

**DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD
MEDICAL PLAN (ICS 206-CG)**

PRIVACY NOTICE

AUTHORITY: USCG is authorized to collect the information pursuant to Emergency Management Manual, Volume IV: Incident Management and Crisis Response, COMDTINST M3010.24; Management of Domestic Incidents, Homeland Security Presidential Directive-5 (HSPD-5); National Preparedness, Presidential Policy Directive-8 (PPD-8); U.S. Coast Guard Emergency Management Manual, Volume I: Emergency Management Planning Policy, COMDTINST M3010.11; 40 C.F.R. § 300.125(a)(b); 14 U.S.C. § 504, Commandant; general powers.

PURPOSE: USCG collects the information of medical aid stations, transportation services, and hospitals near an incident location and to document any special medical emergency procedures.

ROUTINE USES: USCG will use this information to assist the Coast Guard and other agencies in all facets of emergency and incident management to prioritize and gauge the effectiveness of response actions. Information from this form may be disclosed externally pursuant to DHS/USCG/PIA-008 Marine Information for Safety and Law Enforcement (MISLE).

CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION: Providing this information is voluntary. In order to assist with maintaining confidentiality respondents are advised not to disclose any additional personally identifiable information (PII) in their free-form responses.

GENERAL INSTRUCTIONS

Purpose. The Medical Plan (ICS 206-CG) provides information on incident medical aid stations, transportation services, hospitals, and medical emergency procedures. The ICS 206-CG serves as part of the Incident Action Plan.

Preparation. The ICS 206-CG is usually prepared by the Medical Unit Leader if assigned. If a Medical Unit Leader is not assigned to the incident, the Logistics Section Chief is responsible for preparing the Medical Plan. The ICS 206-CG is reviewed by the Safety Officer to ensure ICS coordination. If aviation assets are utilized for rescue, coordinate with Air Operations as needed.

Distribution. The ICS 206-CG is duplicated and attached to the Incident Objectives (ICS 202-CG) and given to all recipients as part of the Incident Action Plan (IAP). Information from the plan pertaining to incident medical aid stations and medical emergency procedures may be noted on the Assignment List (ICS 204-CG). All completed original forms MUST be given to the Documentation Unit.

| Item # | Item Title | Description |
|-----------|---|--|
| 1. | Incident Name | Enter the name assigned to the incident. |
| 2. | Incident Location | Enter the location of the incident / City and State or Country if applicable. |
| 3. | Operational Period | Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies. |
| 4. | Medical Aid Stations | Enter the following information on the incident medical aid station(s): |
| | • Name | Enter name of the medical aid station. |
| | • Location | Enter the location of the medical aid station (e.g., Staging Area, Camp Ground). |
| | • Contact Information | Enter the contact number(s) and frequency for the medical aid station(s). |
| 5. | Transportation | Enter the following information for ambulance services available to the incident: |
| | • Name | Enter name of ambulance service. |
| | • Location | Enter the location of the ambulance service. |
| | • Contact Information | Enter the contact number(s) and frequency for the ambulance service. |
| 6. | Hospitals | Enter the following information for hospital(s) that could serve this incident: |
| | • Name | Enter hospital name and identify any predesignated medivac aircraft by name a frequency. |
| | • Address Lat/Long | Enter the physical address of the hospital and the latitude and longitude if the hospital has a helipad. |
| | • Contact Information | Enter the contact number(s) and/or communications frequency(s) for the hospital. |
| | • Travel Time | Enter the travel time by air and ground from the incident to the hospital. |
| | • Trauma Center | Indicate yes and the trauma level if the hospital has a trauma center. |
| | • Burn Center | Indicate (yes or no) if the hospital has a burn center. |
| • Helipad | Indicate (yes or no) if the hospital has a helipad. Latitude and Longitude data format need to compliment Air Operations. | |
| 7. | Special Medical Emergency Procedures | Note any special emergency instructions for use by incident personnel, including (1) who should be contacted, (2) how should they be contacted; and (3) who manages an incident within an incident due to a rescue, accident, etc. Include procedures for how to report medical emergencies. |
| 8. | Prepared by | Enter the name, ICS position/title, and signature of the person preparing the form. |
| 9. | Approved by (Safety Officer) | Enter the name of the person who approved the plan, typically the Safety Officer. Enter date (month/day/year) and time reviewed (24-hour clock). |
| | • Name • Position/Title • Signature • Date/Time | |

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| | | |
|-------------------|-----------------------|---|
| 1. Incident Name: | 2. Incident Location: | 3. Operational Period (Date/Time): From: _____ To: _____ |
|-------------------|-----------------------|---|

| 4. Medical Aid Stations: | | | |
|--------------------------|----------|---------------------|--|
| Name | Location | Contact Information | Paramedics Onsite? |
| | | | <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 |

| 5. Transportation: | | | |
|--------------------|----------|---------------------|---|
| Ambulance Service | Location | Contact Information | 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 |

| 6. Hospitals: | | | | | | | |
|---------------|--------------------------------|---------------------|-------------|--------|---|---|---|
| Name | Address Lat/Long if Helipad | Contact Information | 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 |

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|--|
| 7. Special Medical Emergency Procedures: |
|--|

| | | | |
|-----------------|-------|-----------|------------|
| 8. Prepared by: | Name: | Position: | Signature: |
|-----------------|-------|-----------|------------|

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| 9. Reviewed by: (Safety Officer) |
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|-------|-----------------|------------|------------|
| Name: | Position Title: | Signature: | Date/Time: |
|-------|-----------------|------------|------------|