

## MEDICAL PLAN (ICS 206)

<b>1. Incident Name:</b>		<b>2. Operational Period:</b>		Date From: <input type="text"/> Date	Date To: <input type="text"/> Date		
				Time From: <input type="text"/> HHMM	Time To: <input type="text"/> HHMM		
<b>3. Medical Aid Stations:</b>							
Name	Location	Contact Number(s)/Frequency	Paramedics on Site?				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>4. Transportation (indicate air or ground):</b>							
Ambulance Service	Location	Contact Number(s)/Frequency	Level of Service				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
<b>5. Hospitals:</b>							
Hospital Name	Address, Latitude & Longitude if Helipad	Contact Number(s)/Frequency	Travel Time		Trauma Center	Burn Center	Helipad
			Air	Ground			
					<input type="checkbox"/> Yes Level: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes Level: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes Level: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes Level: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes Level: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6. Special Medical Emergency Procedures:</b>							
<input type="checkbox"/> Check box if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations.							
<b>7. Prepared by (Medical Unit Leader):</b> Name: _____				Signature: _____			
<b>8. Approved by (Safety Officer):</b> Name: _____				Signature: _____			
ICS 206	IAP Page	Date/Time: <input type="text"/> Date					