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