STAFF MEDICAL PLAN



1. INCIDENT NAME				
2. DATE PREPARED	3. TIME PREPARED		4. OPERATIONAL PERIOD DATE / TIME	
2. DATE FILL AND	3. HIVIE PHERAILED		4. OF ENATIONAL PENIOD DATE / THINE	
5. TREATMENT OF INJURED / ILL STA	AFF			
Location of Staff Treatment Area		Contact Information	on	
Treatment Area Team Leader		Contact Information	on	
Special Instructions				
				······
				·····-
6 DECOUDERS ON HAND				
6. RESOURCES ON HAND	AAFDIGAL TRANSPORTATION	AFRICATION	CURRUEO	
STAFF	MEDICAL TRANSPORTATION	MEDICATION	SUPPLIES	
MD/DO PA/NP	Litters Portable Beds			
				·····
RN/LPN	Transport Wheelchairs			·····
Technicians/CN	vvneeichairs			
Ancillary/Other				
7. ALTERNATE CARE SITE(S)				
NAME	ADDRESS	PHONE	SPECIALTY CARE (SPECIFY)	
				······
				······
				······
8. PREPARED BY (SUPPORT BRANCH DIRECTOR)		9. FACILITY NAME		