

# MEDICAL PLAN

Mission Number	Operational Period	Date	Time
- -			

## Medical Emergency Procedures


## Available Medical Personnel and Special Equipment

Name / Equipment	Team #	Location	Credentials

## Available Transportation to Medical Facilities

Name of Transport	Location	Phone Number	Paramedic	EMT
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

## Area Medical Facilities

Name	Location	Phone Number	Travel Time Ground	Travel Time Air	Helipad
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

	Name	Title
<b>Prepared by</b>		
<b>Reviewed by</b>		