| HICS_blue.epsHICS_blue.eps**1. Incident Name** | 2. Operational Period (# )  DATE: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |
| **3. Treatment Areas** |
| **Area Name** | **Location** | **Unit / Team Leader Contact number / Channel** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **4. Resources On Hand** (numbers) |
| **Staff** | **Transportation Devices** | **Medication** | **Supplies** |
| MD/DO  | Litters  |  |  |
| PA/NP  | Portable Beds  |  |  |
| RN/LPN  | Gurneys  |  |  |
| Technicians/can | Wheelchairs  |  |  |
| Ancillary/Other  | Evac. Assist Devices |  |  |

|  |
| --- |
| **5. Transportation** (indicate air or ground) |
| **Ambulance, Bus, Van, Private Vehicle, Air** | **Location** | **Contact Number / Frequency** | **Level of Service** |
|  |  |  | ⬜ ALS ⬜ BLS |
|  |  |  | ⬜ ALS ⬜ BLS |
|  |  |  | ⬜ ALS ⬜ BLS |
|  |  |  | ⬜ ALS ⬜ BLS |
|  |  |  | ⬜ ALS ⬜ BLS |
| **6. Alternate Care Site(s)** |
| **FACILITY NAME** | **ADDRESS** | **CONTACT NUMBER / FREQUENCY** | **SPECIALTY CARE** (SPECIFY) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **7. Special Instructions** |
| **8. Prepared by**  | PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE/TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **9. Approved by** | PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE/TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Purpose: The HICS 206 - Staff Medical Plan addresses the treatment plan for injured or ill staff members and / or volunteers. The HICS 206 provides information on staff treatment areas, resources on-hand, transportation services, and special instructions.

ORIGINATION: Prepared by the Logistics Section Employee Health and Well-Being Unit Leader

COPIES TO: Duplicate and provide to all recipients as part of the Incident Action Plan (IAP). Information from the plan pertaining to staff treatment areas and special instructions may be noted on the Assignment List (HICS 204). All completed original forms must be given to the Documentation Unit Leader.

Notes: If additional pages are needed, use a blank HICS 206 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

| NUMBER | TITLE | INSTRUCTIONS |
| --- | --- | --- |
| **1** | **Incident Name** | Enter the name assigned to the incident. |
| **2** | **Operational Period** | Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies. |
| **3** | **Treatment Areas** | Enter the name of the treatment area, the location, and the contact numbers.  |
| **4** | **Resources On Hand** | Enter the number of listed resources that are available and assigned to the treatment areas. |
| **5** | **Transportation**  | Enter the information for transportation services available to the incident. |
| **6** | **Alternate Care Site(s)** | Enter the information for alternate care sites that could serve this incident. |
| **7** | **Special Instructions** | Note any special emergency instructions for use by incident personnel, including who should be contacted, how should they be contacted; and who manages an incident within an incident due to a rescue, accident, etc.  |
| **8** | **Prepared by** | Enter the name and signature of the person preparing the form, typically the Employee Health and Well-Being Unit Leader. Enter date (m/d/y), time prepared (24-hour clock), and facility. |
| **9** | **Approved by** | Enter the name of the person who approved the plan. Enter date (m/d/y), time reviewed (24-hour clock), and facility. |