

<b>MEDICAL PLAN</b>	<b>1. INCIDENT NAME</b>	<b>2. DATE PREPARED</b>	<b>3. TIME PREPARED</b>	<b>4. OPERATIONAL PERIOD</b>		
<b>5. INCIDENT MEDICAL AID STATION</b>						
<b>MEDICAL AID STATIONS</b>	<b>LOCATION</b>					<b>PARA MEDICS?</b>
						<b>YES</b>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
<b>6. TRANSPORTATION</b>						
<b>A. AMBULANCE SERVICES</b>						
<b>NAME</b>	<b>ADDRESS</b>			<b>PHONE</b>	<b>PARA MEDICS?</b>	
					<b>YES</b>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
<b>B. INCIDENT AMBULANCES</b>						
<b>NAME</b>	<b>LOCATION</b>					<b>PARA MEDICS?</b>
						<b>YES</b>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
<b>7. HOSPITALS</b>						
<b>NAME</b>	<b>ADDRESS</b>	<b>PHONE</b>	<b>TRAVEL TIME</b>	<b>TRAUMA CENTER?</b>	<b>HELIPAD ?</b>	<b>BURN CENTER?</b>
				<b>YES</b>	<b>YES</b>	<b>YES</b>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. MEDICAL EMERGENCY PROCEDURES</b>						
<b>9. PREPARED BY (MEDICAL UNIT LEADER)</b>				<b>10. REVIEWED BY (SAFETY OFFICER)</b>		