TASK FORCE MEDICAL PLAN (TF 206)

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 & Longitude if Helipad	Contact Number(s)/ Frequency	Travel Time		Trauma Center	Burn Center	Helipad
			Air	Ground			
					☐ Yes Level:_____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:_____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:_____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:_____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:_____ ☐ No	☐ 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 : Name: _____ Signature: _____

8. Approved by (Safety Officer)**:** Name: _____ Signature: _____

TF 206		Date/Time: _____