



MEDICAL PLAN

ICS 206

1. INCIDENT/EVENT NAME				2. OPERATIONAL PERIOD From (Date and Time): To (Date and Time):							
3. MEDICAL AID STATIONS											
Name	Location	Contact Person	Contact Number(s)	With Paramedics?		Remarks					
				Yes	No						
4. AMBULANCE/ MEDICAL TRANSPORTATION SERVICES											
Name	Location	Contact Person	Contact Number(s)	Level of Service		Remarks					
				BLS	ALS						
5. HOSPITALS											
Name	Location	Contact Person	Contact Number(s)	Travel Time		With Trauma Center?		With Burn Center?		With Helipad?	
				Air	Land	Yes	No	Yes	No	Yes	No
6. MEDICAL EMERGENCY PROCEDURES											
<p>___ Check if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations Branch.</p>											
7. Prepared by MEDL		Name and Signature:		Date Prepared:		Time Prepared:					
8. Reviewed by SOFR		Name and Signature:		Date Reviewed:		Time Reviewed:					