|  |  |  |
| --- | --- | --- |
| 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. |