OBJECTIVES: The objective of this lesson is to provide a basic understanding of the Aeromedical Evacuation (AE) system and the AE Unit Type Codes (UTC) utilized to build a Theater Aeromedical Evacuation System (TAES).

REFERENCES:
- DODI 6000.11, Patient Movement
- JP 4-02, Health Service Support
- AFTTP 3-42.5, Aeromedical Evacuation (AE)
- AFI 41-106, Medical Readiness Planning and Training
- AFI 41-301, Worldwide Aeromedical Evacuation System
- AFI 41-307, Patient Care

1. Introduction

   a. History of AE. The history of AE dates back to 1943, when the Army Air Corps School of AE began training medical crews at Bowman Field, Kentucky. The Army Air Corps developed a dual-purpose, quick change aircraft concept that provided the Army with a large fleet of cargo aircraft designed to transport troops and war materiel to overseas areas. On the return trip, the reconfigured aircraft carried patients. This provided the battlefield wounded with a speedy return to medical facilities for specialized care. During World War II, there were about 1.5 million patients airlifted. In 1949, the DOD conducted a study of the sick and injured military members moved by air. The result was an official policy by the Secretary of Defense: “…that in peace and war, the movement of patients of the Armed Forces shall be accomplished by airlift if available and conditions are suitable for aeromedical evacuation, unless medically contraindicated.” This policy still stands today.

   b. Mission of Air Force AE System. The primary mission of the DOD patient movement system is to safely transport US military casualties from the combat zone to field or fixed medical treatment facilities, as required (JP 4-02). The Air Force AE mission is to rapidly evacuate regulated patients under the supervision of aeromedical evacuation crewmembers.
(AECMs) on fixed-wing aircraft. It is important to note that other forms of patient movement occur routinely throughout the Area of Responsibility (AOR) which are not considered aeromedical evacuation. Casualty evacuation (CASEVAC) is the movement of unregulated casualties by ground or air transport. Medical evacuation (MEDEVAC) is patient movement using pre-designated ground/air assets equipped and staffed for en-route medical care.

The AE system exists primarily for the wartime evacuation of patients from the battle zone. In a contingency environment, patients may be moved via the theater AE system (TAES) which, when executed correctly is a fully functional, highly capable, force multiplying weapon system. During peacetime, the mission is to train to be prepared for war. Today, this is accomplished primarily through training missions called Aeromedical Readiness Missions (ARMS).

The AE system provides:
1. Integrated control of casualty movement by air transport
2. Clinical and operational support personnel
3. Equipment for in-flight medical care and ground support operations
4. Critical Care Air Transport Teams (CCATTs) to monitor and manage specific patients requiring intensive care
5. En route staging capability/patient preparation at or near secure airstrips for the processing and care of casualties entering, en route, or leaving the AE system

2. AE Force Structure

Approximately 88 percent of the total Air Force AE capability resides in the Air Reserve Components (ARC). There are four active duty AE squadrons (AESs):
1) 375 AES, Scott AFB, Illinois
2) 43 AES, Pope Field, Fort Bragg, North Carolina
3) 18 AES, Kadena AB, Japan
4) 86 AES, Ramstein AB, Germany

In addition to these four active component units, there are 28 Guard and Reserve AE units. Most AES units are co-located with an airlift wing and fly operational missions on local aircraft.

3. AE Unit Type Codes (UTCs)

AE UTCs are developed based on the building block principle. This principle allows planners to select specific UTCs capable of supporting the range of steady state, and contingency or major regional conflict. AE assets can be incrementally planned and can build from a small liaison team, a single AE crew, and critical care air transport team (CCATT), to a full TAES. The AE UTCs referenced below are not an all-inclusive list, but are the primary UTCs utilized in a TAES. At a minimum, in order for a TAES to exist, UTCs must be deployed to:
1) establish a command and control (C2) structure and a communication link between the user and the AE system
2) provide patient staging at an airfield
3) provide in-flight care
AE squadrons operationally align under the Operations Group (OG) and do not fall in the medical Surgeon General (SG) chain of command; however AE UTCs are comprised from both medical and operational requirements to be fully functional.

**a. Command and Control (C2) Capabilities.**

(1) **Aeromedical Evacuation Control Team (AECT).** Although the AECT is comprised of AE personnel, it falls under the command and control functional area and is not an AE UTC. The AECT is responsible for aeromedical evacuation coordination, integration and scheduling and is the central source of expertise for AE within a theater. This capability will be described further under the Air Operations Center paragraph in section 6.

(2) **AE Command Squadron (AECS).** This 8-person team provides command of assigned AE forces in a theater of operation. This team advises expeditionary wing and operations group commanders and other appropriate personnel/agencies on AE Concept of Operations (CONOPS), capabilities, and requirements. The AECS also provides procedural and technical guidance and management oversight for support of assigned, attached, and transiting AE activities. When required, this team can also serve as the AE advanced echelon (ADVON) team to arrange support requirements for follow-on AE forces.

**b. Patient Care UTCs.**

(1) **AE Crew/UTC: FFQDE.** This 5-person team (2 flight nurses, 3 AE medical technicians) performs in-flight medical care and meets training requirements to function safely on board fixed-wing aircraft. The type of aircraft, patient load, patient acuity and length of mission will dictate whether a crew needs to be augmented with additional crewmembers and/or CCATT(s).

(2) **Critical Care Air Transport Team (CCATT)/UTC: FFCCT.** This 3-person team provides the essential critical care requirements, in conjunction with AE crews, to evacuate critically injured and/or ill patients requiring advanced care during transport. Each team can support a maximum of three vented patients but up to six critically ill patients. Although CCATTs are a medical UTC which belongs to the SG, when deployed they fall under the AE squadron which is aligned under the operations group.

(3) **Mobile Aeromedical Staging Facility (MASF)/UTC: FFVNM.** The 13-person MASF provides rapid response AE patient staging capability to support small scale contingencies (SSC), humanitarian and civil disaster response operations. The MASF includes the capability to receive, process, and support patients awaiting AE. The MASF is normally located at or near an airfield capable of supporting fixed-wing aircraft. The unit is staffed and equipped to stage up to 40 patients per day. The MASF should be able to sustain this tempo for 72 hours before augmentation is required.

(4) **Contingency Aeromedical Staging Facility (CASF).** The CASF provides 24-hour staging operations for patients transiting the AE worldwide system. The CASF coordinates and communicates with the medical and AE elements to accomplish patient care, patient feeding, staging and patient movement, including ground transportation of patients in the AE system. The CASF personnel package is composed of 3 building block UTCs that are combined in various ways to customize the CASF depending on the nature and size of the mission. A CASF is usually
placed at an intratheater/intertheater hub and supports transient patients within the AE system who may need to wait for longer periods of time for fixed-wing AE movement. A 250-bed CASF is staffed and equipped to care for 500 patients in a 24-hour period.

a. CASF Command Function/UTC: FFVCF. The 10-person CASF command function provides basic command and control functions for a CASF and is always deployed with additional CASF UTCs (FFVNF and FFVSF). This UTC brings additional capabilities of biomedical equipment repair and supplements existing administrative, physician, and logistics specialists. This UTC ensures patients are administratively prepared for flight and regulated in the AE system and provides clinical and administrative expertise to patients moving in the AE system.

b. CASF Nursing Function/UTC: FFVNF. This 24-person team provides basic nursing functions for all sizes of a CASF from basic to a 250-bed CASF and can deploy alone as a basic to augment an existing MTF. This UTC is added to other UTCs for larger CASF builds and administratively prepares patients for flight, ensures patients are clinically supported while in the CASF awaiting AE, and transports CASF patients to and from aircraft.

c. CASF Specialty Function/UTC: FFVSF. This 13-person UTC provides additional specialty functions for 100 and 250-bed CASFs and always deploys with FFVNF and FFVCF to complete the CASF construct. This UTC brings additional services of critical care nurse, physician, logistics, and diet therapy. The FFVSF ensures patients are medically and administratively prepared for flight, however the primary role is to ensure patients are clinically supported while in the CASF and expands the support care available while waiting for AE. This UTC can also be used to augment fixed MTFs where services contained herein are required for disaster assistance.

c. Support UTCs.

(1) Aeromedical Evacuation Liaison Team (AELT)/UTC: FFQLL. This 2-person team provides a direct communications link and immediate coordination between the user service and the theater AE system for emergent, steady state, low intensity conflicts, small scale contingencies (SSC) and/or early stages of major theater wars (MTW). The AELT verifies and coordinates physiology of flight issues and patient flight/movement requirements. Communications equipment can be transported in man-portable mode. An AELT can be located at any level where AF fixed-wing patient movement requests are initiated. An AELT deploys with organic communications, billeting, equipment, a vehicle and may deploy with FFQCR communications team depending on the availability of communication within the area of responsibility. An AELT requires DOD or host nation base support for food services, medical, medical equipment repair, bioenvironmental engineering, security, logistics and civil engineering.

(2) Aeromedical Evacuation Operations Team (AEOT)/UTC: FFQNT. This 8-person team provides operations and mission management support to airfields supporting AE. The AEOT provides supervision and crew management for all assigned, attached or transiting AE crews and CCATTs. The AEOT also performs AE crew/CCATT scheduling and coordinates AE crew and CCATT requirements for life support, billeting, food service, transportation, finance and administration. Members will assist with aircraft configuration for AE missions,
manage AE supplies and equipment, and assist with enplaning/deplaning as required. The AEOT can integrate with mobility air forces (MAF) flight crew stage management teams at strategic AE hubs and CONUS reception airfields. The AEOT can support up to 10 AE crews and 4 CCATTs and manage 4 mission launches or recoveries in a 24-hour timeframe. If augmentation is required, there is an AEOT Manpower Augmentation Team (FFQCM) which can be utilized.

(3) Aeromedical Evacuation Support Cell/UTC: FFQSC. This 4-person team provides full spectrum administrative, logistical, aerospace ground equipment (AGE) maintenance and communications equipment maintenance support to all teams assigned to a TAES. The support cell deploys to locations capable of supporting multiple AE teams and may be co-located with the AE Command Squadron or any AE UTC to sustain theater AE ops.

(4) AE Communications Team/UTC: FFQCR. This 2-person UTC does not deploy independently and provides communications augmentation to any AE UTC when necessary communication is unavailable.

4. Aircraft Used for AE

There are many aircraft that can be utilized for the movement of patients however there is no dedicated aircraft for patient movement. Instead aircraft are designated and then configured for AE missions. These can be scheduled missions or may be obtained as an in-system select (ISS) when a requirement exists and there is no scheduled mission available.

a. C-130 Hercules. The C-130 is a high wing, four-engine turboprop aircraft. For AE purposes, it is predominantly used for intratheater rather than intertheater evacuation. It can land and take-off on short runways which allows rapid transportation of personnel and equipment. The C-130 can be readily configured for AE by using seat and litter provisions stowed in the cargo compartment. It can hold a maximum of 87 litters, depending on the availability and serviceability of inherent equipment and the model of the aircraft, 44 ambulatory patients and/or a variety of combinations of litter and ambulatory. The C-130 poses several constraints for AE operations. These include cabin noise, which can make patient evaluation difficult and inadequate lighting for many patient care activities. The aircraft oxygen system needs to be supplemented by a self-contained AE system for therapeutic oxygen delivery. The single lavatory is on the cargo ramp and is difficult for some otherwise ambulatory patients to use. During engines-running on-load and off-load, operations at rudimentary airfields with blowing objects and dust can present eye hazards and stress to crew and patients.

b. C-17 Globemaster III. The C-17 is the nation’s newest operational strategic airlifter capable of transporting patients. It is powered by four turbofan engines and cruises at about 550 miles per hour with an unrefueled range in excess of 5,250 miles. The C-17 has three aeromedical stations stowed on the sidewall to accommodate 9 litters. If additional litter stanchions are added to the aircraft, the C-17 can transport a total of 36 litter patients. A litter stanchion augmentation set (LSAS) container can be utilized to store the required equipment and can easily be loaded and secured onto the aircraft. The C-17 can also be configured with patient support pallets (PSPs) for AE missions to provide enhanced patient movement capability. Normally C-17s are used for intertheater rather than intratheater airlift.
c. **KC-135 Stratotanker.** Tanker aircraft is also used for intertheater AE missions. The KC-135 provides long-range aerial refueling support and through the years has been altered to do other missions including aeromedical evacuation. For AE missions, it can accommodate up to 11 litter and 22 ambulatory patients depending on the configuration and utilization of the Patient Support Pallets (PSPs) which can be configured with seats or litters to enhance the patient evacuation capability. These pallets can be used on other non-traditional AE aircraft as well. A stacking litter system (SLS) has recently been fielded and can also be utilized instead of the PSP. The SLS is lightweight, weighing less than 150 pounds and does not require a forklift to transport to and from the aircraft. High deck platform loading equipment is required to use this airframe, including the Patient Loading System (PLS) and the K-loader.

d. **C-21.** The C-21 is also used for intratheater aeromedical evacuation missions when movement of 1 or 2 patients is required, however the C-21 is utilized for AE on a limited basis, primarily at Ramstein AB, Germany and Scott AFB, Illinois. Due to size constraints, the AE crew consists of only 1 flight nurse and 1 AE technician. The C-21A can carry one litter patient and utilizes the Spectrum which is a litter support platform with oxygen and electrical hookups.

e. **Civil Reserve Air Fleet (CRAF).** In order to overcome shortfalls in fulfilling wartime AE requirements with retrograde airlift, the USTRANSCOM Commander can activate the AE CRAF segment with Secretary of Defense approval (from DODD 5158.4 USTC) to provide aircraft dedicated to the strategic AE mission. The CRAF is composed of civil air carriers who contractually commit themselves to provide operating and support personnel, facilities, and aircraft to USTRANSCOM under stated conditions. The primary aircraft to provide support for aeromedical airlift is the Boeing 767. Once activated, each Boeing 767 would be reconfigured from its passenger configuration to an aeromedical configuration with shipsets and supplemental kits that are stored in a warehouse in Forth Worth Texas. With airline delivery time factored in, the planning estimate is 72 hours from notification until the aircraft can be reconfigured. The capacity of the aircraft once it is reconfigured is 87 litters and 20-35 seats. Each configured Boeing 767 would remain in the AE system until the operation no longer requires it.

f. **Non-Traditional Aeromedical Evacuation Aircraft.** Instances may occur that require the use of aircraft other than those normally used to support AE operations (C-5, KC-10, C-12). AE missions can be flown on these aircraft with careful planning consideration for the loading and unloading of patients and placement of patients during flight. On those occasions when AECMs may be required to accompany patients on nontraditional aircraft, AECMs should work closely with the flight crew and receive, at a minimum, a briefing on emergency egress, oxygen, and electrical system capability as it relates to patient and/or emergency use. Guidelines followed on other AE missions should be observed as much as possible. AECMs should refer to AE regulations for further guidance on utilizing specific aircraft.

5. **Patient Movement Requirements Centers (PMRCs)***

PMRCs are joint activities that coordinate patient movement for all service members and other eligible beneficiaries. PMRCs are the single responsible agents in their respective theaters or AOR for collaborative patient movement planning, patient movement management, and patient in-transit visibility.
(1) Global Patient Movement Requirements Center (GPMRC), Scott AFB IL. GPMRC is responsible for coordinating all intertheater and CONUS patient movement. GPMRC will notify the receiving MTFs of the aircraft’s arrival time and types and numbers of patients to be off-loaded. GPMRC is co-located with the 618th Air Operations Center, formerly called the Tanker Airlift Control Center (TACC) to effectively coordinate patient requirements and necessary airlift to move the patients within the prescribed timeframe based on precedence.

(2) Theater Patient Movement Requirements Center (TPMRC). The TPMRC is a theater office designated to regulate patients within the assigned theater. TPMRCs are located in the PACOM and EUCOM theaters at Hickam AFB, HI and Ramstein AB, GE respectively.

(3) Joint Patient Movement Requirements Center (JPMRC). A JPMRC is a deployable UTC that provides the core manpower complement to establish PMRC operations to support a Joint Task Force (JTF) and/or to augment/backfill theater or CONUS PMRC operations. Based on operations tempo, the JPMRC may require augmentation from supported commands to provide additional staffing. A JPMRC is currently operational for the CENTCOM AOR.

6. Air and Space Operations Center (AOC)

The AOC is the theater’s single focal point for command and control (C2) of intra-theater air assets to include air mobility. The AOC provides centralized planning, tasking, scheduling, coordination, and C2 for all theater-assigned aircraft. If air assets from more than one service are utilized, it is called a Joint Air Operations Center (JAOC). If air assets from more than one country are utilized, it is called a Coalition Air Operations Center (CAOC).

a. Air Mobility Division (AMD). The AMD is one of five divisions within the AOC. The AMD will plan, coordinate, task and execute all intra-theater airlift, aeromedical evacuation (AE) and air refueling (AR) missions. The AMD provides for integration and support of all air mobility missions. The AMD schedules intra-theater airlift requests in conjunction with the Joint Force Commander’s (JFCs) airlift priorities through the Deployment Distribution Operations Center (DDOC) and the 618 AOC (TACC). The AMD will integrate and direct execution of theater-assigned and United States Transportation Command (USTRANSCOM)-assigned mobility forces operating in the AOR/joint operations area (JOA) in support of the JFC’s requirements/objectives.

b. Aeromedical Evacuation Control Team (AECT). The Aeromedical Evacuation Control Team (AECT) is the team within the AOC responsible for aeromedical evacuation coordination, integration and scheduling. The AECT is the central source of expertise for AE within a theater. The AECT develops plans and strategies to determine appropriate force lay-down of AE ground forces in support of joint patient movement operations and provides the critical interface between AE and airlift operations. This team is responsible for operational planning, scheduling, and execution of scheduled and unscheduled AE missions through the appropriate AE elements. The AECT receives patient requirements from the PMRC, coordinates airlift to meet AE requirements, tasks the appropriate AE elements, and notifies the PMRC when missions are scheduled in order to maintain full patient in-transit visibility. The AECT also
monitors execution of AE missions and coordinates and communicates with theater planning cells and AE command elements as necessary. The AECT advises the AOC Director, Director of Mobility Forces, and AMD Chief and liaises with Joint Task Force/Component Surgeons on AE issues.

NOTE: The AECT is often mistakenly described as an AE UTC. The UTC’s that make up the AOC, its divisions, teams, and augmentation forces fall under the command and control functional area. Because of this, Functional Area Management responsibilities reside in the MAJCOM-level division with responsibility for AOC operations. For Mobility Air Forces this is the C2/Expeditionary Operations Division (AMC/A3C).

7. The Patient Movement process

The patient movement process begins when the user service determines that his/her patient’s injuries exceed the capabilities of the medical treatment facility (MTF). Once this determination has been made, the next step is to submit a patient movement request (PMR) to the respective PMRC through the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES). TRAC2ES is a web-based patient movement automated information system which is used globally to submit and validate patient requirements, monitor missions and track patients while in the AE system.

The PMRC must validate the PMR which includes both clinical and administrative validation. Clinical validation is required to ensure a patient is stabilized and fit to fly whereas the administrative validation ensures a patient is eligible for patient movement and that all necessary administrative requirements are met. Before a PMR can be validated, a patient must also be regulated, meaning his or her medical needs are matched against the gaining MTF’s medical capability and bed availability. Thus, the PMRC validates patient movement requests, regulates patients to appropriate medical facilities for continued medical care, and determines the mode of transportation (air, sea, and ground).

Once the PMR is validated, the PMRC will give the requirement to the AOC or AMOCC (as appropriate) to obtain airlift if there is not already a scheduled mission to transport the patient within the prescribed timeline based on the patient’s precedence which is illustrated below:
• **URGENT:** Movement ASAP to save life, limb or eyesight
  Goal: within 12hrs of PMR validation

• **PRIORITY:** Movement within 24 hrs to save life, limb or eyesight
  with PMR validation

• **ROUTINE:** Movement required, but can wait for a regularly
  scheduled mission
  Goal: within 72hrs of PMR validation

The AOC/AMOCC will execute the AE mission by optimizing the use of available multi-
mission aircraft; mixing cargo and AE on mobility missions and integrating AE requirements
into cargo channel routes. Airlift for urgent and priority patients will be tasked from alert AE
crews, diversion of in-system select (ISS) aircraft, or contracting with a civilian air ambulance
(CAA).

The AE division/cell is the source of AE clinical and operational expertise and mission
execution within the AOC/AMOCC. The AE cell provides the critical link between C2
operations and is the clinical interface with airlift operations and the PMRC. The AE Cell
maintains operational control over mission planning and tasking, scheduling and mission
monitoring of airlift and AE assets to support patient movement. Additionally, the AE cell
coordinates with the PMRC for medical issues. In a contingency environment, the AE Control
Team (AECT) is responsible for AE operational planning, tasking, and mission execution. Once
the mission has been identified, the AOC/AMOCC will task mobility wings for airlift, crews,
and augmentation assets (equipment and/or specialized medical personnel support). The AE cell
or AECT will pass mission information, including aircraft arrival and departure times to the
respective AE Operations Team (AEOT) as well as to the servicing PMRC. The PMRC is
responsible for ensuring origination and destination health care facilities are aware of AE
missions to include departure and arrival times. The AE cell or AECT will track and follow all
operational aspects of the AE mission during execution.

The Patient Movement CONOPS below illustrates how patients are treated and
transported through the system beginning with care on the battlefield and how AE fits into the
overall process to move patients on fixed wing aircraft, within/out of the theater and all the way
back to CONUS when needed.
Patient Movement CONOPS

- Battlefield
- First Aid/Buddy Care/Aid Station
- CASEVAC / MEDEVAC
- Patient Movement CONOPS
- Level 1
  - CSB/FLEET HOSPITAL/EMEDS
  - ABLE (Assists w/ comm)
- Level 2
  - TRAC2ES
  - Tactical Airlift
  - MASH/CASB
- Level 3
  - TRAC2ES
  - Strategic Airlift
- Level 4
  - TRAC2ES
  - Strategic Airlift
  - CONUS Medical Facilities
  - LRMIC
    - Landstuhl Regional Medical Center
8. Defense Support to Civil Authorities (DSCA)

In addition to its primary mission, the National Response Framework (NRF) calls for the DOD to support state, local and tribal authorities when appropriate requests for federal assistance are made as part of the National Disaster Medical System (NDMS). Although disaster response is largely a state and local responsibility, the federal government can provide assistance when state and local governments are overwhelmed. The federal government can provide medical resources to include evacuation of hospital patients during disasters through the NDMS. There are three components of the NDMS: medical response, patient movement and definitive medical care.

In response to a natural disaster or other contingency, DOD may be asked to evacuate patients in either a pre or post contingency situation. Responses to hurricanes in recent years has shown that typical wartime UTCs and CONOPS were not adequate for DSCA operations. Subsequently, a great deal of planning has occurred to increase AE response and capability during a DSCA event. The MASF construct was revised to increase staging capability and a Disaster Aeromedical Staging Facility (DASF) was created specifically for disaster situations. A DASF is an 83-person federal staging facility capable of managing 140 stabilized patients per aerial port of embarkation (APOE) per day. The focus is on providing temporary patient holding and limited critical care capability for 1-2 hours with integrated administration, medical logistics and communications support. Planning factors include 40 - 48 hours to evacuate patients pre-landfall (hurricane), two AE missions per APOE per day and a 20% critical care ratio.

Systems changes were also made to TRAC2ES to tailor a Disaster PMR specifically for situations where there is extremely limited information on each patient. Although it is optimal to have detailed information on patients, in most disaster situations it is just not possible to obtain that level of detail for the PMR, and the disaster PMR will still allow adequate tracking for patients that are moved in a contingency. Continued interaction between federal and state organizations will build on the improvements that have already occurred so that AE response capabilities are further refined to meet all requirements.

9. Summary

Aeromedical evacuation is a highly complex and successful system, absolutely critical in today’s wartime and contingency environment. The global war on terror has achieved over a 98% casualty survival rate, the highest in US history. The ability to rapidly transport wounded and sick patients to higher levels of care fulfills America’s promise to the warfighter: to move our nation’s heroes to the appropriate medical care to save their lives. The AE system delivers this promise!
### AE Acronyms

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<td>Advanced Echelon</td>
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<td>AE</td>
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<td>AECM</td>
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