NATO STANDARD

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FORWARD AEROMEDICAL EVACUATION

Edition A Version 1

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NORTH ATLANTIC TREATY ORGANIZATION

ALLIED AEROMEDICAL PUBLICATION

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

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NATO LETTER OF PROMULGATION

23 April 2018

1. The enclosed Allied Aeromedical Publication AAMedP-1.5, Edition A, Version 1, FORWARD AEROMEDICAL EVACUATION, which has been approved by the nations in the Military Committee Air Standardization Board (MCASB), is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2087.

2. AAMedP-1.5, Edition A, Version 1, is effective upon receipt.

4. This publication shall be handled in accordance with C-M(2002)60.

Zoltán GULYÁS
Brigadier General, HUNAF
Director, NATO Standardization Office

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.	

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
HRV	Republic of Croatia implements this document with reservations in following parts: Chapter 2 – due to lack of adequately trained flight medical crew, especially for Dependancy 1 in-flight medical support (as specified in STANAG 3204/AAMedP–1.1). Chapter 5, paragraph 2 – due to lack of adequate aeromedical equipment, especially for Dependency 1 in-flight medical support (as specified in STANAG 3204/AAMedP–1.1 and STANAG 7112 / AAMedP–1.20).
TUR	1. There is no medical crew/personnel specially trained on aeromedical evacuation on deck of helos and surface combatants. 2. In case of emergency, during medical evacuation via helos on ship or helos called out for, medical evacuations are made with the medical crew and limited medical supplies of the ship.
FRA	The aircraft commander cannot be responsible for the location of the casualties. This is the responsibility of the medical mission director based on observed medical conditions and preparations. The final authorizing officer for a MEDEVAC mission cannot be the medical personnel, but the operational chain on the theatre, notably in consultation with the medical chain. Medical confidentiality required in paragraph 5.1 can only be ensured if encrypted communications are available.

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CHAPTER 1 GENERAL

1.1 DEFINITION

Forward aeromedical evacuation (FwdAE) is defined as the phase of medical evacuation that provides airlift for patients under medical supervision between the point of injury or illness and the first Medical Treatment Facility (MTF) within the area of operations.

1.2 PRINCIPLES

FwdAE must be performed in accordance with or as close as reasonably practicable to NATO medical planning timelines (AJP-4.10). Aeronautical and tactical considerations in the combat area or aircraft fleet availability could implement a delay.

FwdAE is concerned with the timely movement of the patients to the most appropriate MTF, in order to reduce mortality, morbidity and permanent disability.

1.3 MISSIONS

1.3.1 PRIMARY MEDICAL MISSION

The primary mission is to provide AE in accordance with the asset prioritisation determined by the Patient Evacuation Coordinating Cell (PECC) in cooperation with OPS. The commander of the aeromedical team is typically the Medical Crew Director (MCD).

1.3.2 SECONDARY MISSIONS

Secondary missions of the medical units and/or of air transport made available for medical purposes may include:

a. Airlift of critical medical supplies.

b. Air movement of medical specialist personnel.

c. Other medical evacuation missions as directed.

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CHAPTER 2 MEANS

Normally, helicopters and V/STOL aircraft will be used for FwdAE.

Patients will frequently be untreated or inadequately stabilized prior to evacuation. Therefore, whenever possible, medical care in this phase should incorporate personnel trained to deliver tactical combat casualty care in flight. To the maximum extent possible, the medical crew should consist of personnel specially trained in the principles of aeromedical evacuation. Operational situations may preclude use of aeromedical escorts with advanced skills.

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CHAPTER 3 MISSION COORDINATION

3.1 PLANNING

The responsibilities of the Combined Joint Force HQ Medical Director (MEDDIR) includes planning and executing an effective FwdAE system, in close coordination with CJ3 Ops and CJ3 Air Ops to ensure that the most appropriate available platforms are used to move patients. The Patient Evacuation Coordinating Cell (PECC) is the element that will provide this coordination capability for the forward area. CJTF MEDDIR will decide on the number and location of PECCs necessary to support the mission, in close coordination with the MEDADs of the respective components and/or regional commands. As such, each PECC has an area of responsibility.

3.2 REQUEST FOR AEROMEDICAL EVACUATION

1. The unit in charge of the patient initiates an aeromedical mission by directly contacting the command concerned, e.g. the battle group/regiment, the division and the corps of the army. Requests for these missions may be processed through medical and/or command channels, according to local directives and the organization of the force concerned.

2. In order to provide the PECC with the information required to evaluate and establish categories for AE, the standardized format of the voice MEDEVAC request (“9-Liner”) is contained in STANAG 2627/ATP-97 and the electronic version is in the NATO Message Catalog STANAG 7149/APP-11.

Additional information can be given using the Mechanism Injury Symptoms Treatment (MIST-AT) template (STANAG 2627/ATP-97).

3.3 COMMAND AND CONTROL

1. FwdAE is controlled from the theatre headquarters that controls the air and ground transport assets. Upon receiving the medical evacuation request, the PECC provides the medical analysis of this request and decides on the type (ground/air) and number of evacuation assets and AE crew required for the mission. For the use of air assets, close liaison between this medical dispatching element and the assigned aircraft tasking authority is essential.

2. The PECC will coordinate and liaise with the destination MTF, including ensuring that any necessary ground transportation between the helicopter landing zone and the MTF is provided as required. If a PECC receives a request for medical evacuation outside its area of responsibility, this PECC will immediately forward this request to the appropriate regional PECC, and provide further liaison and coordination as necessary.

CHAPTER 4 RESPONSIBILITIES

4.1 REQUESTING UNIT RESPONSIBILITIES

1. The requesting unit is responsible for:

   a. Providing immediate buddy aid to the casualty.

   b. Marking and providing protection to the landing zone.

   c. The movement of the patient(s) to the loading sites.

   d. Providing personnel at the landing zone to assist in patient loading.

   e. Handing over written or verbal information (MIST) relating to treatment given to date.

   f. Conducting security checks of the evacuees to ensure they do not pose a threat during AE transport.

4.2 COMMAND PILOT OF THE AIRCRAFT

The aircraft commander is responsible for:

   a. The final decision as to how many patients may be safely loaded and as to their location. However, the AE MCD should advise him in his decision.

   b. Ensuring that all patients and medical equipment are loaded and secured in the aircraft in accordance with the prescribed methods outlined in the applicable flight handbook.

4.3 COMMANDER OF THE AEROMEDICAL TEAM (MEDICAL CREW DIRECTOR)

1. The AE team commander is responsible for:

   a. Loading supervision and aircrew advice.

   b. Supervision and provision of inflight care.

   c. Communication with the air crew.

d. Providing all pertinent medical information to the receiving physician at the destination MTF in a standardized format (MIST-AT).

4.4 COMMANDERS OF MEDICAL TREATMENT FACILITIES

The MTF commander is responsible for:

a. Providing personnel at the landing zone to off-load the patients under the direction of the AE team and aircraft commander.

b. Providing transportation for the movement of patients from the landing site to the MTF.

c. Conducting security checks of incoming patients to ensure the security and integrity of the receiving MTF and its personnel.

CHAPTER 5 MISCELLANEOUS

5.1 COMMUNICATION AND INFORMATION SYSTEMS (CIS)

A reliable communication capability, which provides for direct or minimal delay of transmissions, between the authority controlling medical missions, the aircraft and the requesting unit is to be provided. Communications are to be minimized by relaying accurate information in the original request for AE and update its evolution during flight. A ground-to-air communications capability at the landing zone is desirable. An in-flight communication system is highly desirable when undertaking rotary-wing transfers to ensure efficient communication between AE medical crew members and between the MCD and the pilot or receiving MTF. Medical confidentiality must be maintained.

5.2 MEDICAL EQUIPMENT

The recommended minimum scaling of medical equipment is given in STANAG 7112/AAMedP-1.20. All medical equipment used in AE aircraft must be airworthy and certified by the appropriate national or EU authority for use on aircraft; suggested minimum specifications of such equipment are included in STANAG 3204/AAMedP-1.1.

5.3 AIRCRAFT IDENTIFICATION

Aircraft permanently used and dedicated to AE missions should be marked with the emblem stipulated in Geneva Conventions, although markings may be masked or camouflaged as a theatre command decision.

AAMedP-1.5(A)(1)