ANNEX A

DAVIS COUNTY MEDICAL INCIDENT RESPONSE PLAN

Davis County EMS

Davis County Sheriff
South Davis Metro Fire
Farmington Fire
Kaysville Fire
Layton Fire
Clearfield Fire
Syracuse Fire
Clinton Fire
Sunset Fire
South Weber Fire
Davis Hospital
Lakeview Hospital

MEDICAL INCIDENT RESPONSE PLAN

This Plan identifies emergency medical response disaster protocols and procedures in Davis County. All EMS providers in Davis County should familiarize themselves with this plan through training and exercising. It is the purpose of this plan to formally standardize disaster medical operations within Davis County. This plan will follow the National Incident Management System (NIMS) command structure. By doing so, all jurisdictions that respond to a medical disaster in Davis County will do so in a fully integrated manner thus enhancing resource effectiveness and efficiency. The plan is divided into three Areas or Protocols: 1) On-scene, 2) Casualty Collection Points (CCP), and 3) Mass Casualty Trailers (MCI trailers).

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MEDICAL PLAN OVERVIEW

This Plan is a joint effort between all EMS providers in Davis County. It identifies and outlines emergency medical response disaster protocols and procedures in Davis County. All EMS providers in Davis County should familiarize themselves with this plan through training and exercising.

The purpose of this plan is to formally standardize disaster medical operations within Davis County. By doing so, all jurisdictions that respond to a medical disaster in Davis County will do so in a fully integrated manner thus enhancing resource effectiveness and efficiency. This plan will follow the National Incident Management System (NIMS) command structure. The goal is to make response to a Mass Casualty Incident in Davis County, a standardized procedure complete with guidelines which all EMS providers are familiar with, and can subscribe to. This will decrease confusion at an incident because only one system will be used for response throughout the county, no matter the jurisdiction.

The plan is divided into three Areas or Protocols:

1) On-scene
2) Casualty Collection Points (CCP), and
3) Mass Casualty Trailers (MCI trailers).

The On-scene Protocol describes:

5 levels of MCI response
Standard Operating Guidelines for resources on-scene ICS
Medical Branch Positions
Documentation Forms

The Casualty Collection Points (CCP) Protocol describes:
Activation of the CCPs

The On-scene Protocol and the MCI trailers are used by EMS responders at a single site Mass Casualty Incident. The Casualty Collection Point Protocol is for use by a city or the county to gather injured victims from a widespread incident. The CCP Protocol is only activated by a city or county EOC. It is a location where citizens can gather wounded from all around the city(ies) or county, and have a single community site where citizens can transfer the wounded over to the EMS system.

ON-SCENE PROTOCOL

Introduction:

The "On-Scene Protocol" of the Davis County Medical Incident Response Plan outlines a specific on-scene management system. The Plan includes a triage system which will be consistently applied in all mass casualty incidents in the county, by all jurisdictions and agencies responsible for, or supportive of, emergency medical services. The On-Scene Protocol is comprised of five (5) levels:

- Level 1 - Medical Priority Dispatch 1- 5 Patients
- Level 2 - Expanded Medical Emergency 6 - 15 Patients
- Level 3 - Major Medical Emergency 16 - 35 Patients
- Level 4 - Medical Disaster 36+ Patients
- Level 5 - CCP Activation EOC Activated

Level 1, Emergency Medical is a normal day-to-day operational response and is **not** a declaration of extraordinary circumstances. However, for clarity and consistency, normal day operational response needs to be defined within the on-scene protocol for comparison and to demonstrate where it fits operationally within the overall incident response plan. Level 2 - Expanded Medical Emergency , Level 3 - Major Medical Emergency, Level 4 - Medical Disaster protocols, and Level 5 - CCP Activation, **are** a declaration of an extraordinary medical situation requiring additional resources and formalized ICS medical branch positions.

Response levels 1 through 4 are protocols which are formally declared by on-scene commanders or medical supervisors to alert dispatch that additional resources will be required. Commanders will communicate the response level information to dispatch. The levels are determined by the number of casualties at an incident, and Commanders/Medical Supervisors will formally *"declare"* the incident.

Response Level 5, CCP Activation, is part of the on-scene protocol that denotes an extremely extraordinary medical incident that affects a large area, and possibly the entire county. However, this response level, is not declared by an on-scene commander, but rather, it is declared by a city or county Emergency Operations Center (EOC). The EM functional representative in the EOC should be able to declare level 5, but only after counseling with the Chief Elected Official.

Note: ***Refer to the appropriate response level on the following pages for resource guidelines.***

Summary:

Level 1 – Medical Priority Dispatch	Normal day-to-day operations. Declared by dispatch and confirmed by ICS
Level 2 - Expanded Medical Emergency Level 3 - Major Medical Emergency Level 4 - Medical Disaster	Declared by Incident Command, confirmed by dispatch. Extraordinary circumstances requiring additional resources, and notifications. Mass Casualty Incident trailers are deployable at these levels.
Level 5 - CCP Activation	EOC Activated. Activates one or more Casualty Collection Points in the county.

Operational Guidelines

The following response levels have been developed for "Mass-Casualty Incidents" and correspond with all jurisdictional response plans within Davis County.

Level # - Name of protocol	Number of patients/Who declares	
Level 1 - Medical Priority Dispatch	1 - 5 Patients	/ Dispatch
Level 2 - Expanded Medical Emergency	6 - 15 Patients	/ On-scene command
Level 3 - Major Medical Emergency	16 - 35 Patients	/ On-scene command
Level 4 - Medical Disaster	36+ Patients	/ On-scene command
Level 5 - CCP Activation	Non-specific	/ City or County EOC

Declaration of a Response Level

First arriving responders must declare and communicate the response level to Dispatch. The level is dependent upon the number of casualties (for levels 1-4) and will guide resource allocation to the incident if the protocol is followed correctly. Responders and dispatchers should refer to the appropriate resource guidelines which will be outlined later.

Level 1

Dispatch will declare Level 1 emergencies. Level 1 emergencies are normal day-to-day operations and need only be dispatched following the guidelines established by the medical priority dispatch system. The “Level 1" emergency response need not be formally declared. It is normal day-to-day medical response.

Level 2 - 4

Dispatchers can and should indicate to first responders what level of incident that they may be responding to if the numbers of injured are greater than a Level 1 emergency. 911 call takers are generally the first to receive such information and should inform dispatchers of the potential for a higher level response if so indicated by the caller. ***On-scene command will declare levels 2 - 4. If dispatch notifies first responders while they are enroute that an incident may be a high level response, then those first responders, while en route, have the option of requesting additional resources at that time.*** This will depend upon the

information coming from what they deem to be reliable sources. However, only upon arrival of the first responding units, will the actual level be officially declared**.** It is important to note that the actual response level is not officially declared until a trained public safety responder is on scene. ***On-scene responders do not declare a Level 5.*** Resources outlined in levels 1-4 are suggested. On-scene Commanders have the option of requesting more or fewer resources as outlined here-in.

Level # - Name of protocol	**Who declares**
Level 1 - Medical Emergency	Dispatch
Level 2 - Expanded Medical Emergency	On-scene command
Level 3 - Major Medical Emergency	On-scene command
Level 4 - Medical Disaster	On-scene command
Level 5 - CCP Activation	City or County EOC

Level 5
A Level 5 emergency, Casualty Collection Point (CCP) Activation, will only be declared by a City or County Emergency Operations Center. *The determination for activation of a CCP is not "numbers" oriented; i.e., determined by the number of victims, but rather, it is determined by the severity of the incident.* A Level 5 emergency will be characterized by an incident that 1) effects the entire county, 2) has overwhelmed the EMS system **and** both hospitals in the county, 3) disrupts transportation of injured to the hospitals, and 4) hinders ability of hospital workers to report to their duty stations at the hospitals. The activation of a Level 5 medical response would be due to a catastrophic event that basically effects the entire county. It would also, more than likely, require the intervention of State resources and possibly federal response resources from the U.S. Public Health Services.

If a Level 5 emergency is declared, then a CCP Commander will be dispatched to that site. This will usually be an engine company or medic unit depending upon the availability of resources. Citizens who are C.E.R.T. volunteers will assist at these CCPs and will be under the direction of a Branch Director. If such a director is not available, then the most qualified C.E.R.T. volunteer will command the site until such time as a qualified replacement arrives. A qualified replacement is an EMT or Paramedic who is familiar with and understands the mission and capabilities of the C.E.R.T. program. CCPs are, but not limited to the pre-determined Points of Distribution (PODs) which can be found on pages 56-60 in this plan.

<u>On-scene Resources</u>
The intent of the On-scene Protocol is to create an easy method whereby resources can be requested by on-scene commanders. ***By creating this protocol, dispatch can easily anticipate additional resources that Commanders will need by referring to the checklists provided for each response level. All that an on-scene Commander need do, is to declare the type of incident and dispatch can automatically deploy an additional predetermined number and type of resources as outlined in this plan unless otherwise instructed by the IC.*** This is based upon the procedure that on any given call, dispatch will use the medical priority system which does not delineate numbers of resources. Standard dispatch is "no more than, 1 engine, 1 rescue and 1 ambulance." All response levels will take this "base" number, and will direct dispatch to deploy "additional" resources. "Additional" resources are in addition to this initial Level 1 dispatch. Therefore, for example, an "additional 2 engines" will mean that there will be 3 engines on site because of the initial Level 1 dispatch. Commanders do retain the right to request additional or fewer resources than outlined in this plan.

Additionally, the On-scene Protocol provides for the planning, maintenance, and use (deployment) of Mass Casualty Incident (MCI) Trailers. These trailers will be staged strategically throughout the county and will be a quick response support to an incident commander for medical supplies at an MCI. These trailers will be stocked with supplies sufficient to handle 15 victims. There will be 3 trailers, all of which can be requested at an incident if necessary.

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Note: Refer to the appropriate response levels on the following pages for resource guidelines.

Summary - On-scene Resources

Level 1 - Medical Priority Dispatch (1-5)

- Medical Priority Dispatch
    - Usually this is 1 Engine Company, 1 Medic unit, 1 Ambulance
- All subsequent levels listed below are based upon initial dispatch "plus" additional resources
    - All subsequent levels are based upon Level 1 resources being present
    - All subsequent levels assume initial dispatch of a *complete* Level 1 response
- IC can request additional resources without moving to a higher level (ie request 1 ambulance)

Level 2 - Expanded Medical Emergency (6-15)

- Deploy an *additional* 1 Engine Company, 1 Medic Unit, 3 Ambulances, 3 Chief Officers
    - This will make a total deployment of 2 engines, 4 ambulance, 2 Medic Units, and 3 Chief Officers onsite.
- Deploy 1 EMS Helicopter (Designate a landing zone / Standby fire engine for safety)
- Notify Hospitals

Level 3 - Major Medical Incident (16-35)

- Deploy an *additional* 2 Engines, 2 Ambulances, and 1 Medic Unit, 1 Chief Officer,
    - This will make a total deployment of 4 engines, 6 ambulances, 3 Medic Units, and 4 Chief Officers onsite
- Deploy 2 EMS Helicopters (Designate a landing zone / Standby fire engine for safety)
- Deploy 1 MCI Trailers
- Deploy 1 UTA/School Bus
- Deploy MCC Unit (Mobile Command Center)
- Notify out of County Hospitals and obtain a bed count if possible
- Note:
    - Consider additional air ambulance and/or UTA/School buses
    - Notify Red Cross
    - Consider additional MCI Trailer (2^{nd} trailer)

Level 4 - Medical Disaster (36+)

- Deploy an *additional* 3 Engines, 3 Ambulances, 3 Medic Units, 2 Chief Officers
    - This will make a total deployment of 7 Engines, 9 Ambulances, 6 Medic Units, 6 Chief Officers onsite.
- Deploy 4 EMS Helicopters (Designate a landing zone / Standby fire engine for safety)
- Deploy 2 MCI Trailers
- Deploy 2 UTA/School buses
- Deploy MCC (Mobile Command Center)
- Notify out of County Hospitals and obtain a bed count if possible
- Note:
    - Place additional air ambulances on stand-by
    - Consider additional MCI trailer as necessary
    - Consider Scene Support units
    - Notify Red Cross

Level 5 - CCP Activation (Non-specific)

– EOC Activated (City or County)
-- Deploy EMS Resources as available to activated sites
-- Deploy at least one engine company and/or Medic Unit if possible to CCP
-- Establish a Branch Supervisor for the CPP

Recommended Triage Principles

RECOGNITION OF THE ADOPTION OF THE S.T.A.R.T. PROGRAM FOR TRIAGE

Davis County officially adopts the S.T.A.R.T. Triage system (Simple Triage and Rapid Transport) as the triage system to be used **during** a disaster situation. The objective of triage is to accomplish the greatest medical good for the greatest number of patients. S.T.A.R.T. is not used for normal daily protocol.

A primary goal of triage is to select the patients in greatest need of urgent care. It is recognized that triage in a mass casualty situation offers little time or resources for doing CPR, taking blood pressures, or even counting accurate pulse rates. However, minimal intervention to stabilize the airway or to control hemorrhage is done at the same time as the initial triage.

S.T.A.R.T. Triage allows the first responders to triage patients in 60 seconds or less, depending on three simple observations. These physical assessments are:

Respiration;
Pulse, and;
Mental Status.

The S.T.A.R.T. plan does ***not attempt to make diagnoses.***

Triage personnel must tag **ALL** patients. **IT IS A TIME CONSUMING AND OFTEN FATAL MISTAKE TO TRIAGE IN THE FIELD WITHOUT TAGGING A PATIENT.** Patients are tagged so that rescuers arriving later can immediately turn their attention to the patients most in need. A triage tag has been adopted by this jurisdiction in conjunction with the State Department of Health.

Triage personnel must rate or place the injured into one of four categories:

Category		Tag
1. Immediate	-	Red Surveyor Tape
2. Delayed	-	Yellow
3. Minor	-	Green
4. Deceased (non salvageable)	-	Black or Black/White Stripe

Immediate: Ventilation present only after positioning the airway;
OR respirations over 30 per minute;
OR radial pulse not present and/or perfusion greater than 2 seconds;
OR patient fails to follow simple commands.

Delayed: Any patient who does not fit either the immediate or minor categories.

Minor: These patients are separated from the general group at the start of triage by ordering, "Anyone who can walk...," followed by an area assignment for the patients to walk to. These patients are ambulatory and can move out of the triage area into an assigned treatment area or they can even be asked to assist medical personnel.

Deceased: No ventilation present even after attempting to position the airway **twice.**

NOTE: ***There is only one Triage Officer per 10 victims. This is a very important concept.***

"Immediate" Category

Patients designated as "Immediate," are those that have life threatening injuries that are correctable, and with immediate definitive care, their life can be saved. These are the Golden Hour Patients.

Basic S.T.A.R.T. triage defines immediate as :

Respiration- Greater than 30/min. or less than 10/min. and where the airway must be physically or mechanically maintained.

OR:

Pulse- Absent radial pulse.

OR:

Mental- Fails to follow simple commands.

NOTE: ***These patients are tagged "Red."***

"Delayed" Category

Patients designated as "Delayed," are those requiring therapy, but can be delayed without significant risk to life or limb. In addition, where resources are truly overwhelmed, those patients whose chances of survival are not dependent on extensive and/or highly sophisticated procedures to sustain life.

Basic S.T.A.R.T. triage defines Delayed as :

Ventilation- Between 10 and 30/min.

AND:

Radial Pulse- Radial pulse present.

AND:

Mental-Status Follows simple commands - Non-ambulatory.

NOTE: ***These patients are tagged "Yellow."***

"Minor" Category

Patients classified as "Minor," are those whose therapy, if required, can be delayed with little risk to life or limb. In addition, where the mechanism of injury warrants a complete physical assessment, patients should be offered, and, a complete physical performed. These patients may not require, or may refuse, transport to a hospital for a complete physical; however, documentation should be completed prior to release. These patients are also sometimes referred to as the "Walking Wounded."

Basic S.T.A.R.T. defines Minor as :

Ventilation-	Between 10 and 30/min.
AND:	
Radial Pulse-	Radial pulse present.
AND:	
Mental-Status	Follows simple commands - Ambulatory.

A simple triage methodology in a multi-casualty situation used to identify "minor" status victims, is to yell out to the victims, "Anyone who can hear me and walk, come to me." Other quick methods to separate or sort the "greens" from the rest of the injured may be used. This example is just an illustration of one quick method to separate out the "walking wounded," or "greens."

NOTE: ***These patients are tagged "Green."***

Reverse Triage / Inverted Triage Situations

Although S.T.A.R.T is extremely effective in most triage situations, there are occasions were "Reverse Triage" or "Inverted Triage" may play a vital role in treating the most viable victims first that would otherwise be sorted less effectively.

This form of triage has regained much popularity in countries inflicted with terror incidents involving explosive devises such as IED's and countries commonly impacted by pandemics and other disease outbreaks. Note: This form of triage does not follow a single set criteria, however, is dynamic in nature. Example: The reverse triage process for multiple victims involved in an "IED" incident is considerably different from the process used for multiple victims involved in a "Lightening Strike" incident. This process must be announced by the individual declaring "Reverse Triage" or "Inverted Triage".

In the event "Reverse Triage" or "Inverted Triage" is declared, it must be announced by Incident Command ASAP. Failure to declare this strategy early into an incident will compromise the effectiveness of the entire triage operations.

IED / Explosives - Incidences involving explosives and/or suspected secondary devices designed to target rescue responders. Rapidly removing all ambulatory victims to a "Safe Zone" or "Treatment Area" away

from the scene as 1st priority will greatly increase the overall survivability of all victims. Non-ambulatory victims become secondary priority. This will aid in the reduction of potential secondary device victims, while allowing security forces establish a safer perimeter to protect victims and rescuers from additional attacks while providing ongoing searches for secondary devices. This form of Triage places priority on "mobility" of patients regardless of regular triage criteria.

Pandemic - Situations where medical personnel are potentially among affected population. Regardless of triage status, it may be advantageous to ensure medical personnel are treated as "Priority" so they may continue providing care. This especially applies when dispensing vaccines or other medications. Healthcare providers should receive priority treatment whenever possible, regardless of symptomatic status.

Lighting Strikes - Involving multiple victims – Victims without a pulse potentially have a higher chance of survival if treated immediately even though they would normally be classified as "Deceased" or meet "Black" triage criteria. This triage process would require treating "Pulseless" victims as first priority.

Cold Water - Involving multiple victims – Victims without a pulse potentially have a higher chance of survival when BLS treatment is rendered immediately even though they would normally be classified as "Deceased" or meet "Black" triaging criteria. This triage process would require treating "Pulseless" victims as first priority.

Mass-Casualty Incident Treatment Tag "Example"

Instruction / Sample

Note: The treatment tags are numbered. The numbers will be used for patient tracking and documentation. These tags are intended for use in the treatment areas.

Shade in injury site or sites.

Circle type of injury(s).

Other: Briefly write in explanation of injury(s).

Vital Signs:

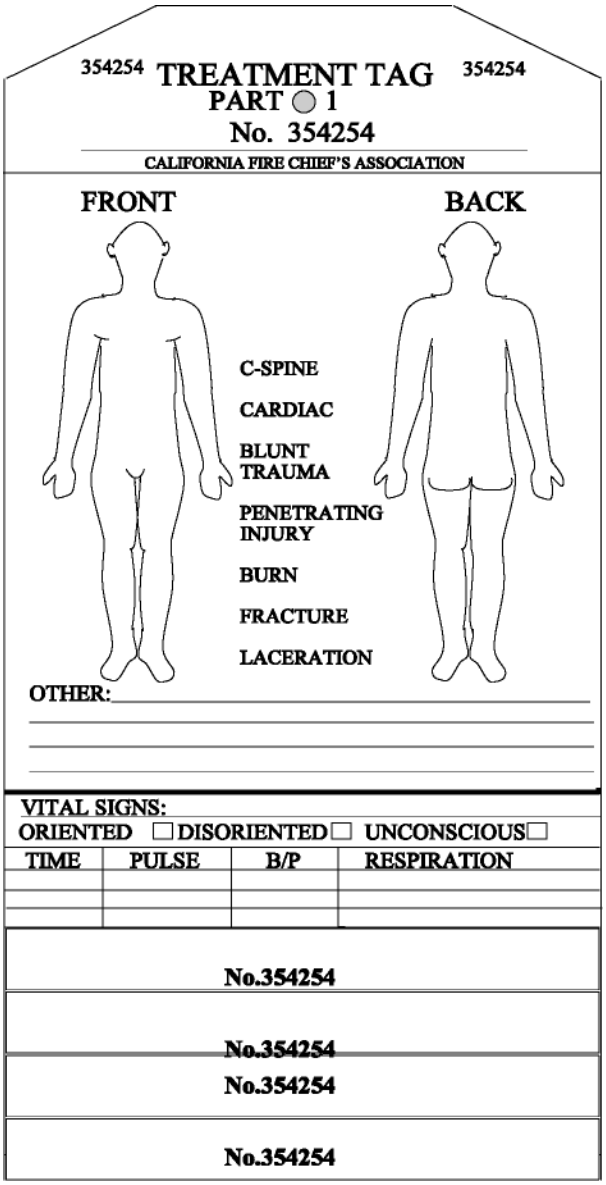
Fill in the time vitals were taken. Blood pressure/Pulse/Respirations. *Keep the stub you tear off so the patient can be tracked after transport.*

The tags will be a single color. **Patient triage is indicated by colored surveyor tape, not the tag.**

Number on the tag is used for patient tracking. When a patient is moved through a treatment or transportation area, then a supervisor, or worker can remove the most bottom portion of the tag, and retain it for documentation.

Documentation will include, writing the time of patient transfer on the *retained part of the tag.* Other information could include transport name and number as well as destination.

Note: This will not replace official documentation on ICS forms, or upon the State MICU/Polaris form. But, it will help facilitate such documentation.



SAMPLE CONTINUED...
Information should be filled out by personnel at the Treatment Station

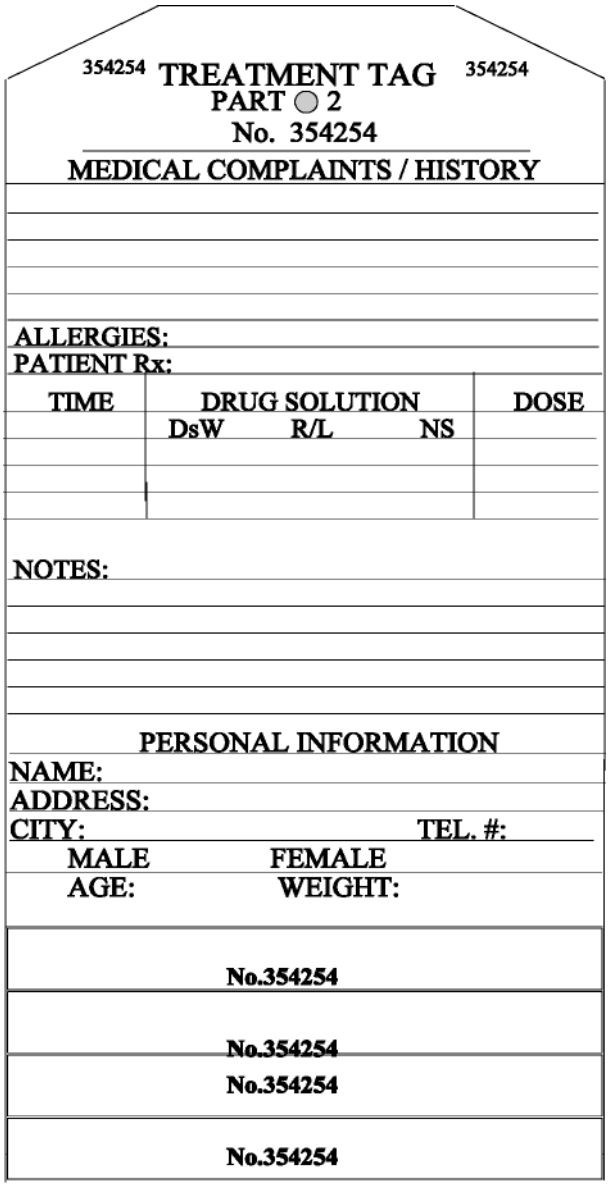
Brief complaints/history
Medical Problems

Allergies to medications

What medication is the patient taking?

What treatment is the patient being given?

Patient information if available



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Documentation will include, writing the time of patient transfer on the retained part of the tag. Other information could include transport name and number as well as destination. Note: This will not replace official documentation on ICS forms or the State MICU/Polaris Form, but, it will help facilitate such documentation.

Mortality Management Guidelines During Disaster Operations

In the event of a major disaster within the State of Utah, it may be some time before bodies can be collected and cared for by the Office of the Chief Medical Examiner.

Therefore, the following guidelines have been prepared to aid local agencies in handling the dead until the OME can relieve those agencies of that responsibility.

Handling the Dead

When it becomes necessary to remove bodies from disaster sites due to rescue work, or health and safety of others, a set of specific procedures must be followed:

1. DO NOT remove any personal effects from the body. The personal effects must remain with the body at all times.

2. Attach tag or label to the body with the following information:
    a. Date and time found
    b. Exact location where found, including floor/room number.
    c. Name/address of deceased, if known
    d. If identified, how and when
    e. Name/phone of the person making identity and/or filling out tag
    f. If the body is contaminated, so state

3. Place the body in a disaster pouch, or in plastic sheeting, and securely tie to prevent unwrapping. Attach a second tag to the sheeting or pouch.

4. If personal effects are found and are thought to belong to a body, place them in a separate container and tag. Do not assume any loose effects belong to a body. Document location where they were found.

5. Move the properly tagged body with their personal effects to one locale, i.e., garage or other cool building, preferably one with refrigeration.

    ***Note:** **Portable air-conditioning may be obtained or self-contained refrigerated van/trucks or rail cars can be used. Do not use a vehicle or storage area with floors that can become permeated with body fluids or other liquids**.*

6. Notify your local law enforcement agency of the location/identity of the body.

7. Keep insects and other animal life away from the body. In case of extreme heat or direct sunlight, move the body to a cool shaded area or refrigerated room as soon as possible.

8. Bodies must be secured or safeguarded at all times, even after the arrival of the OME or his authorized representative. Security at all times must be coordinated with local Law Enforcement and the OME.

Response Levels 1-5 Medical Branch Checklists

The following checklists are provided as initial guidelines for first arriving EMS units. These checklists also outline the initial resources that should be sent by dispatch once a "Level" is declared. Declaration should only take place once initial responders on-scene have "declared" the MCI Level. On-scene Commanders have the option of requesting additional or fewer resources as the incident requires.

The guidelines will be used ***automatically*** by dispatch to deploy or dispatch additional units once a level is declared, unless otherwise directed by the On-scene Command. The deployments for each level are based upon a full Level 1 deployment PLUS the additional units listed under EMS Response on each checklist. A full Level 1 deployment is 1 engine, 1 ambulance and 1 Paramedic Rescue. It is intended that the automatic dispatching of additional units based upon the level declared will assist the commander during an intense period of initial response.

The guidelines are initial actions only. On-scene command can request additional, or fewer resources as deemed necessary.

Level 1 - Medical Priority Dispatch
(1 - 5 Patients)

1. EMS RESPONSE
   - Medical Priority Dispatch
     - Baseline response is “usually” 1 Engine, 1 Ambulance, and 1 Medic Unit

2. ESTABLISH COMMAND
   - Upon arrival on-scene “declare command”
   - Radio the type of situation and "confirm the incident"
     - Establish the total number of victims and categories
   - Radio the exact location of the incident and best access route for in-coming equipment

3. QUICKLY TRIAGE AND TAG ALL PATIENTS USING THE “ S.T.A.R.T “ TRIAGE CONCEPT
   - One (1) triage officer
     - Triage officer stays with victims (mother hen concept) until all are moved to an established treatment area at the scene or until he/she transitions to treatment officer role
   - Tag patients with treatment tag if requested or coordinated with Treatment Area. If Triage Officers tag patients in the triage area with treatment tags, then Triage Officers should retain one of the detachable sections of the tag and record times for documentation.

4. DETERMINE WHAT ADDITIONAL RESOURCES ARE NEEDED
   - Additional Response determined by Incident Commander
     - Rule of thumb (Personnel):
       - 1 firefighter/EMT/PM/Responder for each immediate patient
       - 1 firefighter/EMT/Responder for each 3 delayed patients
       - 2 firefighter/ for each hose line
       - 2-3 firefighters per rescue operation (air bag, jaws, etc.)

5. QUICKLY OVERVIEW SCENE SAFETY
   - Do you have adequate medical personnel and resources?
   - Are hose lines for fire safety in place with adequate personnel?
   - Is traffic or crowd situation under control or endangering medical operations?
   - Are patients and medical response staff in unsafe locations?
   - If Hazardous Material (Firefighting)
     - Note wind direction and weather
     - Work within appropriately established cold, warm and/or hot zones
     - Stay aware/briefed on all aspects of Haz-Mat operations/hazard
     - Consider medical operations/equipment that may effect hazardous condition

6. DIRECT INCOMING PERSONNEL AND EQUIPMENT

7. COORDINATE WITH ASSISTING AGENCIES(LAW, FIRE, EMS, ECT..)

8. OVERSEE THE SITUATION AND ADJUST RESOURCES AS NEEDED

Level 2 - Expanded Medical Emergency
6 - 15 Patients

1. EMS RESPONSE
   - Deploy an *additional* 1 Engine, 3 Ambulance, and 1 Medic Unit, 3 Chief Officers
     - This will make a total deployment of 2 engines, 4 ambulances, 2 Medic Units, 3 Chief Officers onsite
   - Notify Hospitals
   - Deploy 1 EMS air ambulance

2. ESTABLISH COMMAND
   - Upon arrival at scene "declare command."
   - Radio the type of situation and "declare the incident level" (2-Expanded Medical Emergency)
     - Establish the total number of victims and categories
   - Radio the exact location of the incident and best access route for in-coming equipment
     - Establish staging and/or ingress and egress traffic plan

3. QUICKLY TRIAGE AND TAG ALL PATIENTS USING THE " S.T.A.R.T " TRIAGE CONCEPT
   - One (1) triage officer per ten (10) victims
     - Triage officer stays with 10 victims (mother hen concept) until all ten are moved to an established treatment area at the scene
   - Tag patients with treatment tag if requested or coordinated with Treatment Area. If Triage Officers tag patients in the triage area with treatment tags, then Triage Officers should retain one of the detachable sections of the tag and record times for documentation.

4. DETERMINE WHAT ADDITIONAL RESOURCES ARE NEEDED
   - Additional response determined by the Incident Commander or Medical Branch Director
     - Rule of thumb (Personnel):
       - 1 Firefighter/EMT/ PM/Responder for each immediate patient
       - 1 Firefighter/EMT/Responder for each 3 delayed patients
       - 2 firefighter per hose line
       - 2-3 firefighters per rescue operation (airbags, jaws, ect/)

5. QUICKLY OVERVIEW SCENE SAFETY
   - Do you have adequate medical personnel and resources?
   - Are hose lines for fire safety in place with adequate personnel?
   - Is traffic or crowd situation under control or endangering medical operations?
   - Are patients and medical response staff in unsafe locations?
   - If Hazardous Material (Firefighting)
     - Note wind direction and weather
     - Work within appropriately established cold, warm and/or hot zones
     - Stay aware/briefed on all aspects of Haz-Mat operations/hazard
     - Consider medical operations/equipment that may effect hazardous condition

6. CONSIDER DESIGNATING A MEDICAL BRANCH DIRECTOR
7. DIRECT INCOMING PERSONNEL AND EQUIPMENT
8. OVERSEE THE SITUATION AND ADJUST RESOURCES AS NEEDED. COORDINATE WITH ASSISTING AGENCIES (LAW, EMS, ETC.) CONSIDER UNIFIED COMMAND
9. CONTACT CRITICAL INCIDENT STRESS DEBRIEFING TEAM
10. CONDUCT AN INCIDENT DEBRIEFING AND CRITIQUE

Level 3 - Major Medical Incident
16 - 35 Patients

1. EMS RESPONSE
   - Deploy an *additional* 2 Engines, 2 Ambulances, 1 Medic unit, 1 Chief Officer
     - This will make a total deployment of 4 Engines, 6 Ambulances, and 3 Medic Units, 4 Chief Officers onsite.
   - Deploy 2 EMS Helicopters (Designate a landing zone / Standby fire engine for safety)
   - Deploy 1 UTA/School Bus
   - Deploy 1 MCI Trailer
   - Deploy MCC (Mobile Command Center)
   - Notify out of County Hospitals and obtain a bed count if possible.
   - Note:
     - Consider additional air ambulance and/or UTA/School buses
     - Notify Red Cross
     - Consider additional MCI Trailer (2^{nd} trailer)

2. ESTABLISH COMMAND
   - Upon arrival at scene "declare command."
   - Radio the type of situation and "declare the incident level" (3-Major Medical Incident)
     - Establish the total number of victims and categories
   - Radio the exact location of the incident and best access route for in-coming equipment
     - Establish staging and/or ingress and egress traffic plan
     - Establish Communications Plan

3. QUICKLY TRIAGE AND TAG ALL PATIENTS USING THE " S.T.A.R.T " TRIAGE CONCEPT
   - One (1) triage officer per ten (10) victims
     - Triage officer stays with 10 victims (mother hen concept) until all ten are moved to an established treatment area at the scene
   - Tag patients with treatment tag if requested or coordinated with Treatment Area. If Triage Officers tag patients in the triage area with treatment tags, then Triage Officers should retain one of the detachable sections of the tag and record times for documentation.

4. REQUEST ADDITIONAL FIRE AND LOCAL EMS RESOURCES
   - Additional response determined by Incident Commander or Medical Branch Director
     - Rule of thumb (Personnel):
       - 1 EMT/PM 1 immediate patient - 1 EMT / 3 delayed patients
       - 2 firefighter per hose line - 2-3 firefighters per rescue operation

5. QUICKLY OVERVIEW SCENE SAFETY
   - Do you have adequate medical personnel and resources?
   - Are hose lines for fire safety in place with adequate personnel?
   - Is traffic or crowd situation under control or endangering medical operations?
   - Are patients and medical response staff in unsafe locations?
   - If Hazardous Material (Firefighting)
     - Note wind direction and weather
     - Work within appropriately established cold, warm and/or hot zones
     - Stay aware/briefed on all aspects of Haz-Mat operations/hazard
     - Consider medical operations/equipment that may effect hazardous condition

6. BUILD MEDICAL BRANCH AS APPROPRIATE
   Note: Position checklists for all categories are found on pages 27-44.
7. COORDINATE WITH ASSISTING AGENCIES (LAW ENFORCEMENT, EMS, ETC.)
8. ESTABLISH UNIFIED COMMAND
9. CONTACT CRITICAL INCIDENT STRESS DEBRIEFING TEAM
10. CONDUCT AN INCIDENT DEBRIEFING AND CRITIQUE
11. OVERSEE THE SITUATION AND ADJUST RESOURCES AS NEEDED.

Level 4 - Medical Disaster
36+ Patients

1. EMS RESPONSE
   - Deploy an *additional* 3 Engines, 3 Ambulances, 3 Medic Units, 2 Chief Officers
     - This will make a total deployment of 7 Engines, 9 Ambulances, 6 Medic Units, 6 Chief Officers onsite.
   - Deploy 4 EMS Helicopters (Designate a landing zone / Standby fire engine for safety)
   - Deploy 2 MCI Trailers
   - Deploy 2 UTA/School buses
   - Notify out of County Hospitals and obtain a bed count if possible.
   - Note:
     - Place additional air ambulances on stand-by
     - Consider additional MCI trailers as necessary
     - Consider Scene Support units
     - Notify Red Cross
   -

2. ESTABLISH COMMAND
   - Upon arrival at scene "declare command."
   - Radio the type of situation and "declare the incident" (4-Medical Disaster)
     - Establish the total number of victims and categories
   - Radio the exact location of the incident and best access route for in-coming equipment
     - Establish staging and/or ingress and egress traffic plan
     - Establish Communications Plan

3. QUICKLY TRIAGE AND TAG ALL PATIENTS USING THE " S.T.A.R.T " TRIAGE CONCEPT
   - One (1) triage officer per ten (10) victims
     - Triage officer stays with 10 victims (mother hen concept) until all ten are moved to an established treatment area at the scene
   - Tag patients with treatment tag if requested or coordinated with Treatment Area. If Triage Officers tag patients in the triage area with treatment tags, then Triage Officers should retain one of the detachable sections of the tag and record times for documentation.

4. REQUEST ADDITIONAL FIRE AND LOCAL EMS RESOURCES
   - Additional response determined by the Incident Commander or Medical Branch Director
     - Rule of thumb (Personnel):
       - 1 EMT/ PM /1 immediate patient - 1 EMT / 3 delayed patients
       - 2 firefighter per hose line - 2-3 firefighters for each rescue operation

5. QUICKLY OVERVIEW SCENE SAFETY
   - Do you have adequate medical personnel and resources?
   - Are hose lines for fire safety in place with adequate personnel?
   - Is traffic or crowd situation under control or endangering medical operations?
   - Are patients and medical response staff in unsafe locations?
   - If Hazardous Material (Firefighting)
     - Note wind direction and weather
     - Work within appropriately established cold, warm and/or hot zones
     - Stay aware/briefed on all aspects of Haz-Mat operations/hazard
     - Consider medical operations/equipment that may effect hazardous condition

6. BUILD MEDICAL BRANCH AS APPROPRIATE
   Note: Position checklists for all categories found on pages 27-44
7. OVERSEE T HE SITUATION & RESOURCES AS NEEDED
8. DIRECT INCOMING PERSONNEL & EQUIPMENT

9. COORDINATE WITH ASSISTING AGENCIES (LAW ENFORCEMENT, EMS, ETC.)
10. ESTABLISH UNIFIED COMMAND
11. CONTACT CRITICAL INCIDENT STRESS DEBRIEFING TEAM
12. CONDUCT AN INCIDENT DEBRIEFING AND CRITIQUE (OPERATIONAL)

Level 5 - Casualty Collection Point (CCP) Activation
Non-specific number of Patients

1. EMS RESPONSE
   - Deploy at least one Engine Company and/or Medic unit if possible to each CCP
   - Establish a Branch Supervisor for the CCP
     - Deploy available EMS personnel to CCP as needed. (prioritized)

2. ESTABLISH COMMAND
   - Upon arrival at scene "declare command."
     - Use school name as tactical name for command
     - Establish the total number of victims and categories
   - Radio the exact location of the CCP and best access route for in-coming equipment
     - Establish staging and ingress and egress traffic plan
   - Establish Communications with C.E.R.T. team leadership ***if present.***
     - Transfer command from C.E.R.T. to Fire/EMS
   - Establish Joint or Unified Command with C.E.R.T.

2. QUICKLY ASSESS ALL PATIENTS - VERIFY TRIAGE USING THE " S.T.A.R.T " TRIAGE CONCEPT
   - -- Quickly re-assess patients in "Red" treatment area first,
   - Assign Treatment Group Supervisor and develop Treatment Area organization

3. DEVELOP MEDICAL BRANCH ORGANIZATION
   - Assume Medical Branch Director position
     - Coordinate triage activities with C.E.R.T. Triage Group Supervisor
     - Develop appropriate Transportation Group
   - Liaison with C.E.R.T. Team Leader
     - Reassign C.E.R.T. members as necessary

4. REQUEST ADDITIONAL FIRE AND LOCAL EMS RESOURCES
   - Additional response determined by the Incident Commander or Medical Branch Director
     - Rule of thumb (Personnel):
       - 1 EMT/PM /1 immediate patient - 1 EMT/3 delayed patients OR
       - 1 C.E.R.T./1 immediate patient -1 C.E.R.T./3 delayed patients

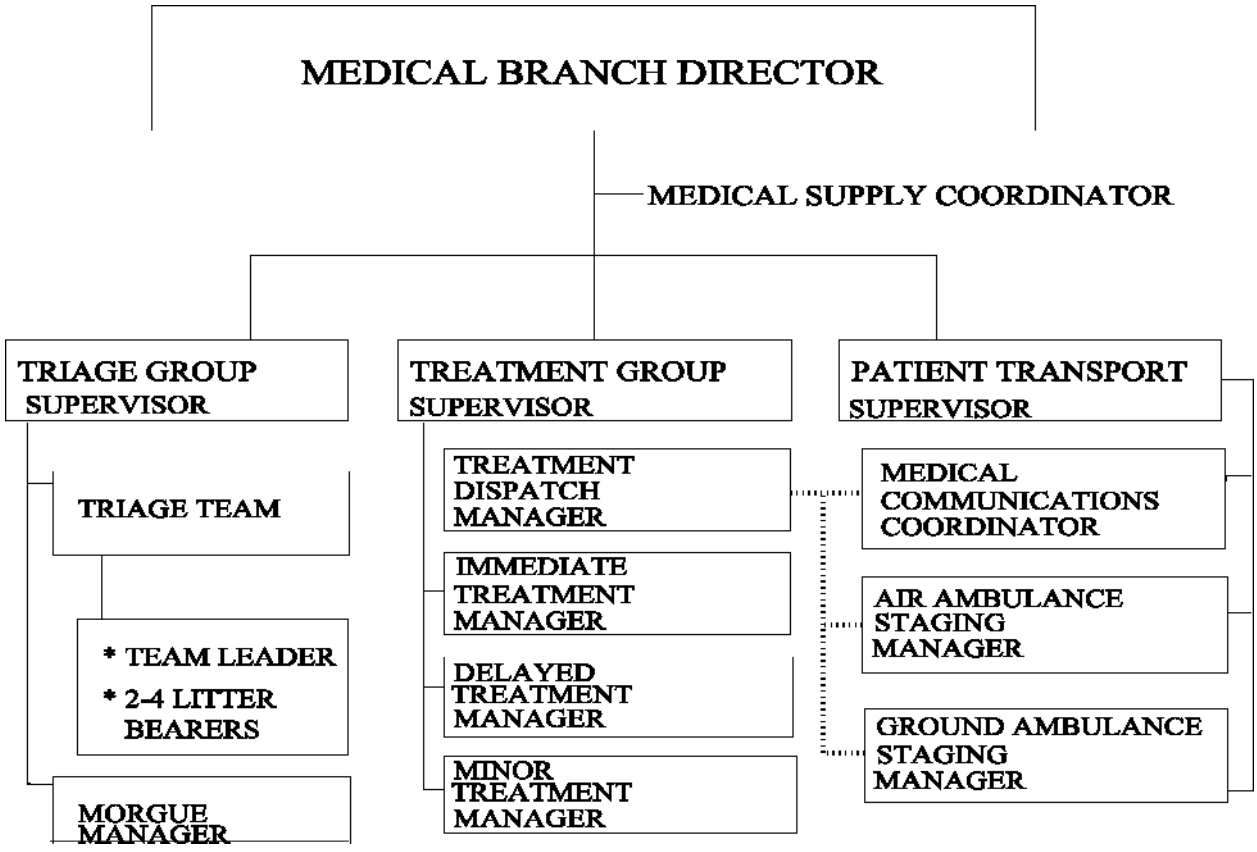
5. DOCUMENTATION
   - Designate/assign aide to maintain logs, forms, and patient information.
   - Document patient destination

6. NOTIFICATION
   - Notify City or County EOC of on-scene information
     - Submit patient situation report to EOC
     - See pages 46-51 for information documentation forms

ICS Medical Branch Position Description Checklist

The ICS Medical Branch Position Description Checklists are intended to assist on-scene incident management with position responsibilities and tasks. They provide a clearer understanding of the coordination required at the scene between the different medical response personnel and helps to create an effective and efficient ICS Medical Branch.

Medical Branch ICS Structure

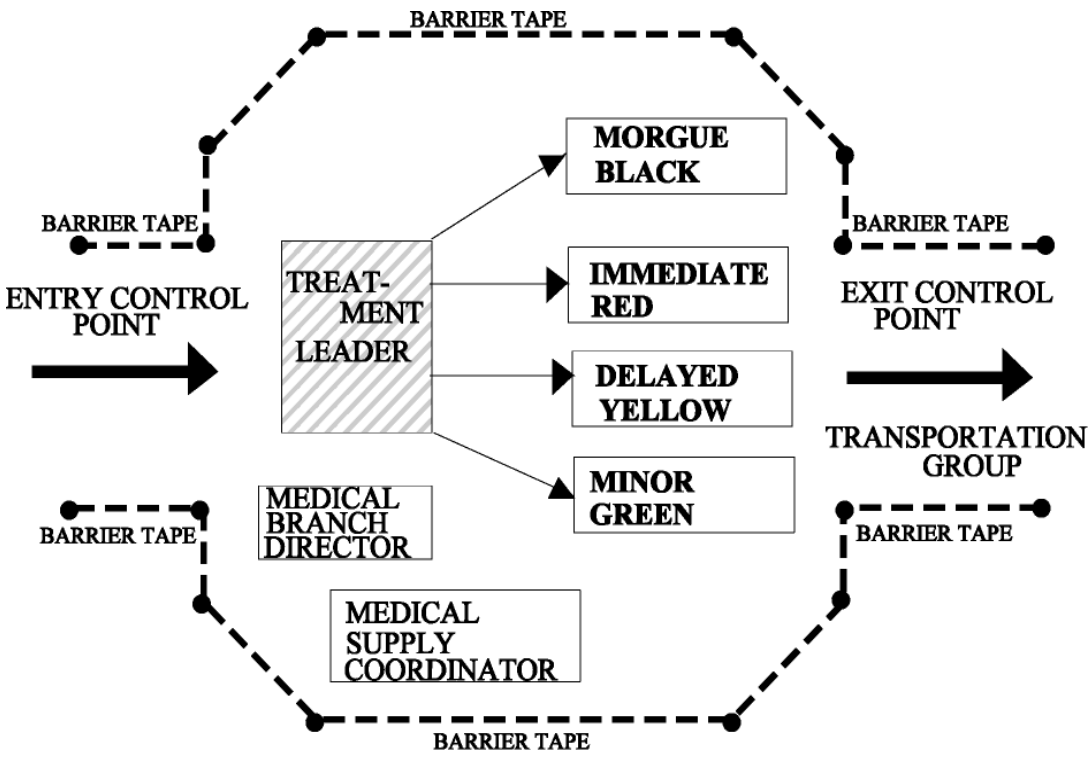


NOTE: Positions titles (Branch Director, Group Supervisor) may change based upon size of operations. Branches may become Groups, Groups may become teams. Size of organization is based upon needs of the incident and the resource requirements.

This plan uses the above "Branch" model. Adapt titles (Branch Director, Group Supervisor) as necessary. This illustration also does not show a "Division" model, but is fully acceptable within the basic ICS principles.

- A Triage Team is comprised of one (1) Triage Officer who is also the Team Leader, and 2 - 4 Litter Bearers.

MEDICAL BRANCH SCHEMATIC



NOTE: This illustration is an attempt to assist the responder in visualizing the physical layout needed to facilitate the Medical Branch's response. The Triage Group would likely be, in this illustration, to the left of the Entry Control Point, conducting triage and field transportation functions. The Treatment Group would be working within the barrier tape in their respective Treatment Areas, and the Transportation group would be working at the Exit Control Point. Notice the location of the Medical Branch Director and the Medical Supply Coordinator. Deceased should be left in place of death for investigation and scene management. Treatment area morgue is for deceased in that area. Refer to pages 16 and 34 for additional guidelines on mortality management.

Medical Branch Director

DEFINITION: Battalion Chief, Captain, Acting Captain, Paramedic, EMT-I

SUPERVISED BY: Incident Commander or Operations Section Chief

SUBORDINATES: Treatment Group, Triage Group, and Transportation Group Supervisors/or Division Supervisors.

FUNCTIONS: Coordinate and supervise EMS operations as a Branch within the Operations Section. Establish command and control of Medical Branch activities to assure best medical care.

DUTIES:

1. Receive briefing from IC or Ops Section Chief. Manage all Medical Branch activities.
2. Establish and supervise a Medical Branch at a level of personnel and other resources sufficient to handle the magnitude of the incident.
3. Liaison and coordinate with the Medical Group Supervisors (Triage, Treatment and Transport Supervisors) depending on how the Branch is organized. Establish coordination between these Group Supervisors.
4. Liaison and coordinate with the other Branches that have been created, depending upon how the Operations Section is organized. Ensure law enforcement or OME involvement as necessary.
5. Establish priorities and action plan, using the appropriate Operational Guidelines for the various declared levels. Direct trained personnel to appropriate Group Supervisors.
6. Coordinate the amount and types of additional EMS and fire and rescue equipment needed, such as medical caches, ambulances, helicopters, UTA/School buses, protective hose lines, extrication equipment, air packs, backboards, medical supplies, splints, bandages, I.V.'s, ect..
7. Coordinate incoming and outgoing routes of ground travel with the Staging Manager and the Transportation Group Supervisor. Set boundaries for treatment and transportation areas. Ensure security, traffic control and access is established.
8. Coordinate air operations with the Transportation Group Supervisor and the Air Ambulance Staging Manager or Landing Zone Manager depending on how Branch is organized.

   Note: Assign a safety standby Engine Company or other appropriate measure to the designated helicopter landing zone
9. Provide for the needs of your personnel: Rest/Rehabilitation, Rotation, Relief
10. Maintain records. Use Form #1 - Multi-Casualty Branch Worksheet. Determine need for scribe. Track treatment tags. Log all calls.

Medical Branch Director Continued....

OPERATIONAL CONSIDERATIONS:

1. Establish Branch Command Location for Group Supervisors

    A. Safe area close to Triage/Treatment/Transport Areas and within law enforcement perimeter control.

2. Ambulance traffic pattern and Patient Loading Areas (Transportation Group Supervisor).

3. Treatment Areas - Consider isolating from each other:
    a. Immediate
    b. Delayed
    c. Minor
    d. Morgue
        1. Consider security and remoteness.
        2. Not a high priority if resources are in short supply.
        3. Trauma condition of bodies and the proximity of dead to living and response personnel. Cover and/or move bodies if traumatic stress is a consideration as well as to show respect to the dead.

Refer to Mortality Management Guidelines During Disaster Operations on page 16.

Medical Supply Coordinator

DEFINTION: Qualified personnel as assigned (EMT/Firefighter)

SUPERVISED BY: Medical Branch Director

SUBORDINATES: Personnel as required, "Assistants"

FUNCTION: Acquire, maintain control of, and distribute appropriate medical equipment and supplies within the Medical Branch. Establish supplies at positions near treatment areas. (See Medial Branch Schematic)

DUTIES:

1. Receive briefing from Medical Branch Director
2. Acquire, distribute, maintain status of medical equipment and supplies within the medical branch. Establish supplies at positions near treatment areas. (See Medical Branch Schematic)
3. Request additional medical supplies (medical caches, ambulance supplies, hospital supplies) as needed through the Medical Branch Director.
4. Coordinate and distribute medical supplies with Treatment Area Mangers. **If logistics section is established, this position would report to and receive direction from the Supply Unit Leader.**
5. Use Inventory List Form #5. Track source of all supplies for reimbursement purposes.
6. Alert ambulances to drop off supplies in a specific area before leaving for the hospital. Alert additional ambulances (air & ground) to allocate additional supplies from hospitals on return trip if necessary.
7. Request, utilized and mange supplies from MCI trailers as necessary.

Triage Group Supervisor

DEFINTION: Qualified Unit Leader

SUPERVISED BY: Medical Branch Director or Division Supervisor

SUBORDINATES: Medical Teams / personnel

FUNCTION: Assume responsibility for providing triage management and movement of all from within the Triage Area. When triage is completed, he/she may be reassigned as needed.

DUTIES:

1. Receive briefing from Medical Branch Director

2. Implement S.T.A.R.T triage process; brief and supervise Triage Officers as necessary. Use one (1) Triage Officer for every ten (10) patients.

3. Form Field Transportation Teams (litter bearers), 2-4 members per team, for transport of victims from triage areas to treatment areas. Assemble and supply as many teams as deemed necessary to perform task. Assign (2) teams to every (1) Triage Officer. This will create a Triage Team. (See ICS Medical Branch)

   Note: You may use untrained volunteers to augment ***transport*** personnel in this area. However, assure that there is a minimum of one (1) EMT on each transport team. If each team has one (1) EMT, then the EMT can monitor patients during triage transport, and maintain airways if necessary.

4. Acquire medical supplies from the Medical Supply Coordinator for triage areas. (i.e. backboards, stretchers, c-collars, bandages, splints ect..)

5. Coordinate with Treatment Group Supervisors to assure that the Field Transportation Teams (Litter Bearers) are delivering patients to the correct treatment areas.

6. Maintain area security and control of the triage area in coordination with the Branch Director and/or law enforcement.

7. Create and isolate a Triage Area Morgue if necessary. Refer to Mortality Management Guidelines During Disaster Operations on page 16. Coordinate with Branch Director, Office of Medical Examiner (OME), and Treatment Group Supervisor.

Note:** **Remember
- Assign only one (1) Triage Officer for every ten (10) patients
- Assign 2-4 litter bearers (Field Transporters) to each Triage Officer

Triage Group Supervisor Continued….

RESPONSIBILITIES

1. Manage and coordinate all triage activities at the incident scene.

2. Assemble Triage Teams
   – 1 Triage Officer (Team Leader)
   – Field Transport Team of 2 to 4 Litter Bearers

3. Direct the triage and movement of injured from the triage area to the treatment area.

4. Establish and maintain a safe triage area.

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
   A. Personnel (Triage Officers and Litter bearers)
   B. Equipment and supplies
   C. Relief Units

2. Inform Medical Branch Director of minimum needs

3. Consult with Triage Officers (triage team leaders)

4. Give job assignments
   a. Safety
   b. Records
   c. Triage Personnel
   d. Transporters

5. Establish morgue location if necessary. Assign a Morgue Leader, refer to Morgue Leader position description on page 34 and the Mortality Management Guideline During Disaster Operations on page 16

Note:** ***Do not allow deceased patients to be removed from their original locations unless absolutely necessary. If possible, take pictures and mark locations of the deceased. This information is essential to the medical Examiner. Upon arrival of the Medical Examiner's Office (OME), the OME may take charge of all OME-related functions within the morgue area.

6. SAFETY SHALL BE THE NUMBER ONE PRIORTY

Triage Officer / Triage Team Leader

DEFINITION: Medically qualified personnel – ALS or BLS Triage

SUPERVISED BY: Group Supervisor

FUNCTION: To Triage patients on-scene (S.T.A.R.T. Triage), assign them to appropriate treatment areas, coordinate movement of patients to respective treatment areas, and to monitor assigned patients for as long as they are in the Triage Area (Mother hen concept).

DUTIES:

1. Receive briefing form Triage Group Supervisor

2. Report to designated on-scene triage location with triage equipment.

3. Direct and manage activities of Triage Team. This includes the Litter Bearers assigned to you.

4. Triage and tag (10) injured patients. Classify patients with tags, "Red", "Yellow", or "Green".

5. Provide appropriate medical treatment (ABC's) to patients prior to movement, according to S.T.A.R.T. Field Guide.

6. Direct movement of patients to proper treatment areas with Litter Bearers Field Transport: **Move Immediate "Reds" First!**

Note:** **Use formula of one (1) Triage officer for every ten (10) patients. Triage Officers do not transport. Triage Officers stay with their respective (10) patients until they are out of the Triage Area and are in the Treatment Area.
"Mother Hen" concept to their (10) patients. Once triage is accomplished, Triage Officers can perform limited treatment as time permits while waiting for transporters to move victims to treatment areas.

7. When all ten (10) victims are carried to the Treatment Area, report with assigned transport team to the Triage Group Supervisor for rehab. or reassignment.

Field Transport Team

DEFINITION: Qualified personnel consists of at least one BLS provider who is able to render care while transporting. These persons are litter bearers, and assist the triage area by transporting the injured to the treatment areas. Untrained volunteers can assist EMT's in this function.

SUPERVISED BY: The Triage Officer

FUNCTION: Assume responsibility for transporting patients from the disaster site/triage area to a treatment area (immediate/delayed/minor) on a backboard or other appropriate device and render medical care during transport if necessary.

DUITES:

1. Receive briefing and assignment form Triage Group Supervisor. Transport Teams are assigned directly to Triage Officer. Together they comprise a Triage Team. Triage Teams are lead by the Triage Officer and can consist the Triage Officer and 2 or 4 litter bearers.

2. Acquire appropriate equipment from the Medical Supply Coordinator to accomplish tasks. (Backboards, c-collars, ect..)

3. Under Triage Officers direction at disaster site, properly manage patients with c-collars, backboards, dressings, ect…while transporting patient to appropriate treatment area.

4. *Guideline:* Each Field Transport Team should carry no more than 10 Patients form the triage area to the respective treatment area before going to rehab. or being reassigned/rotated.

5. Obtained additional help from untrained volunteers or bystanders to assist:
   (Remember: at least one EMT per Field Transport Team)

6. Report back to Triage Group Supervisor with Triage Officer (Team Leader) for rehab. or reassignment.

Morgue Manager

DEFINITION: Personnel assigned (firefighter, law enforcement, medical examiner)

SUPERVISOR: Triage Group Supervisor / OME representative

FUNCTION: Tag / Account / Document all fatalities in medical incident in Triage Area.

DUITIES: Locate, tag, and mark locations of all deceased in the Triage Area.

Do Not move deceased to morgue area without permission or contact from representative from the coroners office. Maintain dignity of the deceased.

Coordinate if necessary with Treatment Group Supervisors or Treatment Area Morgue.

RESPONSIBILITIES:

1. Manage all Morgue Area activities as outlined in the Mortality Management Guidelines during Disaster Operation on pg. 16

2. Keep area off limits to all personnel unless except those needed.

3. Coordinate with law enforcement and assist the coroners office as necessary.

4. Keep identity of deceased confidential. Maintain records including tentative identity (if available), where the deceased was found, ect…

5. Establish an Incident Morgue location if necessary. Ensure that it is secluded from direct site if possible. Assign security. Coordinate with Treatment Group Supervisor of movement if any of victims who become unsalvageable while in a treatment area. Advise Triage Group Supervisor of location.

OPERATIONAL CONSIDERATIONS:

1. Assess resource needs
   a. Equipment and supplies (Body bags, Tags, Privacy Screens)
   b. Personnel / Relief Personnel
   c. Law enforcement, OME

2. Give job assignments (Security, Documentation, Litter Bearers,)

3. Morgue location
   a. Remove form triage area. (OME permission needed)
   b. Not readily available to other patients
   c. Accessible to vehicle (ambulance, OME, law enforcement)

Note: Do not move deceased to morgue area without the permission from the coroners office. Follow Mortality Management Guidelines.

Treatment Group Supervisor

DEFINTION: Paramedic level or above

SUPERVISED BY: Medical Branch Director

SUBORDINATES:
1. Treatment Dispatch Manager
2. Immediate Treatment Manager
3. Minor Treatment Manager
4. Delayed Treatment Manger

FUNCTION: Assume responsibility for treatment, prepare for transport, and coordination of patient treatment in treatment areas. Coordinate movement of patients from triage area to treatment area and from treatment to transportation locations.

DUTIES:

1. Receive briefing from Medical Group Supervisor. Use form #1 "Multi-Casualty Branch Worksheet," Form #2 "Treatment Area Worksheet." Develop organization sufficient to handle assignment.

2. Manage all activities within the Treatment Group. Implement, direct, and supervise Treatment Dispatcher, and Immediate, Delayed, and Minor Treatment Area Managers.

3. Plan layout. See Medical Branch schematic pg. #26.

4. Designate Treatment Mangers and Treatment Areas as appropriate. Isolate Morgue and Minor Treatment Areas from Immediate and Delayed Treatment Areas. Coordinate with Triage Group Morgue Manger if necessary.

5. Request sufficient and qualified emergency medical personnel to staff Treatment Areas. Request medical supplies as needed. Consider communications, equipment supplies, relief personnel, and record keeping/tracking.

6. Communicate and coordinate patient movement with Triage Group Supervisor.

7. Receive patients from Field Transport Teams and direct them to appropriate treatment areas. DON NOT RETRIAGE AT THIS TIME OR LOCATION.

8. Designate/assign an aid to maintain logs, forms, and patient information.

9. Maintain triage assessment of patients throughout treatment areas.

10. Keeps areas off limits to all personnel except needed. Acquire law enforcement assistance to enforce treatment area security.

11. Communicate and coordinate movement with Patient Transportation Supervisor. THE MOST CIRTICAL PATIENTS SHOULD BE TRANSPORTED FIRST.

Treatment Dispatch Manager

DEFINITION: Paramedic / EMT

SUPERVISED BY: Treatment Group Supervisor

FUNCTION: Provide coordination between Treatment Area Managers and the Transportation Groups Staging Managers and Medical Communications Coordinator for priority transport.

RESPONSIBILITIES:

1. Receive assignment and briefing from Treatment Group Supervisor. Coordinate treatment dispatch function with Treatment Managers and Transportation Group

2. Establish and maintain communication with treatment managers

3. Verify patient transportation priority "Red", "Yellow", or "Green".

4. Designate aid to maintain appropriate forms and patient information if necessary.

5. Establish and maintain communications with Medical Communications Coordinator for transportation of patients.

THE MOST CRITICAL PATIENTS SHOULD BE TRANSPORTED FIRST

   a. Coordinate patient loading and ambulance departure/destination.
   b. Direct movement of patients to loading locations

7. Maintain appropriate records. Use form #2 "Treatment Area Worksheet."

OPERATINAL CONSIDERATIONS:

1. Need direct communications with Hospital Communications Coordinator
2. Need direct communication with Air and Ground Staging Managers
3. Need direct communication with Treatment Group Supervisors & Treatment Managers.
4. Assess resource needs
   a. Communications
   b. Equipment and supplies
   c. Records and other personnel.

Immediate Treatment Manager

DEFINITION: Paramedic / EMT-I

SUPERVISED BY: Treatment Group Supervisors

SUBORDINATES: Medical personnel or teams assign to Immediate Treatment Area

FUNCTION: Responsible for treatment and re-triage of patients assigned to Immediate Area

DUTIES:

1. Receive briefing from Treatment Group Supervisor and brief subordinates.

2. Receive patients from Field Transport Teams. Reassess and treat appropriately.

3. Request or establish medical personnel as necessary.

4. Assign treatment personnel to patients received in the Immediate Treatment Area

Note: ***Rule of thumb: 1 EMT / 1 patient***

5. Designate aid to maintain appropriate forms and patient information.

6. Assure that patients are prioritized for transportation.

7. Coordinate transport of patients with Treatment Dispatch Manager. Notify Treatment Dispatch Manager of patient's readiness and priority for transportation.

8. Assure that appropriate patient information is recorded. Use form #2 Treatment Area Worksheet.

Delayed Treatment Manager

DEFINITION: Firefighter / EMT

SUPERVISED BY: Treatment Group Supervisor

SUBORDINATES: Medical personnel or teams assigned to Delayed Treatment Area

FEUNCTION: Responsible for treatment and re-triage of patients assigned to Delayed Treatment Area.

DUTIES:

1. Receive briefing from Treatment Group Supervisor and brief subordinates.

2. Receive patients from Field Transport Teams. Reassess and treat appropriately.

3. Request or establish medical personnel as necessary.

Note: ***Rule of thumb: 1 EMT / 3 patients***

4. Assign treatment personnel to patients received in the Delayed Treatment Area.

5. Assure proper prioritization and re-evaluation of patients for re-assignment to Immediate Treatment Areas if condition worsens.

6. Designate aid to maintain appropriate forms and patient information.

7. Assure that patients are prioritized for transportation.

8. Coordinated transport of patient's with Treatment Dispatch Manager and the Immediate Treatment Area Manager. Notify Treatment Dispatch Manager of Patient's readiness and priority for transportation.

9. Assure that appropriate patient information is recorded. Use form #2 Treatment Area Worksheet.

Minor Treatment Manager

DEFINTITION: Firefighter / EMT

SUPERVISED BY: Treatment Group Supervisor

SUBORDINATES: Medical personnel or teams assigned to Minor Treatment Area.

FUNCTIONS: Responsible for treatment and re-triage of patients assigned to Minor Treatment Area.

DUTIES:

1. Receive briefing from Treatment Group Supervisor and brief subordinates.

2. Receive patients from Field Transport Teams and ambulatory patients. Reassess and treat appropriately.

3. Request medical personnel as necessary. Assign treatment personnel to patients received in the Minor Treatment Area.

Note: ***Do not overuse critical medical resources here. One EMT can take care of several injured, or recruit other "Greens " to assist in the care.***

4. Assure proper prioritization and re-evaluation of patients for re-assignment to Delayed Treatment Areas if condition worsens.

5. Treatment of patients triaged to the Minor Treatment Area.

6. Assure that appropriate patient information is recorded prior to patient release or transportation. Designate aid to maintain appropriate forms and patient information. Use form #2 Treatment Area Worksheet.

7. Coordinated transport of patient's with Treatment Dispatch Manager and the Immediate and/or Delayed Treatment Area Manager. Notify Treatment Dispatch Manager of Patient's readiness and priority for transportation.

Triage Group Supervisor

DEFINTION: Qualified Manager

SUPERVISED BY: Medical Branch Director

SUBORDIANTES: Medical Communications Director, Ground Ambulance Manger, Air Ambulance Manager.

FUNCTION: Coordination of patient transportation and maintenance of records related to patient identification, injuries, mode of transportation and destination.

DUITIES:

1. Receive briefing from Medical Branch Director. Develop organization sufficient to handle assignments.

2. Ensure establishment of hospital communications. Ensure activation of hospital alert system. Maintain records of all hospitals being utilized and their handling capabilities for proper dispatching. Use Form #3 Hospital Resource Availability.

3. Designate Ambulance Staging Managers. Coordinate staging areas.

4. Assign an aid to maintain forms and patient information, if necessary.

5. Direct the transportation of patients as determined by the Treatment Group Supervisor. Ensure proper coordination between Treatment Dispatch Manager and the Transportation Group.

6. Assure that patient information and destination is recorded. Use Form #4 Ambulance Staging Resource Status, Form #3 Hospital Resource Availability. Coordinate with Treatment Group Supervisor and Medical Communications Coordinator, use Form #2 Treatment Area Worksheet.

7. Control all ambulance loading activities and movements. Maintain an accurate account of injured sent to hospitals and their classification. Patient destination will be determined by medical personnel through the Medical Communications Coordinator.

8. Request additional ambulances as required.

9. Assume Transportation Recorder and Ambulance Manager functions until they have been activated.

10. Notify Ambulance Staging Manger of ambulance requests.

11. Establish ground ambulance staging area with the Medical Branch Director and Ground Ambulance Staging Manager.

12. Establish air ambulance landing zones with the Medical Branch Director and Ground Ambulance Staging Manager.

OPERATIONAL CONSIDERATIONS:

1. A command location for patient transportation function. Remain in close proximity to the Treatment Group Supervisor, Medical Branch Director, and the transportation area.

2. Develop and ambulance traffic pattern (if possible) to avoid confusion. Use Medical Branch schematic.

3. Designate staging areas early in the operations.

4. Security and safety in the transportation area are a priority.

5. Ensure documentation of patient destinations. (Critical for family notifications)

6. Ensure documentation of State MICU / Polaris forms to be completed for each victim.

Medical Communications Coordinator

DUTIES: Qualified Coordinator

SUPERVISED BY: Transportation Group Supervisor

SUBORDINATES: Transportation Recorder and personnel as required

FUNCTION: Maintain communication with hospitals and other facilities to assure proper patient transportation and destination. Coordinate information through Transportation Group Supervisor, the Dispatch Treatment Manager and both air and ground ambulance staging managers.

DUTIES:

1. Establish a communications link with hospitals.

2. Determine hospital availability. Obtain hospital availability information. Use Form #3 Hospital Resource Availability.

3. Designate aid to maintain appropriate forms and patient information (if necessary).

4. Receive basic patient information and injury status from Treatment Dispatch Manager. Communicate patient disposition to destination facility.

5. Communicate appropriate hospital availability to Treatment Dispatch Manager.

6. Select patient destinations for patients leaving the treatment area.

7. Record and maintain appropriate transportation records. Use Form #2 Treatment Area Worksheet. (Coordinate with Treatment Dispatch Manager)

9. Maintain close liaison and information coordination with the Transportation Group Staff and Treatment Dispatch Manager.

10. Coordinate patient loading and destination assignments with the Treatment Dispatch Manager and staging managers. Select mode of transportation of patients leaving the treatment areas.

Ground Ambulance Staging Manager

DEFINITION: Personnel as assigned

SUPERVISED BY: Transportation Group Supervisor

SUBORDIANTES: Personnel as required

FUNCTION: Manage the ground ambulance staging area

DUTIES:

1. Receive briefing form the Transportation Group Supervisor

2. Establish appropriate staging area for ground ambulances. Notify Transportation Group Supervisor of location.

3. Develop organization sufficient to handle assignment.

4. Manage all ground ambulance staging activities. Control apparatus parking and movement.

5. Establish ambulance ingress and egress (route of travel) for incident action plan.

6. Plan layout of Staging area. Consider immediate and future needs. Refer to medical branch schematic.

7. Provide ambulances upon request. Coordinate activities with Transportation Group Supervisor and Treatment Dispatch Manager.

8. Maintain records as required. Use Form #4 Ambulance Staging Resource Status.

9. Assure that necessary supplies are unloaded from the ambulance for treatment area needs. (For use at the scene through the Medical Supply Coordinator) Provide a medical supply resource inventory.

10. Establish immediate contact with ambulance agencies at the scene.

11. Recommend additional transportation resources as necessary.

Air Ambulance Staging Manager

DEFINITION: Personnel assigned who are trained in landing zone management

SUPERVISED BY: Transportation Group Supervisor

SUBORDINATES: Personnel as assigned

FUNCTION: Manage the air ambulance staging area and dispatch air ambulances as needed.

DUTIES:

1. Receive briefing from Transportation Group Supervisor. Coordinate all activities with group supervisor.

2. Establish appropriate staging area for air ambulances. Manage all air ambulance staging area activities. Use standard landing zone practices.

3. Plan layout of staging area and establish landing zones for air ambulances. Develop organization sufficient to handle assignments. Consider immediate and future needs.

4. Maintain tight security and safety zones for landing management. Coordinate law enforcement needs with Group Supervisor if necessary.

5. Notify Transportation Group Supervisor of staging locations.

6. Provide air ambulances upon request. Coordinate group patient loading with Transportation Group Supervisor and the Treatment Dispatch Manager.

7. Maintain record as required. Use Form #4 Ambulance Staging Resource Status.

8. Air ambulances, upon return trips, may be requested to bring supplies to the scene. Assure that supplies are obtained and given to the Medical Supply Coordinator.

9. Establish communications with air ambulances over appropriate pre-designated frequencies.

10. Recommend additional transportation resources as appropriate.

ICS Medical Branch Forms

MULTI-CASUALTY-MEDICAL BRANCH WORKSHEET

Incident Command/Name:	Date:	Time:
Incident Commander:		
Operations Section Chief:		
Staging Area Manager:	Location:	
Medical Branch Director:		
Medical Supply Coordinator:		
Triage Group Supervisor:	Treatment Group Supervisor	Patient Transport Group Supervisor:
Triage Team/Members Leader:	Treatment Dispatch Manager:	Medical Communications Coordinator:
Field Transport Team Leader:	Immediate Area Manager:	Air Ambulance Staging Manager:
Field Transport Team Leader:	Delayed Area Manager:	Ground Ambulance Staging Manager:
	Minor Area Manager:	

	Needed?			Needed?
OME:	Y N	Locations:	Buses:	Y N
Air Ambulances:	Y N		Ground Staging:	
Red Cross:	Y N	Details:	Air Staging:	
Radio Frequencies:			Radio Frequesncies:	

FORM #2

TREATMENT AREA WORKSHEET

Immediate / Delayed / Minor (Circle Appropriate Area)

Time In:	Patient Triage Tag#	Time Out:	Hospital Destination:	Transport Unit #

FORM #3

HOSPITAL RESOURCE AVAILABILITY

HOSPITAL	CRITICAL	NON-CRITICAL

FORM #4

AMBULANCE STAGING RESOURCE STATUS

AGENCY	UNIT #	IN	OUT

FORM #5

MEDICAL SUPPLY INVENTORY LIST

HOSPITAL/AMBULANCE UNIT #	ITEM & AMOUNT:	DISTRIBUTED TO:

DAVIS COUNTY EMS INCIDENT WORKSHEET

Command: _____ ***Incident #*** _____ ***Dispatch Time:*** _____

Elapsed Times: *5 10 15 20 25 30 35 40*

Number of Patients					
Immediate					
Delayed					
Minor					
Dead/Dying					
Total					

Responding EMS Units			
Staged	**Unit**	**Assigned**	**Left Scene**

Helicopters			

Upon Arrival

- ❑ Initial Report
- ❑ Command Established
- ❑ Scene Safety
  - o Lanes Blocked
- ❑ Upgrade Needed
- ❑ **START** Triage Initiated
- ❑ Groups established
  - o Triage
  - o Extrication
  - o Treatment
  - o Transport
  - o Safety
  - o LZ

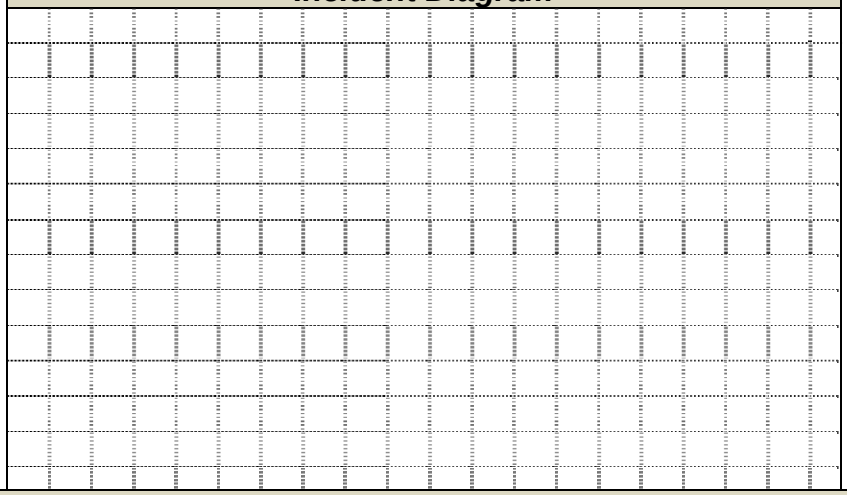
Benchmarks

- ❑ **Triage Complete** - # of patients identified & priority determined
- ❑ **All Clear** – extrication complete on all vehicles
- ❑ **All Immediate patients transported**
- ❑ **All patients transported** (Delayed & Minor)
- ❑ **Scene Hazards secured**

Transportation Group

- ❑ Hospital Status Done / Severity of Pt's Accepted / Bed Space Availability
- ❑ # of Ambulances _____ # of Medic Units _____
- ❑ Treatment Area Location (s) _____
- ❑ Ambulance Staging Location _____
- ❑ Landing Zone Location (s) _____

Incident Diagram



Divisions / Groups						
Triage	***Extrication***	***Treatment***	***Transport***	***Safety***	***LZ***	***PIO***

PT	***Level***	***Age***	***Sex***	***Hospital***	***Unit (s)***	***PT***	***Level***	***Age***	***Sex***	***Hospital***	***Unit (s)***
1						**6**					
2						**7**					
3						**8**					
4						**9**					
5						**10**					

CASUALTY COLLECTION POINTS (CCP) PRTOCOL

CASUALTY COLLECTION POINT (CCP) PROTOCOL

CCP Overview

The Casualty Collection Point (CCP) protocol is an emergency, or disaster response concept that will allow for, or at least take into consideration, an emergency that has wide spread impact throughout the community, and as such, overwhelms and paralyzes the normal EMS response. A disaster that would create this kind of scenario might, for example, be an earthquake that injures hundreds of citizens throughout the county, perhaps affecting main transportation routes and possibly damaging Davis County's two hospitals. Hundreds of injured spread throughout the county would overwhelm the EMS system and cause it to be unable to respond to the hundreds of calls for medical assistance. If this were the case, some kind of gathering the wounded would be critical.

If this scenario were compounded by damage to the highway infrastructure, victims would then become isolated from emergency medical care. If victims are unable to be transported to the hospitals, then the hospital employees would have the same dilemma and would be unable to report to their duty stations at their respective hospitals.

If an earthquake affect the county to the extent that there are hundreds of injured, then it stands to reason that the hospitals in Davis County would also receive some type of damage. Therefore the basic premise of a large earthquake injuring hundreds from across the county also creates a very plausible situation wherein transportation is hindered and damages to medical infrastructure will also occur.

Casualty Collection Points (CCP) are created for extreme situations where the EMS system is completely overwhelmed and unable to respond to all incidents without some kind of protocol that will allow for activation of locations where the injured can be taken by citizens and then transferred to the county EMS system. Rather than attempt to send the already overwhelmed EMS to each victim, the victim, through private or organized means can be brought to the EMS system, triaged and transported appropriately via CCP.

Locations

In Davis County, there are 70 pre-determined locations where CCP's could be activated. (See pages 56-60 for list) These sites coincide with the Points of Distribution (POD) locations. Each site is capable of hosting a CCP. The purpose in identifying multiple sites for a CCP is to have in reserve multiple areas which can be chosen to implement CCP's assuming many pre-determined sites may be damaged by the same incident requiring the activation of the CCP.

CCP Planning Concept

Activation

Activation of a CCP is the jurisdiction of the local city or county in which the CCP is located. The city EOC or county EOC may exercise the authority to open a CCP. A policy decision by Chief Elected Officials, under advisement from that jurisdiction's chief medical or fire officer is all that is needed for a city to activate a CCP. Notification between hospitals, county wide EMS providers, and county emergency management is necessary to unsure successful incident action planning.

Advisement and/or requests for activation may also come from the hospitals or other jurisdictions within Davis County. It would be anticipated that a situation warranting activation of a CCP were to exist in one jurisdiction, then it is highly likely that this same situation exists in other jurisdictions within Davis County. Activation of any CCP in Davis County would warrant EOC activation for the affected city as well as the county.

Command and Control

Once a CCP is activated, there needs to be a command and control element at that facility to organize and manage the medical operations. Due to the nature that would warrant activation of a CCP, it is highly likely that the Community Emergency Response Team (C.E.R.T.) would be activated. If EMS resources are not available, command and control would rest with the community's C.E.R.T leadership. If EMS resources were available, a medical officer would be expected assume command of he CCP site.

Command and Control - C.E.R.T.

When activated, the CCP will require several personnel to conduct search and rescue, transport the injured to the site, conduct triage and treatment and coordinate transportation of victims to a medical facility if possible. C.E.R.T. personnel will be required to staff at a minimum the following management positions:

Incident Commander -	Oversee operations / liaison with city EOC
Medical Supply Coordinator -	Oversee logistics / Distribute and document medical supply needs and use.
Search & Rescue Group Supervisor -	Coordinate searching, triaging and field transportation of injured to the CCP site.
Treatment Group Supervisor -	Oversee CCP treatment areas
Transportation Group Supervisor -	Coordinate transportation of victims to medical facilities.
Communications Coordinator-	A.R.E.S. communication team members provide with city / county EOC's and with area hospitals.

C.E.R.T. team members will use the ICS Medical Branch positions and will follow that protocol at CCP sites.

Command and Control – Fire/EMS

Upon activation of a CCP, if fire/EMS resources are available, they are to take command of the CCP. If they are unavailable, then C.E.R.T. will command the site for the city or county. Only fully qualified fire/EMS personnel who are trained in C.E.R.T. capabilities and methodologies are to assume the role of IC. In the case of limited resources, most operational management positions should be retained by C.E.R.T. leadership, thus freeing fire/EMS resources to oversee patient management. Fire and EMS commanders must, upon arrival at the CCP, make contact and establish liaison with C.E.R.T. leadership. On-site medical branch protocols are still in effect at a CCP.

MCI Trailers

When an MCI incident occurs, up to three (3) MCI trailers may be deployed to that specific site for use by fire/EMS personnel. These three (3) trailers were constructed and staged to support county and region wide fire/EMS resources. If the situation is such that local EMS supplies are insufficient, or will be overwhelmed at an MCI, Incident Commanders shall have the authority to request any or all of the MCI trailers, take the necessary supplies and apply them to the specific MCI site.

If an Incident Commander orders the use off any of the MCI trailers, then full documentation of what was taken, what was used, and where it was taken must be made.

Based upon on-site protocol listed earlier in this plan, MCI trailers will be automatically deployed as follows:

Response Level Declaration	**Number of Trailers Dispatched**
Level 1 – Medical Priority Dispatch	No Trailer Dispatched
Level 2 – Expanded Medical Emergency	No Trailer Dispatched
Level 3 – Major Medical Emergency	One Trailer Dispatched
Level 4 – Medical Disaster	Two MCI Trailers
Level 5 – CCP Activation	Can Deploy all Three

Trailers should be dispatched automatically when a response level is declared by on-scene command. If additional trailers are or will be requested, then on-scene command will need to notify dispatch of he specific request.

Authority to Use

Any fire/EMS commander has authority to use an MCI trailer. This use is automatic upon declaration of a response level and augmented with a special request for additional trailers from Incident Command.

MCI Trailer Storage / Deployment Locations

1. Fruit Heights Public Works Building
2. South Davis Metro Fire Station #81
3. Layton City Fire Department Station #53

DAVIS COUNTY	COUNTY, UTAH POINT OF DISTRIBUTION LIST					DATE ENTERED	DATE SENT	DATE REVISED
For Full Assessment Unit POD Capability Ratings see RVIII UT POD Database						9-Jan-08		05-Mar-08
#	Site ID #	Facility Name	TYPE	City	Facility Address	Facility Phone #	Latitude	Longitude
1	UT4089401119011	West Bountiful Elementary School	TYPE III	West Bountiful	750 West 400 North West Bountiful, UT 84087	801-402-2000	40.53.668	111.54.023
2	UT4087831119001	Woods Cross Elementary School	TYPE III	Woods Cross	745 West 1100 South Woods Cross, UT 84087	801-402-1800	40.52.698	111.53.998
3	UT4087331118822	Bountiful Elementary School	TYPE III	Bountiful	1620 South 50 West Bountiful, UT 84010	801-402-1350	40.52.433	111.52.958
4	UT4088231118879	Washington Elementary School	TYPE III	Bountiful	340 West 650 South Bountiful, UT 84010	801-402-1950	40.52.903	111.53.308
5	UT4088291118747	Oak Hills Elementary School	TYPE III	Bountiful	1235 East 600 South Bountiful, UT 84010	801-402-1650	40.52.952	111.51.308
6	UT4087681118678	Valley View Elementary School	TYPE III	Bountiful	1395 South 600 East Bountiful, UT 84010	801-402-2050	40.52.550	111.52.131
7	UT4086121118857	Boulton Elementary School	TYPE III	Bountiful	2611 Orchard Drive Bountiful, UT 84010	801-402-1300	40.51.684	111.53.108
8	UT4085041119000	Adelaide Elementary School	TYPE III	Bountiful	731 West 3600 South Bountiful, UT 84010	801-402-1250	40.51.024	111.54.05
9	UT4084191119050	Orchard Elementary School	TYPE III	North Salt Lake	205 E. Center St. North Salt Lake, UT 84054	801-402-1700	40.50.527	111.54.422
10	UT4084641118746	North Canyon Park	TYPE III	Bountiful	3900 S. Bountiful Blvd. Bountiful, UT 84010	801-298-6220	40.50.757	111.52.553
11	UT4086511118719	Muir Elementary School	TYPE III	Bountiful	2275 S. Davis Blvd. Bountiful, UT 84010	801-402-1550	40.51.929	111.52.281
12	UT4089211118602	Holbrook Elementary School	TYPE III C	Bountiful	1018 East 250 North Bountiful, UT 84010	801-402-1450	40.53.523	111.51.661
13	UT4090141118744	Tolman Elementary School	TYPE III	Bountiful	300 East 1200 North Bountiful, UT 84010	801-402-1900	40.54.086	111.52.534
14	UT4089561118856	South Davis Recreation Center	TYPE II	Bountiful	550 North 200 West Bountiful, UT 84010	801-298-6220	40.52.719	111.53.096
15	UT4089791118888	Meadowbrook Elementary School	TYPE III	Bountiful	700 North 325 West Bountiful, UT 84010	801-402-1600	40.53.803	111.53.267
16	UT4103241119736	Angel Street Park	TYPE II	Kaysville	150 S. Angel St. Kaysville, UT 84037	801-546-4046	41.01.935	111.58.419

17	**UT40980611191122**	Davis County Fairgrounds	TYPE II	Farmington	151 S. 1100 W. Farmington, UT 84025	801-451-4080	40.58.763	111.54.541
18	**UT4098211119296**	Eagle Bay Elementary School	TYPE II	Farmington	1933 Clark Ln Farmington, UT 84025	801-402-3800	40.58.913	111.55.666
19	**UT4092051118770**	Centerville Elementary School	TYPE III C	Centerville	350 N. 100 E Centerville, UT 84014	801-402-1400	40.55.277	111.52.608
20	**UT4090661118741**	J.A. Taylor Elementary School	TYPE III	Centerville	295 Pages Ln Centerville, UT 84014	801-402-1500	40.54.409	11152.55100
21	**UT4093161118790**	Stewart Elementary School	TYPE III	Centerville	1155 N. Main St Centerville, UT 84014	801-402-1850	40.55.832	111.52.803
22	**UT4094741118857**	Reading Elementary School	TYPE III	Centerville	360 W. 2025 N Centerville, UT 84014	801-402-1750	40.56.858	111.53.026
23	**UT4097561118832**	Woodland Park	TYPE III	Farmington	300 S 200 E Farmington, UT 84025	801-451-0953	40.58.523	111.53.015
24	**UT4097881118836**	Monte Vista Elementary School	TYPE III C	Farmington	100 S 200 E Farmington, UT 84025	801-402-3050	40.58.731	111.53.005
25	**UT4097691118895**	Farmington Elementary School	TYPE III	Farmington	50 W 200 S Farmington, UT 84025	801-402-2950	40.58.629	111.53.365
26	**UT4097871118875**	Main City Park	TYPE III	Farmington	100 S. Main Farmington, UT 80425	801-451-0953	40.58.691	111.53.299
27	**UT4100071119048**	Knowlton Elementary School	TYPE III	Farmington	801 Shepard Lane Farmington, UT 84025	801-402-3000	41.00.034	111.54.295
28	**UT4101361119223**	Windridge Elementary School	TYPE III	Kaysville	1300 S. 700 E Kaysville, UT 84037	801-402-3550	41.00.780	111.55.394
29	**UT4101791119396**	Ponds Park South	TYPE III C	Kaysville	1000 S 50 W Kaysville, UT 84037	801-546-4046	41.00.864	111.56.248
30	**UT4102871119395**	Columbia Elementary School	TYPE III	Kaysville	378 S 50 W Kaysville, UT 84037	801-402-3350	41.01.683	111.56.358
31	**UT4103561119362**	Kaysville Elementary School	TYPE III	Kaysville	50 N. 100 E. Kaysville, UT 84037	801-402-3400	41.02.106	111.56.065
32	**UT4103181119195**	Burton Elementary School	TYPE III	Kaysville	827 E 200 S Kaysville, UT 84037	801-402-3150	41.01.920	111.55.172
33	**UT4105161119190**	Morgan Elementary School	TYPE III	Kaysville	1065 Thornfield Rd Kaysville, UT 84037	801-402-3450	41.03.086	111.55.134
34	**UT4105071119429**	Creekside Elementary School	TYPE III C	Kaysville	275 W Mutton Hollow Rd Kaysville, UT 84037	801-402-3650	41.03.072	111.52.517
35	**UT4110051120068**	Fisher Park	TYPE III	Clearfield	920 South 1000 East Clearfield, UT 84015	801-525-2790	41.06.031	112.00.470
36	**UT4110341120073**	South Clearfield Elementary School	TYPE III	Clearfield	990 East 700 South Clearfield, UT 84015	801-402-2500	41.06.182	112.00.447
37	**UT4110801120067**	Hill Field Elementary School	TYPE III	Clearfield	389 S 1000 E Clearfield, UT 84015	801-402-2350	41.06.479	112.00.390
38	**UT4111371120210**	Wasatch Elementary School	TYPE III	Clearfield	270 E Center St Clearfield, UT 84015	801-402-2650	41.06.812	112.01.233

39	**UT4112011120454**	Holt Elementary School	TYPE III	Clearfield	448 N 1100 W Clearfield, UT 84015	801-402-2400	41.07.224	112.02.699
40	**UT4112781120308**	Doxey Elementary School	TYPE III	Clearfield	944 N. 250 W Clearfield, UT 84015	801-402-2250	41.07.666	112.01.837
41	**UT4114291120307**	Sunset Elementary School	TYPE III	Clearfield	2014 N 250 W Clearfield, UT 84015	801-402-2550	41.08.556	112.01.844
42	**UT4115031120295**	Fremont Elementary School	TYPE III	Clearfield	160 W 2525 N Clearfield, UT 84015	801-402-2300	41.09.029	112.01.739
43	**UT4114661120548**	Parkside Elementary School	TYPE II	Clearfield	2262 N 1500 W Clearfield, UT 84015	801-402-1150	41.08.811	112.03.210
44	**UT4113981120472**	Clinton Elementary School	TYPE III	Clearfield	1101 W 1800 N Clearfield, UT 84015	801-402-2150	41.08.376	112.02.789
45	**UT4114001120804**	West Clinton Elementary School	TYPE II	Clearfield	2826 W 1800 N Clearfield, UT 84015	801-402-2700	41.08.405	112.04.821
46	**UT4112531120827**	Lakeside Elementary School	TYPE III	Clearfield	2941 W 800 N Clearfield, UT 84015	801-402-2900	41.07.471	112.05.003
47	**UT4111811120989**	West Point Elementary School	TYPE III	Clearfield	3788 W 300 N Clearfield, UT 84015	801-402-2750	41.07.140	112.05.969
48	**UT4108551120838**	Fremont Park	NC	Syracuse	1950 S 3000 W Syracuse, UT 84075	801-614-9660	41.05.008	112.04.056
49	**UT4109051120740**	Canterbury Park	TYPE III C	Syracuse	2500 W 1600 S Syracuse, UT 84075	801-614-9660	41.05.025	112.04.020
50	**UT8109191120644**	Syracuse Elementary School	TYPE III	Syracuse	1503 S 2000 W Syracuse, UT 84075	801-402-2600	41.05.029	112.03.051
51	**UT4109411120485**	Cook Elementary School	TYPE III	Syracuse	1175 W 1350 S Syracuse, UT 84075	801-402-2200	41.05.038	112.02.054
52	**UT4107591120399**	Bluff Ridge Elementary School	TYPE III	Syracuse	2680 S. 775 W Syracuse, UT 84075	801-402-2850	41.04.034	112.02.025
53	**UT4108731120262**	Antelope Elementary School	TYPE III	Clearfield	1810 S. Main Clearfield, UT 84015	801-402-2100	41.05.014	112.01.035
54	**UT4107051119696**	Crestview Elementary School	TYPE III	Layton	185 W. Golden Ave Layton, UT 84040	801-402-3200	41.04.224	111.58.182
55	**UT4106001119732**	Layton Elementary School	TYPE III	Layton	319 W Gentile St Layton, UT 84041	801-402-3500	41.03.601	111.58.339
56	**UT4104431119916**	Heritage Elementary School	TYPE III	Layton	1354 Weaver Lane Layton, UT 84041	801-402-1200	41.02.703	111.59.430
57	**UT4106371120260**	Sand Springs Elementary School	TYPE III	Layton	242 N. 3200 W Layton, UT 84041	801-402-3850	41.03.064	112.01.572
58	**UT4106991120069**	Ellison Park	TYPE II	Layton	700 N 2200 W Layton, UT 84041	801-336-3900	41.04.079	112.00.242
59	**UT4108391119952**	Vae View Park	TYPE III	Layton	1600 N. Main Layton, UT 84041	801-336-3900	41.04.967	111.59.837
60	**UT4108281119992**	Vae View Elementary School	TYPE III	Layton	1750 W. 1600 N Layton, UT 84041	801-402-2800	41.04.968	111.59.837
61	**UT4108901119768**	Lincoln Elementary School	TYPE III	Layton	591 W. Antelope Dr. Layton, UT 84041	801-402-2450	41.05.340	111.58.610
62	**UT4108271119662**	Woodward Park	TYPE III C	Layton	1505 N. 25 E. Layton, UT 84041	801-336-3900	41.04.926	111.57.975

63	UT4110281119317	Mountain View Elementary School	TYPE III	Layton	2025 E. 3100 N Layton, UT 84040	801-402-3700	41.06.250	111.55.707
64	UT4109381119238	Oak Forest Park	TYPE II C	Layton	2250 E 2400 N Layton, UT 84040	801-336-3900	41.05.562	111.55.464
65	UT4109531119260	Adams Elementary School	TYPE III	Layton	2200 E. 2500 N Layton, UT 84040	801-402-3100	41.05.738	111.55.512
66	UT4108091119181	East Layton Elementary School	TYPE III	Layton	2470 E. Cherry Ln Layton, UT 84040	801-402-3250	41.04.852	111.55.118
67	UT4107421119340	Andy Adams Park	TYPE III	Layton	1713 E. Gordon Ave Layton, UT 84040	801-336-3900	41.04.477	111.55.990
68	UT4107451119540	King Elementary School	TYPE III	Layton	601 E. Gordon Ave Layton, UT 84041	801-402-3300	41.04.495	111.57.289
69	UT4106381119525	White Sides Elementary School	TYPE III	Layton	233 Colonial Ave Layton, UT 84041	801-402-3600	41.03.789	111.57.179
70	UT4106611119606	Layton Commons Park	TYPE III	Layton	437 N. Wasatch Dr. Layton, UT 84041	801-336-3900	41.03.986	111.57.652
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	RVIII UT POD ASSESSMENT SURVEY SUMMARY POINTS OF CONTACT FOR		**DAVIS COUNTY**
	UT State Primary State Point of Contact:	**FEMA RVIII Coordination & Planning Branch Chief:**	
	Utah Division of Homeland Security Office of Emergency Services Program Manager Joe Thornton 801-538-3740 Email: jthornton@utah.gov Room 110, State Office Building Salt Lake City, Utah 84114 1-800-753-2858 FAX 801-538-3770	**FEMA Assessment Lead: Brad Bonnema DHS/ FEMA RVIII DOD LG BLDG 710 POBOX 25267 DFC Denver, CO80225-0267 Office: 303-235-4800 Cell: 303-842-4777 Fax: 303-235-4652 Email: brad.bonnema@dhs.gov**	
	Davis County Primary Point of Contact:	**FEMA RVIII Assessment Planning Unit Specialist:**	

	Davis County Sheriff's Office Davis County Emergency Services Coordinator: Sgt.Brent Peters 800 West State Street Farmington, Utah 84025 Office: (801) 451-4100/Cell: 801 541-1373 Fax: (801) 451-4167 E-Mail: bpeters@co.davis.ut.us		**Planning Specialist: Maggie Jo Holmes DHS/ FEMA RVIII DOD LG BLDG 710 POBOX 25267 DFC Denver, CO80225-0267 Office: 303-235-4800 Fax: 303-235-4652**	
	Davis County	**Secondary Point of Contact:**		

	RVIII CO POD ASSESSMENT SURVEY SUMMARY KEY		
	TYPE II	**TYPE II FULLY CAPABLE**	**7**
	TYPE III	**TYPE III FULLY CAPABLE**	**54**
	TYPE II C	**TYPE II CAPABLE WITH/ WITHOUT MITIGATION**	**1**
	TYPE III C	**TYPE III CAPABLE WITH MITIGATION**	**7**
	NC	**TYPE III NOT CAPABLE**	**1**
	TYPE II OSA	**OSA CAPABLE STAGING AREA**	**0**
	TYPE II MOB	**MOBILIZATION CENTER/ FOSA**	**0**
		TOTAL SITES ASSESSED	**70**