NATO STANDARD

AMedP-2.3

PATIENT EVACUATION COORDINATION CELL (PECC) TASKS AND RESPONSIBILITIES

Edition A, Version 1

JULY 2026

NORTH ATLANTIC TREATY ORGANIZATION

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NATO LETTER OF PROMULGATION

9 July 2026

1. The enclosed Allied Medical Publication AMedP-2.3, Edition A, Version 1, PATIENT EVACUATION COORDINATION CELL (PECC) TASKS AND RESPONSIBILITIES, which has been approved by the nations in THE MILITARY COMMITTEE MEDICAL STANDARDIZATION BOARD (MCMedSB), is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 6532.

2. AMedP-2.3, Edition A, Version 1, is effective upon receipt.

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

Thierry POULETTE
Major General, FRA (A)
Director, NATO Standardization Office

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RECORD OF RESERVATIONS

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

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
MNE	The Armed Forces of Montenegro have a limited number of medical personnel therefore, it is currently not possible to ensure their continuous 24/7 engagement as required by this STANAG. Furthermore, the Armed Forces of Montenegro are obliged to comply with national regulations governing working hours, rest periods, religious holidays, and annual leave. In the future, through an increase in the number of medical personnel, their additional training, and the fulfillment of other requirements defined by this STANAG, the Armed Forces of Montenegro will be in a position to accept and implement this STANAG, with or without reservations, depending on the extent to which the aforementioned conditions are met.
NOR	Chapter 4 - 4.2.2 and Chapter 5 - 5.1.2: Norwegian legislation is strict in regards to patient record or health record systems (medical records). Compliance with these paragraphs will be restricted by the ability to access or pass on information limited to a patient record or health record system by Norwegian legislation.
USA	Para 2.2., U.S. Army doctrine does not establish a formal medical regulating body, such as a PECC, at the Brigade Combat Team (BCT) level. Mandating a PECC at the brigade level contradicts the U.S. Army's organizational structure and C2 philosophy for tactical medical support. The functions described for the Brigade PECC will be performed by the Brigade Medical Operations section, which will serve as the liaison to the PECC at the next higher echelon. Para 3.1.8., This para assigns a primary role to the PECC ("develop and maintain close working relationships") that belongs to other staff sections in US/ Joint doctrine. US policy assigns responsibility for liaison and coordination with civilians, host nation, and non-governmental organizations to Civil Affairs, not the PECC. The PECC's role is not to lead this effort, but to act as the essential medical subject matter expert in support of it. Para 5.1.2.a. It may not be feasible to ensure PECC personnel are trained on all potential software systems they may encounter prior to deploying. Interoperability is achieved through technical compliance with data standards. US implementation will focus on ensuring its national systems are compliant with established NATO data exchange standards.

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CHAPTER 1 INTRODUCTION

1.1. INTRODUCTION

1. Medical evacuation (MEDEVAC) is 'the medically supervised process of moving patients who are wounded, injured or ill to and/or between medical treatment facilities (MTFs)'.[1] It is an integral part of the treatment continuum and will be conducted in accordance with the rules of eligibility which results in MEDEVAC falling into two categories. The first category is responsive in nature, when assets are called to an incident: The second is planned when patients are moved between MTFs. MEDEVAC requires specific medical personnel, assets and equipment appropriate to the operational environment and the phase within the patient pathway. MEDEVAC forms part of the continuum of a patient's care and needs to be appropriately managed through patient flow management (PFM).

2. There are two types of command and control (C2)[2] of the MEDEVAC chain: a centralised MEDEVAC system; and a decentralised MEDEVAC system[3]. A centralised system should be used when possible and a decentralised system used when necessary. A decentralised can manage large numbers of casualties in situations that are highly fluid and uncertain due to a lack of information and communication. Casualties are evacuated following a pre-determined plan with no direct guidance from higher headquarters. This approach is sometimes referred to as a 'Push' system and may be preferable in highly dynamic tactical situations where centralized decision-making may be difficult due to a lack of situational awareness, poor communications, or a high cyber threat environment. However, a centralised MEDEVAC system (sometimes referred to as a 'Pull' system) should be used wherever possible as it is able to provide the optimum MEDEVAC solution for each patient and optimises patient tracking to support a near real-time recognized medical picture.

3. The medical control and coordination of patient evacuation is essential for military operations. In a centralised MEDEVAC system, to enable MEDEVAC and PFM to occur, a dedicated team, known as a Patient Evacuation Coordination Cell (PECC), provides a patient regulation function with the purpose to collate, analyse and present information in a timely fashion to enable commanders to make informed decisions about how to respond to patient evacuation requests. This works in conjunction with force components, theatre logistics and movement control agencies by planning, coordinating and tasking assets for the evacuation of casualties and patients. As an integral part of deployed headquarters (HQ) operations rooms, PECCs provide theatre MEDEVAC coordination for all patients, irrespective of formations.

[1] NATO*Term* 22089.
[2] It is recognised that a PECC does not have MEDEVAC assets under its command but has the coordination function.
[3] STANAG 2546 AJMedP-2 Medical Evacuation provides more details on C2 systems for MEDEVAC.

4. A PECC is the medical staff element providing MEDEVAC regulating functions for all patients within a theatre of operations[4]. The PECC provides coordination for the effective en route care and efficient movement of patients. PECCs are formed of dedicated teams operating within a deployed 1*[5] or above HQ, in complex (COIN, Humanitarian) and large scale (Article 5, War Fighting at Scale) operational environments. Multiple PECCs may function at varying levels of command, each responsible for patient evacuation and PFM within their designated areas of responsibility. There may also be functions within smaller deployments to facilitate patient evacuation coordination. A PECC's primary responsibility is to facilitate appropriate treatment in-theatre, with the responsibility for facilitating an evacuation of a patient out of theatre through a national support element (NSE) PECC or through a rearward MEDEVAC coordination centre (RMCC)[6] to facilitate movement to a rearward MEDEVAC hub[7].

1.2. CONTEXT

As medical capability becomes increasingly more versatile and adaptable, the number of options for effecting patient evacuation increases, which offers a distinct advantage in denied operating environments. Concurrently, this expansion of options has introduced greater complexity in the planning control and coordination of patient evacuation operations. PECCs are essential in mitigating this complexity and ensure intelligently tasked medical evacuation missions. They empower commanders with the knowledge necessary to effectively utilize the full range of available evacuation assets, irrespective of the operational scale, in complex operational environments while providing critical insights into potential clinical ramifications of large-scale patient movement as could be expected in Article 5 operations.

1.3. SCOPE

1. The main objective of this document is to define a common standard for the responsibilities, composition, personnel and equipment requirements of a PECC. In addition, this document establishes a standard framework for a PECC, outlining their responsibilities, organizational structure and requirements for personnel and equipment. It also details the procedures for coordinating MEDEVAC.

2. This document deliberately does not cover details of the function of patient evacuation control and the overall principles of command and control of MEDEVAC; these details are provided in the AJMedP-2 Allied Joint Doctrine for Medical Evacuation and the PFM Guideline[8].

[4] NATO*Term* 25356. *A designated area, which may include one or more joint operations areas.*
[5] Brigade or equivalent.
[6] In the Revised Allied Command Operations Patient Flow Management Guideline dated 17 Apr 24, this is referred to as a Rearward MEDEVAC patient evacuation coordination centre; however, the agreed term for NATOTerm will be RMCC.
[7] The Revised Allied Command Operations Patient Flow Management Guideline dated 17 Apr 24 provides details of rearward MEDEVAC including rearward MEDEVAC patient evacuation coordination centres and Hubs. NATO*Terms* are in development.
[8] Revised Allied Command Operations Patient Flow Management Guideline dated 17 Apr 24.

1.4. APPLICATION

This standard should be applied by all personnel, Allies and Partner nations engaged on NATO operations and activities.

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CHAPTER 2 ORGANIZATION

2.1. COMPOSITION OF A PATIENT EVACUATION COORDINATION CELL

1. The size and composition of the Patient Evacuation Coordination Cell (PECC) will vary based on the patient estimate and the complexity of the operation. However, it must have the ability to coordinate the evacuation of patients 24/7[9] and as soon as possible as the operational scenario permits. In order to facilitate continuous operation, a PECC normally consists of two or three shifts of personnel with both clinical and medical support functions being available to each shift.

2. Medical staff within the PECC must be suitably qualified and experienced to facilitate the enablement of medical missions. This necessitates being able to interact with operations staffs (J3/N3/G3/A3) to justify requests for resources and plan in a highly dynamic, resource scarce environment. Medical staff must understand the multitude of mechanisms by which the evacuation process can be conducted within the operating environment and advocate for the patient based on the medical implications for their illness or injuries[10].

2.2. COMMAND AND CONTROL

1. PECCs are utilized in a centralized command and control system and are required as part of the headquarters of a joint task force, formation or maritime task group. A PECC will be established in Brigade, Divisional, Corps and higher HQs, in order to conduct patient evacuation and movement across the area of operations.[11] However, depending on the complexity or scale of the operation, there may be multiple PECCs in the joint operations area (JOA)[12] at various levels of command.

2. The PECC is usually a component of the joint medical staff, which plans and conducts medical operations for the respective formation. A close interaction with operations staff (i.e. J3) is essential; therefore, the PECC should usually be physically situated within the Operations Centre.

3. PECCs are situated to provide a point of commonality and interoperability for multinational patient pathways. Where the operational situation permits nationally executed Strategic MEDEVAC[13], nations may decide to deploy a national PECC element attached to the national support element (NSE)[14] to organize medical evacuation (MEDEVAC) to their home country.

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[9] 24 hours a day, 7 days a week.
[10] Clinical authority will continue to rest with Medical Director or designated clinical lead.
[11] NATO*Term* 8130. *An area within a joint operations area defined by the joint force commander for conducting tactical level operations.*
[12] NATO*Term* 6762. *A temporary area within a theatre of operations defined by the Supreme Allied Commander Europe, in which a designated joint force commander plans and executes a specific mission at the operational level.*
[13] Operational situation with no activated NATO coordinated Rearward MEDEVAC
[14] Any national organization or activity that primarily supports national forces that are part of a NATO force. **Note:** A national support element is under the operational control of its national authorities and not formally part of a NATO force (NATO*Term* 24170).

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CHAPTER 3 TASKS AND RESPONSIBILITIES

3.1. RESPONSIBILITIES AND TASKS

A Patient Evacuation Coordination Cell (PECC) must be able to provide timely medical advice to support the activities of the Operations Command Centre it is supporting. Within their respective formations, each PECC has several responsibilities that are detailed below.

3.1.1. Patient flow management

1. Patient flow is, "The movement of patients through a medical treatment and evacuation chain."[15] Patient flow management (PFM) is the active process of directing, controlling and coordinating the transfer of patients within and outside a Joint Operations Area (JOA) from the point of wounding or onset of disease through the continuum of care, in order to facilitate the most effective use of medical treatment and evacuation resources, and to ensure that the patient receives appropriate care in a timely manner.[16] However, in a warfighting scenario the function may be required to clear medical treatment facilities (MTFs) as quickly as possible. The PECC represents and advocates the needs of the patients to the operations room commander[17].

2. The management of patients through the continuum of care is a dynamic process based on a medical support plan; the medical support plan is developed to support the operations of the unit being supported, including the expected casualty rate, and determines the required medical footprint. PFM requires a high level of situational awareness, and it takes into consideration many planning and operational factors, such as:

- patient's medical condition (to include requirements for any special medical evacuation (MEDEVAC) assets or escort and eligibility for treatment (see AJP 4.2 *Allied Joint Doctrine for Medical Support* for information on medical rules of eligibility);
- availability of evacuation assets at the tactical and strategic level;
- MTF availability, their capacity and specialist capabilities, medical equipment and supply status and staffing levels;
- current bed occupancy status at each relevant MTF including any surgical backlog;
- location of airport / seaport of embarkation, railheads or other points of embarkation for tactical, rearward and strategic MEDEVAC;
- location and number of patients (if possible, nationality of the patients);
- current tactical situation and associated risk from movement to patients or evacuation assets;

[15] NATO*Term* 25637.
[16] Revised Allied Command Operations Patient Flow Management Guideline dated 17 Apr 24.
[17] As part of its role in supporting 'Intelligent tasking' a PECC ensures that each patient is taken to an MTF that is most able to manage their illness or injury to achieve the best clinical outcomes for the patient.

- restrictions on movement (chemical, biological, radiological and nuclear (CBRN) contaminated patients, infectious diseases, route restrictions, etc);
- communication status in the regulating chain (to include emissions control status and cyber threat); and
- theatre patient return policy.

3.1.2. Patient tracking

The PECC is responsible for the precise and continuous monitoring of the current location of patients and their intended destination in collaboration with J1/N1/G1/A1; for rearward MEDEVAC, there will be a requirement for the PECC to engage with National Support Element (NSEs), Host Nation Support facilities and Joint Support and Enabling Command (JSEC). This not only contributes to patient flow management but further ensures that commanders are able to account for personnel under their command, understand the implications on the operational capability of the patient's unit of origin and manage external interests into the welfare of patients. This responsibility is handed over to the next higher formation PECC once the patient leaves the initial PECC's area of responsibility.

3.1.3. Maintenance of the medical treatment facility (MTF) database.

1. The PECC is to maintain a database of all the MTFs in its area of responsibility, along with close cooperation with movement control (air, road, rail, sea). Information from this data will be used in daily briefings within the Ops room and wider circulation and contributes to the Recognized Medical Picture. The database should include the following details:

- type (e.g. Role 1, Role 2 Basic, Casualty Staging Units (CSUs));
- nationality;
- location;
- clinical capability (e.g., neurosurgery, computed tomography, dental);
- isolation capability;
- CBRN capability;
- bed capacity (bed status);
- medical equipment/supply status;
- limitations;
- notice to move (for mobile operations);
- location of veterinary services (for military working dogs); and
- contact information.

2. To maintain seamless PFM, rearward MEDEVAC coordination centres (RMCC) will also need to maintain an appropriate database that includes details of CSUs (usually Role 2E and above), embarkation points for rearward MEDEVAC (air, road, rail and sea) and rearward MEDEVAC hubs.[18]

[18] The Revised Allied Command Operations Patient Flow Management Guideline dated 17 Apr 24 provides details of rearward MEDEVAC including rearward MEDEVAC coordination centres and Hubs. NATO*Terms* are in development.

3.1.4. Maintenance of a medical evacuation assets availability database

The PECC is required to maintain a database of medical evacuation assets within their area of responsibility. The database should include details of the type of asset and the availability status of each.

3.1.5. Coordination with other PECCs

Each PECC should ensure they coordinate with all other PECCs in the theatre of operations; this will include PECCs from superior, subordinate, supporting, and flanking formations. RMCCs will be required to coordinate with NSEs, rearward MEDEVAC Hubs, JSEC and Aeromedical Evacuation Coordination Centres (AECC)[19] to ensure seamless PFM.

3.1.6. Response to evacuation requests

In line with the endorsed medical rules of eligibility and the patient return policy, a PECC coordinates patient evacuation requests from across its area of responsibility. Upon receipt of an evacuation request (MEDEVAC 9-Liner[20] for centralized forward MEDEVAC or patient movement request (PMR) and/or Bulk PMR for tactical, rearward or strategic MEDEVAC),[21] the PECC must respond, based on quantity and type of injuries/patients. This is to include the following.

a. Receive, prioritize, and provide the medical analysis to determine the appropriate type and quantity of evacuation assets (surface and air) for the mission.

b. Determine appropriate destination MTF(s).

c. Assign the medical mission to the appropriate evacuation asset(s). Each medical mission will be assigned a unique alphanumeric identifier to track progress.

d. Ensure with the destination MTF(s) (Land or Maritime) that any necessary ground transportation is arranged between the helicopter landing site, airhead, railhead or seaport and the MTF.

e. Inform the destination MTF(s) of the estimated time of arrival of patients and any available clinical information on the patient(s).[22]

[19] Details on AECC are in Chapter 6.1.
[20] MEDEVAC 9-liner format is included in ATP-97 *NATO Land Urgent Voice Messages (LUVM) Pocketbook.*
[21] PMRs are used to initiate tactical, rearward or strategic medical evacuation. PMR format is included in STANAG 2542 SRD-1 to AJMedP-1 Military Medical Reports and Returns Guideline.
[22] For forward medical evacuation, information may be available as part of the Mechanism, Injury, Symptoms, Treatment report that should accompany a MEDEVAC 9-Liner request (see ATP-97 *NATO Land Urgent Voice Messages (LUVM) Pocketbook*). For tactical medical evacuation, information will be provided in the PMR by the initiating MTF.

f. Ensure the destination MTF is aware of any patients with, or suspected of having, highly communicable infectious disease.

g. Determine the level of medical care required for the medical evacuation (MEDEVAC) asset. e.g. up to a Critical Care Air Support Team.

h. Confirm any route restrictions with operations staff and inform the evacuation asset.

i. Coordinate with Operations staff for force protection elements for evacuation assets[23].

j. For forward aeromedical evacuation, coordinate with Operations and Air as the aircraft launch authorities.

k. If the request is outside its AOR, immediately forward this request to the next higher formation PECC.

l. Provide further liaison and coordination, as necessary.

3.1.7. Mass Casualty Planning

During anticipated high intensity operations, mass casualty events and high casualty numbers will severely strain MEDEVAC capabilities. To mitigate this, pre-planned and standardized protocols for rapid authorization and utilization of improvised casualty evacuation assets, including civilian vehicles, must be considered. Bulk MEDEVAC assets (surface and air) will need to be considered for bulk movement of casualties and patients throughout the MEDEVAC chain.

3.1.8. Civil-military interaction

To ensure operational readiness for civilian evacuation, the PECC will develop and maintain close working relationships with civilian healthcare facilities (either directly or via J9 (civilian-military cooperation)) enabling the integration of host nation, non-governmental organization, or international organizations evacuation resources to establish evacuation plans. For rearward evacuation of patients, rearward MEDEVAC patient evacuation coordination centres will need to coordinate with civilian MEDEVAC and healthcare facilities.

3.2. OTHER ROLES AND TASKS

3.2.1. Medical logistics

A PECC has no formal contribution to the delivery of medical supplies. However, it may play a role in the coordination of emergency medical resupply to troops on the ground or to MTFs within the operations area. In this respect, a request for emergency

[23] In kinetic and large-scale combat operations, this may even include planning a deliberate MEDEVAC operation including supporting Joint Fires, Electronic Warfare etc.

resupply may be passed as part of, or in isolation to, a patient evacuation request. Where such requests are received, they may be considered alongside planning for other enablers; however, this emergency resupply route should only deliver pre-prepared packages of items that have been consumed. Typically, resupply requests may include blood, critical medication and/or specialist personnel.

3.2.2. Liaison with home base health services

A PECC has a notable role as a point of coordination and linkage between the home base and operational theatres. The patient flow management system may move patients throughout the continuum of care from the point of injury/illness in the joint operations area to an appropriate Role 4 MTF[24], ideally in the patient's home nation, or a rearward MEDEVAC hub (for definitive care and rehabilitation prior to return to duty or onward strategic MEDEVAC) in case of large-scale patient flow during Article 5 operations.[25] The underlying principle is to transport every patient to the most appropriate MTF as quickly as possible. A PECC's primary responsibility is to facilitate appropriate treatment in-theatre, with the responsibility for facilitating an evacuation of a patient out of theatre through a NSE PECC or through a rearward MEDEVAC patient evacuation coordination centre to facilitate movement to a rearward MEDEVAC hub. Nonetheless, a PECC must have the necessary means to communicate medical information effectively with home base facilities. As such, a PECC is often well placed to facilitate national (and even multinational) medical linkages between theatre and home nation providers.

[24] Movement to a Role 4 MTF is required if the patient return policy precludes definitive care and return to duty within the joint operations area.
[25] Rearward MEDEVAC hub is explained in the revised ACO patient flow management guideline 17 Apr 24 and STANAG 2546 AJMedP-2 *Allied Joint Medical Doctrine for Medical Evacuation*.

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CHAPTER 4 PERSONNEL AND TRAINING

4.1. WORKFORCE REQUIREMENTS

1. A Patient Evacuation Coordination Cell (PECC) may vary in size, but it must be able to operate on a 24/7 basis with all functions performed and must be resourced accordingly in line with the requirements of the supported mission along with an appropriate mix of medical personnel.

2. Where air platforms are or may be made available to conduct medical evacuation (MEDEVAC) missions, a suitably qualified and experienced person in the conduct of aeromedical evacuation missions should be available.

4.2. EDUCATION AND TRAINING

1. PECC staff must have completed appropriate specific PECC training. An example being the NATO PECC Course delivered by the NATO Centre of Excellence for Military Medicine.

2. All medical staff must be able to initiate, receive, communicate, manage, and assure time critical medical information including patient records and health information as and when required.

3. Personnel must be trained to perform their primary function in both austere and well-founded locations as well as on mobile platforms if required across the full spectrum of operational environments. It is anticipated that individual training will cover training in:

a. The planning and execution of MEDEVAC missions.

b. The delivery and performance of MEDEVAC missions.

c. Any communication and information systems used.

d. Any training mandated by the headquarters (HQ) within which the PECC will operate.

4. **Collective training and mission rehearsal**. Where possible, a PECC should conduct collective training with the deploying force ahead of the deployment. New personnel joining an established PECC should receive mission specific training as part of their induction into the PECC and the supported HQ.

5. **Medical evaluation**. The performance of the PECC and its cooperation with the Medical Treatment Facilities should be the subject of medical evaluation.[26]

6. **Lessons Learned**. A PECC should be part of the learning organization. Observations regarding patient evacuation must be recorded and reported so that lessons can be identified. The outcome should be implemented in a way that improves the procedures and processes of a PECC.

[26] For procedures of medical evaluation, see AMedP-1.6 *Medical Evaluation*. As a PECC is an integral part of an Operations headquarters, it's performance (procedures) may also be assessed along with the rest of the headquarters.

CHAPTER 5 COMMUNICATION AND INFORMATION

5.1. INFORMATION

1. Definitions of casualty and patient:

   a. **Casualty**. 'A person who is lost to an organization by reason of being declared dead, wounded, injured, or diseased.'[27]

   b. **Patient**. 'A person who has entered the medical care system for, diagnosis and / or treatment.'[28]

2. An effective Patient Evacuation Coordination Cell (PECC) is reliant on the reliable flow of accurate and up to date information. A PECC must be able to pass medical and mission specific / critical information in an appropriate manner between authorized stakeholders regardless of the type, classification or nationality. An example of required information flows for a PECC is at Annex A and the following are key.

   a. **Patient Movement Software**. On most multinational missions there will be a requirement to use NATO or a lead nation's patient movement software for tactical, rearward or strategic medical evacuation. Ideally, PECC personnel should be trained on such systems prior to deploying to theatre but if that is not possible, they should receive induction training when they join the PECC.

   b. **Evacuation asset information database**. At the beginning of any operation, and as circumstances change, each PECC must compile a database of all evacuation assets which may be called upon in their respective area of responsibility.

3. A PECC will require either direct access to medical information systems and communications and information systems (CIS), or appropriate interfaces that can store, transmit and/or assign the necessary credentials to allow the user to use the system in a timely and effective manner. Typically, information will be passed in a pre-agreed and standardized manner, often using templates, thereby ensuring appropriate handling and treatment of medically sensitive information. Where this is not possible or practical, such as when providing a reach back bridge between other (deployed) assets, the passage of this information should not interfere with a PECC's ability to perform its primary functions or to provide timely advice to the commander. A PECC must also be able to adapt to any necessary changes in the information architecture

[27] NATO*Term* 25565.
[28] NATO*Term* 4201.

upon which it is reliant for its ability to perform its primary functions and as such should be incorporated into the supported HQ's CIS plan.

4. Every care must be taken to maintain patient confidentiality and security by sharing only the information necessary for effective patient evacuation coordination with legitimate stakeholders and protecting against the loss of information. Appropriate measures should be put in place to protect information from those who may wish to use it maliciously whilst safeguarding appropriate access by those, including international partners, who require it accordingly. Patient information can lead to medical intelligence and information, which can be of value for an opponent.

5.2. EQUIPMENT

1. A PECC is an integral part of the HQ and the Operations Centre. As such, it cannot function independently from the HQ it is supporting and requires accommodation and real-life support within the parenting HQ. The equipment requirements will be primarily administrative and CIS equipment, to be met by the parenting HQ. Any resilience capabilities and or planning must be harmonized with those of the parenting HQ.

2. A PECC does not directly own and control medical assets to deliver any medical effect but rather coordinates and regulates the provision by others. As such there are no medical capability requirements to be held by the PECC, but good relationships with asset owners and an accurate understanding of the recognized medical picture (RMedP) is critical. This will include serviceability of equipment and numbers of patients/bed availability to inform intelligent tasking and patient regulation.

CHAPTER 6 SPECIAL CONSIDERATIONS

6.1. AEROMEDICAL EVACUATION

There are special considerations for aeromedical evacuation (AE). Patient evacuation coordination for Strategic AE out of the JOA is managed through the Aeromedical Evacuation Control Centre (AECC) which functions as the Patient Evacuation Coordination Cell (PECC) within the Joint Force Air Component (JFAC).

6.2. MARITIME EVACUATION

The complexity of the maritime domain requires a PECC at the Task Force (TF) and Task Group (TG) level. The TF/TG PECC coordinates medical evacuation (MEDEVAC) between ships and from ships to shore.

6.3. SPECIAL OPERATIONS FORCES

MEDEVAC, or casualty evacuation with qualified medical escort, for special operations forces (SOF) missions must be coordinated with the responsible PECC in the joint operations area, to ensure seamless transition of casualties / patients from the SOF medical system to the conventional medical system. Special attention for mission security is required.

6.4. HUMANITARIAN ASSISTANCE AND DISASTER RELIEF OPERATIONS

During humanitarian assistance or disaster relief operations there is often an early sense of confusion and / or disorganization until non-military actors[29] arrive in theatre. There may be a need for military forces, including medical providers, to assist in controlling situations until the appropriate civilian authorities or agencies arrive. PECCs are inherently optimized for supporting this role in controlling and coordinating patient flow management, tracking and tracing and providing a point of interoperability between nations and / or providers. A PECC should be considered as being able to provide mission critical functionality and command advice on such missions[30].

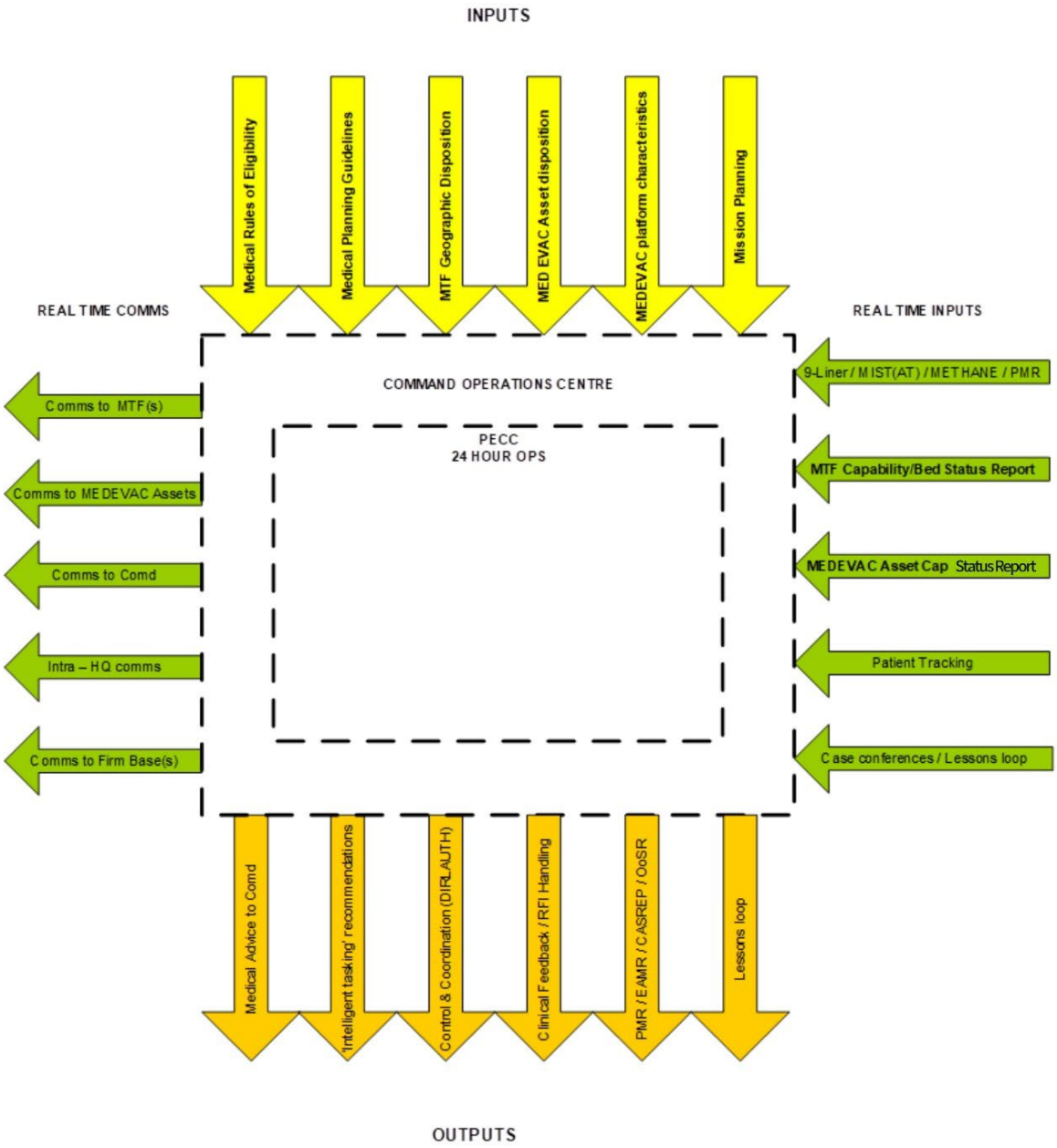
6.5. PEACEKEEPING OPERATIONS

During peacekeeping operations, the PECC must account for complex political sensitivities, limited freedom and multinational coordination challenges. Evacuations often require host nation consent and close coordination with coalition partners, which can significantly delay evacuation timelines. The PECC must navigate restrictive

[29] For example, host nation, non-Governmental organizations and international organizations.
[30] All HA and disaster relief activity should be conducted in accordance with UNOCHA principles and guidelines Civil-military coordination | OCHA (unocha.org). Personnel forming a PECC on such operations should be trained in the application of the principles, concepts, tasks and responsibilities described therein, and work in CC with the J9 branch.

medical rules of eligibility (MRoE), limited security for evacuation routes and constrained access to air or ground assets.

ANNEX A AN EXAMPLE OF PATIENT EVACUATION COORDINATION CELL INFORMATION ARCHITECTURE



Key:
CASREP – Casualty Report
Comd – Commander.
Comms – Communication.
DIRLAUTH – Direct Liaison Authority. Note: If required and granted
HQ – Headquarters.

MEDEVAC – Medical Evacuation.
MIST(AT) – Mechanism of injury; injury or illness sustained; symptoms and vital signs; treatment given; age of casualty; and time of wounding.
MTF – Medical Treatment Facility.
PECC – Patient Evacuation Coordination Cell.
PMR – Patient Movement Request.
RFI – Request for information

Notes:

- PMRs may include bulk PMRs.
- Firm base includes National Support Elements.
- Medical advice to the Commander that is not related to a MEDEVAC mission is provided by the Medical Advisor (MEDAD).

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AMedP-2.3(A)(1)