



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

Check if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations Branch.

7. Prepared by MEDL	Name and Signature:	Date Prepared:	Time Prepared:		
8. Reviewed by SOFR	Name and Signature:	Date Reviewed:	Time Reviewed:		