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SECRETARY OF THE AIR FORCE

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Operations

EMERGENCY HEALTH POWERS ON AIR FORCE INSTALLATIONS

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Air Force Instruction (AFI) 10-2603, *Emergency Health Powers on Air Force Installations*, provides guidance to protect Air Force installations, facilities, and personnel in the event of a public health emergency due to biological warfare, terrorism, or other public health emergency involving a communicable disease epidemic. This instruction implements provisions contained in DoD Directive 6200.3, *Emergency Health Powers on Military Installations*, 12 May 2003, and Air Force Policy Directive (AFPD) 10-26, Counter-Nuclear, Biological, And Chemical Operational Preparedness.

This instruction applies to all installations and activities under Air Force command (hereby referred to collectively as “installations”). This includes Air National Guard (ANG) and Air Force Reserve Command (AFRC), or other geographically separated units (GSUs) to the extent possible given location and assigned manpower. The term “commanders,” as used in this instruction, refers to personnel assigned as installation commanders, to include the heads of Field Operating Agencies and Direct Reporting Units as appropriate (e.g., non-tenant units).

This instruction also applies to military personnel and those civilian personnel, dependents of military or civilian personnel, contractors, and other individuals visiting or who are present on an Air Force installation (collectively referred to as “non-military personnel”); Air Force facilities; Air Force-owned, leased or managed infrastructure and assets critical to mission accomplishment; and other Air Force-owned, leased, or managed mission essential assets overseas and in the United States, its territories, and possessions.

In areas outside the continental United States (OCONUS), this instruction applies to the extent consistent with local conditions, and treaty requirements, agreements, and other arrangements with foreign governments and allied forces.

This instruction *does not*: (1) take precedence over actions covered by Air Force Policy Directive (AFPD) 10-8, *Homeland Security*, AFI 10-801, *Assistance to Civilian Law Enforcement Agencies*, and AFI 10-802, *Military Support to Civil Authorities*; (2) apply to foreign disasters covered by AFPD 32-40, *Disaster Preparedness*, AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*,

and Air Force Manual (AFMAN) 32-4004, *Emergency Response Operations*; (3) integrate contingency war planning as a supplement of Air Force Installation response.

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Chapter 1

EMERGENCY HEALTH POWERS ON MILITARY INSTALLATIONS

Section IA—Overview

1.1. Purpose. This AFI implements guidance from existing Air Force publications and DoD Directive 6200.3. It specifies the authority of installation commanders and assigns responsibilities for declaring, reporting, and managing a public health emergency. It also identifies the responsibilities and tasks of the Public Health Emergency Officer (PHEO).

1.2. Biological Incidents. Public health emergencies and disease outbreaks (whether naturally occurring or as a result of a biological attack) can appear and spread rapidly, leading to widespread health, social, and economic consequences. Commanders must be prepared to make timely decisions for actions to control an outbreak which will protect the lives and well being of personnel and enable Air Force units to continue operations. Early recognition of cases and application of appropriate infection control measures are critical in controlling outbreaks; therefore, rapid collection and assessment of pertinent data is necessary in responding to disease outbreaks. Commanders should expect a level of uncertainty during the decision-making process, especially during early stages of an outbreak. Efforts that strengthen lines of communication across the Wing (to include the commander's staff) with civilian decision makers at the community level will greatly enhance the response's effectiveness.

1.3. Overseas Limitations. Host nation ownership and control of overseas installations may prevent commanders from unilaterally implementing many of the provisions of this instruction. Ultimately, U.S. prerogatives and control at overseas locations are subject to the sovereignty of the host nation, except as otherwise defined in applicable international agreements, such as status of forces agreements (SOFAs), defense cooperation agreements, and base rights agreements.

1.3.1. A U.S. military commander's authority overseas over personnel is also limited. That authority extends generally only to U.S. service members, civilian employees of U.S. forces, U.S. DoD contractor employees (when specified by agreements), and the dependents of these categories of personnel.

1.3.2. With regard to emergency health powers, a commander's authority may be limited in scope as it pertains to host nation personnel. Overseas installations will review their respective host nation agreement and incorporate by supplement to this AFI the authority local commanders have as it pertains to host nation personnel.

1.3.3. Many of the authorities cited in this publication are inapplicable or cannot be implemented in an overseas environment without the cooperation of host nation authorities, except to the extent as may be specified by governing international agreements.

1.4. AFRC, ANG, and GSU Limitations. AFRC, ANG, and other GSUs may not have the resident capability or personnel to prepare for, or respond to, a public health emergency. This will ultimately limit a commander's ability to implement many of the provisions of this instruction, to include designating a PHEO. As a result, these organizations may rely heavily on civilian agencies/local authorities for emergency response.

1.4.1. Commanders of GSUs will review their respective emergency response plans and incorporate measures from this AFI that are reasonable and appropriate given their GSUs' situation. At a minimum, such measures will include coordination of emergency response procedures and plans with applicable local and/or state authorities.

1.4.2. The Senior Health Technician at each ANG medical unit will coordinate with his/her Public Health Technician to advise the installation commander on potential public health emergency situations.

1.4.3. The Traditional Reserve PHEO point of contact for AFRC installations will be employed (as a civilian) in the same state as his/her unit of assignment and be familiar with civilian agencies/local authorities for emergency response for that state.

1.4.3.1. For AFRC installations, the training and exercise requirements in **Attachment 4** of this instruction will to the greatest extent possible be combined with and integrated into existing local exercises and annual installation Antiterrorism/Force Protection (AT/FP) exercises.

Section 1B—Policy

1.5. National Policy.

1.5.1. Homeland Security Presidential Directive (HSPD) 5. Published in Feb 03, the purpose of HSPD-5 is to enhance the ability of the U.S. to manage domestic incidents by establishing a single, comprehensive national incident management system. This system promotes a single, comprehensive national approach to the management of a domestic incident that ensures all levels of government and the private sector work together.

1.5.2. National Incident Management System (NIMS). Established by HSPD-5, the NIMS provides a core set of concepts, principles, and terminology for incident command and multi-agency coordination of efforts responding to a domestic incident at all echelons of government (i.e., local, state, and federal).

1.5.3. National Response Plan (NRP). The NRP provides the national framework for domestic incident management across all categories of incident type. It establishes incident/potential incident monitoring and reporting protocols. It typically is enacted only for incidents of national significance, which include credible threats/indications/acts of terrorism within CONUS, major disasters or emergencies (as defined by the Stafford Act, *Title 42, United States Code, Section 5121 et seq*), catastrophic incidents, or unique situations that may require the Department of Homeland Security to aid in coordination of incident management.

1.6. DoD Policy.

1.6.1. Per DoD Directive 6200.3, it is DoD policy that military installations, property, and personnel and other individuals working, residing, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Applicable legal authorities include:

1.6.1.1. *Title 10, United States Code, Sections 113, 3013, 5013, and 8013*, which generally provides the Secretary of Defense and service secretaries authority to conduct the affairs of the DoD authorized by the Constitution and laws of the United States.

1.6.1.2. *Title 50, United States Code*, Section 797, which criminalizes the willful violation of lawfully promulgated military security regulations.

1.6.1.3. *Title 18, United States Code*, Section 1382, which criminalizes the unlawful entry onto military installations.

1.6.1.4. *Title 5, United States Code*, Section 301, which authorizes regulations for the custody, use, and preservation of government property.

1.6.1.5. *Title 42, United States Code*, Sections 243, 264, 266; Executive Order 13295, *Revised List of Quarantinable Communicable Diseases*, 4 Apr 03; Title 42, Code of Federal Regulations, Part 70, *Interstate Quarantine*, current edition, which together authorize and enforce a quarantine to prevent the spread of communicable diseases into the United States; from state to state; in time of war, affecting military and other national defense personnel; and to support state quarantines.

1.6.2. Per DoD Instruction 2000.18, *DoD Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Emergency Response Guidelines*, it is DoD policy that:

1.6.2.1. Installation commanders be prepared to respond to and protect personnel and installations from the effects of a CBRNE incident.

1.6.2.2. Commanders at all levels have the authority and responsibility to protect persons and property subject to their control.

1.7. Air Force Policy. Guidance for this AFI is found in a number of cross-functional AFPDs related to biological incidents.

1.7.1. AFPD 10-26, *Counter-Nuclear, Biological, and Chemical (C-NBC) Operational Preparedness*, assigns commanders at all levels responsibility for planning and implementing C-NBC preparedness. It requires the Air Force to incorporate C-NBC considerations into appropriate Concepts of Operations and other procedural guidance.

1.7.2. AFPD 48-1, *Aerospace Medical Program*, directs the Air Force to focus on identifying and reducing risks of illness or injury using formal disease and injury prevention programs to curb the transmission of diseases and to work toward their elimination. It also states the Air Force will ensure the occupational health of its people by identifying work-site health hazards, recommending control measures, assessing fitness for work, conducting medical surveillance, educating workers, and providing clinical services.

1.7.3. AFPD 10-25, *Full Spectrum Threat Response (FSTR)*, provides guidance for activities that support a full spectrum of physical threats, to include terrorist use of Weapons of Mass Destruction (WMD) involving the use of CBRNE material. It establishes the FSTR program addressing the full spectrum of physical risks, threats, and passive defense measures. The FSTR program includes components of passive defense and consequence management as they relate to “all hazards” emergency response and recovery operations, to include integration of the NIMS and NRP.

Chapter 2

GENERAL ROLES AND RESPONSIBILITIES

Section 2A—Installation Commanders

2.1. The installation commander will ensure all units/tenants comply with requirements for preventing and controlling diseases, injuries and other reportable conditions IAW with current installation, Major Command (MAJCOM), and Air Force instructions, and PHEO guidance.

2.1.1. OCONUS Considerations. Implementation of these provisions at overseas installations will require working arrangements with host nation authorities and allied/coalition forces, and may require creating and periodically updating an installation-wide Emergency Health Response Plan in coordination with host nation authorities.

2.1.1.1. OCONUS MAJCOM commanders and applicable Commanders of Air Force Forces (COMAFFORs) should consider whether theater-wide standardization of such plans would best serve the needs of their installations, taking into consideration local host nation conditions, international agreements, and the need for uniformity. All such plans will be coordinated with the applicable Combatant Command (COCOM) to ensure uniformity between the various Services in the Area of Responsibility.

2.1.1.2. If it becomes necessary to enter into international agreements to adequately address the requirements of this instruction, OCONUS MAJCOMS and COMAFFORs will consult AFI 51-701, *Negotiating, Concluding, Reporting, and Maintaining International Agreements*, and applicable COCOM regulations to determine whether authority exists, or must be requested, to negotiate and conclude such agreements.

2.2. Every installation commander will designate, in writing, the installation PHEO and an alternate PHEO to provide emergency management recommendations (to include medical and/or public health recommendations) in response to public health emergencies.

2.2.1. The PHEO and alternate PHEO will be a Medical Corps officer with experience in preventive medicine/emergency response such as the assigned Chief of Aerospace Medicine (SGP) or Chief of Medical Services (SGH). The PHEO will work closely with other medical personnel (see [Section 2C](#) of this instruction) and, in the case of overseas installations, with the host nation public health authorities or corresponding agency, and local public health authorities to identify, confirm, and control a public health emergency.

2.2.1.1. The PHEO may be included as a member of the installation Force Protection Working Group (FPWG) and Threat Working Group (TWG).

2.2.1.2. Installation commanders, in coordination with their Medical Treatment Facility (MTF) commanders, may assign the PHEO or alternate PHEO to fill one of two roles for the Air Force Incident Management System: the Incident Commander for Pandemic, Epidemic, or Public Health Emergencies, or (in relation to the NRP) the Emergency Support Function #8 (Public Health and Medical Services) within the installation's Emergency Operations Center. Assignment to either of these positions requires specific qualifications (as outlined in the NIMS), and will make the individual subject to additional training requirements beyond the scope of this instruction.

2.2.2. The name and contact information for each PHEO and alternate PHEO will be submitted to the applicable MAJCOM Surgeon and Director of Operations. MAJCOM Surgeons will compile and maintain a complete list of installation PHEOs and provide quarterly updates, including contact info, to HQ USAF/XOS-FC and AF/SGO via Defense Message System (DMS). Updates are due by the end of the first week of the quarter.

2.3. The installation commander will declare a public health emergency for the installation under his/her command upon determining a public health emergency exists. Commanders of overseas installations will exercise only those emergency health powers that have been previously arranged with host nation authorities under the installation's Emergency Health Response Plan, are granted to him/her under applicable international agreement, or are otherwise within his/her inherent authority. At overseas installations, such action must be coordinated and arrangements made with host nation authorities to meet the intent of this provision. Note that the PHEO will still be the Commander's advisor during a public health emergency regardless of host nation actions.

2.3.1. Such declaration will be immediately reported by the commander via an OPREP-3 PINNACLE report to the National Military Command Center, who will forward to the Secretary of Defense.

2.3.2. Declarations will terminate automatically in 30 days, unless renewed and re-reported. Declarations may be terminated sooner by the commander who made the declaration, any senior commander in the chain of command, the Secretary of the Air Force, or the Secretary of Defense.

2.4. CONUS installation commanders will exercise emergency health powers, in consultation with the PHEO, during a declared public health emergency. To the extent necessary for protecting or securing military property or places, associated U.S. military personnel, or the installation mission, such emergency health powers may also apply to property not owned by the Air Force, but is present on an Air Force installation or other area under Air Force control. Such emergency health powers may include the following:

2.4.1. Close, direct the evacuation of, or decontaminate any facility.

2.4.2. Decontaminate or destroy any affected material.

2.4.3. Assert control over any animal that endangers the public health.

2.4.4. Authorize the use of facilities, materials, and services for purposes to include (but not limited to): communications, transportation, occupancy, fuel, food, clothing, and healthcare.

2.4.5. Control or restrict the distribution of commodities (e.g., food, water) as may be reasonable and necessary for emergency response.

2.4.6. Control evacuation routes on, and ingress and egress to and from, the affected military installation.

2.4.7. Authorize measures to safely dispose of infectious waste as may be reasonable and necessary for emergency response.

2.4.8. Take reasonable and necessary measures, IAW AFI 41-209, *Medical Logistics Support*, chapter 4, to obtain needed healthcare supplies, and control use and distribution of such supplies to achieve the greatest public health benefit. Installation commanders have local purchase (LP) approval authority for medical materiel, non-medical materiel, and services. Commanders may delegate this approval

authority to an authorized representative (usually the Medical Treatment Facility Commander or Medical Logistics Flight Commander).

2.4.9. Direct the collection of specimens from and tests on any property or on any animal, living or deceased, as may be reasonable and necessary for emergency response.

2.4.10. Direct U.S. military personnel to submit to a physical examination and/or testing as necessary for diagnosis or treatment. Persons other than U.S. military personnel may be required, as a condition of exemption or release from restrictions of movement, to submit to a physical examination and/or testing (IAW base, MAJCOM and Air Force instructions) from medical providers credentialed to the installation as necessary to diagnose the person and prevent the transmission of a communicable disease. The physical examination and/or testing shall not be likely to result in serious harm to the individual.

2.4.11. Implement restrictions of movement and approve enforcement rules of engagement (ROE) to prevent the spread of communicable diseases (Note: ROE should be developed in coordination with applicable HQ USAF and MAJCOM guidelines, to include decisions regarding treatment in place or movement of contagious diseases). In the case of U.S. military personnel, restriction of movement, including isolation or quarantine, or any other measure necessary to prevent or limit transmission of a communicable disease may be implemented. In the case of persons other than U.S. military personnel, restrictions of movement may include limiting ingress and egress to, from, or on a military installation, isolation, or quarantine.

2.4.11.1. Individuals who are asymptomatic but are presumed to have been exposed to a communicable disease may be placed in quarantine to prevent the spread of a disease. If quarantine measures are implemented, the installation commander will ensure the following actions are conducted:

2.4.11.1.1. Coordinate with the Centers for Disease Control (CDC) regarding actions under the quarantine authorities provided in 42 U.S.C. 243, 264, and 266, E.O. 13295, and the 42 CFR Part 70 (responsibility for coordination may be delegated to the PHEO). OCONUS commanders will coordinate with appropriate host-nation public health officials IAW appropriate SOFA guidance (or other international arrangements, as applicable).

2.4.11.1.2. Provide for the basic needs of quarantined persons, such as food, shelter, clothing, medical care and other necessities, as required.

2.4.11.1.3. Maintain quarantine locations in a safe and hygienic manner designed to minimize transmission of infection or other harm to persons subject to quarantine.

2.4.11.1.4. Ensure persons subject to quarantine obey the established rules and orders, do not go beyond the quarantine premises, and do not put themselves in contact with any person not subject to quarantine, except as the PHEO authorizes.

2.4.11.1.5. Ensure only personnel authorized by the PHEO enter quarantined premises.

2.4.11.1.6. Ensure any unauthorized individual who enters the quarantine area remains quarantined for the duration of the public health emergency or until granted permission to leave quarantine IAW guidelines in this instruction.

2.4.11.1.7. Execute quarantine measures through the least restrictive means available, consistent with protection of public health.

2.4.11.1.8. Terminate the quarantine of individuals IAW criteria established by the PHEO, when no longer necessary to protect the public health.

2.4.11.2. Individuals who are symptomatic or infected may be isolated to prevent the spread of a communicable disease. Isolation measures may be implemented in healthcare facilities, living quarters, or other buildings on a military installation. Isolation measures do not lessen the responsibilities of the Air Force Medical Service to provide the best medical care feasible to infected persons.

2.4.11.2.1. Actions listed in [2.4.11.1.1.](#) through [2.4.11.1.8.](#) of this instruction apply to the implementation of isolation measures.

2.4.11.2.2. If the level of medical care required for the public health emergency is beyond the capability of the installation's medical capabilities, support will be sought from local, state, or host-nation agencies IAW section [A3.18.](#) of this instruction.

2.4.11.3. An installation commander may order a military member to report to a civilian-run quarantine or isolation location if, under the circumstances, a commander believes that ordering the military member to report to a civilian-run quarantine facility serves a military purpose (e.g., protection of other military members, military readiness, etc).

2.4.11.4. All non-military personnel subject to quarantine/isolation who contest the reason for quarantine/isolation will be provided an opportunity to present information supporting an exemption or release. The commander or a designated representative will make the final determination.

2.4.11.4.1. Upon receiving such information, the PHEO will provide the request to the installation commander within eight hours of receipt of such information.

2.4.11.4.2. The commander may designate a senior officer or employee of the command as a reviewing official. The reviewing official must not have been previously involved in any factual determination concerning the person requesting exemption or release from quarantine. The reviewing official will exercise independent judgment in making the determination.

2.4.11.4.3. The reviewing official will consult with medical and legal personnel regarding the request for release to ensure he/she is informed of all pertinent facts prior to making a decision. The reviewing official will provide the requesting member with a written decision on the need for quarantine within twelve hours from the time the PHEO submits the member's initial request for quarantine exemption or release to the installation commander.

2.4.12. U.S. military personnel may be ordered to submit, as determined by the PHEO, to vaccination or treatment, subject to special rules applicable to use of investigational new drugs (I.A.W. DoD Directive 6200.2, *Use of Investigational New Drugs for Force Health Protection*, 1 Aug 2000). Persons other than U.S. military personnel may be required, as a condition of exemption or release from an otherwise lawful restriction of movement or quarantine, to submit to vaccination or treatment as necessary to prevent the transmission of a communicable disease. The provisions of DoD Instruction 6205.4, Section 5 (Immunization of Other Than U.S. Forces for Biological Warfare Defense) relating to voluntary vaccinations do not apply to vaccinations as described in this paragraph.

2.5. The installation commander will cooperate with authorized law enforcement agencies investigating an actual or potential terrorist act or other crime.

2.6. The installation commander will inform military members and other individuals subject to U.S. criminal jurisdiction who are also subject to any emergency health powers that violators of orders may be charged with a crime under 50 U.S.C. 797 and be subject to punishment of a fine up to \$5,000 or imprisoned for not more than 1 year, or both.

2.6.1. In the case of U.S. military personnel, these potential sanctions are in addition to applicable provisions of the Uniform Code of Military Justice, to the extent allowed by law.

2.6.2. In the case of any person who refuses to obey or otherwise violates a lawful order under this instruction, the commander of an Air Force installation, under his inherent authority, may detain those not subject to military law until civil authorities can respond. The commander will coordinate with civil authorities to ensure the response is appropriate for the public health emergency.

2.7. CONUS installation commanders will approve and forward requests for delivery and transfer of Strategic National Stockpile (SNS) assets for sustainment of a response to a public health emergency on their installation. Requests will be forwarded through the chain of command to the Assistant Secretary of Defense for Homeland Defense for action. Note: SNS assets will not be relied upon as part of an installation's initial response capability to a public health emergency.

2.8. The installation commander may lend manpower and/or materiel support to local authorities when responding to a public health event that could threaten Air Force personnel off base.

2.8.1. Such support may be executed unilaterally by the installation commander at the request of local authorities when faced with imminently serious conditions resulting from any civil emergency that require immediate action to save lives, prevent human suffering, or mitigate great property damage.

2.8.2. IAW AFI 41-209, paragraph 13.13, Medical War Reserve Materiel may be used to save life or prevent undue suffering when authorized by the Military Treatment Facility Commander.

2.8.3. In other circumstances, approval must be sought from higher headquarters prior to providing support, and may be limited by federal laws and regulations (e.g., Posse Comitatus Act). Generally, any support provided by DoD is enacted through the NIMS and NRP (see [1.5.2.](#) – [1.5.3.](#)).

2.9. The installation commander will organize, train, equip, and exercise personnel to conduct and sustain FSTR operations IAW AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*. Leverage the synergy achieved, when every airman acts as a sensor to form an effective Integrated Base Defense program. The installation commander will include a public health emergency as one of the major FSTR exercises at least every two years (see [Attachment 4](#) for detailed guidance on consolidation with existing exercises).

Section 2B—Public Health Emergency Officer

2.10. The PHEO will be the central point of contact and clearinghouse for health-related information during a suspected or declared public health emergency. The PHEO will work closely with other medical personnel (see [Section 2C](#) of this instruction) and local public health authorities to identify, confirm, and control a public health emergency that may affect the installation.

2.10.1. General duties of the PHEO are to:

2.10.1.1. Ascertain the existence of cases suggesting a public health emergency.

- 2.10.1.2. Collaborate with Public Health to develop a case definition of the outbreak.
- 2.10.1.3. Investigate all suspected public health emergency cases for sources of infection.
- 2.10.1.4. Recommend to the installation commander implementation of proper control measures (to include declaration of a public health emergency).
- 2.10.1.5. Define the distribution of the illness or health condition.
- 2.10.1.6. Direct the response to the emergency, to include the diagnosis, treatment, and isolation/quarantine measures.
- 2.10.1.7. Assess risks, capabilities and capacity to adequately respond to a potential public health emergency, including a terrorist attack utilizing biological agents, in conjunction with the Medical Intelligence, CBRNE Casualty Management, and CBRNE Medical Defense Officers.
- 2.10.1.8. Evaluate and determine existing vulnerabilities to the installation threat response plan.
- 2.10.1.9. Develop procedures to implement public health emergency declaration. This includes implementation of procedures in the installation's FSTR Plan 10-2 and creation/updating of an annex to the MCRP on the Medical Group's response to a public health emergency.

2.11. PHEO responsibilities include:

- 2.11.1. Immediately upon declaration of a public health emergency by the commander, report the declaration to HQ USAF/SG through appropriate channels via Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C), who will in turn notify the Assistant Secretary of Defense for Health Affairs. In addition, report the declaration to the CDC and appropriate State and local public health agencies.
- 2.11.2. Inform affected individuals, in coordination with installation Public Affairs, of the:
 - 2.11.2.1. Declaration of a public health emergency and its termination.
 - 2.11.2.2. Steps individuals should take to protect themselves.
 - 2.11.2.3. Actions taken to control or mitigate the emergency.
- 2.11.3. Identify all individuals thought to have been exposed to the illness or health condition.
- 2.11.4. As necessary, counsel and interview individuals thought to have been exposed to the illness to assist in positively identifying exposed individuals and developing information relating to the source and spread of the illness or health condition.
- 2.11.5. Examine facilities or materials that may endanger the public health. If necessary, direct the closing, evacuation, or decontamination of any facility or decontaminate or destroy any material contributing to the public health emergency.
- 2.11.6. Establish rules and orders for quarantine/isolation once directed by the commander. This includes:
 - 2.11.6.1. Establish quarantine/isolation premises.
 - 2.11.6.2. Provide guidelines regarding contact with any person not subject to quarantine/isolation.
 - 2.11.6.3. Except as provided in [2.4.11.4.](#), establish criteria for termination of quarantine/isolation.

2.11.7. Share information discovered during activities, in coordination with installation Public Affairs, with federal, state, local, or host nation officials responsible for public health and public safety. Such information may include personally identifiable health information only to the extent necessary to protect the public health and safety and as otherwise permitted by law.

2.11.8. Notify the installation Antiterrorism Officer and appropriate law enforcement authorities through applicable military channels of any information indicating a possible terrorist incident or other crime.

2.11.9. When necessary to save life or prevent suffering, the MTF commander or other competent medical authority (such as a PHEO) may authorize direct purchase of emergency medical supplies without the prior involvement of base contracting. Use this means of procurement only when Prime Vendor, decentralized blanket purchase agreement, or Government Purchase Card sources are unable to support emergency requirements (refer to AFI 41-209 for specific procedures).

2.12. The PHEO will ensure every individual subject to quarantine/isolation is provided written notice of the reason for quarantine and the plan of examination, testing, and/or treatment designed to resolve the reason for the quarantine. Written notice will be provided within two (2) hours of establishing quarantine. A template quarantine notice is found in [Attachment 9](#).

2.12.1. All non-military personnel subject to quarantine/isolation who contest the reason for quarantine/isolation will be provided an opportunity to present information supporting an exemption or release. Such information will be provided from the person subject to quarantine to the PHEO, who will provide the request to the installation commander. To ensure fair and timely processing of the request for exemption or release, the PHEO will provide the information to the commander within eight hours of receipt.

2.13. The PHEO, in coordination with applicable organizations, will take reasonable and necessary measures for testing and safely disposing of remains (to include those of animals) in order to prevent the spread of disease, ensuring proper labeling, identification, and records regarding the circumstances of death and disposal. Refer to [Attachment 7](#) of this instruction for specific measures and references to applicable additional guidance.

2.14. Protected health information may be used and disclosed by the PHEO as necessary to ensure proper treatment of individuals and prevent the spread of communicable diseases.

2.15. The PHEO will maintain close contact and seek close coordination with the local and state health departments and the CDC concerning all actions taken under this instruction (to include seeking Memorandums of Understanding/Agreement, as appropriate). OCONUS, the PHEO will coordinate with appropriate host-nation and, if applicable, other allied forces' public health officials.

2.15.1. Consistent with the protection of military installations, facilities, and personnel, the PHEO will facilitate the assumption of public health emergency responsibilities by civilian agencies for other-than-U.S. military personnel and non-Air Force property. Responsibility will only be given to civilian agencies with appropriate jurisdiction over the persons or property.

2.15.2. In CONUS, the PHEO will recommend to the installation commander when access to the SNS is warranted to sustain the response to a public health emergency on the installation. Installations will

normally receive SNS assets as part of their State and local governments' SNS distribution plan. See [Attachment 3](#) for additional details on utilizing SNS assets.

2.16. The PHEO will cooperate with authorized law enforcement agencies investigating an actual or potential terrorist act or other crime.

2.17. In executing duties during a declared public health emergency, the PHEO may delegate oversight of select actions in this instruction to the alternate PHEO or appropriate Public Health personnel to better manage the evolving situation. Preparatory actions prescribed in this instruction, however, must be overseen by the PHEO.

Section 2C—Other Medical Personnel

2.18. Installation medical personnel responsible for disease surveillance and reporting will continue approved Air Force/DoD processes with the following inclusions:

2.18.1. Public Health personnel and Medical Intelligence Officer/Non-Commissioned Officer will, in addition to duties described in AFI 48-105, *Surveillance, Prevention, And Control Of Diseases And Conditions Of Public Health Or Military Significance*, and 41-106, *Medical Readiness Planning and Training*, include the PHEO as a recipient of public health assessments of installation threats and prompt notification of disease rates that increase above established installation baselines or disease patterns that suggest a public health emergency.

2.18.2. Healthcare providers and/or medical examiners will immediately report to PHEO and Public Health Officer (PHO) reports of illnesses or health conditions that suggest a public health emergency.

2.18.3. Installation pharmacy and medical laboratory reporting procedures will be modified to include the PHEO and PHO as a prompt recipient of any report of suspicious rates, types or trends that suggest a public health emergency.

2.18.4. DoD veterinarians responsible for military working dogs and/or other animals on the installation will include the PHEO and PHO as a prompt recipient of any report of animal diseases that suggest a public health emergency.

2.18.5. Bioenvironmental Engineering and the CBRNE Medical Defense Officer (MDO) will provide health risk assessment advice, with associated development of environmental sampling and monitoring. Included in the assessment advice will be recommendations for protective equipment and other control measures. These tasks will be done in close coordination with the Civil Engineer Squadron. Bioenvironmental engineering will provide this information to the PHEO, PHO, and other appropriate individuals and offices as identified in local Medical Contingency Response Plan checklists.

2.18.6. The Casualty Management Officer (CMO) will, in addition to duties described in AFI 41-106, include the PHEO as a recipient of all clinical capability/treatment impact assessments associated with medical contingency planning/preparation.

2.19. MTF commanders will ensure those who receive medical care are tracked and documentation is recorded IAW AFI 41-210, *Patient Administration Functions*, and cost recovery actions occur IAW with DoD 6010.15M, *Military Treatment Facility Uniform Business Office Manual*, and AFI 41-120, *Medical Resource Operations*.

2.20. The MTF Infection Control Officer (ICO) will assist in developing infection control guidelines for the MTF, isolation and quarantine facilities. This includes but is not limited to recommendation of appropriate healthcare worker Personal Protective Equipment, appropriate disinfectants and guidelines for use, and general infection control guidelines for the population at risk. The ICO will also assist Bioenvironmental and Civil Engineer units with identification of appropriate isolation and quarantine facilities.

Section 2D—Public Affairs (PA)

2.21. In preparation for a public health emergency, the installation PA will:

- 2.21.1. Identify means to obtain information release authority.
- 2.21.2. Publicize the existence of the PA Straight Talk Center by the internal information program, newsletters, base bulletins, and meetings.
- 2.21.3. Include a Public Affairs annex to the installation CBRNE Incident Response Plan and conduct annual training and/or an exercise related to internal and external notification processes.

2.22. In the event of a declared public health emergency, the installation PA will establish a Straight Talk Center manned by PA personnel and subject matter experts designated by the installation commander to provide base personnel with an authoritative point of contact for current, accurate information about the status of any health-related issue and the command's actions. PA will publicize the existence of the Straight Talk Center during a public health emergency by the internal information program, newsletters, base bulletins, and meetings.

2.23. PA personnel and augmentees manning the Straight Talk Center will perform tasks such as:

- 2.23.1. Preparing fact sheets, messages for automatic telephone answering devices (if used), e-mail messages, straight talk Web page on the intranet, Commander's channel, and news articles for base newspapers.
- 2.23.2. Making updated statements available to base telephone operators.
- 2.23.3. Making periodic updates on the situation, when available, on the Straight Talk Center's automatic answering service (a.k.a. Straight Talk Line).

2.24. Depending on the scope of the incident, PA may need to establish a Media Operations Center to handle news media interest. The center will be staffed in part by designated augmentees and subject matter experts specific to the type of emergency at hand.

CARROL H. CHANDLER, Lt Gen, USAF
DCS/Air & Space Operations

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Title 5, United States Code, Section 301

Title 10, United States Code, Sections 113, 3013, 5013

Title 18, United States Code, Section 1382

Title 42, United States Code, Sections 243, 264, 266

Title 50, United States Code, Section 797

Title 42, Code of Federal Regulations, Part 70, *Interstate Quarantine*, current edition

Executive Order 13295, *Revised List of Quarantinable Communicable Diseases*, 4 Apr 2003

Executive Order 13375, *Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases*, 1 Apr 2005

DoD Directive 2000.12, *DoD Antiterrorism/AT Program*, 18 Aug 2003

DoD Directive 3025.15, *Military Assistance to Civil Authorities*, 18 Feb 1997

DoD Directive 4715.1E, *Environment, Safety, and Occupational Health*, 19 Mar 2005

DoD Directive 5530.3, *International Agreements*, 11 Jun 1987

DoD Directive 6200.2, *Use of Investigational New Drugs for Force Health Protection*, 1 Aug 2000

DoD Directive 6200.3, *Emergency Health Powers on Military Installations*, 12 May 2003

DoD Directive 6205.3, *DoD Immunization Program for Biological Warfare Defense*, 26 Nov 2003

DoD Instruction 2000.16, *DoD Antiterrorism Standards*, 14 Jun 2001

DoD Instruction 2000.18, *Department of Defense Installation CBRNE Emergency Response Guidelines*, 4 Dec 2002

DoD Instruction 6205.4, *Immunization of Other Than U.S. Forces for Biological Warfare Defense*, 14 Apr 2000

DoD Regulation 6025.18R, *DoD Health Information Privacy Regulation*, Jan 2003

DoD 6010.15M, *Military Treatment Facility Uniform Business Office Manual*, Apr 1997

Joint Publication 4-06, *Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations*, 28 Aug 04

AFTTP 3-34.32, *Home Station Response to CBRNE Events*

AFPD 10-8, *Homeland Security*

AFPD 10-25, *Full Spectrum Threat Response (FSTR)*

AFPD 10-26, *Counter-Nuclear, Biological, and Chemical (C-NBC) Operational Preparedness*

AFPD 31-2, *Law Enforcement*

AFPD 32-40, Disaster Preparedness

AFPD 48-1, Aerospace Medical Program

AFPD 90-8, Environment, Safety, and Occupational Health

AFI 10-206, Operational Reporting

AFI 10-245, Air Force Antiterrorism (AT) Standards

AFI 10-801, Assistance to Civilian Law Enforcement Agencies

AFI 10-802, Military Support to Civil Authorities

AFI 10-2501, FSTR Planning & Ops

AFI 34-242, Mortuary Affairs Program

AFI 35-101, Public Affairs Policies and Procedures (Chapter 7 - Crisis Communications)

AFI 41-106, Medical Readiness Planning and Training

AFI 41-115, Authorized Health Care and Health Care Benefits in the MHSS

AFI 41-209, Medical Logistics Support

AFI 41-210, Patient Administration Functions

AFI 44-108, Infection Control Program

AFI 44-153, Critical Incident Stress Management

AFJI 48-110, Immunization and Chemoprophylaxis

AFJI 48-131, Veterinary Health Services

AFI 48-105, Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance

AFI 51-701, Negotiating, Concluding, Reporting, and Maintaining International Agreements

AFMAN 23-110, Air Force Medical Material Management System

AFMAN 32-4004, Emergency Response Operations

AFMAN 32-4005, Personal Protection and Attack Actions

AFMAN 37-123 (will convert to 33-363), Management of Records

AFMAN 44-156(I), Treatment of Biological Warfare Agent Casualties

AFH 10-2502, USAF WMD Threat Planning and Response Handbook

Air Force Medical Service Health Information Protection Privacy Act (HIPPA) Regulations

Air Force Bio-Defense Guidelines

DoD Pandemic Influenza Preparation and Response Planning Guidance

DoD Smallpox Response Plan

National Incident Management System

National Response Plan

Abbreviations and Acronyms

AFJI—Air Force Joint Instruction

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMS—Air Force Medical Service

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

ANG—Air National Guard

AOR—Area of Responsibility

AT—Antiterrorism

AT/FP—Antiterrorism/Force Protection

BW—Biological Warfare

CBRNE—Chemical, Biological, Radiological, Nuclear, or High-Yield Explosives

CBRNE MDO—Chemical, Biological, Radiological, Nuclear, and High-Yield Explosives Medical Defense Officer

CDC—Centers for Disease Control and Prevention

CFR—Code of Federal Regulations

CMO—Casualty Management Officer

C-NBC—Counter-Nuclear, Biological and Chemical

COCOM—Combatant Commander/Combatant Command

COMAFFOR—Commander of Air Force Forces

CONUS—Continental United States

DMS—Defense Message System

DOD—Department of Defense

FEMA—Federal Emergency Management Agency

FPWG—Force Protection Working Group

FSTR—Full Spectrum Threat Response

GSU—Geographically Separated Unit

HHS—United States Department of Health and Human Services

HSPD—Homeland Security Policy Directive

IBD—Integrated Base Defense

ICO—Infection Control Officer

IND—Investigational New Drug

LP—Local Purchase
MAA—Mutual Aid Agreement
MOA—Memorandum of Agreement
MOU—Memorandum of Understanding
MAJCOM—Major Command
MCRP—Medical Contingency Response Plan
MTF—Medical Treatment Facility
NIMS—National Incident Management System
NRP—National Response Plan
OCONUS—Outside the Continental United States
PA—Public Affairs
PHEO—Public Health Emergency Officer
PHO—Public Health Officer
RDS—Records Disposition Schedule
ROE—Rules of Engagement
ROM—Restriction of Movement
SME—Subject Matter Expert
SNS—Strategic National Stockpile
SOFAs—Status of Forces Agreements
TWG—Threat Working Group
UCMJ—Uniform Code of Military Justice
USC—United States Code
WMD—Weapons of Mass Destruction

Terms

Antiterrorism—Defensive measures used to reduce the vulnerability of individuals and property to terrorist acts, to include limited response and containment by local military forces.

Biological Agent—A microorganism that causes disease in personnel, plants, or animals or causes the deterioration of material.

Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Incident—The deliberate or inadvertent release of chemical, biological, radiological, nuclear or high-yield explosive devices with potential to cause significant numbers of casualties and high levels of destruction.

Communicable Disease—An illness due to an infectious agent or its toxic product, which may be transmitted from a reservoir to a susceptible host either directly as from an infected person or animal or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Communicable Period—The time during which an infectious agent may be transferred directly or indirectly from an infected person to another person, from an infected animal to humans, or from an infected person to animals, including arthropods.

Confirmatory Testing—A process that provides for the identification of a suspect BW agent by means of devices, materials, or technologies that detect biological markers using two or more independent biological marker results. The field confirmation identification process can be accomplished in a matter of hours (6 to 8 hours). Examples might include the findings of the presumptive biomarker identification with the addition of a positive polymerase chain reaction, enzyme-linked immunosorbent assay, or electrochemiluminescence results, using specific target nucleic acid sequences for the organism and antibody recognition of agent specific antigen sites, respectively. This is equivalent to field sample or specimen identification conducted by forward-deployed or forward-positioned laboratories such as the United States Air Force biological augmentation team, the Army Medical Laboratory, forward-deployed preventive medical unit (USN), or homeland security Laboratory Response Network Level B or C asset (USA community hospitals or medical centers). BW agent field confirmation identification is also available aboard selected aircraft carriers and amphibious ships, and selected medical facilities. These laboratories also have a reach-back capability with a definitive lab for consultation.

Consequence Management—Air Force CBRNE consequence management involves responding to the effects of CBRNE use against the United States, its military forces, and its interests abroad, by assisting the United States and its allies to restore essential services in a permissive environment.

Contact—A person or animal that has been in such association with an infected person or animal or a contaminated environment as to have had an opportunity to acquire the infection/disease of interest.

Close Contact. Having cared for, lived with or been in close proximity with an infected person. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or briefly sitting across a waiting room or office.

Household Contact. A close contact living in the same household as an infected person (see close contact).

Crisis Management—Measures to identify, acquire, plan, and use the resources needed to anticipate, prevent, and resolve a threat or act of terrorism.

Domestic Emergencies—Emergencies affecting the public welfare and occurring within the 50 States, District of Columbia, Commonwealth of Puerto Rico, U.S. possessions and territories, or any political subdivision thereof, as a result of enemy attack, insurrection, civil disturbance, earthquake, fire, flood, or other public disasters or equivalent emergencies that endanger life and property or disrupt the usual process of government.

First Responders—Firefighters, law enforcement and/or security personnel, emergency medical personnel, and Explosive Ordinance Disposal personnel (for suspected explosive CBRNE events) that provide the initial, immediate response.

Force Protection—Commander's program designed to protect Service member, civilian employees, family members, facilities, information and equipment, in all locations and situations, accomplished through planned and integrated application of combating terrorism, physical security, operations security, and personal protective services and supported by intelligence, counterintelligence and other security

programs.

Installation—A grouping of facilities, located in the same vicinity, which support particular functions. Installations may be elements of a base.

Installation Commander—The individual responsible for all operations performed by an installation.

Isolation—The separation of a person or group of persons infected with a communicable disease, while such disease is in a communicable stage, from other people to prevent the spread of infection.

Lead Agency—The department or agency assigned responsibility to manage and coordinate the response in a specific functional area. Lead agencies support the lead federal agency during all phases of the response.

Lead Federal Agency (LFA)—The federal agency designated by the President to coordinate the overall federal response which is determined by the type of emergency. Specific responsibilities of a LFA vary according to the agency's unique statutory authorities. The Federal Bureau of Investigation is the LFA for all crisis management, foreign or domestic. Federal Emergency Management Agency is the LFA for domestic consequence management and the Department of State is the LFA for foreign consequence management.

National Disaster Medical System—A nationwide Medical Assistance Administration network between the federal and non-federal sectors that includes medical response, patient evacuation, and definitive medical care. At the federal level, it is a partnership among the Health and Human Services, the Department of Defense, the Department of Veterans Affairs, and the Federal Emergency Management Agency (FEMA).

Natural Disaster—An emergency situation posing significant danger to life and property that results from a natural cause.

Non-Military Personnel—Civilian personnel, dependents of military or civilian personnel, contractors, and other individuals visiting or who are present on an Air Force installation.

Public Health Emergency—An occurrence or imminent threat of an illness or health condition, caused by biological warfare or terrorism, epidemic or pandemic disease, or highly fatal infection agent or biological toxin, that poses a substantial risk of a significant number of human casualties.

Quarantinable Communicable Disease—Consistent with E.O. 13295, as amended by Executive Order 13295, *Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases*, 1 Apr 2005, includes Cholera, Diphtheria, infectious Tuberculosis, Plague, Smallpox, Yellow Fever, SARS, and Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Congo-Crimean, South American, and others not yet isolated or named). Any subsequent changes to E.O. 13295 are automatically incorporated into this definition.

Quarantine—Compulsory detention or other similar restriction, including isolation, for purposes of preventing or limiting the spread of disease, of individuals or groups reasonably believed to be infected with a communicable disease while such disease is in a communicable stage, or is in a pre-communicable stage if the disease would be likely to cause a public health emergency if transmitted to other individuals.

Restriction of Movement—Limiting people's movement to prevent or limit the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation, isolation, or quarantine.

Strategic National Stockpile—A national repository of antibiotics, chemical antidotes, antitoxins, life support medications, intravenous administration, airway maintenance supplies, and medical/surgical items. The Strategic National Stockpile supplements overwhelmed or depleted state and local medical materiel needed for the medical consequences of CBRNE events, natural disasters, industrial accidents, public health or other emergencies.

Support Agreements—Agreements that address varying levels of cooperation between the Air Force and other organizations. Examples include:

Intraservice Agreements. Agreements between Air Force to Air Force organizations.

Interservice Agreements. Agreements between the Air Force and other Service or DoD components.

Intragovernmental Agreements. Agreements between the Air Force to other non-DoD activities.

Memorandum of Agreement (MOA). An agreement that defines areas of responsibility and agreement between two or more parties, normally at headquarters or MAJCOM level. MOAs normally document the exchange of services and resources and establish parameters from which support agreements may be authorized.

Memorandum of Understanding (MOU). An umbrella agreement that defines broad areas of mutual understanding between two or more parties, normally at MAJCOM or higher level.

Mutual Aid Agreement (MAA). Reciprocal assistance by local government and an installation for emergency services under a prearranged plan. Mutual aid is synonymous with “mutual assistance,” “outside aid,” “memorandums of understanding,” “memorandums of agreement,” “letters of agreement,” “cooperative assistance agreement,” “intergovernmental compacts,” or other similar agreements, written or verbal, that constitute an agreed reciprocal assistance plan for emergency services for sharing purposes. MAAs between entities are an effective means to obtain resources and will be developed whenever possible. MAAs will be in writing, be reviewed by legal counsel, and be signed by a responsible official.

Terrorism—The calculated use of unlawful violence or threat of unlawful violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological.

Trigger Event—An event that initiates a response to a real or suspected biological warfare (BW) or infectious disease event. Four possible triggers might signal such events:

Intelligence trigger occurs when a commander receives an intelligence report indicating that an enemy possesses an offensive biological capability, that there is unusual enemy activity consistent with the logistics and operational use of a biological agent, or that an installation may be attacked with a biological agent. Information and intelligence from multiple sources (e.g., the general public, military intelligence, national intelligence institutions in the host country, etc.) can provide advance warning of a biological attack.

Weapons Event trigger refers to an overt attack by weapon systems, such as theater ballistic missiles, submunitions, or artillery that might be armed with BW. Where intelligence has assessed a biological weapon capability, it is reasonable to react to weapons events in high-threat areas as if they were biological attacks.

Detector Alarm trigger refers to the discovery of a BW event via a signal from a detection device that a bio-agent is present in the environment. Detectors may or may not indicate presence of BW agents

(due to the sensitivity of the devices and the possibility of false positives). Networked aerosol detectors and positive presumptive test results help to discriminate a biological event before the onset of casualties.

Sentinel Casualties trigger refers to the medical community's detection of a BW or infectious disease event by assessing trends in medical symptoms amongst base personnel reporting to clinics or diagnosis of an index case. Alternatively, monitoring domestic livestock or wildlife for unexplained illness or death or monitoring water and food for the presence of bio-agents or infectious disease may also be useful in identifying a biological event.

Vulnerability—The susceptibility of a nation or military force to any action by any means through which its war potential or combat effectiveness may be reduced or its will to fight diminished.

Vulnerability Assessment—A DoD, command, or unit-level evaluation (assessment) to determine the vulnerability to terrorist attack of an installation, unit, exercise, port, ship, residence, facility, or other site. Identifies areas of improvement to withstand, mitigate, or deter acts of violence or terrorism.

Attachment 2

RESTRICTION OF MOVEMENT

A2.1. General. Restriction of movement (ROM) is a broad concept encompassing a number of measures for limiting people's movement to prevent or limit the transmission of a communicable disease. The measures that compose ROM may be used individually or collectively, and include limiting ingress and egress to, from, or on a military installation (in part or in whole), quarantine, and isolation. Commanders must use the least restrictive means of ROM available while ensuring protection of the public's health. The decision to implement ROM measures will be based upon multi-functional collaboration, and the combinations and/or types of measures employed will vary based on scope and severity of the situation.

A2.2. ROM Measures. Measures that may be implemented by commanders include:

A2.2.1. Minimal Manning. Instruct non-essential personnel to stay home/inside.

A2.2.2. Limit Installation Access. Depending on circumstances, commanders can institute several forms of limitations:

A2.2.2.1. Limit ingress and/or egress to the installation via perimeter gates and/or closing of the airfield.

A2.2.2.2. Limit access to certain sectors of the base. As an example, roads leading into and out of base housing could be closed to support certain quarantine measures.

A2.2.2.3. Certain areas of the installation or select facilities could have access limited to asymptomatic mission essential personnel only (e.g., ops centers, squadron facilities, designated dining facilities).

A2.2.3. Close Base Facilities. Actions can be taken when a trigger event suggests the possibility of an attack or outbreak. Prior to confirmatory identification, which may take several days, commanders can close certain facilities on the base, or close the entire base in order to reduce possible transmission of a disease onto the base from the local community (or from the base to the local community) until a more complete picture of the public health threat is developed. Consideration should be given to closing select facilities such as: schools, childcare facilities, commissary, exchange, fitness centers, movie theaters, and dining halls.

A2.2.4. Quarantine.

A2.2.4.1. Quarantine is detention or other similar restriction for purposes of preventing or limiting the spread of disease. Although quarantine measures may be instituted and enforced for both individual persons and populations, the term is used more frequently for measures employed at a population-wide level.

A2.2.4.2. Quarantine may be monitored through either passive or active means to limit the activities of persons and prevent transmission of a disease. Applicable laws will vary across jurisdictions.

A2.2.4.3. Quarantine may be applied to individuals while a disease is in a communicable stage, or while the disease is in a pre-communicable stage (if it would be likely to cause a public health emergency if transmitted to other individuals).

A2.2.4.3.1. Confirmation of infection is not necessarily a precondition for quarantine. As determined by the PHEO, individuals who are believed to be infected with a communicable disease may be quarantined while confirmatory testing takes place. Quarantine may be done while such disease is in a communicable or a pre-communicable stage.

A2.2.4.4. Home/dormitory quarantine may be suitable for contacts (i.e., persons that have come into contact with an individual with a suspected or confirmed infection) if it meets their basic needs and unexposed home members can be protected from exposure.

A2.2.4.5. Community-based facilities (e.g., billeting, bowling alley, fitness center/gym) may be appropriate for those contacts that normally reside in the dormitory or where home quarantine is not a viable option.

A2.2.4.6. Work quarantine may allow healthcare workers and other mission essential personnel, who have been exposed (but are asymptomatic), to continue to work with appropriate infection control precautions. When off-duty, personnel must return directly to home or community-based quarantine facilities.

A2.2.5. Isolation. Isolation is a subset of quarantine that refers to the separation of symptomatic persons with a communicable disease from those who are healthy.

A2.2.5.1. Isolation is a mandatory form of restriction; however, applicable laws may vary across jurisdictions.

A2.2.5.2. Isolation allows for the focused delivery of specialized health care to persons at home or in a designated facility.

A2.2.5.3. As a subset of quarantine, persons isolated are subject to the same notifications and rights as outlined in [Section 2A](#) and [Section 2B](#) of this instruction.

Attachment 3

PREPARATION AND PLANNING ACTIVITIES

A3.1. General. Emergency Health Powers in general, and ROM specifically, is a complex process requiring significant coordination among an installation's command organizations and local, state, and federal agencies. Below are preparation and planning activities the installation must consider prior to exercising and implementing Emergency Health Powers. These planning activities should be incorporated into the Medical Group's Medical Contingency Response Plan (MCRP) and, as applicable, to installation's FSTR Plan 10-2.

A3.2. Assure statutes are reviewed to allow public health intervention and implementation of restriction of movement measures (to include quarantine and isolation) in a lawful and timely manner.

A3.3. Identify personnel responsible for coordination of ROM activities to include but not limited to quarantine and isolation.

A3.3.1. The PHEO will coordinate with the installations Security Forces and Judge Advocate to establish rules of engagement (ROE) for personnel who will enforce ROM, quarantine, and isolation measures.

A3.4. Identify appropriate facilities to be utilized for quarantine and isolation of ill patients.

A3.4.1. The installation's Infection Control Officer, CMO, Bioenvironmental Engineer, and appropriate elements from the Civil Engineer squadron will coordinate to identify the appropriate facilities.

A3.5. Identify appropriate entities to enforce quarantine and isolation orders.

A3.5.1. Establish procedures for all non-military personnel subject to quarantine/isolation who contest their detention to present information supporting an exemption or release to the commander for a decision. Such procedures will include the identification of personnel who will be delegated by the commander the authority to approve or deny requests for release IAW sections **2.4.11.4.** and **2.12.1.** of this instruction.

A3.6. Establish procedures for monitoring and controlling access and shipping and receiving goods to facilities or areas used for quarantine/isolation, or to areas/facilities deemed as restricted by the commander.

A3.7. Establish procedures for appropriate disposal of medical waste when using a non-medical facility. Beyond the Public Health Flight, additional assistance/information is available from the local Health Department and the National Institutes of Health (<http://orf.od.nih.gov/waste/wasteguide.html>).

A3.8. Establish laundry arrangements for sites used for quarantine/isolation.

A3.9. Arrange for food service support for sites used for quarantine/isolation.

A3.10. Establish procedures for monitoring health status of facility staff and plans for transport.

A3.11. Conduct a vulnerability assessment and incorporate observations and lessons learned into other planning activities. Such assessments should be incorporated into the existing Air Force Integrated Vulnerability Assessment. See **Attachment 6** for specific details on assessments.

A3.12. Have procedures in place and personnel identified to conduct contact tracing both on base and off base (note: off-base may depend on liaison with local or state health department).

A3.13. Establish communications with local civilian departments of health or other civilian organizations tasked with tracking communicable diseases in the local community.

A3.14. Consider alternate housing options and satellite pharmacy locations for the base population, as necessary.

A3.15. Include in public health and disease outbreak emergency response planning:

A3.15.1. Support and/or protection of critical infrastructure nodes on the installation (and possible support, as appropriate, off the installation) that may affect an installation's ability to conduct its mission.

A3.15.2. Procedures to ensure requirements and procedures for use of Investigational New Drugs (IND), as contained in DoD Directive 6200.2, *Use of Investigational New Drugs for Force Health Protection*, and Air Force Joint Instruction (AFJI) 48-110, are reviewed and understood by appropriate command and medical personnel.

A3.16. Develop communication guidelines, to include:

A3.16.1. Tailored public affairs guidance, to include identification of means to obtain information release authority.

A3.16.2. Standard operating procedures for use of communications equipment (as necessary), such as frequency assignments, call signs, etc.

A3.17. Conduct an annual review of public health and disease outbreak emergency response program and plans to facilitate program enhancement and to ensure compliance with the guidance contained in this instruction.

A3.18. If not already done, implement support agreements with local, state, or host nation public health authorities, emergency response organizations, or healthcare facilities to minimize the risk of overwhelming installation capabilities in the event of a public health emergency.

A3.19. Include as part of the agreements in **A3.18.** the establishment of request protocols for the installation receiving Strategic National Stockpile (SNS) assets as part of the state and/or local governments' SNS distribution plan.

A3.19.1. The unique challenges of responding to a public health emergency on a military installation may result in a situation requiring DoD to request SNS assets directly from Health and Human Services. These requests will be separate from the established State and local governments' SNS request protocol.

A3.19.1.1. In this situation, SNS assets provided to DoD will be in specific configurations on a case-by-case basis. Air Force installations are likely to receive SNS-managed inventory rather than a 12-hour Push Package.

Attachment 4**TRAINING AND EXERCISES**

A4.1. The PHEO and alternate PHEO will receive initial training upon assignment to the position. The training will be developed and approved by HQ USAF/SG.

A4.2. A Public Health and Disease Outbreak Emergency Response Training Program will be developed and conducted on each installation annually for senior leadership. The Wing Plans and Programs office (or equivalent; i.e., XP) will schedule, ensure funding, and coordinate installation leadership training requirements. The training itself will be conducted by the PHEO, in conjunction with the Civil Engineer Squadron, public health/medical readiness subject matter experts (SMEs), Judge Advocate, and the Wing XP.

A4.2.1. This training will be a mandatory requirement for the following installation leadership positions:

A4.2.1.1. Commander.

A4.2.1.2. Vice-Commander.

A4.2.1.3. Operations Group Commander.

A4.2.1.4. Medical Group Commander (or, for Reserves, the Aeromedical Staging Squadron Commander).

A4.2.1.5. Mission Support Group Commander.

A4.2.2. This training will address:

A4.2.2.1. An overview of the provisions contained in this instruction.

A4.2.2.2. Specific pre-incident implementation actions unique to the installation that require Command involvement and/or action.

A4.2.2.3. Familiarization with the installation public health and disease outbreak emergency response plan (or ANG Emergency Operations Plan).

A4.2.2.4. An overview of the National Incident Management System and National Response Plan, with emphasis on the Area Commands established under them.

A4.3. A public health and disease outbreak emergency response training and coordination session will be scheduled, funded, and coordinated by the Wing XP. Training will be conducted for functional leadership on each installation annually by the PHEO.

A4.3.1. Attendance of this session will be a mandatory requirement for the following installation personnel due to their prominent roles in the execution of the provisions in this instruction:

A4.3.1.1. Aerospace Medicine Squadron Commander.

A4.3.1.2. Chief of Aerospace Medicine.

A4.3.1.3. Civil Engineer Squadron Commander.

A4.3.1.4. Logistics Readiness Squadron Commander.

- A4.3.1.5. Medical Operations Squadron Commander.
- A4.3.1.6. Security Forces Squadron Commander.
- A4.3.1.7. Services Squadron Commander.
- A4.3.1.8. Mental Health Flight Commander.
- A4.3.1.9. Public Health Flight Commander.
- A4.3.1.10. Alternate PHEO.
- A4.3.1.11. Judge Advocate.
- A4.3.1.12. Wing Plans and Programs Chief.
- A4.3.1.13. Civil Engineer Readiness Flight Commander.
- A4.3.1.14. Mortuary Affairs Officer.
- A4.3.1.15. Public Affairs Officer.
- A4.3.1.16. CBRNE MDO.
- A4.3.1.17. Medical Readiness Officer/NCO.
- A4.3.1.18. Casualty Management Officer.
- A4.3.1.19. Antiterrorism Officer.

A4.3.2. This session will include:

- A4.3.2.1. An overview of existing standards and tactics, techniques, and procedures for public health and disease outbreak response, to include those required by this instruction.
- A4.3.2.2. Familiarization with the installation public health and disease outbreak emergency response plan and/or necessary updates to existing emergency response plans based on guidance in this instruction.
- A4.3.2.3. A review of pre and post-incident implementation actions that each functional is responsible for.
- A4.3.2.4. Identification of necessary follow-up training or education for personnel in the functional's organization.

A4.4. Installations will conduct annual public health and disease outbreak exercises (either table-top or field) using realistic outbreak scenarios appropriate to the installation's mission and vulnerabilities to validate the concept of operations articulated in their public health and disease outbreak emergency response plan.

- A4.4.1. Scenarios will consider terrorism, naturally occurring outbreaks, and contingencies that may result in disease outbreaks and public health releases and incidents.
- A4.4.2. Public health and disease outbreak emergency response exercises will be coordinated with the installation Antiterrorism Officer and may be combined with existing annual installation Antiterrorism/Force Protection (AT/FP) exercises.
- A4.4.3. Exercises will include participants from all emergency response functions on the installation and, as appropriate, local, state, federal, and host-nation participants.

A4.4.4. Paragraph [2.9](#) of this instruction requires a public health emergency be included as one of the major FSTR exercises (i.e., Mass Casualty, CBRN, or Biological Incident) on an installation at least every two years. In the years that this is executed, the exercise will fulfill the requirement in [A4.4](#) above.

A4.5. Installations are encouraged to align their installation exercise and training schedules with that of the Department of Justice, the Office of Domestic Preparedness exercise and training programs for state, and local preparedness programs, to include National Guard, as appropriate. When appropriate, OCONUS installations will align their installation exercise and training schedule with the Combatant Commanders, host-nation, and the Department of State-related public health and disease outbreak exercises.

Attachment 5

SUSTAINMENT OF EMERGENCY RESPONSE

A5.1. General. A large-scale public health and disease outbreak incident can quickly exhaust installation emergency responders and require the capabilities of local, state, or federal emergency responders. Installation commanders, in addition to training and working with local emergency responders, will establish liaison with appropriate state and federal emergency response officials to better understand whom to contact and how the integration of state and federal assets would occur should the level of emergency response on an installation require augmentation by one or more of these assets.

A5.1.1. Each installation must plan for the sustainment of its Public Health and Disease Outbreak Emergency Responder Preparedness Program.

A5.1.2. Public health and disease outbreak emergency response plans should be updated, based on feedback from exercises, organizational changes, threat changes, and major world events, etc.

A5.1.3. Public health and disease outbreak emergency response training sustainment will include mechanisms to train new installation emergency responders.

A5.1.4. Public health and disease outbreak emergency response equipment will include requirements for sustainment, to include replenishment of consumables, spare parts, and maintenance. Plans will include coordination with local civil emergency management personnel to gain access to the Centers for Disease Control Strategic National Stockpile medical assets.

A5.1.5. CONUS installations will establish contact with the appropriate state and federal emergency response officials within the installation's respective Federal Emergency Management Agency (FEMA) region and coordinate public health and disease outbreak emergency response plans for response to a public health and disease outbreak incident on the installation. NOTE: ANG members may already be tasked by the Incident Command System or State Emergency Operations Center.

A5.1.5.1. If situations dictate, consideration should be given to including other Air Force or military installations residing in close proximity to one another in the response planning with State and Federal emergency response officials.

A5.1.6. Installations located OCONUS will pursue contacts at local and regional emergency response organizations to obtain formal or informal agreements on disease outbreak emergency response plans.

Attachment 6

ASSESSMENTS

A6.1. General. Public health and disease outbreak emergency response program elements include threat assessments, vulnerability assessments, compliance assessments, planning, exercises, program reviews, and training. The process or sequence of public health and disease outbreak emergency response program elements should be iterative and serve continuously to refine the installation public health and disease outbreak emergency response plan.

A6.2. Antiterrorism Assessments. Commanders will incorporate Public Health assessments into the annual antiterrorism assessment process.

A6.3. Resource and Materiel Assessments. The PHEO, in conjunction with the installation antiterrorism officer, will assess current personnel, resources, and equipment to respond to a public health and disease outbreak incident at each installation. This assessment will:

A6.3.1. Be conducted on organizations to include fire and/or HazMat and rescue, law enforcement and/or security personnel, and emergency medical management at a minimum.

A6.3.2. Include an inventory of assets on the installation as well as what is available through mutual aid agreements with outside communities.

A6.4. Vulnerability Assessment. Currently, every Air Force installation receives a higher headquarters vulnerability assessment every three years. This assessment may be conducted by the Joint Staff Integrated Vulnerability Assessment teams, Air Force Integrated Vulnerability Assessment Teams, or a team composed of required representative from the respective MAJCOM. These higher headquarters assessments review the installation's threat criticality, and vulnerability assessments as well as the installation's emergency response plans. These vulnerability assessments will be used by the PHEO in the process detailed in [A6.6](#). to address specific health-related areas of emphasis, such as:

A6.4.1. Developing a plan to identify base population (to include civilians, contractors, command sponsored and non-command sponsored dependents).

A6.4.2. Developing processes to identify at-risk population (those that have received vaccinations and those who have not; other individuals who require special needs).

A6.5. Assessment of Public Health and Disease Outbreak Emergency Response Programs. Public health and disease outbreak emergency response programs will be subject to annual assessments to avoid complacency. Evolving terrorism threats and changing local emergency responder conditions make periodic assessments essential. This assessment will determine the assessed installation's ability to protect personnel and critical infrastructure, to include the full range of public health and disease outbreak emergency response from pre-incident to mitigation. Techniques include procedural measures such as security force training, security surveys, and medical surveillance for unnatural disease outbreaks. The assessment will also consider commercial off-the-shelf technology enhancements and potential solutions for those circumstances where existing technology or procedural modifications do not provide satisfactory solutions. The assessment will examine:

A6.5.1. The assessed installation's ability to determine its vulnerabilities against the most common public health and disease outbreak possibilities within the region. The assessment will further examine the ability to provide installation infrastructure protection against such events. The ability to respond to an event, with emphasis on a mass casualty situation, will also be examined.

A6.5.2. Written plans and/or programs designed to support areas of:

A6.5.2.1. Pre-incident planning.

A6.5.2.2. Emergency response.

A6.5.2.3. Medical needs.

A6.5.2.4. Equipment.

A6.5.2.5. Law enforcement.

A6.5.2.6. Training.

A6.5.2.7. Intelligence support.

A6.5.2.8. Security.

A6.5.2.9. Antiterrorism.

A6.5.2.10. Post-incident response (the ability of the activity to respond to an incident, especially a mass casualty event, to include contamination control and disease outbreak caused by terrorist use of biological weapons).

A6.5.3. The availability of resources to support plans as written and the frequency and extent to which plans have been exercised. The assessment will determine the status of formal and informal agreements with supporting organizations.

A6.6. Risk Assessment. Commanders are currently required to conduct AT risk assessments, IAW AFI 10-245 *Air Force Antiterrorism (AT) Standards*, that address the vulnerability of critical infrastructures, facilities, food and water, programs, and systems to acts of terrorism. The results of this annual AT risk assessment will be infused with information gathered through medical surveillance activities outlined in AFI 48-105 to ensure the full spectrum of risk to public health emergency response is addressed. The results of the assessment will be reviewed annually by the installation FPWG. The PHEO and AT Officer will take the lead for resolving any unsatisfactory levels of risk.

Attachment 7**TESTING AND DISPOSITION OF CBRNE CONTAMINATED REMAINS**

A7.1. General. Depending on the nature and scale of a public health emergency (i.e., act of nature vs. act of terrorism vs. act of war), humans and animals may succumb to disease or infection. The following guidance for testing and disposition of remains incorporates existing guidance, and provides supplemental guidance for disposition of potentially contaminated remains in situations other than war. All actions below will be executed by appropriate personnel, and relevant information reported up to the PHEO in a timely manner.

A7.2. Measures for Testing Human Remains. Per AFI 41-210, *Patient Administration Functions*, testing of human remains or post-mortem examination/autopsy is accomplished by medical service on service members when the cause of death might constitute a menace to public health. In the event the installation is under a public health emergency, results of testing on human remains will be reported to the PHEO in a timely manner.

A7.3. Measures for Disposal of Human Remains.

A7.3.1. CONUS. The vast majority of CONUS installations are not “Total Federal Jurisdiction” and thus the state/local medical examiner or coroner will have operational custody of the remains and will probably react to any mass fatalities before a PHEO arrives on scene. Since there is no capability to decontaminate all forms of biologically-contaminated remains, a PHEO may not necessarily have the means to evaluate the state/local’s capabilities for decontamination or handling of contaminated remains.

A7.3.1.1. PHEOs, in conjunction with Services and the installation mortuary affairs officer, will coordinate plans with the state and/or local coroner to dispose of contaminated remains and verify (if possible) the state/local coroner possesses the necessary capabilities for decontamination and/or handling of contaminated remains.

A7.3.1.2. In the event the state/local coroner does not possess such capability, the installation’s Services squadron and mortuary affairs officer will be consulted to formulate plans for temporary internment of contaminated remains on the installation (IAW AFI 34-242, *Mortuary Affairs Program*) until appropriate decontamination and means of permanent disposal can be arranged.

A7.3.1.2.1. Installations may, at the commander’s discretion, provide assistance to local communities who do not possess capabilities to test, decontaminate, or dispose of contaminated remains. Priority will be given to controlling the situation on the installation prior to any assistance, and any assistance rendered must not interfere with the ability to protect the installation’s property and personnel against communicable diseases associated with biological warfare or terrorism or other public health emergency.

A7.3.1.3. In the event of fatalities resulting from a declared public health emergency, the PHEO may authorize the temporary internment of human remains prior to confirmatory identification of the infectious agent or disease. This determination may take several days and will need to be executed in coordination with the installation Services squadron and the mortuary affairs officer.

A7.3.2. OCONUS.

A7.3.2.1. Wartime OCONUS. Per AFI 34-242, Air Force Services' wartime role in the process of dealing with contaminated human remains is to perform temporary internment after a determination has been made that the remains cannot be decontaminated.

A7.3.2.2. Peacetime OCONUS. Permanent disposition of human remains requires decontamination, which is governed by Joint Publication 4-06. Theater Command Surgeons will provide guidance on decontamination standards. Theater senior medical advisors establish specific procedures for further handling of remains based on the type of contamination. Remains contaminated with any agent listed in 42 CFR, Chapter 1, 73.3(b) have unique requirements for handling, as addressed in Joint Publication 4-06.

A7.3.2.3. Existing theater or COCOM guidance may exist which supplements or supercedes the guidance in sections [A7.3.2.1.](#) and [A7.3.2.2.](#) above.

A7.4. Measures for Testing and Disposal of Animal Remains. All installations will have a defined procedure for testing and disposing of animal remains. Such procedures will vary depending upon the services available at the installation, and are enacted IAW one of the following instructions: Air Force Joint Instruction (AFJI) 48-131, *Veterinary Health Services*, AFI 48-105, *Surveillance, Prevention, And Control Of Diseases And Conditions Of Public Health Or Military Significance*, and AFI 32-1053, *Pest Management Program*.

Attachment 8

TEMPLATE: DECLARATION OF A PUBLIC HEALTH EMERGENCY

A8.1. General. The content that follows will be added to Installation or Wing letterhead (as appropriate) with the appropriate information filled into the italicized fields contained within brackets. The document will be signed by the installation commander. Upon signing, the information therein must be communicated to the installation population using the most effective and timely means available (e.g., featured at a Commander's Call, an e-mail from the commander to the base population, photo-copies of the memorandum handed out at the gates, closed-circuit television announcement, etc.). Additional guidance or information on the public health emergency will be formulated by the PHEO and attached to this memorandum prior to distribution.

{DATE}

MEMORANDUM FORRECORD

FROM: *{Wing or Installation Commander Designation}*

SUBJECT: Declaration of a Public Health Emergency

I have been notified by my Public Health Emergency Officer (PHEO) of a possible public health situation on our installation involving *{agent or disease name}* that requires immediate action. Based on the PHEO's recommendations and the results of a preliminary investigation, I am declaring a public health emergency IAW Air Force Instruction (AFI) 10-2603, *Emergency Health Powers on Air Force Installations*. This declaration will terminate automatically 30 days from the date of this memorandum unless it is renewed and re-reported, or terminated sooner by myself or a senior commander in the chain of command.

The installation PHEO and Public Health personnel are hereby directed to identify, confirm, and control this public health emergency utilizing all the necessary means outlined in AFI 10-2603. To implement my direction, the PHEO may issue guidance that affects installation personnel and property, and other individuals working, residing, or visiting this installation (e.g., closing base facilities, restricting movement, or implementing quarantine for select individuals).

The installation command and the PHEO will coordinate activities and share information with federal, state, and local *{NOTE: for OCONUS commands, replace "federal, state, local" with "host nation"}* officials responsible for public health and public safety to ensure our response is appropriate for the public health emergency. Shared information may include personally identifiable health information only to the extent necessary to protect the public health and safety.

Any person who refuses to obey or otherwise violates an order during this declared public health emergency will be detained. Those not subject to military law will be detained until civil authorities can respond. Violators of procedures, protocols, provisions, and/or orders issued in conjunction with this public health emergency may be charged with a crime under the Uniform Code of Military Justice and/or under *Title 50, United States Code, Section 797*. Pursuant to 50 U.S.C 797, violators are subject to a fine up to \$5,000 or imprisonment for not more than 1 year, or both.

{Signature Block}

Attachment 9

TEMPLATE: NOTICE OF QUARANTINE

A9.1. General. The content that follows will be added to Installation or Wing letterhead (as appropriate) with the appropriate information filled into the italicized fields contained within brackets. The document will be signed by the PHEO, and photocopies will be provided to all individuals subject to quarantine within two hours of quarantine being established. A copy of the Declaration of a Public Health Emergency signed by the installation commander will be attached. Any supporting information or guidance deemed necessary can also be attached to this notice.

{DATE}

MEMORANDUM FOR INDIVIDUALS SUBJECT TO QUARANTINE

FROM: Public Health Emergency Officer (PHEO), *{Wing or Installation Designation}*

SUBJECT: Notice of Quarantine

In response to a declared public health emergency by the installation commander, this is a formal notice that we are invoking quarantine procedures. As the installation's PHEO, I am providing you the following directions and information on the situation.

{Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order.}

{A brief statement of the facts warranting the quarantine.}

{Conditions for termination of the order.}

{Specified duration of quarantine.}

{The place or area of quarantine.}

{No contact with non-quarantined individuals except as approved by the PHEO.}

{Symptoms of the subject disease and a course of treatment.}

{Instructions on the disinfecting or disposal of any personal property.}

{Precautions to prevent the spread of the subject disease.}

All non-military personnel subject to quarantine have the right to contest the reason for quarantine. Information supporting an exemption or release can be provided to myself or one of my designated representatives, who will provide the information to the installation commander (or a designated representative) for final determination. The total time from submission to response will not exceed 20 hours.

Procedures for the declaration of a public health emergency, quarantine, and the actions prescribed above are found in DoD Directive 6200.3, *Emergency Health Powers on Military Installations*, and Air Force Instruction 10-2603, *Emergency Health Powers on Air Force Installations*. It is DoD and Air Force policy that military installations, property, and personnel and other individuals working on, residing on, or visiting military installations will be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Violators of procedures, protocols, provisions, and/or orders detailed in this memorandum may be charged with a

crime under *Title 50, United States Code*, Section 797 and subject to punishment of a fine up to \$5,000 or imprisonment for not more than 1 year, or both.

A wide range of professionals, in addition to myself, are working hard to bring this situation to an resolution that guarantees your health and the safety of the general public.

{NAME IN ALL CAPS, Rank}, USAF

Public Health Emergency Officer

{Wing or Installation Designation}

Attachment:

Declaration of Public Health Emergency