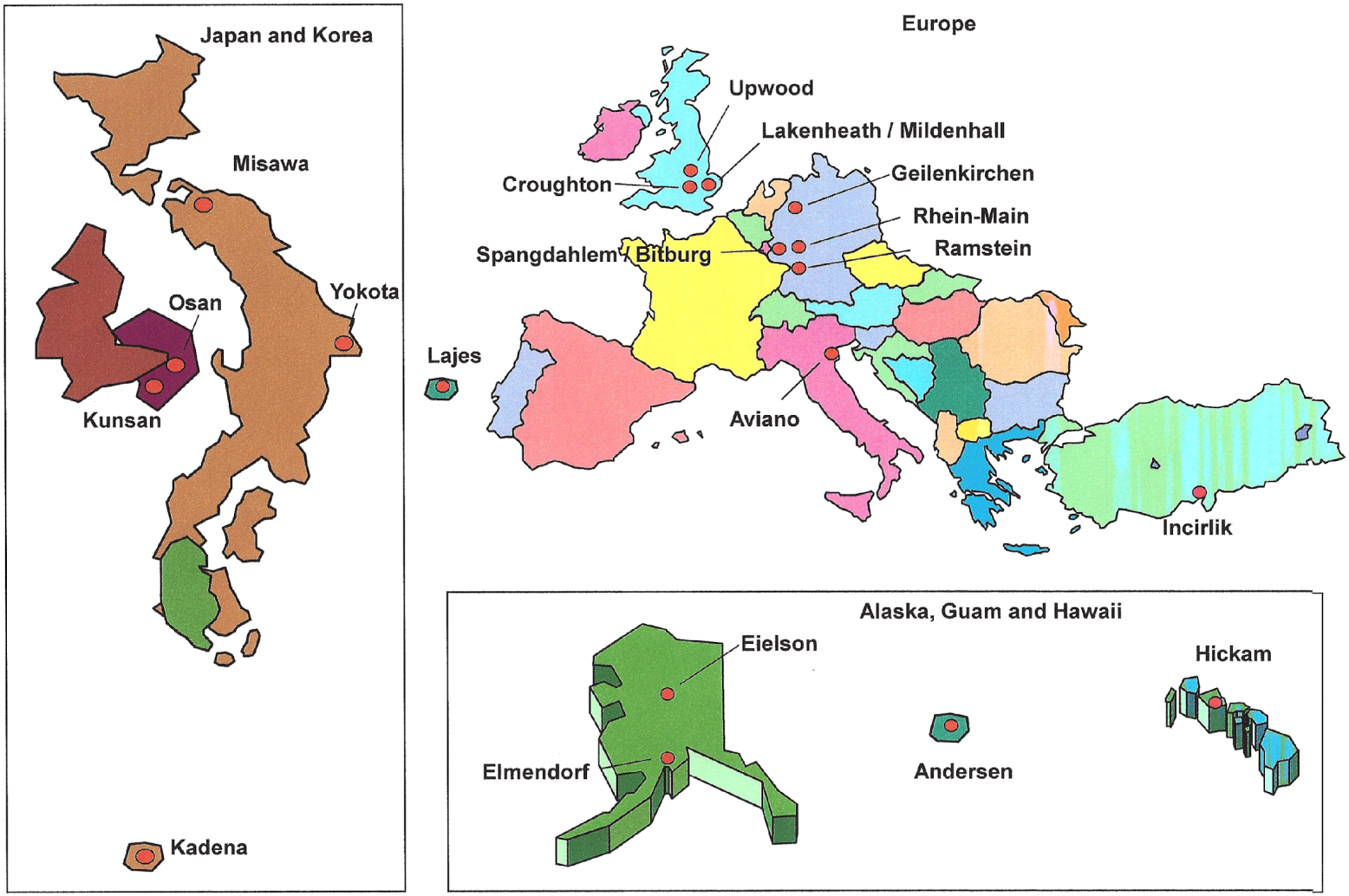


Figure 6.



AIR FORCE MTFs




Japan and Korea
Misawa
Yokota
Osan
Kunsan
Kadena
Europe
Upwood
Lakenheath / Mildenhall
Croughton
Geilenkirchen
Rhein-Main
Spangdahlem / Bitburg
Ramstein
Lajes
Aviano
Incirlik
Alaska, Guam and Hawaii
Eielson
Hickam
Elmendorf
Andersen

BIOMEDICAL SCIENCES CORPS

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 infections 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, training, medical intelligence, research and development, 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-Present	Brig Gen James J. Carroll	Aerospace Physiologist



HISTORY of the AIR FORCE 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 AAPAconference, "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 ver 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

2010

- 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)

BSC Badges

(Aeronautical, Duty and Occupational Badges)
AFI 36-2903, (2Aug2006), Dress and Personal Appearance of Air Force Personnel, para 5.9 (p 135)

- 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 Chief, Biomedical Sciences Corps" and "Chief Military Consultant to the AF Surgeon General for Physician Assistants" What's 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 0-6 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 him and his 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 Corporate Advisory Board (CAB) which sets policy for the Corps as a whole. The Associate Corps Chief also sits 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). He is 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, he will chair the board). Chairs the board for PA AFMS awards. Co-champion of Integrated Forecast Board Primary Care Panel where he screens and vets all BSC fellowship and AFIT advanced academic degree requests. Oversees equitable distribution of AFIT short course authorizations. Coordinates with AFPC for all FGO and special duty assignments.

So What Difference Does That Make for Me?

The Chief Consultant is the AFSC-specific bridge between the Surgeon General and the field. He is not in your chain of command so he should be looked on as a low-threat asset that is accessible to every member of the career field. He has the rank and experience to be effective but the currency he deals in is information. He is open to gripes, ideas for improvement, mentoring questions, counseling, rumor control, career broadening requests, etc. Ultimately it's his 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 him know your plans and desires early on. Chances are your application (or a request to vouch for you) will flow through him anyway before approval.

Associate Chiefs of the Biomedical Science Corps
(Chief Military 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-	**Col Cheryl E. Gregorio**	**Class #800227**

*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

Biomedical Science Corps (BSC) Contribution to AFMS Effects

The following is to give you an overview of the other specialties of the Biomedical Sciences Corps and how they each contribute to accomplishing the mission of the AFMS. Some of the more obscure BSC specialties can easily be underappreciated. To help, here's some basic AFMS doctrine.

The AFMS Mission is to provide seamless health service support to the USAF whether in-garrison or deployed. It directly supports USAF operations and theater aeromedical evacuation (AE) of joint and combined forces. The AFMS operates and manages a world-wide healthcare system capable of responding to a full spectrum of anticipated health requirements and provides an integrated healthcare system from forward deployed locations through definitive care with an emphasis on prevention of illness and injury. It arranges for healthcare that it does not possess. It promotes and advocates for optimizing human performance (sustainment and enhancement) for the warfighters, including the optimal integration of human capabilities with systems. Moreover, the AFMS assists in sustaining the performance, health and fitness of every Airman.

Effects are the desired results of achieving military objectives. The AFMS effects describe health service support for the warfighter. These effects are what the AFMS "brings to the fight." The four effects are:

1. Ensure a fit and healthy force.
2. Prevent casualties
3. Restore health
4. Enhance human performance

Capabilities are the means necessary to accomplish the desired effects listed above.

	BSC Contribution to AFMS Effects			
BSC Specialty	**Ensure Fit & Healthy Force**	**Prevent Casualties**	**Restore Health**	**Enhance Human Performance**
42B Physical Therapy	• Develop physical conditioning program • Establish occupationally-based physical standards • Develop physical conditioning, strengthening, and flexibility program for prolonged expeditionary environments	• Sports Injury Prevention • Back care education • Prescribe braces and trusses to protect against back, joint, and muscle injury	• Assess and correct back injury • Assess and correct joint injury • Assess and repair muscle injury • Develop health restoration tools and techniques for use in expeditionary environment • Develop expeditionary capability to deliver physical therapy in a theater hospital	• Brace design • Exoskeleton design • Optimize physical performance • Biomechanics of movement • Non-destructive pain induction
42E Optometry	• Conduct vision aspects of PHA • Establish standards based on occupation • Develop strengthening exercises to maintain/improve eyesight	• Eye protection • Sight preservation • Establish contrast, color and intensity standards for various types of work	• Identify disease related eyesight reduction • Identify candidates for corrective surgery • Correct vision anywhere • Develop expeditionary capability to deliver optometric support in a theater hospital	• Deception/Camouflage • Adversary Perception • Super Vision • Integrate vision correction with protective equipment • Computational algorithms to sight (Make computers “see”) • Light induced incapacitation • Apply sight protection principles to “seeing” weapon systems
42F Podiatry	• Provide foot care education • Identify foot related occupational limitations • Develop foot & ankle strengthening exercises	• Design footwear to prevent common foot injury • Design supports to prevent ankle injury	• Assess and correct illness/injury • Identify disease related foot problems • Develop expeditionary procedures and tools to stabilize foot and ankle injuries in theater to improve recovery rate	• Design footwear to mitigate fatigue • Design footwear to improve physical performance

	BSC Contribution to AFMS Effects			
BSC Specialty	**Ensure Fit & Healthy Force**	**Prevent Casualties**	**Restore Health**	**Enhance Human Performance**
42G Physician Assistant	• Conduct/manage PHA • Establish occupationally-based medical standards • Health and Wellness Program Managers	• Disease prevention education • Identify disease incidents/patterns of concern • Identify pre-symptomatic illness • Casualty Decontamination • Develop expeditionary capability in prevention and primary care delivery in Prevention/ Aerospace Medicine UTCs, EMEDS and theater hospitals	• Assess and correct illness and injury • Manage mass casualties • Develop patient care protocols • Surgical assist	• Calmative agent use and procedures • Sedative/stimulant agent use and procedures • Health effects of weapon systems • Apply understanding of human physiology to performance enhancement
42N Audiology/Speech Pathology	• Conduct hearing aspects of PHA • Develop techniques to improve communication abilities	• Develop hearing protection devices • Build hearing loss prevention education program • Design communication devices integral to personal protective equipment	• Assess and correct hearing problems • Assess and correct speech problems	• Develop computational algorithms to sound and speech recognition (make computers hear) • Reduce sound to protect operators • Reduce sound to hide from adversary • Develop sound-induced incapacitation tools and procedures • Develop non-destructive sound-induced stress tools and procedures • Optimize audio perception

	BSC Contribution to AFMS Effects			
BSC Specialty	**Ensure Fit & Healthy Force**	**Prevent Casualties**	**Restore Health**	**Enhance Human Performance**
42P Psychology	• Conduct psychological review to support PHA • Establish occupationally-based psychological standards	• Psychiatric casualty prevention education • Identify potential stressors prior to difficulties • Enhance expeditionary capability to support casualty prevention	• Rapidly return casualties to full duty • Enhance expeditionary capability to support health restoration	• Enhance perception • Reduce adversary perception of friendly intentions • Profile adversary leaders and followers • Develop predictive models of human behavior • Develop non-destructive psychological stress tools and techniques • Develop tools to influence adversary behavior • Improve cognition
42S Social Work	• Determine social standards required of new recruits	• Develop group and buddy care education to prevent casualties • Identify and correct unit stressors to prevent dysfunction • Enhance expeditionary capability to support casualty prevention	• Restore and maintain unit cohesion • Enhance expeditionary capability to support casualty prevention	• Enhance ability to deceive adversary population • Develop predictive model of crowd and adversary population behavior • Assess adversary psychological willingness to continue struggle • Develop tools and techniques to influence target population behavior
42T Occupational Therapy	• Establish occupational physical standards	• Design work around human – ergonomics • Develop occupational injury/illness prevention education • Design protective equipment	• Identify and correct occupationally related illness and injury • Integrate impaired Airmen with work • Develop options to return impaired Airmen to duty to maximize contribution and investment	• Integrate human-system interface

	BSC Contribution to AFMS Effects			
BSC Specialty	**Ensure Fit & Healthy Force**	**Prevent Casualties**	**Restore Health**	**Enhance Human Performance**
43A Aerospace Physiology	• Establish air and space flight physical standards • Design fit & healthy program for various occupations • Centrifuge and hyperbaric chamber training	• Provide aircrew mission briefings on physiological considerations • Identify and correct potentially hazardous air and space crew environments • Develop guidance and tools to counter fatigue	• Identify and correct altitude induced illness and injury • Develop expeditionary capability to manage altitude-induced illness and injury	• Enhance air and space crew performance • Counter fatigue management • Human system interface • Minimize impact to human when transiting from space to air to ground ops
43B Biomedical Scientist	• Establish occupationally based physical and medical standards • Determine genetic predisposition to disease	• Design and develop personal protective equipment to include ground crew ensemble • Optimize human system interface	• Develop decision support systems • Develop diagnostic systems • Develop analytical procedures and systems	• Bioinformatics • Biomimicry • Biocomputation • Complex adaptive system development • Health impact of weapon systems • Nano- and Micro-technology • Swarming technology • Deception/Camouflage • Physical endurance enhancement
43D Dietetics	• Develop activity and occupationally based diet plans • Design weight management diet plans	• Develop diet education program to prevent casualties • Design expeditionary meals to meet dietary needs • Assess dietary fads and provide advice on use • Assess diet supplements and provide advice on use	• Assess and prescribe dietary plans to counter disease • Prescribe dietary plans to support holistic approach to health restoration	• Develop dietary supplements to counter fatigue, improve cognitive performance, and increase strength

43E Bioenvironmental Engineer	• Assess baseline exposures • Control potentially harmful exposures	• Anticipate and identify health hazards • Assess health hazards • Prescribe health hazard controls • Assess effectiveness of health hazard controls • Develop environmental surveillance tools to assess physical, chemical, biological, and radiological exposures • Develop guidance and tools for hardening facilities • Enhance expeditionary capability to prevent casualties	• Develop contamination control strategies • Integrate exposure assessment and control systems with medical diagnostic results	• Assess environmental and health hazards associated with weapon system maintenance and use • Determine long-term impact of target and weapon selection on environment and surrounding population • Translate knowledge of toxicology and dose-response relationships to weapon system development • Optimize human system interface (ergonomics)
43ExG (Health Physicist) 43ExM (Medical Physicist)	• Enforce control of radioisotopes and ambient exposures to radiation	• Assess and recommend exposure controls • Develop environmental surveillance tools to assess electromagnetic exposures • Enhance expeditionary capability to support rapid hazard assessment and mitigation recommendations	• Develop new diagnostic and therapeutic systems utilizing the entire electromagnetic spectrum	• Non-destructive application of electromagnetic spectrum to control human behavior • Translate health impact of electromagnetic energy to AF weapon systems

43H Public Health	• Establish baseline exposure documentation • Determine status of immunizations • Monitor deployment/expeditionary limiting illnesses/injuries	• Assess food quality • Identify and control vector borne diseases • Identify and control communicable diseases • Ensure prophylaxis and immunizations for deployment • Monitor incidence of disease and illness in population and deployed locations • Educate population on local and deployed hazards and prescribed preventive measures • Enhance expeditionary capability to prevent casualties	• Ensure post-exposure prophylaxis and treatment regime completed • Advise professional staff on new and emerging diseases of concern	• Integrate medical surveillance, intelligence and reconnaissance with DoD and World ISR capabilities • Monitor biological science advancements for potential military application
43M Entomology	• Keep disease carrying vectors under control	• Educate population on insect borne disease • Eradicate vectors • Develop protective measures • Develop expeditionary capability to support theater entomological operations	• Identify and recommend treatment profiles for insect borne disease	• Apply insect behaviors to military solutions • Apply insect protective measures to military solutions

43P Pharmacy	• Develop complete understanding of pharmacological interference and interaction • Develop non-drug or low drug solutions to treatment • Identify equivalent drugs and drug names throughout the world	• Ensure drug interactions are well understood and communicated to providers • Maintain complete drug usage record for all beneficiaries • Assess diet supplements and provide advise on use • Assess performance enhancement drugs and advise on use • Assess OTC drugs and advise on use and interactions	• Develop treatment regimes minimizing use of medications while maximizing effectiveness • Rapidly incorporate promising drugs into system and advise providers on use and indications • Enhance expeditionary pharmacy operations to support EMEDS and theater hospitals	• Develop counter fatigue drugs that don't interfere with mission • Develop physical performance enhancement supplements • Develop pre and post exposure prophylactic medications to counter CBRN agents of concern • Develop cognitive performance enhancement supplements • Develop calmative agents and procedures for military use • Develop non-destructive drugs to enhance interrogation
43T Laboratory	• Determine genetic predisposition to disease	• Identify biomarkers as precursors to disease	• Develop diagnostic techniques and systems • Link diagnostic systems to global healthcare • Develop genomic and proteomic solutions to restoration capabilities • Enhance expeditionary pharmacy operations to support EMEDS and theater hospitals	• Monitor genetic research and development for military application • Pursue genetic modification of organisms to enhance AF mission and human performance

PERSONNEL

MANAGEMENT

(AFPC ISSUES)

Managing Your AFSC

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 indicates the Chief Clinical Consultant for the specialty. Does not attach to the DAFSC.

A **“J”** prefix identifies officers serving in, or qualified to serve in, positions requiring parachutist qualifications (“jump qualified”). Put on the DAFSC when in the job. On a primary, secondary or tertiary when out of the job and removed altogether when no longer qualified.

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 successful family medicine practice 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 one-year PA specialty fellowships fulfill those. All specialty PAs who have completed an AF fellowship should have a PAFC and DAFSC showing 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 (ENT)
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. Getting it right is worth the effort.

CLINICAL AF SPECIALTY CODES

(from the AFOCD)

AFSC	CORPS	DESCRIPTION
40C0	All	Medical Commander
41A3	MSC	Health Services Administrator
42B3	BSC	Physical Therapist
42E3	BSC	Optometrist
42F3	BSC	Podiatrist
42G3	BSC	Physician Assistant
42G3A	BSC	Physician Assistant, Orthopedics
42G3B	BSC	Physician Assistant, ENT
42G3C	BSC	Physician Assistant, Gen Surgery
42G3D	BSC	Physician Assistant, Perfusionist (deleted Jan 2008)
42G3E	BSC	Physician Assistant, Emergency Room
42G3F	BSC	Physician Assistant, Oncology (deleted Jan 2008)
42N3	BSC	Audiology/Speech Pathologist
42N3A	BSC	Audiologist
42N3B	BSC	Speech Pathologist
42P3	BSC	Clinical Psychologist
42P3A	BSC	Clinical Neuropsychologist
42P3B	BSC	Health Psychologist
42P3C	BSC	Child and Adolescent Psychologist
42P3D	BSC	Aviation Psychologist
42S3	BSC	Clinical Social Worker
42T3	BSC	Occupational Therapist
43A3	BSC	Aerospace and Operational Physiologist
43B3	BSC	Biomedical Scientist
43D3	BSC	Dietician
43E3	BSC	Bioenvironmental Engineer
43E3A	BSC	Bioenvironmental Engineer, General
43E3B	BSC	Bioenvironmental Engineer, Industrial Hygiene
43E3C	BSC	Bioenvironmental Engineer, Medical Construction
43E3D	BSC	Bioenvironmental Engineer, Environmental
43E3E	BSC	Bioenvironmental Engineer, Architecture
43E3G	BSC	Bioenvironmental Engineer, Bioenvironmental/Health Physics (old 43Y3)
43E3M	BSC	Bioenvironmental Engineer, Medical Physics (old 43Y3A)
43H3	BSC	Public Health Officer
43M3	BSC	Medical Entomologist

43P3	BSC	Pharmacist
43P3A	BSC	Pharmacist, Clinical Pharmacy
43T3	BSC	Biomedical Laboratory
43T3A	BSC	Biomedical Laboratory Science
43T3B	BSC	Microbiology
43T3C	BSC	Clinical Chemistry
43T3D	BSC	Environmental and Industrial Hygiene Chemistry
43T3E	BSC	Blood Bank
43T3F	BSC	Toxicologist
43T3H	BSC	Hematology
44A3	MC	Chief Hospital/Clinic Services
44B3	MC	Preventive Medicine Specialist
44D3	MC	Pathologist
44D3A	MC	Pathologist, Hematology
44D3B	MC	Pathologist, Cytology
44D3C	MC	Pathologist, GYN
44D3D	MC	Pathologist, Forensic
44D3E	MC	Pathologist, Neuropathology
44E3	MC	Emergency Services Physician
44E3A	MC	Emergency Services Phys, Emergency Specialist
44F3	MC	Family Physician
44G3	MC	General Practice Physician
44H3	MC	Nuclear Medicine
44K3	MC	Pediatrician
44K3A	MC	Pediatrician, Adolescent
44K3B	MC	Pediatrician, Cardiology
44K3C	MC	Pediatrician, Developmental Ped
44K3D	MC	Pediatrician, Endocrinologist
44K3E	MC	Pediatrician, Neonatologist
44K3F	MC	Pediatrician, Gastroenterologist
44K3G	MC	Pediatrician, Hematologist
44K3H	MC	Pediatrician, Neurologist
44K3J	MC	Pediatrician, Pulmonologist
44K3K	MC	Pediatrician, Infectious Disease
44K3L	MC	Pediatrician, Medical Genetics
44K3M	MC	Pediatrician, Nephrologist
44M3	MC	Internist
44M3A	MC	Internist, Oncologist
44M3B	MC	Internist, Cardiologist
44M3C	MC	Internist, Endocrinologist
44M3D	MC	Internist, Gastroenterologist

44M3E	MC	Internist, Hematologist
44M3F	MC	Internist, Rheumatologist
44M3G	MC	Internist, Pulmonary Diseases
44M3H	MC	Internist, Infectious Diseases
44M3J	MC	Internist, Nephrologist
44N3	MC	Neurologist
44P3	MC	Psychiatrist
44P3A	MC	Psychiatrist, Child Psychiatry
44P3B	MC	Forensic Psychiatry
44R3	MC	Diagnostic Radiology
44R3A	MC	Diagnostic Radiology, Neuroradiology
44R3B	MC	Diagnostic Radiology, Special Procedures
44S3	MC	Dermatologist
44S3A	MC	Dermatologist, Derm Surgery
44S3B	MC	Dermatologist, Derm Pathology
44T3	MC	Radiotherapist
44U3	MC	Occupational Medicine Specialist
44Y3	MC	Critical Care Medicine
44Y3A	MC	Critical Care Medicine, Pediatrics
44Z3	MC	Allergist
45A3	MC	Anesthesiology
45B3	MC	Orthopedic Surgeon
45B3A	MC	Orthopedic, Hand
45B3B	MC	Orthopedic, Pediatrics
45B3C	MC	Orthopedic, Biomechanical
45B3D	MC	Orthopedic, Sports Medicine
45B3E	MC	Orthopedic, Spine Surgery
45B3F	MC	Orthopedic, Oncology
45B3G	MC	Orthopedic, Replacement Arthroplasty
45B3H	MC	Orthopedic, Traumatology
45E3	MC	Ophthalmologist
45E3A	MC	Ophthalmologist, Oculoplastics
45E3B	MC	Ophthalmologist, Cornea/External Disease
45E3C	MC	Ophthalmologist, Glaucoma
45E3D	MC	Ophthalmologist, Neuro-Ophthalmologist
45E3E	MC	Ophthalmologist, Pathology
45E3F	MC	Ophthalmologist, Strabismus/Ped
45E3G	MC	Ophthalmologist, Vitreous/Retina
45G3	MC	OB/GYN
45G3A	MC	OB/GYN, Endocrinologist
45G3B	MC	OB/GYN, Oncology

45G3C	MC	OB/GYN, Pathology
45G3D	MC	OB/GYN, Maternal-Fetal Medicine
45N3	MC	ENT
45P3	MC	Physical Medicine Physician
45S3	MC	Surgeon
45S3A	MC	Surgeon, Thoracic
45S3B	MC	Surgeon, Colon/Rectal
45S3C	MC	Surgeon, Cardiac
45S3D	MC	Surgeon, Pediatric
45S3E	MC	Surgeon, Peripheral Vascular
45S3F	MC	Surgeon, Neurological
45S3G	MC	Surgeon, Plastic
45S3H	MC	Surgeon, Oncology
45S3J	MC	Surgeon, Multi-Organ Transplant (Delete Jan 08)
45U3	MC	Urologist
45U3A	MC	Urologist, Pediatrics
45U3B	MC	Urologist, Oncology
45U3C	MC	Urologist, Kidney or Pancreas Transplant
46A4	NC	Nursing Administrator
46F3	NC	Flight Nurse
46N3	NC	Clinical Nurse
46N3D	NC	Clinical Nurse, Staff Development
46N3E	NC	Clinical Nurse, Critical Care
46N3F	NC	Clinical Nurse, Neonatal Intensive Care
46N3G	NC	Clinical Nurse, Obstetrical
46N3J	NC	Clinical Nurse, Emergency/Trauma
46P3	NC	Mental Health Nurse Specialist
46S3	NC	Operating Room Nurse
46Y3A	NC	Privileged Advanced Practice Nurse (P-APN), Women's Health Care Nurse Practitioner
46Y3B	NC	Privileged Advanced Practice Nurse (P-APN), Pediatric Nurse Practitioner
46Y3C	NC	Privileged Advanced Practice Nurse (P-APN), Adult Nurse Practitioner (or Acute Care NP)
46Y3G	NC	Privileged Advanced Practice Nurse, Certified Nurse Midwife
46Y3H	NC	Privileged Advanced Practice Nurse, Family Nurse Practitioner
46Y3M	NC	Privileged Advanced Practice Nurse (P-APN), Certified Registered Nurse Anesthesia
46Y3P	NC	Privileged Advanced Practice Nurse (P-APN), Adult Psychiatric & Mental Health Nurse Practioner
47G4	DC	Dental Staff Officer
47G3	DC	Dental Officer

47G3A	DC	Dental Officer, Comprehensive Dentist
47G3B	DC	Dental Officer, Advanced Clinical Dentist
47G3C	DC	Dental Officer, General Clinical Dentist
47S3	DC	Oral Maxillofacial Surgeon
47H3	DC	Periodontist
47P3	DC	Prosthodontist
47B3	DC	Orthodontist
47D3	DC	Oral Pathologist
47E3	DC	Endodontist
47K3	DC	Pediatric Dentist
48A3	MC	Aerospace Medicine Physician, Spec
48G3	MC	Aerospace Medicine Physician (non-residency trained)
48R3	MC	Residency Trained Aerospace Medicine (RAM) Physician

4A0X1	Enlisted	Health Services Management
4A1X1	Enlisted	Medical Materiel
4A2X1	Enlisted	Biomedical Equipment
4B0X1	Enlisted	Bioenvironmental Engineering
4C0X1	Enlisted	Mental Health Service
4D0X1	Enlisted	Diet Therapy
4E0X1	Enlisted	Public Health
4F0X1	Enlisted	Aeromedical
4H0X1	Enlisted	Cardiopulmonary Lab Technician
4J0X1	Enlisted	Occupational Therapy
4J0X2	Enlisted	Physical Therapy Technician
4M0X1	Enlisted	Aerospace Physiology
4N0X1	Enlisted	Medical Service Technician
4N090	Enlisted	Medical Service Superintendent
4N0X1B	Enlisted	Neurology Technician
4N0X1C	Enlisted	Independent Duty Medical Technician
4N1X1	Enlisted	OR, Technician
4N1X1B	Enlisted	OR, Technician, Urology

4N1X1C	Enlisted	OR, Technician, Ortho
4N1X1D	Enlisted	OR, Technician, ENT
4P0X1	Enlisted	Pharmacy Technician
4R0XI	Enlisted	Radiology Technician
4R0X2	Enlisted	Nuclear Medicine Technician
4T0X1	Enlisted	Medical Laboratory Technician
4U0X1	Enlisted	..Orthotic Technician
4V0X1A	Enlisted	Ophthalmology/Optometry Technician
4Y0X1	Enlisted	Dental Technician

ASSIGNMENTS

Maj Alicia N. Burke, HQ AFPC/DPAMW

This section provides helpful information for understanding the PCS match process. 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-Apr	Jun-Sep
Fall	Apr	May-Jun	Jun	Jun-Jul	Oct-Jan

- **Initial VML:** The initial Vulnerable to Move List (VML) is released early to mid Nov to squadron commanders. This normally lists officers with sufficient TOS (time on station) to move (current policy is 48 months) . Also included on the VML are AFIT graduates, graduating squadron commanders and officers with a Jun to Sep DEROS.

- **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 and 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 six week 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 is a developmental game plan rather than a specific job preference request**.** The ADP must be routed through your reviewer (SQ/CC or equivalent) and forwarded to AFPC by this date. 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 has four other specialties in addition to the 42G. She/he works closely with each Associate Chief and generally works through the list in this order:

    1) OCONUS backfills (particularly Korea, then all other OCONUS)
    2) PRP
    3) Special programs: e.g. FHI
    4) Remaining clinical billets

- **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 your Associate Chief.** AFPC works closely with him/her 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 your Consultant and the assignments officer know if you are interested in these jobs, and remember **you must be released by 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 MPF six months prior to your intended separation. **You must have 10 years commissioned time in service in order to retire. Only under extreme circumstances, and with SecAF waiver, will retirement at highest enlisted rank be authorized.**

- **<u>ADP tips</u>:**

    - 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 in
    - 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 to Apr is the branch's busiest time of the year. Once you are matched to an assignment, the initial notification is sent to the losing SQ/CC who will officially notify you of the match. Another notification is sent to the gaining SQ/CC and to you. AFPC runs daily batch uploads to MilPDS, and the MPF is usually able to see the information the next day in order to generate an assignment RIP. After you sign the RIP for official acceptance of the assignment, orders are generated locally.

PA Assignment contact numbers are: DSN 665-3821 or Commercial 210-565-3821

COMMON AFPC ACRONYMS:

FCA: Fund Cite Authorization (Not "*site*", it's a citation, not a place)

RIP: Report on Individual Personnel

SURF: Single Unit Retrieval Format

GENERAL LINKS to AFPC INFORMATION

Assignments:

BSC Page at AFPC

BSC Force Management Page (BSC VTC's, Flight Path, SGB-designated squadrons and divisions)

Officer Developmental Education

Assignment Policy Page

Promotions:

Officer Promotions Support (Promotion lists, DOR charts, eligibility criteria)

Military Personnel Flight Memorandums on Promotion (Official messages with board-specific information)

Miscellaneous:

High School Senior Assignment Deferment (HSSAD)

SGB List and Criteria (through AF Portal)

Multi-Corps Job Opportunities

Korea Assignment Incentive Pay

Retirement

You are eligible to retire on the first day of the month following completion of 20 years of Total Active Federal Military Service, 10 years of Total Active Federal Commissioned Service (in order to retire in officer status), and have fulfilled all Active Duty Service Commitments (ADSC). Other factors which may affect retirement eligibility are civil or military investigations, Article 15, court martial actions, or and medical conditions that must be resolved prior to the retirement date. Applications for retirement can be submitted no earlier than 12 months before the retirement effective date and no later than 120 days plus the number of days terminal leave and permissive temporary duty (PTDY) requested.
If you desire to apply with less than the required 120-day notification period, a waiver request must accompany the retirement request that includes full justification and the commander's recommendation. Applications submitted more than 12 months in advance of requested retirement date may only be submitted in conjunction with officer assignment declination procedures (or specific announced programs) or from enlisted personnel at base closure locations who desire retirement rather that PCS. Even if approved under these conditions, retirement orders cannot be prepared more than 12 months in advance of requested date. Bottom line: completing 20 years total active federal military service is not the only eligibility factor to consider for approval of a specific retirement date.
References: AFI 36-3203, Service Retirements and AFI 36-3003, Military Leave Program

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, paragraph 3.7. 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:

> **3.7. Officers Desiring Retirement in Enlisted Status.** Only under hardship situations or an established mandatory DOS as determined by the SAF or designee, officers with 20 years TAFMS who wish to retire before completing 10 years of active commissioned service must first request and be approved for resignation or release from active duty according to AFI 36-3207, *Separating Commissioned Officers*. They must also be accepted for, and enlisted in, the Regular Air Force for the purpose of retirement.
> 3.7.1. For regular or reserve 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. Without meeting both of these requirements, they are ineligible for retirement as an officer regardless of TAFMS. 10 USC §8914, that allows for enlisted members to retire, 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 offices to effect a retirement of an officer in enlisted status. To participate, an officer on active duty must:

3.7.1.1. Apply for separation; then
3.7.1.2. Apply for active-duty enlistment and accession; and then
3.7.1.3. Apply for retirement in that active-duty enlisted status.
(***)
3.7.8. When that member's active duty plus service on the retired list totals 30 years, the member will be advanced to the highest grade held satisfactorily on active duty as determined by the SAF.

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

The most recent force shaping programs have specifically excluded PAs because of their value to the force.

PA SPECIAL PAYS

Full information and eligibility criteria on Medical Special Pays can be found at:
https://kx.afms.mil/medicalspecialpays

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 Physician Assistant
  - Requires a 12-month contract commitment
  - Paid in equal monthly disbursements
- Retention Bonus
  - A method of increasing compensation to help retain select professions
  - Must meet requirements of "Fully Qualified" as an AF Physician Assistant
  - Requires a 24, 36, or 48-month contract commitment
  - Provides bonus pay in addition to Incentive Pay to ensure additional obligation
  - Paid in annual lump sums
- Board Certification Pay
  - Eligibility for PAs: NCCPA certification and an advanced academic degree in the specialty-copy of diploma required
  - Paid in equal monthly disbursements

Consolidation of Special Pays for Physician Assistants

HEALTH PROFESSIONS SPECIALTY	Amt per Yr for 1-Year obligation	Amt per Yr for 2-Year obligation	Amt per Yr for 3-Year obligation	Amt per Yr for 4-Year obligation
42G PHYSICIAN ASSISTANT				
AB -Accession Bonus/yr	N/A	N/A	$12,500	$15,000
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, CURRENCY and CONDUCT

“FULLY QUALIFIED”: CERTIFICATON / RECERTIFICATION & LICENSURE REQUIREMENTS

Physician Assistants are accessed into the Air Force only when “fully qualified”. 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. (ARC-PA) 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. Those who are not certified at the twelve month point will be assigned to a different career field (but still retain their service obligation from training). PAs are required to maintain NCCPA certification. (See AFI 41-104 for reimbursement rules for certification maintenance). AFI 44-119 para 4.6 provides direction if certification is not maintained (lack of CME, inability to pass recertification exam, etc.).

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 (“Medical Quality Operations”):

> 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, ASD(HA) 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 promotion to Field Grade. 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: family practice. 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.

The main ways for a Capt or Maj PA to broaden are *clinically* (specialty fellowships, joining the faculty at IPAP, clinical research, clinic flight command) or *operationally* (White House PA, International Health Specialist, 820 SFG, 365-day deployments, AFSOC, AFMESA, readiness, force health protection, homeland defense, information technology, etc.). The list is always changing, and usually expanding, as people discover what PAs can do and how well they do it. There is overlap between the two paths because again, all broadening is built on your clinical excellence in primary care. That expertise is then applied to more and more diverse situations.

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. Make sure your developmental education (PME) is up to date then apply and let the selection process do the picking. These are all highly rewarding and highly satisfying jobs where you can know you make a difference.

Finally, don't pass up any opportunity to learn about how the AF, and especially the AFMS, works, even if it doesn't seem immediately relevant. At the 2006 PA Refresher Course, the AF Deputy Surgeon General gave a great talk on the mission of the AF, how the AFMS was excelling in that mission and how PAs had a key role. Later a Captain came up to me and said "That was a waste and didn't apply to me at all. I want to hear something that's practical for me in the clinic." That PA may continue to do fine in the clinic but unless he changes his perspective he'll stay disconnected from the big picture. Unbeknownst to him, the reason we're paid to be in a blue suit is because (and only because) of the big picture. My opinion is if you don't understand the map of the world you're in you'll never know if you're going somewhere and accomplishing something meaningful or just getting more lost. We must aim higher.

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.

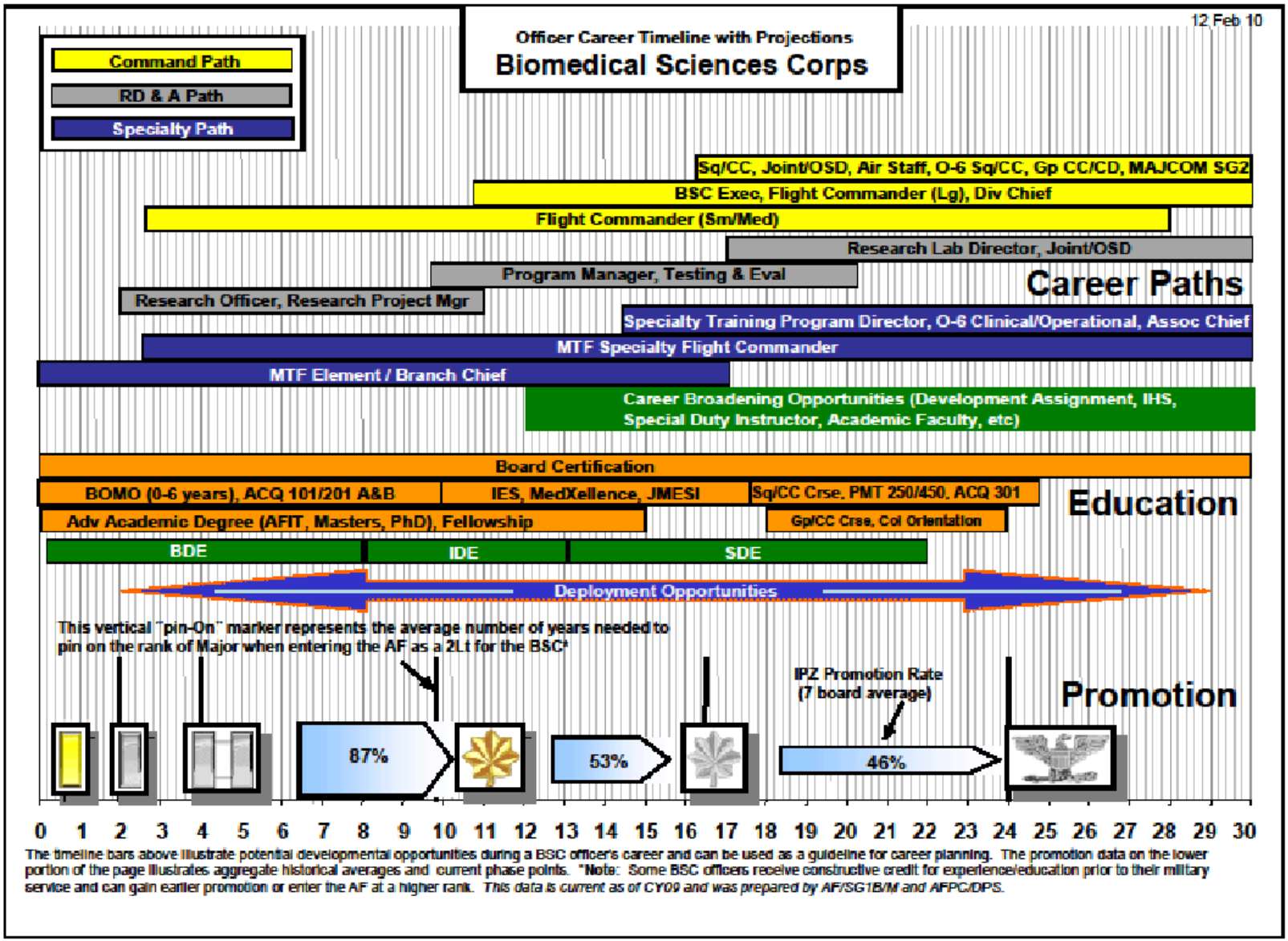
Professional Military Education (PME) provides officers with the academic background in military subjects necessary to understand the working environment. Lieutenant colonels are expected to have completed Intermediate Service School, and colonels are expected to have completed Senior Service School, by either correspondence or seminar if not selected for in-residence 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 in-residence 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.

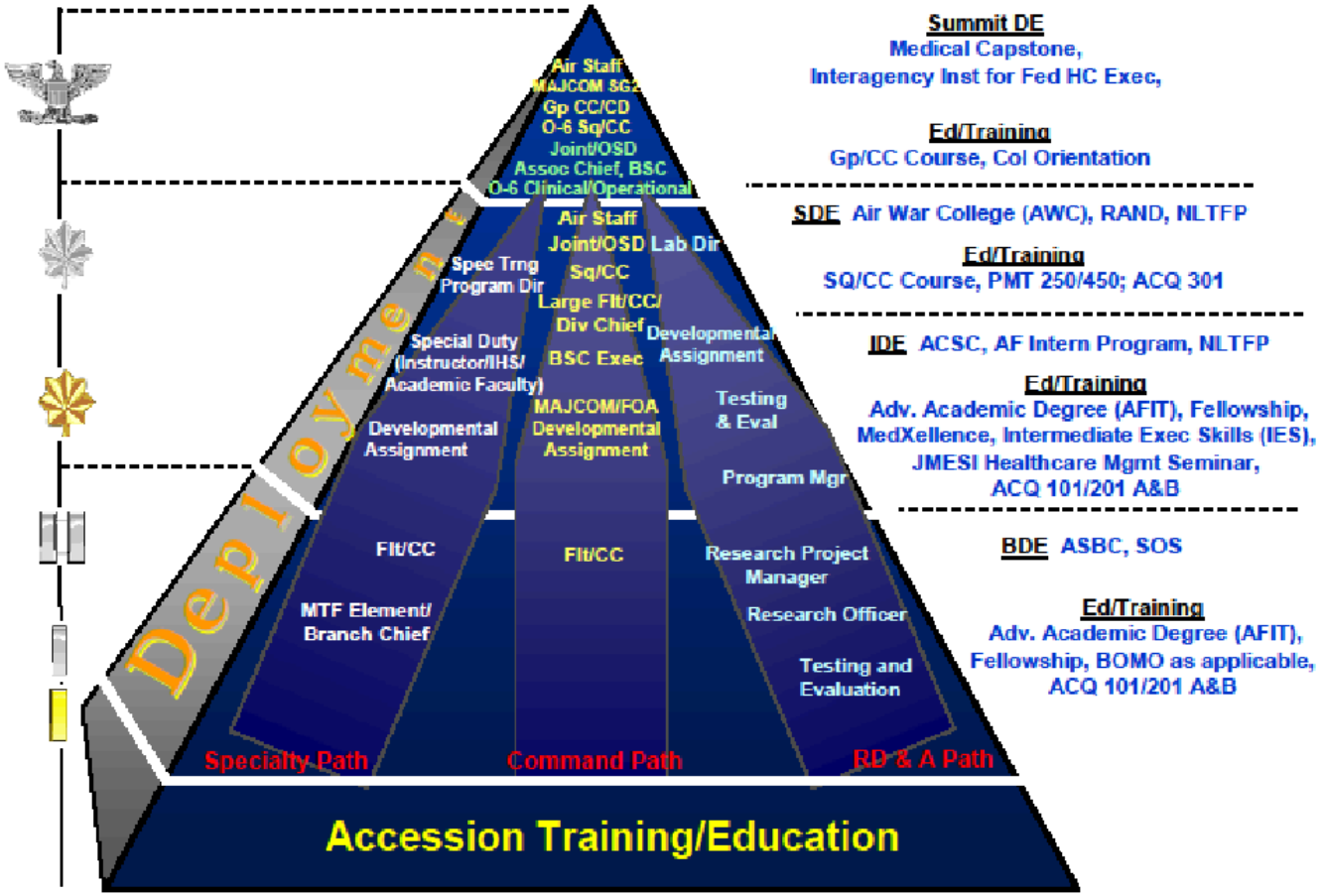
Abundant leadership opportunities exist in the areas of research/academics, clinical specialization and staff assignments. However, the key prerequisite for leadership at the most senior levels is command. Officers who prepare themselves by effectively performing in progressively tougher roles as Flight 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



22 Jan 10



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 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	Developmental Assignments
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 JCAHO/HSI/AAAHC expectations Health Promotions Member, Grp-level committees	BDE ASBC ASBC Masters/Education	Biennial CME Clinical Specialty Fellowships C-4 Expert Field Medical Badge RSV Courses Readiness Courses (OEMS, TCCC, etc.)	Exec Officer Readiness
Operational (Mid-Capt – Lt Col)	MAJCOM Staff Officer White House PA Air Staff/Operations IG Team IPAP Instructor Joint Medical Planning AFMS Tactical Doctrine Special Operations Squadron Command Deputy Group CC AFMESA AFPC 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	41A Tricare 43B Research 81T Instructor 83R Recruiting AFPC Force Utilization Expeditionary Command
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)
L. David Carnes (2009-
Joseph Uzpen (2009-

AWARDS FOR THE AIR FORCE PA

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. For example, the AF Medical Service "PA of the Year" award is the only accomplishment I've seen that consistently has given passed-over PAs a chance for an APZ promotion (deservedly, since the AFMS award indicates the member also winning the respective Unit, Base and MAJCOM awards).

Air Force Medical Service (AFMS), see AFI36-2856 for details

- David Gwinn USAF Field Grade Physician Assistant of the Year
- Jesse Edwards USAF Company Grade Physician Assistant of the Year

American Academy of Physician Assistants (AAPA)

- "Federal Service PA of the Year Award" (nominated by the board of directors of your federal constituent chapter, in our case the Society of AF PAs [SAFPA]. Approach SAFPA and ask them what to do to be considered)

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/)

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

Society of Air Force Physician Assistants (SAFPA) (see http://www.safpa.org/History/SAFPA_Awards/SAFPA_Awards_Review.php?AwardID=16)

- The Jerrold L. Wheaton Award. Presented annually to the Fellow member who has best exemplified the leadership qualities and professional attributes of an Air Force Physician Assistant. Nominees must be a Captain or above with at least four years commissioned service as a military Physician Assistant—active duty or reservist/guard or a retiree.
- The SAFPA Excellence Award is presented to the outstanding Physician Assistant with less than four years of commissioned service as a PA.
- The SAFPA Publication Award is awarded to that Air Force Physician Assistant who has had an article published in a regional or national medical periodical either as the sole author or one of a team of authors.
- SAFPA Contributor's Award. For outstanding contribution of an article to the Society newsletter, the Towner-Shafer Report. One award for each of the following subject areas: Clinical, Deployment, and Professional.

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 he will welcome the opportunity to endorse you, especially if you make it easy for him. You are facilitating his meeting one of his 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 he or she says "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 HIS (or her) 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)

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 his or her peers citing examples that occurred during the specified nomination period. Nomination packages are graded on a hundred-point scale and must include the following headings:

- **Leadership and Job Performance** (80 points): 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. Quarterly or annual awards may also be included in this section.
- **Significant Self-Improvement** (10 points): 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.
- **Base and Community Involvement** (10 points): 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.

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

MAXIMS

If the AF offers you education, TAKE IT, no matter how irrelevant or unwanted it seems

- This includes all Developmental Education. Do your PME as soon as you’re eligible
- I didn’t think I’d stay in past Major but I did ACSC anyway; didn’t expect Col but did AWC
- I ended up crossing every bridge I didn’t burn

The 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 do now if you want to get chosen for an AFIT Advanced Academic Degree (AAD) or clinical fellowship (e.g. orthopedics 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. Include a push statement towards AFIT on your OPR

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 Integrated Forecast Board (IFB) 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 and the time comes to actually apply, follow the directions! The original application goes directly to AFPC while a copy goes to the Associate Corps Chief for the specialty for his/her endorsement. The Associate Corps Chief writes an endorsement letter to the selection board for each applicant applying from his career field. He will give his recommendation or non-recommendation and his reasons. He will also prioritize (stratify) those recommended. The Board still makes the selection. The Consultant cannot prevent anyone from meeting the board and the board has no obligation to follow his advice.

There are five BSC officers on the BSC AFIT selection board. Their first evaluation action is the “quality cut”. Members grade all the records, disregarding both AFSC and program, ranking them for quality on a 6.0 – 10.0 scale, 10 being outstanding. Those not scoring at least an 8.0 (averaged among the five members) 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”), he would get that program if his score was higher than anyone else applying. However, if someone else applied for Program A and scored higher, he 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.

Writing Your "Why I Want to Do This" Letter

For many career broadening assignments you will be selected by a board that will require a formal application, including a letter by you telling the board why you should be chosen above other applicants. 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 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. Members are eligible to use this funding no more often than every other year. Things to know:

1. Always check http://www.afit.edu/cme/corps_specific_biomed.cfm for current information
2. Application window opens 1 June each year. Applications must be sent to the PA Associate Corps Chief by 15 August.
3. Requested courses must offer at least 6 CE credit hours or 6 class hours per day. Only courses that earn Category 1 credit by one of the professional organizations acceptable to the NCCPA are authorized.
4. Individuals who attended an AFIT funded course in the previous FY are not eligible.
5. Course dates must be with the approved FY however, it is recommended courses in Oct be avoided, no course should start prior to 1 Nov.
6. CONUS-based officers should select a TDY location within CONUS. OCONUS-based officers may select a TDY site within theater or to CONUS.
7. AFIT will not fund more than the "member" fee for O-4 and higher (i.e., non-member registration fee) if attending an organizational meeting.
8. For the BSC, CME application packages are coordinated by the designated BSC Executive at the medical treatment facility or organization. Selection will be by respective Associate Chief.
9. An application consists of
    a. AF 1983 (AFIT CE Course Application), signed
    b. AFIT TDY Worksheet (from the website), signed
    c. Course brochure or brochure info on registration fees and CME credit
10. AFIT/ENEM CME will send confirmation letter to selects, cut orders and fax/e-mail them to the members Ed & Training office (where available).
11. Individual must submit copy of completed/filed travel voucher to AFIT/ENEM CME upon return from course.

CME PEARLS

* Local funding can be combined with AFIT short course funding to enable enrollment in higher-priced CME, including some certification programs.

* If funds locally don't allow a TDY for CME consider other options that provide needed hours at cheaper rates (and often leave you with an up-to-date reference text).

- ACP Medicine (formerly *Scientific American Medicine*). $370 for 120 Cat I hrs http://www.acpmedicine.com/acpmedicine/institutional/cme_prog.action
- Core Content Review of Family Medicine (from AAFP). $420 for 120 Cat I hrs http://www.corecontent.com/productdetail.cfm?productid=16
- The Annotated List of Online Continuing Medical Education, with links to, and descriptions of, more than 300 Web Sites offering more than 13,000 courses and more than 22,000 hours of CME credit.

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 two 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 The Soldier and the State 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
    - 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? In the 80's? The 90's? 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

Practical 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.

AFI 36-3401 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.

So, do you chuck the program because lack of interest by your assigned mentor or because you have to do all the work? No! AFI 36-3401 allows you to have as many mentors as you feel necessary.

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 him or her 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 AFI 36-3401. 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 him or her, open his eyes to his potential and wisely guide him in professional development. Both of you will be rewarded.

The American Academy of Physician Assistants' Four Principles of Leadership

1. Leadership is defined by knowledge, skills and abilities, rather than by position or title.
2. The core competencies of leadership can be learned, and the learning is a life-long process.
3. PA leaders value diversity and practice inclusion.
4. PA leaders identify and mentor future PA leaders

DEVELOPMENTAL EDUCATION

(Professional Military Education)

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

BASIC DEVELOPMENTAL EDUCATION (BDE):
SQUADRON OFFICER COLLEGE

- **AIR AND SPACE BASIC COURSE**
  - ASBC is a six-week, resident program for 2nd Lts consisting of two weeks of hands-on instruction in expeditionary skills specifically related to the complex requirements of warfare in an expeditionary environment, a week dedicated to building a working knowledge of officer-enlisted relationships through direct interaction between ASBC students and Senior Non-Commissioned Officer Academy students, and three weeks of classroom instruction in the Profession of Arms and Air Force doctrine. The Air Force has established a goal of 100% attendance for its line of the Air Force (LAF) officers to attend ASBC.
  - This course is not a DE requirement for PAs although there are occasional opportunities offered to attend in residence.
  - Course Synopsis: **http://www.au.af.mil/au/soc/asbc**

- **SQUADRON OFFICER SCHOOL**
  - For Capts (pinned on) with < 11 yrs total commissioned service
  - Course Synopsis: **http://sos.maxwell.af.mil/**
  - SOS is a 5-week resident experience, although a non-resident, distance-learning version is also available. The resident program is unabashedly a leadership school. The curriculum is designed to promote self-reflection and build upon the students' experiences to strengthen their leadership skills and knowledge for the good of Air Force units across the globe. Using the Full-Range Leadership Model as its philosophical foundation, the curriculum introduces students to the challenges of leadership and command but also equips them with new skills and knowledge to address those challenges. The curriculum also exposes these young leaders to joint educational requirements as outlined in the Chairman, Joint Chiefs of Staff Officer Professional Military Education Policy (OPMEP), important material that they will use as they progress in their military careers.

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

- For Major and Major-selects with < 18 yrs Total Commissioned Service
- Distance Learning non-Masters option (the most probable for PAs)

    - The curriculum consists of seven courses, to be completed in the following order: The Challenges of Leadership and Command (LC), National Security (NS), Strategy and War (SW), Expeditionary Air and Space Power (AP), Joint Forces (JF), Planning Joint Operations (JP), and Joint Air Operations (JA).
    - 18 months to complete
- ACSC distance learning Master's degree option takes 2-5 years and requires no testing but weekly online classroom participation.
- http://wwwacsc.au.af.mil/distance-learning.asp

SENIOR DEVELOPMENTAL EDUCATION (SDE):

AIR WAR COLLEGE

- For Lt Col select and above
- Course content for both the correspondence and seminar programs contain the same reading selections for five courses that are delivered in three terms and an elective. The nonresident curriculum for both the correspondence and seminar programs are designed to prepare students to function more effectively in an increasingly complex and rapidly changing world environment. The core curriculum focuses on: Future Conflict Studies; Military Strategy, Doctrine and Airpower; Leadership and Ethics; National Security Decision Making; Regional Studies, and CHEX (Crisis Handling Exercise); and Joint Force Employment and CAMPEX (Campaign Planning Exercise).
- http://www.au.af.mil/au/awc/awchome.htm

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

Most questions can be answered at the AFPC Officer Promotions section (http://ask.afpc.randolph.af.mil/officerprom/default.asp?prods3=10&prods2=2&prods1=1&cats1=141&p_cats=141).

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, such as enlisted or officer performance reports, decorations, awards and citations, can affect promotion scores and Developmental Team vectors for senior airmen through general officers.

It's easy for anyone to check and correct their records online through the virtual Military Personnel Flight, or with a single call to the Total Force Service Center at 1-800-525-0102. Airmen receive e-mail notifications around their birthday each year advising them to review their electronic personnel records maintained within the Military Personnel Data System.

To complete a records review, log in to vMPF, read through all records, and print a hard copy for personal safekeeping. If errors are discovered, Airmen can often make needed changes to the record in vMPF, using provided update links. For errors not correctable on-line, the Total Force Service Center is available 24 hours a day to assist Airmen in correcting their information.

The electronic version of a member's record is printed and maintained at the Selection Board Secretariat at the Air Force Personnel Center. These "Officer Selection Records" are kept for the purpose of meeting promotion and evaluation boards.

Requesting a copy of your record can be done several ways. Air Force Instruction 36-3003 allows a member to request a permissive TDY to view the hard copy of their record. If unable to go permissive TDY, you may call DSN 665-2371 for a records review via phone. If you would like to obtain a copy of your record, you may fax a signed request, which must include your name, social security number and signature, to DSN 665-2421. You may also request an e-copy by sending a digitally signed e-mail request to records.review@randolph.af.mil. For more information, visit your Force Support Squadron or call the Total Force Service Center at (800) 525-0102, commercial (210) 565-5000 or DSN 665-5000.

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)*

Important Elements of Successful OPRs

The most important ingredient of your successful Officer Performance Report is, of course, your performance. A pig dressed up doesn't fool anyone but significant accomplishments can go unnoticed if they're not presented well. The new OPR only has four lines for your job description and six lines for your Rater's assessment. 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.

Stratification

The last line in each of the assessment sections is crucial (especially in records supporting a "P" recommendation on your PRF) 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

- Clear stratification
  - My best XXX in 25 years – weak

        - Top 2% I've ever known -- weak
        - My #2 of 200 XXX in 25 years – great
        - #1/100 CGO XXX in AF – (AFMS award winner) – great
    - Be honest
    - 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 on more DP, she would get it," remain prohibited.

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

All questions and concerns should be directed to HQ AFPC Military Evaluation Programs Section (DPSIDE) by email at evalpolicy@randolph.af.mil or by phone at DSN 665-2571 or commercial (210) 565-2571.

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 of 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)

Your PRF is the Executive Summary of your entire career, so it needs to be good.

- Single-line bullet format is MANDATORY (no wraparounds allowed); avoid sub-bullets

- Educational references

    - Advanced academic degree references are allowed, but only if AFIT training reports are on file or if the candidate had an exceptional GPA (> 3.5/4.0)

    - Professional military education (PME): This information is already in the Duty Qualification History Brief, therefore do not repeat unless the person was selected as a DG or earned a special award. The board expects appropriate DE to be completed. Mentioning it adds no strength to the PRF.

- First line must be a hard hitting; an overall performance based assessment

- Follow a career chronology; don't skip around in a larger sequence

    - Present achievements from oldest to most recent (encompass entire career not just the last 2 to 3 years)

    - Group entire career like-accomplishments such as IG ratings, awards won or monies saved in one bullet, placing them in a chronology from left to right

    - Everything must map back to official documentation (OPRs, decoration citations, letters of evaluation, interim achievements that will be included in your next OPR)

- Use impact-oriented, action words and phrases. Avoid acronyms, phrases, or words not commonly used in everyday language

- Use "%" and "$" symbols--they stand out much more than prose of "percent" and "dollars", plus they use less space. Remember you only have 8 lines to map an entire career (the ninth being the recommendation itself)!

- White space is universally perceived as **not good.** It negatively highlights that bullet. It normally it should never be more than 3 to 5 blank spaces. An

exception is some massive, absolutely stupendous achievement but unless you have one, and have no doubt, avoid white space like the plague

- End with a potential-based statement that is clearly supported by the reality of the individual's documented performance

What if I'm Not Promoted?

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

- Take advantage of AFPC's non-select counseling (done by the BSC section, DSN 665-3821/3846)
- Was grade-appropriate Developmental Education (PME) completed before the Board date?
- 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 AFIT, 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).
- Is your Airman Development Plan (ADP, formerly T-ODP) up to date? Did your commander endorse your dreams? Have you followed the direction of the Development Team?
- 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
- Are you complaining or looking for ways to improve?
- Put together a package and get nominated for AFMS PA 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
BSC Development Team IPAP applications due Summer assignment cycle begins	
MARCH	APRIL
PA Selection Board (IPAP)	Fall Assignment Cycle Begins
MAY	JUNE
BSC Development Team Integrated Forecast Board AAPA Conference	
JULY	AUGUST
AFIT Short Course (CME) Application window opens on the 1st. Spring Assignment Cycle Begins	15th is the deadline for AFIT Short Course applications
SEPTEMBER	OCTOBER
BSC Development Team AFIT AAD and Fellowships Board	AFMS Senior Leadership Symposium (Leesburg) AFMS Award nominations due to MAJCOMs
NOVEMBER	DECEMBER
AF PA Annual Refresher Course AMSUS	Complete your ADP in preparation for summer assignment cycle!

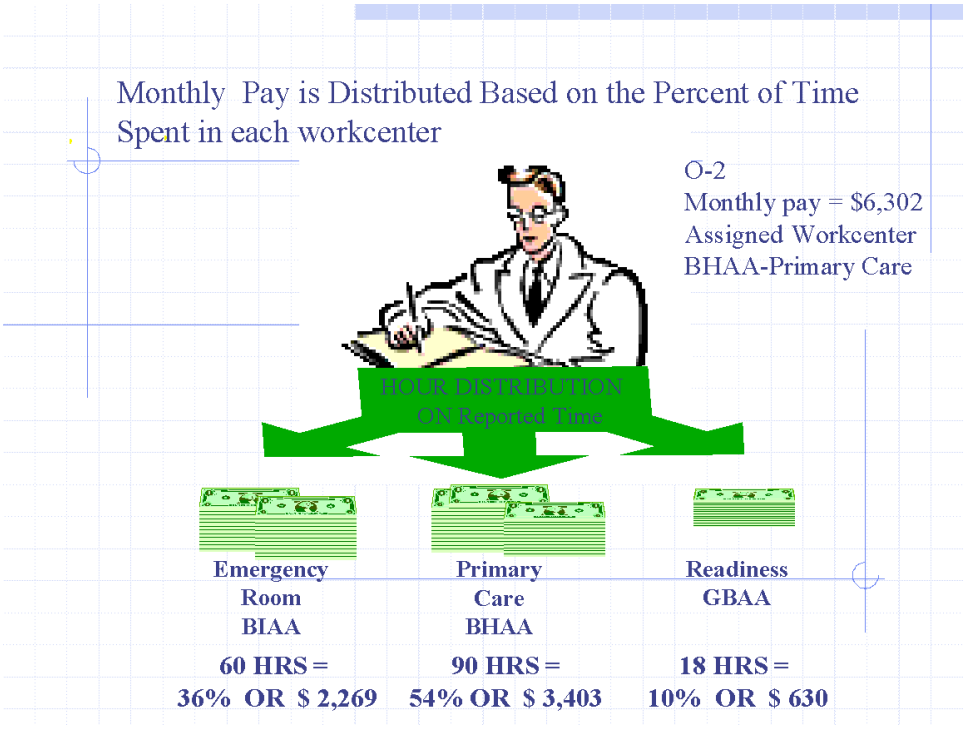
DEMYSTIFYING MEPRS

Time is Money! Getting Maximum Credit for Your Work

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.)

That's the formal definition. So what? How can I make this work to my and my unit's benefit and show how cost-effective I really am? How do I get maximum credit for what I do?

1) Be obsessive about how your time is being recorded in MEPRS. You're probably familiar with MEPRS reporting only as a persistent nuisance that you hope will be invisibly handled by your group practice manager. In actuality it's an 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.



Note: Air Force SG has directed the use of the DMHRSi (Defense Medical Human Resource System, internet) to report all personnel time. It is an individual personal requirement to provide this information when required. (All timesheets are due by close of business on the first Monday after the end of the pay period [every 2 weeks])

Though Your Pay doesn't vary from Month to Month the Percentage of Time Spent in a particular Workcenter May have an impact on the Distribution of your Pay



0-2 = $ 6,302

	Emergency Room BIAA	Primary Care BHAA	Readiness GBAA
If You Worked 168 HRS	60 HRS = 36% OR $ 2,269	90 HRS = 54% OR $ 3,352	18 HRS = 10% OR $ 630 → SALARY = $6,302
If You Worked 204 HRS	60 HRS 29% or $ 1,828	126 HRS 62% or $ 3,907	18 HRS 9% or $ 567
Difference	-$ 441	+$ 555	-$ 63

Failure to Properly Annotate Readiness or Other Activities on Your Timesheet will Result in an Increase in the cost per of Services we are trying to cost out.

TIME SHEET COMPLETED WITH ALL AVAILABLE TIME CHARGED TO WORKCENTER

FTEs / WORKLOAD = $90 A VISIT

TIME SHEET COMPLETED PROPERLY WITH 20% OF AVAILABLE TIME CHARGED TO MEETINGS AND READINESS

FTEs / WORKLOAD = $80 A VISIT

That's the bottom line: *Failure to properly annotate readiness or other **non-clinic activities** on your timesheet will result in an increase in the "cost per" of your services when your Resource Management Office (RMO) costs them out.* You will come across as "expensive" and therefore a target for replacement or 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.

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.

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.

* * *

The next section, from the Air Force MEPRS Program Manager, has guidance on how to correctly account for your hours. For more specific questions, go to your facility's MEPRS manager (in the RMO) (and get a list of available category codes while you're there).

Accounting for Hours in MEPRS

Darrell D. Dorrian, Air Force MEPRS Program Manager
(Darrell.Dorrian@Pentagon.af.mil (703) 588-6456, DSN 425)

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 basketball 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.

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**

Squadron Commander's Call falls under the appropriate squadron

Group Commander's Call falls under **EBBA** - Commanders Special Staff.

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 an 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 do not report time that they are not working. We don't have to account for their full time, only 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.

BOTTOM LINE: 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 "**Nonavailable Time**", which would be charged back to the assigned work center as non-productive time, causing your "cost per" to go up. Ultimately it's to your advantage to see that the time reported for you is reflects reality accurately. If you're not working don't claim the time under a workplace code where clinical production is expected.

* * *

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)
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 Services	Examples: B = Outpatient Care BA = Medical Care BAA = Internal Medicine 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

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	B***
	Group Appt **with** individual Provider contact/SOAP note	B***	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
	SGN, 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 Expense (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

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 Master of Physician Assistant Studies (MPAS) degree from the University of Nebraska.

The Interservice Physician Assistant Program (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.

The Interservice Physician Assistant Program is approved by the North Central Association of Colleges and Schools as an off-campus academic offering of the UNMC. It is also accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

How to Apply to IPAP

Application requirements are subject to change. Always check the current requirements at the BSC Education & Training website: http://ask.afpc.randolph.af.mil/main_content.asp?prods1=1&prods2=14&prods3=189&prods4=1290&prods5=1293&p_faqid=3896

APPLICANT CHECKLIST (the sum of this IS the application):

1. Two years active duty in grades E-3 thru E-8 and maximum of 14 years service as of 30 Aug 08
2. ASVAB or AQE General Score--minimum score of 80
3. Grade Point Average (GPA) (2.5 or better on a 4.0 scale) as computed on AF Form 56 – 29 hours must be in-class study.
    a. Chemistry w/lab 8 semester hours (cannot CLEP this requirement)
    b. Anatomy & Physiology w/lab 8 semester hours (cannot CLEP this requirement)
    c. Algebra 3 sem hrs (cannot CLEP this requirement)
    d. Biology w/lab 4 semester hours (cannot CLEP this requirement)
    e. Social Sciences 6 semester hours (may CLEP this requirement)
    f. English 6 semester hours; Composition Recommended (may CLEP 3 semester hours of this requirement)
    g. Psychology 3 semester hours (cannot CLEP this requirement)
4. SAT Score--within four years of the board date. The minimum score must be 450 in each section of the exam and a composite score of no less than 1425 in the newer version and a minimum composite score of 950 in the previous version.
5. AF Form 56 Grade Point Average (pg 5 only) GPA Worksheet of core courses (Chemistry I/II, A&P I/II, Algebra, & Biology) Minimum 3.0 GPA in the Math & Sciences as computed on AF Form 56
6. Physically qualified for worldwide duty per AF 422 "Commissioning" Physical
7. Never convicted by court martial or received Article 15 during current enlistment
8. Eligible to extend or reenlist for 6 years within 60 days before class start date
9. Meets age limitations (less than 42 years of age upon completion of Phase II Training)
10. NAC (National Agency Check, the initial security clearance)
11. Letters of Recommendation--AF PA, Immediate Supervisor, Staff Physician, and Immediate Unit Commander
12. Statement from Military Personnel Flight or Custodian of Applicant's personnel records
13. Last Five EPRs
15. Signed statement form applicant agreeing to extend or reenlist if necessary
16. Privacy Act Statement
17. Handwritten Essay by the Applicant
18. AF Form 2030, Drug and Alcohol Abuse Certificate
19. DD Form 785, Record of Disenrollment--if applicable
20. A copy of USAF Fitness Program Individual Assessment Report

The applicant is responsible for completing the application before sending it to the Military Personnel Flight (MPF). The MPF will forward the completed application to HQ AFPC/DPAMW. Retraining applications are not required. Only active duty enlisted Air Force members are eligible for this program. ***Incomplete applications or those received after the cut-off date will not meet the selection board.***

Writing a Recommendation for IPAP

The applicant's interview with you is to determine the applicant's motivation for applying, his understanding of the career and his 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. You mail it directly to AFPC. 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. His first goal is to get commissioned
    d. He really wants to go to medical school but…
    e. She's 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. The applicant's letter
    b. The GPA/SAT (correlated with the difficulty of the courses)
    c. The 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 BSC POC

Mr. Kevin M. Smith **HQ AFPC/DPAMW** **550 C Street West, Suite 27** **Randolph AFB, TX 78150-4729**	**DSN 665-2775 COM (210) 565-2775** **FAX (210) 565-6223 (DSN 665-6223)** **E-MAIL: Kevin.smith2@randolph.af.mil**

EXPEDITIONARY MEDICINE AND READINESS

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. Within the medical community "tempo banding" is used to address "low supply/high demand" AFSCs' requirements through use of extended tour lengths and sourcing from across the entire AFMS.

This AEF evolution includes posturing capabilities/UTCs in tempo bands that reflect both the Combatant Commander (CCDR) requirements and the availability of corresponding resources in our postured forces. 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 (one rotation in field to "X" number of rotations at home—"dwelling"), AFMS planners, Consultants and career field managers all work the process of aligning 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 ration does not always mean that 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 a single assignment should be fewer, resulting in less time away from home overall
- Reducing the number of times we need to roll forward to the next AEF cycle to source a requirement enhances the predictability for our personnel and maintains team integrity
- Early engagement of Consultants ensures sending the right people at the right time
- Can articulate clearly to the Joint Staff our deployment thresholds, making it clear what level of contingency response risk we assume when supporting new joint taskings—a critical factor when assigning taskings to one Service over another

What PAs Need to Know:

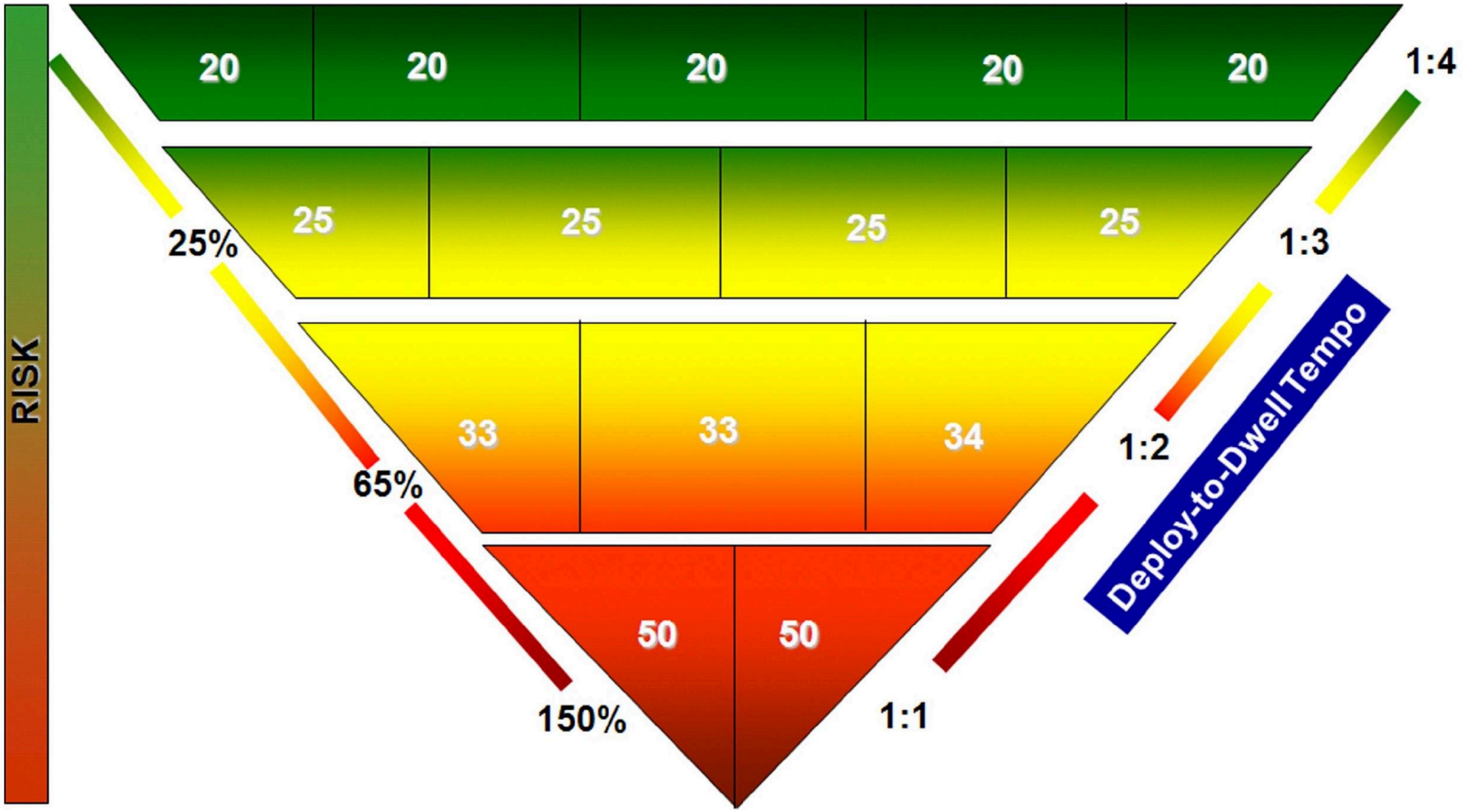
Tempo band calculations are periodically recalculated for all AFMS UTCs because the "Blocks" tend to become unbalanced over time for several reasons: PCS, retirements/separations, new graduates and other taskings. Therefore you, as a PA, need to:

- Make sure your DAFSC/shred/AEFI (block) are correct in the three tracking systems:
    - VMPF (can check on via "AFPC Secure")
    - MILPDS (controlled by your orderly room)
    - MRDSS (controlled by your readiness office)
- If you are active duty you should NOT have a AEF Indicator of "A", it should be C1, C2, C3 or C4

Accurate and even distribution of PAs across the bands has become extremely important since specialty PAs began to be "blocked" separately from Family Medicine PAs to ensure that there were enough specialty PAs to cover all the specialty UTCs (and not use them in their 2AFSC of family medicine until all specialty obligations were 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.

EXPEDITIONARY TEMPO



This graphic represents the air and space expeditionary force deploy-to-dwell tempo. Called AEF Evolution, each career field will fall into a different category of deployment cycles. The deployment categories are called tempo bands. Air Force officials have created five tempo bands: A through E. Tempo Band A reflects the original AEF cycle of a 1:4 dwell ration based on 120-day deployments. Bands B through E are based on 179-day deployments. Tempo band B is a 1:4 dwell ratio -- or six months deployed 24 months home. Tempo band C is a 1:3 dwell, band D is a 1:2 dwell and band E, reserved for the most stressed career fields, is a 1:1 dwell, or six months out, six months in. (U.S. Air Force graphic)

CONSULTANT BALANCED DEPLOYMENTS

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

BSC Low Supply / High Demand Specialties:

42G3 – Physician Assistant
42P3 – Psychologist
42S3 – Clinical Social Worker

42G-RELEVANT UTCs

UTC	REQUIREMENT	MISCAPS (abbreviated)
81STG SPECIAL TACTICS (ST) GROUP HQ	**42G3**	PROVIDES COMMAND & CONTROL, OPERATIONS MANAGEMENT, ST INTEL SUPPORT, ST MEDICAL MGMNT, LOGISTICS PLANNING & FORCE MGMNT OF DEPLOYED SPECIAL TACTICS FORCES. WILL BE DEPLOYED WHEN TWO OR MORE SPECIAL TACTICS UNITS ARE DEPLOYED IN A THEATER & WILL BE RESPONSIBLE TO THE JSOTF/THEATER SOC COMMANDER FOR ALL ISSUES PERTAINING TO SPECIAL TACTICS OPERATIONS. CAPABLE OF 24 HOUR OPERATIONS FOR UP TO 30 DAYS WITHOUT RESUPPLY. AFSC 042G3 CAN BE SUBSTITUTED WITH 048G3 OR 048R3. REVIEWED: NOV 09.
9ACRG CONT RESPONSE GRP HQ	**42G3**	PROVIDES A FORCE PROTECTION COMMAND AND CONTROL TEAM CAPABLE OF ESTABLISHING INTEGRATED BASE DEFENSE AT ANY LOCATION. PROVIDES A FIRST-IN RESPONSE, WITH LIMITED AIRBORNE/AIR ASSAULT CAPABILITY, TO ESTABLISH A FORCE PROTECTION (FP) ORGANIZATION THAT BRIDGES THE C4I GAPS BETWEEN AIRFIELD SEIZURE FORCES AND AIR EXPEDITIONARY FORCES. DETERMINES REQUIREMENTS FOR FOLLOW-ON FP BETWEEN OTHER US MILITARY FORCES AND/OR HOST NATION FORCES. SELF SUFFICIENT FOR 5 DAYS BUT NOT DESIGNED TO PROVIDE SUSTAINMENT/LONG TERM SUPPORT AND MUST BE RELIEVED BY FOLLOW-ON AEF FORCES BASED ON MISSION, ENEMY, TERRAIN, TROOPS, TIME, AND CIVILIANS (METT-TC). CAN BE COMBINED WITH UTC 9AADV (820 SFG ADVON TEAM) OR AUGMENTED BYUTC 9AFPS TO INCREASE THE NEEDED CAPABILITIES OF FORCE PROTECTIONS ASSESSMENTS AND COMMAND AND CONTROL FOR FOLLOW-ON AEF FORCES. INCLUDES UNIT LEVEL LOGISTICS, INTELLIGENCE, C2, AND MEDICAL CAPABILITIES IN ADDITION TO THE ORGANIC FORCE PROTECTION CAPABILITIES. RESPONSE TIME ACCORDING TO DOC STATEMENT. CC IS AUTHORIZED TO SUBSTITUTE AFSCS AND GRADES BASED ON METT-TC. REV: MAR09
FFDCL MED DEPLOYED CLINIC AUGM TM	**42G3**	PROVIDES ADDITIONAL MEDICAL PERSONNEL DURING SUSTAINED OPERATIONS AT AN ESTABLISHED DEPLOYED STAND-ALONE OUTPATIENT CLINIC. CAN AUGMENT AN AFTH OR EQUIVALENT DEPLOYED MTF. PROVIDES CARE FOR PATIENTS WITH ROUTINE AND URGENT MEDICAL CONDITIONS. AUGMENTS FFPCM (MED PRIMARY CARE TM) WHEN ENHANCED OUTPATIENT CLINIC CAPABILITY IS REQUIRED. STAND-ALONE CAPABILITY REQUIRES DEPLOYMENT WITH FFLGE (AIR TRANSPORTABLE CLINIC). CAPABILITY INCLUDES INITIAL TRAUMA RESPONSE AND STABILIZATION. STABILIZED TRAUMA PATIENTS CAN BE HELD FOR UP TO 12 HRS. NON-TRAUMA PATIENTS CAN BE HELD FOR UP TO 48 HRS. ASSUMES HOSPITAL OR AE IS READILY

		AVAILABLE. AUTH SUB FOR THE 042G3 IS A 046Y3H.. DEPLOYS TO MOB. ECS REQUIRED PILOT UNIT/OPR:HQ ACC/SGX. REVIEWED NOV09.

FFEDP MED EMER MED PA AUGM	**42G3E** Emergency Medicine PA	PROVIDES EMERGENCY MEDICINE PHYSICIAN ASST AND MEDICAL TECHNICIAN TO AUGMENT EMERGENCY MEDICINE CAPABILITY DURING SUSTAINED OPERATIONS AT AN ESTABLISHED AFTH OR EQUIVALENT DEPLOYED MTF. PROVIDES RAPID RESPONSE RESUSCITATIVE AND EMERGENCY MEDICAL SUPPORT, TRAUMA SURGERY, AND ADVANCED TRAUMA LIFE SUPPORT. SHOULD DEPLOY WITH FFEDT (MED Emergency Medicine Tm). 042G3E MUST HAVE 12 MONTHS EMER MED EXPERIENCE POST EMERGENCY MEDICINE FELLOWSHIP TRAINING. 4N051 SHOULD HAVE RECENT EMER MED EXPERIENCE (12 MTHS IN THE LAST 36 MTHS). AFSC SUBSTITUTES NOT AUTHORIZED. PILOT UNIT: HQ ACC/SGXM, LANGLEY AFB VA. OPR: HQ ACC/SGX. ACC REV: APR 09.
FFEP4 MED EMEDS AFTH 25 BED PERSONNEL AUGMENTATION	42G3 PAs and P-APNs are **authorized substitutes** for 44F3 (Family Practice physician)	PROVIDES SUPPORT PERSONNEL TO ESTABLISH AN EXPEDITIONARY MEDICAL SUPPORT 25-BED MEDICAL FACILITY (EMEDS+25). PROVIDES 24-HR SICK CALL AND EMER MEDICAL CARE FOR DEPLOYED AEF PERSONNEL. UTC AUGMENTS EMEDS+10. DEPLOYS IN CONJUNCTION WITH UTCS FFEP1/2/3/4/5, FFEPE, FFEE1/2/3/4/5/6/7/8, FFMFS, FFMF1, FFPM1/2/3/4/5, FFF0C X 2, AND FFPCM OR FFDAB TO COMPRISE THE THIRD INCREMENT OF EMEDS AND IS NOT A STAND-ALONE CAPABILITY. EMEDS+25-BED PROVIDES ACLS/ATLS EMER SVCS, LIMITED IN/OUTPATIENT CARE, LAB, PHARMACY, X-RAY, DENTAL SVCS, BASIC PHYSICAL THERAPY, PLANNING, ADMIN, AND LOGISTIC SUPPORT TO 5,000-6,500 PSNL FOR 30 DAYS W/O RESUPPLY IN LOW CBRN THREAT. EMEDS+25 PROVIDES CORE INFRASTRUCTURE FOR LATER ADDITION OF MEDICAL SUB-SPECIALTY UTCS, ANCILLARY SUPPORT, AND MED LOG/EQUIP MAINTENANCE. THE 046A3 MUST BE 05 OR HIGHER. AT LEAST ONE 046N MUST BE 04 OR HIGHER. AFSC 042G3 OR 046Y3H MAY SUBSTITUTE FOR 044F3. ALL OTHER AFSC SUBS AUTH IAW WMP 1, AFMS SUPPLEMENT. SKILL LEVEL SUBS AUTH IAW AFI 10-403. DEPLOYS TO MOB, AOB, FOB, AND BB. PILOT UNIT: 1 MDG/LANGLEY AFB VA. ECS REQUIRED. OPR: HQ ACC/SGX. ACC REVIEW: JAN 09.
FFGK1 MED ANG MEDICAL SPT PERSONNEL	**PRIMARY (*ANG only*)**	PROVIDES MEDICAL SUPPORT OF THE OPERATIONAL MISSION AT AIR NATIONAL GUARD (ANG) INSTALLATIONS. MEDICAL SUPPORT INCLUDES PHYSICAL EXAMS, LIMITED AEROSPACE MEDICINE, DENTAL, OPTOMETRY, AND MEDICAL READINESS OVERSIGHT. THIS UTC HAS THE CAPABILITY TO GENERATE IN-PLACE WITH LIMITED SUPPORTING ASSETS TO PARENT ORGANIZATION. WHEN USED IN CONJUNCTION WITH THE SQUADRON MEDICAL ELEMENT (SME), CAN PROVIDE BASIC SUPPORT TO IN-PLACE FLYING MISSION. AUGMENTS IN-PLACE PATIENT DECONTAMINATION CAPABILITY (IPPDC) FOR HOME STATION SUPPORT. SOURCE: ANG. AFSC CROSS UTILIZATION AUT IAW WMP-1, AF MEDICAL SUPPLEMENT. OTHER SUBS AUTH AS DIRECTED BY HQ ANG/SG.

		SKILL-LEVEL SUBS AUTH IAW AFI 10-403. DEPLOYS TO MOB, COB, SB, BB AND LB. ECS IS REQUIRED. PILOT UNIT: ANG/SGX. OPR: ACC/SGX. REVIEWED: NOV 08

FFGLB PATIENT DECON TEAM--PDT	**42G3** (42G3 is Team Chief)	PROVIDES SUPPORT PERSONNEL TO REMOVE OR NEUTRALIZE, TO THE EXTENT POSSIBLE, CBRN AGENTS ON WARTIME CASUALTIES PRIOR TO BEING ADMITTED TO AN MTF. PROVIDES LIFE-SUSTAINING INTERVENTION BEFORE, DURING AND AFTER THE DECONTAMINATION PROCESS. CAN DECONTAMINATE SOME MEDICAL EQUIPMENT AND PERFORM LIMITED SPOT DECONTAMINATION OF MEDICAL VEHICLES. NOT RESPONSIBLE FOR COMPREHENSIVE VEHICLE DECONTAMINATION. REQUIRED EQUIPMENT IS IN UTC FFGLA. ONE TEAM (FFGLB) & ONE EQUIPMENT PKG (FFGLA) SHOULD BE PROVIDED FOR EACH MEDICAL TREATMENT FACILITY WHERE A CBRN THREAT EXITS. USED IN SUPPORT OF EMEDS/AFTHS OR AEROMEDICAL STAGING FACILITIES IN A CBRN THREAT ENVIRONMENT. ALL POSITIONS MAY BE SUBSTITUTED WITH ANY AFSC 4XXXX EXCEPT 4N071 AND 042G3 (WHERE AVAILABLE).THE 042G3 MAY ONLY BE SUBSTITUTED WITH ANOTHER 4N071. THE 042G3 (OR SUBSTITUTED 4N071) WILL BE THE TEAM CHIEF. ALL 4NOX1 POSITIONS, TO INCLUDE SUBSTITUTES, REQUIRE NATIONAL EMT CERTIFICATION. TEAM CHIEF MUST ENSURE PERSONNEL APPOINTED TO THIS UTC ARE OF SUFFICIENT STATURE AND PHYSICAL CONDITION TO PERFORM FREQUENT LITTER CARRIES AND STRENUOUS MANUAL LABOR IN FULL PROTECTIVE ENSEMBLE. DEPLOYS TO MOB, COB, SB, BB AND LB LOCATIONS. ECS REQUIRED. PILOT UNIT: 55 MDG/OFFUTT. OPR:ACC/SGX. REVIEWED: NOV 08
FFQE8 SOF/CSAR MED ELEMENT AUGMENTATION	42G3	PROVIDES PERSONNEL FOR PREVENTIVE MEDICAL SERVICES, PLANNING, LOGISTICS, AND LIMITED CASUALTY DECONTAMINATION IN SUPPORT OF SPECIAL OPERATIONS OR PERSONNEL RECOVERY FORCES MEDICAL ELEMENTS. ADDS PHYSICIAN EXTENDER SUPPORT FOR CLINICAL MEDICINE ACTIVITIES. ENHANCES CAPABILITY TO PERFORM FOOD AND WATER SAFETY, FIELD HYGIENE/SANITATION, LIMITED NBC DETECTION, AND OCCUPATIONAL/ENVIRONMENTAL HEALTH SITE ASSESSMENT. THE FOLLOWING SUBSTITUTIONS ARE AUTHORIZED: AFSC 041A3 WITH 4A051 OR 4A151 OR 4N051, AFSC 042G3 WITH 048G3, 044F3, 4N071C, AFSC 4B071 WITH 043E3, AND AFSC 4E071 WITH 043H3.OTHERWISE ENLISTED PERSONNEL MAY SUB 1 SKILL UP OR 2 DOWN AND OFFICERS MAY SUB 1 GRADE UP/DOWN. BOS REQUIRED. CAPABLE OF OPERATING FROM: MB, LB, SB, BB. UNIT OPR: 16OSS.

FFSOR MED ORTHOPAEDICS AUGM TM	42G3A Orthopedic Physician Assistant	PROVIDES ORTHOPAEDIC MEDICINE PERSONNEL TO SUPPORT SUSTAINED OPERATIONS AT AN ESTABLISHED AFTH OR EQUIVALENT DEPLOYED MTF. DEPENDENT ON MTF FOR SURGICAL, ANESTHESIA, NURSING, AND ANCILLARY CARE SUPPORT AND IS NOT A STAND-ALONE CAPABILITY. USUALLY DEPLOYS WITH FFS0S (MED ORTHOPAEDIC SURGEON). UTC MAY ALTERNATIVELY BE UTILIZED TO PROVIDE PRIMARY MUSCULOSKELETAL CARE AND GENERAL SURGERY SUPPORT IN AN EXPEDITIONARY FACILITY WITH A LOW VOLUME OF ACUTE SURGICAL CARE. AFSC SUBSTITUTIONS AUTHORIZED IAW WMP-1, AFMS SUPPLEMENT. SKILL LEVEL SUBSTITUTIONS AUTHORIZED IAW AFI 10-403. DEPLOYS TO MOB. ECS REQUIRED. PILOT UNIT: HQ ACC/SGXM, LANGLEY AFB VA. OPR: HQ ACC/SGX. ACC REVIEW: APR 09
FFSPH MED SURG PHYS ASST AUGM	42G3C General Surgery Physician Assistant	PROVIDES GENERAL SURGERY PHYSICIAN ASSISTANT TO AUGMENT GENERAL SURGICAL CAPABILITY DURING SUSTAINED OPERATIONS AT AN AFTH OR EQUIVALENT DEPLOYED MTF. MAY BE ALTERNATIVELY UTILIZED TO PROVIDE GENERAL SURGERY SUPPORT IN AN EXPEDITIONARY FACILITY WITH A LOW VOLUME OF ACUTE SURGICAL CARE. MUST DEPLOY WHERE GEN SURG CAPABILITY IS ALREADY ESTABLISHED. CANNOT DEPLOY FIRST TO FORM AFTH/EQUIVALENT. DEPENDENT ON MTF FOR MEDICAL-SURGICAL NURSING AND ANCILLARY CARE SUPPORT AND IS NOT A STAND-ALONE CAPABILITY. USUALLY DEPLOYS WITH FFSU1 (MED SURGERY TM 1) AND/OR FFSU2 (MED SURGERY TM 2). AFSC SUBSTITUTIONS AUTHORIZED IAW WMP-1, AFMS SUPPLEMENT. SKILL LEVEL SUBSTITUTIONS AUTHORIZED IAW AFI 10-403. DEPLOYS TO MOB. ECS REQUIRED. PILOT UNIT: HQ ACC/SGXM, LANGLEY AFB VA. OPR: HQ ACC/SGX. ACC REVIEW: APR 09

FFVCF CASF COMMAND FUNCTION	**42G3**	PROVIDES BASIC COMMAND FUNCTION FOR CASF+25 THROUGH CASF +250 SIZES. ALWAYS DEPLOYED WITH ADDITIONAL CASF UTCS. BRINGS ADDITIONAL NEW SERVICES OF BIOMEDICAL EQUIPMENT REPAIR AND SUPPLEMENTS EXISTING AFSC OF ADMIN, PHYSICIAN, AND LOGISTICS. SPECIALISTS IN AEROMEDICAL STAGING, FFVCF BRINGS THE COMMAND, CONTROL, AND COMMUNICATION EXPERTISE TO CASF CAPABILITY. PRESENT IN CASF BEDSIZES AS FOLLOWS: 1 FOR CASF +25, 1 FOR CASF +50, 1 FOR CASF +100, AND 2 FOR CASF +250. MUST DEPLOY WITH FFVNF AND FFVSF TO COMPLETE THE CASF PACKAGES. ENSURES PATIENTS ARE ADMINISTRATIVELY PREPARED FOR FLIGHT AND REGULATED IN THE A/E SYSTEM. THE PRIMARY ROLE OF THE FFVCF IS TO PROVIDE CLINICAL AND ADMINISTRATIVE EXPERTISE OF PATIENTS MOVING IN THE A/E SYSTEM. SOURCE: AD AND AFRC. LIMITING FACTORS: ECS REQUIRED FROM AF, DOD, USER SERVICE, OR HOST NATION. MENTAL HEALTH BH SERIES UTCS MUST BE TASKED TO PROVIDE MENTAL HEALTH SERVICES IF REQUIRED AT THE DEPLOYED LOCATION. ONE OF THE 048R3 POSITIONS CAN BE SUBSTITUTED WITH ANY 04XXX PHYSICIAN WHO HAS COMPLETED THE AEROSPACE MEDICINE PRIMARY COURSE. PRIOR COORDINATION WITH THE MAJCOM WILL BE ACCOMPLISHED BY THE UNIT USING THIS SUB RULE. OTHER SUBS IAW AFI 10-403 ANDWMP 1 AFMS SUPPLEMENT. DEPLOYABLE TO AOB, BB, FOB, OR MOB.PILOT UNIT: 932 ASTS. OPR: HQ AMC/SGXP, DSN779-6205. REVIEWED: NOV 09 (This package contains personnel with the knowledge, skills, and experience of the air evac system, & command, communications, and control for a CASF 25 for independent medical care and support. UTC brings MSC administrators, flight surgeons, PA, medical services superintendent, medical logistics, biomedical equipment repair (BMET), and pharmacy technician. Used in building CASF 25, 50, 100, and 250 size facilities. Absent in the CASF-BASIC package since these services are provided by the collocated MTF, whether a fixed CONUS or deployed MTF such as EMEDS.)

QFFAD AIRBORNE FORCE PROTECTION HQ ADVON	J42G3	UTC PROVIDES AN AIRBORNE QUALIFIED SQ HQS FORCE PROTECTION ASSESSMENT/ADVON TEAM. DEPLOYS AS AN ADVANCE ECHELON OF UTC QFFPG AND IS DESIGNED TO BE INTEGRATED WITH 9AADV, QFFAD, 4F9R5, 4F9R6, 4F9R7, 4F9R8, 4F9R9, 7E1AM. PERFORMS LIAISON DURING AIRFIELD SEIZURE IN ORDER TO PROVIDE SEAMLESS IN-PLACE RELIEF OF SEIZURE FORCE. MANAGES EMPLOYMENT OF FOLLOW-ON FORCE PROTECTION FORCES WHILE PROVIDING LIMITED ENGINEERING, COMMUNICATIONS, AND MEDICAL CAPABILITIES. RESPONSE TIME ACCORDING TO DOC STATEMENT. DEPLOYS TO ALL TYPES OF BASES. SELF SUFFICIENT FOR 5 DAYS. BASED ON THE MISSION, SUBSTITUTIONS ON ARE AUTHORIZED FROM THE AFSC'S, GRADES, AND SKILL-LEVELS THAT ARE CONTAINED WITHIN THE QFFPG. REVIEWED: APR 09.
QFFSQ INTEGRATED BASE DEFENSE SQ	42G3	PROVIDES PERSONNEL AND INDIVIDUAL EQUIPMENT FOR 1X BASE DEFENSE SECURITY FORCES SQUADRON RAPIDLY DEPLOYABLE TO VARIOUS MISSIONS THROUGHOUT THE SPECTRUM OF CONFLICT. ENSURES ASSIGNED LOCATION RESOURCES AND PERSONNEL ARE AFFORDED A SECURE ENVIRONMENT TO OPERATE. THE SQUADRON IS MULTI-FUNCTIONAL CONTAINING SECURITY FORCES, INTELLIGENCE AND COUNTER INTELLIGENCE, CBRNE/EMERGENCY MANAGEMENT, ENGINEERING ASSISTANCE, COMMUNICATIONS, MEDICAL, LOGISTICS AND ADMINISTRATION PERSONNEL TO OPERATE WITH LIMITED SUPPORT FROM OTHER AEF FORCES. THE SQUADRON PROVIDES BASE SECURITY, EXTERNAL MOUNTED AND DISMOUNTED PATROLLING OF THE SECURITY AREA, COUNTER INTELLIGENCE, PATROL/EXPLOSIVE DETECTOR DOG TEAM AND COMMAND AND CONTROL OF THE DEFENSE FORCE FOR ONE LARGE BASE OR SEVERAL SMALL SITES. ELEMENTS OF THIS UTC MAINTAIN AIRBORNE AND AIR ASSAULT CAPABILITIES. UTC INCLUDES INDIVIDUAL WEAPONS, CLOSE PRECISION ENGAGEMENT CAPABILITY, NIGHT OBSERVATION DEVICES, AND LIMITED LIFE SUPPORT FOR AUSTERE LOCATION FOR UP TO 5 DAYS. UTC CAN ESTABLISH BASE DEFENSE/FORCE PROTECTION AT ANY LOCATION IN RESPONSE TIME ACCORDING TO DOC STATEMENT. CAN ALSO C2OTHER AEF FORCES. MAY BE DEPLOYED WITH ANY IDENTIFIED SF UTCS. REVIEWED SEP 09.

365-day TDY Deployments

PAs were first tasked for 365-day deployments around Christmastime 2005. At that time we needed four for MNSTC-I missions at forward operating bases (FOB) in Iraq and six for Provincial Reconstruction Team (PRT) missions in Afghanistan. By 2008 the mix had changed and consisted of fewer MNSTC-I missions, around the same number of PRT missions, plus two Embedded Training Team (ETT) missions. Since then the overall number of these longer deployments has dropped significantly while shorter, more predictable, ones have risen.

For assignment purposes, a 365-day TDY gives credit for a short tour remote and resets that date. For volunteers, every effort is made to give base of preference consideration on return. Non-volunteers are ranked according to grade and their Short Tour Overseas Return Date (STRD).

Check out the archives of the ***Towner-Schafer Report*** (http://www.safpa.org/History/TSR.php) for personal reports from PAs assigned to each of these types of teams.

The following are examples of past deployment taskings. Fortunately, 365-day deployments for PAs are now mostly of historical interest.

ETT (Embedded Training Team): Wherever Afghan National Army (ANA) soldiers are deployed across Afghanistan, they do so accompanied by U.S. embedded training teams. For example at a forward operating base a typical ETT of 11 officers and non-commissioned officers would train and advise the men of the assigned ANA unit. An ETT's job is to mentor, train and advise the ANA; to train the leaders and NCOs so that they understand and know how to conduct army business themselves. The PA provides medical support to the ETT and may train medical principles to the ANA.

MNSTC-I (Multi-National Security Transition Command-Iraq): The MNSTC-I mission is to 'Organize, train, equip, and mentor Iraqi security forces, in order to support Iraq's ultimate goal of a unified, stable and democratic Iraq, which provides a representative government for the Iraqi people; is underpinned by new and protected freedoms for all Iraqis and a growing market economy; and is able to defend itself and not pose a threat to the region.'

PRT (Provincial Reconstruction Team): PRTs are an administrative unit of international aid to Afghanistan and Iraq, operating from small bases from which a group of sixty to more than one thousand civilians and military specialists work to perform small reconstruction projects or provide security for others involved in aid and reconstruction work.

Within these PRTs there are typically 3-5 civilians and the remainder is made up of military forces. PRTs are backed by national and international security forces. PRTs were originally built and operated by US forces as means of facilitating reconstruction efforts in provinces outside the capital, Kabul. Following NATO involvement in

Afghanistan, the command of the PRTs was transferred from the US forces to the forces of the nations under the International Security Assistance Force (ISAF).

READINESS SKILLS VERIFICATION

Readiness Skills Verification (RSV) documents attainment of measurable benchmarks to verify that you are familiar with the concepts and skills you will need for deployment. For some clinical personnel, daily practice in a peacetime environment meets practice requirements in a readiness environment. For others, daily practice does not mirror the trauma skills needed to care for combat casualties. Reserve Component clinicians may be granted equivalent training credit based on their civilian employment experience when appropriate documentation is provided. If you are already competent in any of the areas all you need is to have it verified by someone known to be competent in that area and signed off. You are not required to do additional or redundant training. The program is governed by AFI 41-106.

Personnel assigned to a standard UTC must complete the RSV training for their Duty AFSC (DAFSC), usually 42G. In addition, personnel who are used as authorized substitutes on a standard UTC must complete RSVP 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 RSVP training for their own AFSC, not the AFSC they are substituting for.

RSVP is mandatory for all PAs assigned to a Unit Type Code (UTC).

"D" coded UTCs: Personnel assigned to a UTC with an AFWUS code beginning with "D" must complete RSVP training for the AFSC of the UTC position they are filling.

"A" coded UTCs: Personnel assigned to a UTC with an AFWUS code beginning with "A" will complete RSVP training based on their own duty AFSC.

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.

RSVs are listed at: https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=RSVP

Each RSVP skills checklist was created by the SG Consultant and/or the Career Field Manager for their respective AFSC(s), who have responsibility for their 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.

42G RSV CHECKLIST

Minimum currency levels have been set for many skills. These "proficiency standards" imply a level of activity sufficient to maintain skills, but do not necessarily denote competency. Performance areas under each bold face subject should be assessed for knowledge in addition to demonstration.

Skills Specific to AFSC

Skill Set	Knowledge/ Performance	Frequency	Training Sources
1. ADULT/PEDIATRIC EMERGENCY PROCED **a. TRAUMA LIFE SUPPORT:** Successful completion of a provider-level trauma care course. Pre-hospital and small-facility capable emergent stabilization skills. Must maintain currency if one does not have on-going ER privileges (30 days in 3 years)	Performance	Q 48 M	Emergency Procedures (animal lab course at military Clinical Investigation Facility 2) PHTLS (at C4 or other) 3) C-STARS, Emergency War Surgery Course 4) Tactical Combat Casualty Care Course
b.ADVANCED CARDIAC LIFE SUPPORT (ACLS) (as required in AFI 44-102). Successful completion of an ACLS course	Performance	Q 24 M	ACLS Course
c. PEDIATRIC ADVANCED LIFE SUPPORT (PALS) (as required in AFI 44-102). Successful completion of a PALS course. Add review of emergent deliveries (knowledge level) if humanitarian mission expected.	Performance	Q 24 M	PALS Course
d. URGENT CARE: Minor surgical techniques, wound closure, injury stabilization including splinting and casting	Performance	Q 24 M	Everyday work experience validated by supervisor/instructor; 1-2 week ER rotation 2) AAFP/USAFP Sports Medicine Symposium 3) Wilderness Medicine Symposium 4) Pertinent workshops at CME conferences
e. DENTISTRY: Performs limited urgent dental care in an austere environment	Knowledge	Q 24 M	1) Local dental clinic rotation/in-service 2) IDMT course material 3) Book: "Where There is No Dentist" by Murray Dickson 4) Highly recommend refresher rotation 4-6 month prior to deployment
2. MENTAL HEALTH a. TREATS COMBAT STRESS:	Knowledge	Q24M	1) Review one of two attached briefs or use local brief from Life Skills personnel Combat Stress 1 Combat Stress 2 2) Critical Incident Stress Management (CISM) briefing
3. AIR EVACUATION/JOINT SERVICE INTEROPERABILITY a. PATIENT MOVEMENT IN THEATRE: Knowledge of patient stabilization and movement in a joint operations environment. The clinician should be able to request air evac, complete appropriate paperwork, communicate urgency and severity of the condition to air evac personnel.	Knowledge	Q24M	1) Familiarization with AE concepts documents can be taught at MTF 2) Read AE Concepts 3) Aerospace Medicine Primary Course (once)

Skill Set	Knowledge/ Performance	Frequency	Training Sources (recommended)
4. CBRNE a. MANAGEMENT OF CBRNE CASUALTIES: Review of current threats clinical syndromes and management techniques for chemical, biowarfare, bioterrorism, nuclear/radiologic agents	Knowledge	Q 24 M	1) Local MTF by CBRNE, MURT, VTC 2) USAMRII D/USAMRIC courses ***http://www.usamriid.army.mil/education/instruct.htm*** 3) Patient decontamination team training based on USAFSAM Course B3AZYDECON 000 Train the Trainer)
5. UNCOMMON ILLNESSES a. Reviews disease/illnesses uncommon in US practice that may be seen commonly in the deployed environment, to include infections diarrhea, tuberculosis, malaria, parasitic diseases. This requirement is to be focused on the projected AOR for the member's UTC.	Knowledge	Q 24 M	1) MTF: UTC team training, MURT, Public Health in-services) USAMRIID training programs 3) USAF Global Medicine Course (once) 4) www.cdc.gov
6. PREVENTION AND AEROSPACE MEDICINE **a. FIELD OPERATIONS:** Conducts site surveys, provides food/water surveillance, facility sanitation evaluation, food safety inspections, water testing/treatment. Performs wet bulb-globe temperature readings. Basic supply system orientation. (Training required only if assigned to FFGL3, Prevention and Aerospace Medicine (PAM) team or to Provincial Reconstruction Team.	Knowledge	Q 24 M	1) MTF Public Health Instruction 2) IDMT Course materials (or in IDMT refresher session 3) USAFSAM Public Health CONOPS (B3OZYCONOP) course
b. IMMUNIZATIONS: Familiarity with immunization indications and techniques: including small pox and anthrax programs.	Knowledge	Once	Military Public Health Instruction Immunization Clinic
7. MEDICAL OPERATIONS OTHER THAN WAR **a. HUMANITARIAN ASSISTANCE:** Training to prepare primary care providers in executing medical care to civilian populations of all ages in the aftermath of humanitarian emergencies. (Training required only if assigned to a humanitarian deployment or Provincial Reconstruction Team.)	Knowledge	Q 48 M	1) DMRTI's Military Medical Humanitarian (MMHAC) Course 2) Consider Pediatric and Women's Health clinic rotations before deployment if not a significant part of normal patient mix. 3) Neonatal resuscitation (NRP or NALS) training optional

For Readiness Skills Verification Program questions, please contact the Air Force Expeditionary Medical Skills Institute (AFEMSI) office at 210-536-3164 DSN: 240-3164 and/or send correspondence to usafsam.iec.rsvp@brooks.af.mil. For comments or suggested changes to the context of the Readiness Skills Verification skills list, please contact your Surgeon General Consultant or Career Field Manager (CFM) thru your MAJCOM. (Consultant and CFM list can be reached through the AF Clinical Quality Website

https://kx.afms.mil/clinicalquality)

Law of Armed Conflict

A (very) Brief Overview

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, however such conflicts are characterized.

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. Attacks shall be limited strictly to military objectives. 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

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Knowing is not enough; we must apply
Willing is not enough; we must do
-- Goethe

WHAT TO TAKE

Each base will have a list of required mobility bag items. In addition, the following was provided by a now-retired AF PA who has deployed multiple times in many environments in both hemispheres. Sometimes he was at an established facility, other times in more austere locations, like a forward operating base in Iraq. Therefore this is not a prescriptive list but more of a memory jogger for you to pick and choose what might be useful in your own circumstances.

RECOMMENDED ITEMS

REQUIRED

Items recommended on Readiness Deployment List
Uniforms, Dog Tags, Passport, I.D. Card, Military Drivers License
Mobility Bags for assigned area of operation

NICE TO HAVE

A good reliable flashlight (Surefire G2Â® Nitrolon or G2Â® LED are excellent lights that are very reliable and waterproof; or MAG type flashlight) and lots of extra batteries. Spare flashlight, LED Light, Penlight
A headlamp for doing minor procedures
Pen, Pad, and Paper (notebook)
Toilet paper
P.T gear
Spare Boots/footwear/Steel toe/ANSI Rated
Personal entertainment device (iPod type, etc.)
Sunscreen
Trauma Shears
Sun Glasses (Make sure your supply guys get you some good sunglasses and goggles (in case you need to fly or do medevacs)
Ballistic Eyewear with Polarized lenses Inserts
Gortex Jacket/Liner
Poncho Liner
Work Gloves/Liner
Sand scarf/Balaklava
Light Tactical Gloves
Ear Plugs (Yellow-Green Dual purpose if available)
Knee and Elbow pads
New Model of Kevlar Helmet and body armor (Rib and Shoulder armor)
Wristwatch/Watch with analog hands
Food Thermometer
Water purification pills
Camelback and supplies/Thermos (Coffee/Hot Cocoa)

A few folding pocket knives
Compass
Lightweight binoculars
Digital Camera
Phone card
Whistle
Signal mirror
Parachute cord (550 cord)
Duct Tape
18 – 24" tie straps
Tie down straps
Karabiners
Chemical Light Sticks
Hand held Weather Meter/Atmospheric Data Center (Brunton/Kestrel)
Stethoscope
Pocket Otoscope / Ophthalmoscope
Multi-tool (Gerber/Leatherman)…and one for backup
Reading Materials/Deck of Cards
Memory Stick/Jump Drive (if allowed)
Sewing kit
Portable GPS (Handheld)
Fire Fly Rescue Strobe with Infrared Lens
Water Filter Pump/Filters and test kit
NBC Adapter for Camelback
Water Filter for Camelback
Batteries (AA, AAA, D, C)
Fire Starting Items (Never Dull, BlastMatch™ /Stick/Magnesium)

TRAINING

SOME REQUIRED; MOST NOT REQUIRED, BUT YOU MAY CONSIDER

ATLS Course
C-Stars Course
ACLS
PALS
BLS
OEMS (Operational Emergency Medical Support) course
(http://deploymentmedicine.com/OEMS.htm)

> One PA said "OEMS was the single most useful, insightful and practice-changing course I have attended in 17 years of military service and 11 years as an AF physician assistant".

Tactical Combat Casualty Care course
(http://www.cs.amedd.army.mil/courses/TCCC/tccc/index.html)
Combat Casualty Care Course (C4)
(http://www.dmrti.army.mil/dmrti%20courses%20-%20C4%20Course%20description.html)

Army Orientation Combat Operations (Ft. Hood, Ft. Rucker,..)
Convoy/Combat Operations Orientation
M-4 Training/Qualification
M-9 Training/Qualification
AK-47 Training/Qualification
Blue Force Tracker Training
SINGARS Training
Land Navigation Training
Public Health Training (Inspections Facilities/Dormitories/Epidemiology/Vector Control)
Bioenvironmental Training (Weather/Wet Bulb/Work Rest Cycles)
NBC Training
Expert Field Medical Badge (EFMB) Training
Pathfinder Training (LZ Operations)
Air Assault Training (Sling Loads and Palletization)
Medical Supply Orientation (Re-supply account numbers/Signature Cards)
Deployment Pharmacy Orientation (Signature Cards/Credentials)
Vehicle Operation (Convoy/Combat Vehicles)

Third World Personal Equipment List

Pick-&-Choose. Mission Guided

DOCUMENTS

- ☐ Military ID
- ☐ Dog Tags
- ☐ Shot Record
- ☐ Geneva Convention Card
- ☐ Orders
- ☐ Government Passport
- ☐ Government Credit Card
- ☐ SERE (Survival, Evasion, Resistance, & Escape)
- ☐ Anti-Terrorism/Force Protection
- ☐ ISOPREP (Isolated Personnel Report)
- ☐ Information Protection
- ☐ Airman's Manual
- ☐ _____

FOR FLIGHT⇨⇨ ⬜Alice Pack

- ⬜ Lunch
- ⬜ Snacks
- ⬜ Drinks
- ⬜ Afrin (good for ear pain)
- ⬜ Dynamic Earmuffs
- ⬜ Money
- ⬜ Book
- ⬜ CD Player & ⬜ Discs

HYGIENE

- ☐ **Sunblock SPF >45**
- ☐ Chapstick w/ Sunblock
- ☐ Towel, Bath
- ☐ Towel, Hand
- ☐ Soap/ ⬜ Shampoo
- ☐ Toothbrush/ ⬜Toothpaste
- ☐ Razor/Cream/Blades
- ☐ Electric Shaver w/ cord
- ☐ Mirror
- ☐ Antibacterial Hand Gel
- ☐ Toilet Paper
- ☐ Tissue paper
- ☐ Brush/comb
- ☐ Q-tips
- ☐ Bug Spray
- ☐ Skin lotion
- ☐ Baby Powder/ ⬜ Anti Fungal Powder
- ☐ Deodorant
- ☐ Nail Brush/⬜ Nail Clippers/ ⬜ Nail File
- ☐ _____

CLOTHING

- [ ] Combat Boots, x2 pair w/ hat
- [ ] Sneakers
- [ ] Shower Shoes
- [ ] BDU's x 2-3 pair
- [ ] Boonie Hat
- [ ] Bandana/Pullover
- [ ] Gore-Tex Jacket
- [ ] Reflective Belt
- [ ] T-shirts
- [ ] Undershorts
- [ ] Boot Socks
- [ ] Civilian Shirts
- [ ] Civilian Shorts
- [ ] Civilian Pants
- [ ] Civilian Rain Jacket
- [ ] Civilian Socks
- [ ] Civilian Shoes/Docksiders
- [ ] Handkerchiefs
- [ ] Hat w/ brim
- [ ] Extra Shoe Laces
- [ ] PT Uniform?

TOOLS ⇨⇨Mini-Duffle

- [ ] Swiss Army Knife
- [ ] Multi-Tool
- [ ] Mini Flashlight
- [ ] Clothes Line
- [ ] Clothes Pins
- [ ] Lock
- [ ] Scissors
- [ ] Paramedic Shears
- [ ] Calculator
- [ ] Work Gloves
- [ ] Key Chain Thermometer
- [ ] Whistle
- [ ] Mini-fan
- [ ] Mini Area Lantern for reading in bunk
- [ ] Shovel, Folding Camp
- [ ] Saw, Folding Camp
- [ ] Wire Saw
- [ ] Hammer & Nails
- [ ] 3 prong to 2 prong adapter
- [ ] Power strip
- [ ] Power Converter
- [ ] _____
- [ ] _____

☐ _____

Third World Personal Equipment List

(continued)

R&R

- ⬜ Toys for the local kids – Frisbees, soccer balls, etc…
- ⬜ Books
- ⬜ Cards ⬜Chess ⬜Checkers ⬜Backgammon
- ⬜ Black Light
- ⬜ _____
- ⬜

REPAIRS

- ⬜ Sewing Kit
- ⬜ Rubber Bands
- ⬜ Tape (⬜ duct & ⬜ electrical)
- ⬜ Safety Pins
- ⬜ Eye Glass repair Kit

PERSONAL MEDICAL

- ⬜ Spare glasses
- ⬜ Eyeglass leash
- ⬜ Sunglasses
- ⬜ Tylenol
- ⬜ Motrin
- ⬜ Steroid Ointment
- ⬜ Imodium for traveler's diarrhea
- ⬜ Cipro for traveler's diarrhea
- ⬜ Anti-acid
- ⬜ Sudafed
- ⬜ Band-Aids
- ⬜ Moleskin (good for blisters)
- ⬜ Allergy Meds
- ⬜ Prescription Meds w/ documentation

MEDICAL TEXTBOOKS (not very useful)

- ⬜ Merck
- ⬜ Current Emergency
- ⬜ Communicable Disease
- ⬜ Dermatology
- ⬜ Pediatrics
- ⬜ Sanford ABX guide
- ⬜ _____

MEDICAL

- ☐ Stethoscope
- ⬜ Otoscope w/ specula & insufflator
- ⬜ Ophthalmoscope
- ⬜ BP Cuff
- ⬜ PDA w/ charger & pouch
- ⬜ Magnifying Glass

MISCELLANEOUS

- Religious Items
- Unit Coin
- Neck Pocket
- Map
- Country Info
- Language Phrase Book
- Foldable Soft Plastic Shelves
- Small Wash Basin
- Inflatable Travel Pillow
- Fanny Pack/Belt Pack
- Travel Log
- Large Ziploc Bags to pack daily 'unders'*
- Small Ziploc for papers…
- Alarm Clock
- Spare batteries
- Camera w/ spare batteries & charger
- Memory Cards
- Monopod or Tripod
- Video Camera w/charger & spare battery
- Video Tapes
- Collapsible Cloth Chair
- Comfort snacks
- Crystal Light Drink Mix
- Pillow
- Sheet for sleeping bag
- Plastic mattress cover
- Pen & Paper
- Laundry Sack
- Laundry Soap
- Universal Rubber Sink Stopper
- Shoe Shine Kit
- Shower Curtains (dollar store)
- Business Cards

A BAG

- ALICE Pack
- Canteen
- ? Mess Kit?
- Web Belt
- Sleeping Bag
- Mosquito Netting & Poles
- Flashlight
- _____
- _____

* place 1 set of unders in 1 Ziploc for each day

(List courtesy Lt Col Ari Fisher, AFRC)

CUSTOMS
&
TRADITIONS

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 purpose of the dining-in is to bring together members of a unit in an atmosphere of camaraderie, good 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, semi-formal 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	USA	USMC	USN	USAF	USCG	Civilian Men	Civilian Ladies
Official formal and evening functions, state occasions, private and formal dinners or at occasions that are less formal requiring more formality than Service Uniforms *	Blue Mess Evening Dress w/bow tie  or Blue Army Service w/ bow tie or with four-in-hand tie *picture is with four- in-hand tie* 	Evening Dress "A"/"B"  or Blue Dress "A"/"B" *Year-round* or Blue-White "A"/"B" *Summer* ("A" w/ medals "B" w/ ribbons) 	Formal Dress (white tie)  or Dinner Dress Blue/White Jacket  or Dinner Dress Blue/ White 	Mess Dress  or Service Dress 	Formal Dress Blue White Tie *(not pictured)* or Dinner Dress Blue/ White Jacket Black Tie 	*Formal* Tuxedo, Bow Tie is Standard *Formal or Semi-Formal* Tuxedo or Dark Dinner Jacket **	*Formal* Cocktail or Evening Gown *Formal or Semi-Formal* Long or short evening dress or evening trousers with a dressy top **
Parades, ceremonies, reviews, when special honors are being paid, official visits of US or foreign dignitaries *	Blue Army Service or Green Army Service 	Blue Dress or Blue-White "A"/"B" ("A" w/ medals "B" w/ ribbons) (Service "A" may be worn if command directed) 	Full Dress Blue/White (ceremonial)  or Service Dress Blue/White 	Service Dress 	Full Dress Blue/White or Dinner Dress Blue/White or Service Dress Blue/White 	*Informal, Smart or Business Casual* Business Suit or Sport Coat and tie **	*Informal, Smart or Business Casual* Evening or Cocktail attire, Sunday Dress or Business suit or Pant suit **
Business and informal social occasions, uniform of the day, office work	Blue or Green Army Service Class "B" 	Service "A"/"B"/"C" 	Service Khaki *Year-round* Summer White *Summer* 	Service Uniform "Blues" 	Tropical Blue *Year-round* or Winter Dress Blue *Summer* 	*Informal, Smart or Business Casual* Business Suit or Sport Coat w/out tie. Trousers with open collar shirt **	*Informal, Smart or Business Casual* Simple skirt or dress, slacks with jacket, pantsuit. Low or flat shoes acceptable **

Table of Service Equivalent Uniforms

Event When Worn	USA	USMC	USN	USAF	USCG	Civilian Men	Civilian Ladies
Working uniforms, daily work attire, or in a field or plant environment where soiling of clothing is expected	Army Combat Uniform (ACU) 	Utility 	Working Uniform 	Airmen Battle Uniform (ABU) 	Operational Dress 	*Civilian Casual* Slacks with open collar shirt or golf shirt, no sport coat **	*Civilian Casual* Slacks with blouse, Capri pants with sandals or flats **

Note: This matrix is intended to serve as a guideline for appropriate attire. Each service uniform regulation has specific guidelines for wear. Some uniforms are optional, seasonal or required for specific pay grades only. Army White Mess and Air Force Formal Dress are not pictured.

Army – AR 670-1
Marine Corps – MCO P1020.34F
Navy – United States Navy Uniform Regulation NAVPERS 15665I
Air Force – AFI 36-2903
Coast Guard – COMDTINST M1026.6F

Note: Uniforms may deviate from above matrix depending on event and/or directed by host or command

*If host indicates a certain dress, follow the host's intent.

**Determined by host, current fashion, local customs, time and type of event.

Please contact OCJCS Protocol at 703-697-6606 with any changes or updates.
As of February 2010

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 "non-perishable" 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.

Approved versions of the symbols are available at www.af.mil/library/symbol/. If in doubt on any aspect of symbol use, please call the trademark licensing office 703-695-2414 DSN: 225-2414 or e-mail: afstory@pentagon.af.mil

WHICH IS CORRECT?



STAFF OF ASCLEPIUS



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)

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

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 36-2101	**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 Boards Work**
AFI 36-2603	**AF Board for Correction of Military Records**	
AFI 36-2611	**Officer Professional Development**	
AFI 36-2803	**The Air Force Awards and Decorations Program**	
AFI 36-2856	**Air Force Medical Service Awards**	
AFI 36-2903	**Dress and Personal Appearance**	
AFI 36-2905	**Fitness Program**	
AFI 36-3003	**Military Leave Program**	**Permissive TDY tables**
AFI 36-3203	**Retirements**	
AFI 36-3208	**Administrative Separation of Airmen**	
AFI 36-3401	**Air Force Mentoring**	
AFI 38-101	**Air Force Organization**	**Medical Group Structure**
AFI 41-104	**Professional Board/National Certification Examinations**	

AFI 41-105	**Medical Education and Training Programs**	
AFI 41-106	**Unit Level Management of Readiness Programs**	**RSV Program**
AFI 41-108	**Training Affiliation Agreement**	
AFI 41-109	**Special Pay for Health Professionals**	
AFI 41-115	**Authorized Care and Benefits in the MHS**	
AFI 41-117	**Medical Service Officer Education**	**The nitty gritty of running an ed program**
AFI 41-210	**Patient Administration Functions**	
AFI 44-102	**Medical Care Management**	
AFI 44-103	**IDMT Program and Remote Medical Support**	
AFI 44-104	**Medical Consultant/CFM Programs**	
AFI 44-119	**Clinical Quality Management**	**#1 Reference for PA Practice**
AFI 44-162	**International Health Specialist Program**	
AFI 44-170	**Preventive Health Assessment**	
AFI 48-123	**Medical Exams and Standards**	
AFI 51-601	**Gifts to the Department of the Air Force**	
AFI 51-604	**Appointment to and Assumption of Command**	
AFMAN 10-100	**Airman's Manual**	
AFMAN 10-3902	**PRP**	**PRP Program, Competent Medical Authorities, etc.**
AFMAN 44-158	**IDMT Protocols**	
AFPAM 34-1202	**Guide to Protocol**	
AFPAM 36-2241	**Professional Development Guide**	
AFPAM 36-2506	**Officer Promotions**	
AFPAM 36-2607	**AF Board of Correction of Military Records**	
AFPAM 48-133	**Physical Examination Techniques**	

CONSULTANT LIST All SG Chief Consultants **https://kx.afms.mil/sgconsultants**

OFFICER CLASSIFICATION DIRECTORY (AFOCD). Go to the AFPC website 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://www.army.mil/usapa/epubs/40_Series_Collection_1.html)

AR 40-68	**Army Clinical Quality Management**	**Army PA Practice**
AR 40-501	**Army Standards of Medical Fitness**	**Needed if doing MEBs**
NAVMED P-117 (MANMED)	**Manual of the Medical Department**	**“ “ “ “ (see chap 15)**

DA3349 **Army Physical Profile form**

WEBSITES AND OTHER RESOURCES:

AAPA: http://www.aapa.org/
AAPA "PA Development Toolbox": http://www.aapa.org/education-and-certification/pa-development-toolbox
AF Assignment Management System https://afas.afpc.randolph.af.mil/AMSNET/default.aspx
AF Core Values (The "Little Blue Book") http://www.e-publishing.af.mil/pubs/US%20Core%20Values.pdf
AFIT https://www.afit.edu/cip
AFMS Home Page: http://airforcemedicine.afms.mil/
AF SG Home Page https://www.afms.mil/sg/index.htm
AFMS CAG (for AFMS 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://dod411.chamb.disa.mil/
AFMS Knowledge Exchange, Physician Assistants: https://kx.afms.mil/pa
AFMS Virtual Library: https://kx.afms.mil/newvl
AFPC General Personnel Information https://gum-crm.csd.disa.mil/app/login/redirect/home
Air Force Art (including symbol protocol) http://www.af.mil/art/
American College of Clinicians: http://www.amcollege.org/
Biographies, AF: http://www.af.mil/library/biographies/ **(and** http://airforcemedicine.afms.mil/public_affairs/leadershipbios.html

BSC Home Page: https://www.afms.mil/sgcb **(Subscribe as member)**
BSC Utilization Branch (AFPC) https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AFBSCUtilization
BSC Education Branch (AFPC) https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AFBSCEducation
Deployment Resources:

- **AEF Online** https://aefcenter.afpc.randolph.af.mil/
- **Language & Culture** http://fieldsupport.lingnet.org/

Military Health System (MHS) website http://www.health.mil/
MPF (Virtual) https://www.my.af.mil/afpc2ww3/vmpf/Hub/Pages/Confirminfo.asp
My Officer Development Plan (MyODP)
https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?channelPageId=s6925EC134EE60FB5E044080020E329A9
DoD Website: http://www.defenselink.mil/
Performance Report resources https://kx.afms.mil/reportguide
NCCPA: http://www.nccpa.net/
Society of Air Force PAs (SAFPA) website http://www.safpa.org/

U.S. Department of Defense
Office of the Assistant Secretary of Defense (Public Affairs)

"A-Staff" Structure

(Edited News Release)

On the Web:
http://www.defenselink.mil/releases/release.aspx?releaseid=9268
Media contact: +1 (703) 697-5131/697-5132

Public contact:
http://www.defenselink.mil/faq/comment.html
or +1 (703) 428-0711 +1

IMMEDIATE RELEASE

No. 082-06
January 30, 2006

Air Force Reorganizes Staff Structure

TheDepartment of Defense announced today that the staff functions at Headquarters Air Force, major commands and warfighting headquarters will soon all share the same "A-staff" structure.

By Feb. 1, the Air Staff at Headquarters Air Force here will adopt an organizational structure that closely mirrors the Army's "G-staff," the Navy's "N-staff," and the joint "J-staff." "The effort will help the Air Force optimize internal communications and communicate more efficiently with other services", said Brig. Gen. Marshall K. Sabol, the Air Force director for manpower, organization and resources.

"This change will enhance our warfighting capability and help our communications both horizontally and vertically in the Air Force as well as with those on the joint staff and the Office of the Secretary of Defense," Sabol said. "As we operate in deployed and joint environments, our communication will also be more effective and efficient."

The affected Air Force functions will be renamed and realigned so similar functions at all levels are referred to by the same name. Likewise, those same functional groupings will closely match other services and the joint staff.

For example, At Headquarters Air Force, the deputy chief of staff for manpower and personnel is now called "AF/DP." Under the reorganization, he will be referred to as "the A1." The A1 in the Air Force is responsible for plans and policies covering all military life cycles and civilian personnel management.

Similar functions, at all levels, will be "remapped" to nine standardized A-staff areas of responsibility. Those areas include:

-- A1 - Manpower and Personnel
-- A2 - Intelligence
-- A3 - Air, Space and Information Operations
-- A4 - Logistics
-- A5 - Plans and Requirements
-- A6 - Communications
-- A7 - Installations and Mission Support
-- A8 - Strategic Plans and Programs
-- A9 - Analyses, Assessments and Lessons Learned

Also, as part of the A-Staff structure, the Air Force assistant vice chief of staff will also serve as the director of staff. Addition of this title will promote coordination with the joint staff and other services. Retaining the assistant vice chief of staff nomenclature is required to fulfill the representational role the incumbent plays in dealing with attaches and how that person communicates to foreign contingents while representing the chief of staff.

Not all functions of the Air Staff will be affected by the reorganization. Additionally, the reorganization will not change special staff offices assigned to the Secretary of the Air Force and will not filter down to the wing level.

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.