# MEDICAL PLAN

| Mission Number | Operational Period | Date | Time |
|---|---|---|---|
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**Medical Emergency Procedures**

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**Available Medical Personnel and Special Equipment**

| Name / Equipment | Team # | Location | Credentials |
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**Available Transportation to Medical Facilities**

| Name of Transport | Location | Phone Number | Paramedic | EMT |
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| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

**Area Medical Facilities**

| Name | Location | Phone Number | Travel Time Ground | Travel Time Air | Helipad |
|---|---|---|---|---|---|
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| | Name | Title |
|---|---|---|
| Prepared by | | |
| Reviewed by | | |