|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **INCIDENT NAME** |  | | | | | | 1. **OPERATIONAL PERIOD** | | | | | |
| **DATE: FROM:**       **TO:**  **TIME: FROM:**       **TO:** | | | | | |
| 1. **TREATMENT AREAS** | | | | | | | | | | | | |
| **AREA NAME** | | | **LOCATION** | | | | | | **TEAM LEADER & ALTERNATE CONTACT NUMBER** | | | |
|  | | |  | | | | | |  | | | |
|  | | |  | | | | | |  | | | |
|  | | |  | | | | | |  | | | |
| 1. **RESOURCES ON HAND (numbers)** | | | | | | | | | | | | |
| **STAFF** | | **TRANSPORTATION DEVICES** | | | | **MEDICATION** | | | | **SUPPLIES** | | |
| MD/DO | | LITTERS | | | |  | | | |  | | |
| PA/NP | | PORTABLE BEDS | | | |  | | | |  | | |
| RN/LPN | | GURNEYS | | | |  | | | |  | | |
| TECHNICIANS | | WHEELCHAIRS | | | |  | | | |  | | |
| ANCILLARY/OTHER | | EVAC. ASSIST DEVICES | | | |  | | | |  | | |
| 1. **TREATMENT RESOURCES (EXTERNAL)** | | | | | | | | | | | | |
| **NAME** | | | | | **PHONE** | | | **ADDRESS** | | | | |
| **MD/DO** | | | | |  | | |  | | | | |
| **NEAREST HOSPITAL/EMERGENCY ROOM** | | | | |  | | |  | | | | |
| **TREATMENT RESOURCES (EXTERNAL) continued…** | | | | | | | | | | | | |
| **NAME** | | | | | **PHONE** | | | **ADDRESS** | | | | |
| **ALTERNATE HOSPITAL/EMERGENCY ROOM** | | | | |  | | |  | | | | |
| **OCCUPATIONAL HEALTH CLINIC** | | | | |  | | |  | | | | |
| 1. **TRANSPORTATION** | | | | | | | | | | | | |
| **AMBULANCE, BUS, VAN, PRIVATE VEHCILE, AIR** | | **LOCATION** | | | | **CONTACT NUMBER** | | | | **LEVEL OF SERVICE** | | |
|  | |  | | | |  | | | | **ALS**  **BLS** | | |
|  | |  | | | |  | | | | **ALS  BLS** | | |
|  | |  | | | |  | | | | **ALS  BLS** | | |
|  | |  | | | |  | | | | **ALS  BLS** | | |
| 1. **ALTERNATE CARE SITE(S)** | | | | | | | | | | | | |
| **FACILTIY NAME** | | **ADDRESS** | | | | **CONTACT NUMBER** | | | | **SPECIALTY CARE (SPECIFY)** | | |
|  | |  | | | |  | | | |  | | |
|  | |  | | | |  | | | |  | | |
|  | |  | | | |  | | | |  | | |
| 1. **SPECIAL INSTRUCTIONS** | |  | | | | | | | | | | |
| 1. **PREPARED BY SAFETY OFFICER** | | **PRINT NAME:** | |  | | | | **SIGNATURE:** |  | |  | |
| **DATE/TIME:** | |  | | | | **FACILITY:** |  | |  | |
|  | |  | | | |  |  | | |  |
| 1. **APPROVED BY** | | **PRINT NAME:** | |  | | | | **SIGNATURE:** |  | |  | |
| **DATE/TIME:** | |  | | | | **FACILITY:** |  | |  | |
|  | |  | | | |  |  | | |  |

**INSTRUCTIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **PURPOSE:** | | Addresses the treatment plan for injured or ill staff members and / or volunteers. The NHICS 206 provides information on staff treatment areas, resources (external), transportation services, and special instructions. | |
| **ORIGINATION:** | | Safety Officer | |
| **COPIES TO:** | | All IMT staff | |
| **NOTES:** | | If additional pages are needed, use a blank NHICS 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** | **Treatment Resources (External)** | | Enter the contact information for external treatment resources. |
| **6** | **Transportation** | | Enter the information for transportation services available to the incident. |
| **7** | **Alternate Care Site(s)** | | Enter the information for alternate care sites that could serve this incident. |
| **8** | **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. |
| **9** | **Prepared by Safety Officer** | | Enter the name and signature of the person preparing the form, typically the Safety Officer. Enter date (m/d/y), time prepared (24-hour clock), and facility. |
| **10** | **Approved by** | | Enter the name of the person who approved the plan. Enter date (m/d/y), time reviewed (24-hour clock), and facility. |