AMBULANCE STRIKE TEAM (AST)/ MEDICAL TASK FORCE (MTF) SYSTEM MANUAL

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

APRIL 2010
EMSA #215

100 INTRODUCTION

This document is an addendum to the California Disaster Medical Operations Manual (CDMOM). The purpose of this addendum is to provide information, direction and procedures relative to non-fire Ambulance Strike Teams (AST), Medical Task Forces (MTF), Ambulance Strike Team Leaders (ASTL) and others involved in the request, deployment and utilization of Ambulance Strike Teams in California. This document incorporates and executes the original Purpose, Scope and Assumptions contained in the Ambulance Strike Team/Medical Task Forces Guidelines (EMSA #215) approved by the EMS Commission in June 2003 and expands them to achieve consistency with contemporary policy direction as described in the CDMOM and Interim California Disaster Health Operations Manual (CDHOM).

101 AUTHORITIES AND REGULATIONS

REGULATIONS

Chapter 2, Title 22, Section 100063, subdivisions (a,b), Scope of Practice

Chapter 2, Title 22, Section 100064, Operational Skills

Chapter 4, Title 22, Section 100166 (1) During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting local EMS agency.

Government Code Section 8607(d) All State agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations

California Code of Regulations, Section 100390, Emergency Medical Services Continuing Education

California Code of Regulations, Section 100390.3 Continuing Education of EMS Personnel

102 ORGANIZATIONAL BACKGROUND INFORMATION

Soon after the organization's creation in 1981, the Emergency Medical Services Authority (EMSA) recognized the need to develop a statewide mutual aid system for non-fire based ambulance disaster response. Past disasters have demonstrated that ambulances are a critical and often scarce resource. In the early 1980s, the EMSA began a series of meetings with the California Ambulance Association (CAA),

ambulance providers, fire organizations, emergency management partners, and others discussing the concept of regional coordination for ambulance deployment in state-declared emergencies. These meetings led to the creation of the Ambulance Strike Team Committee, which is responsible for the development of California's Ambulance Strike Team concept, and this manual.

In the years before the committee began development of this concept, the need for a well structured and organized Emergency Medical Services (EMS) system to manage the requesting and movement of ambulances in a disaster had become clear. During the floods of 1997, many private sector ambulances responded from various parts of the Sacramento Valley to assist in the evacuation needs in Sutter and Yuba Counties. Although the responding units provided critically needed services, there was a lack of overall coordination, and this left some with a concern that "provider" counties were without sufficient emergency transport resources to address their routine day-to-day needs. More recent events such as the hurricanes and Southern California wildfires have reinforced the importance of a well coordinated response system for ambulances during times of disaster.

This manual supports the tenets established in both the CDMOM and CDHOM documents. Its procedures cover inter-region requests between Operational Area (OA), Region and State, for ambulance resources and/or Medical Task Force (MTF) response between one regional area to another, or between the six California mutual aid regions. Even though the scope of this manual is oriented towards region to region requests, the procedures provided herein have direct application to intra-region and intra-operational area requests as well. The Regional Disaster Medical Health Coordinator/Specialist and Medical Health Operational Area Coordinators (MHOAC) programs, as well as Local EMS Agencies (LEMSA) are responsible for establishing such regional and operational area procedures in cooperation with ambulance providers and other public safety agencies within their Operational Area (OA).

The OAs and LEMSAs within the California Emergency Management Agency Mutual Aid Regions are actively involved in providing medical and health assistance to neighboring jurisdictions. It is the intent of this manual to establish clear and concise activities to create the most effective request, response and reimbursement processes for the utilization of medical transport services. This manual does not discriminate between public or private, ground or air resources.

A disciplined and well-understood process for the request, deployment and receipt of medical and health assets is required for the most effective disaster incident outcome. This manual complies with the intent and tenets of the National Incident Management System (NIMS) and the Standardized Emergency Management System (SEMS).

The AST/MTF Program-related figures throughout this manual are only intended as examples of how an AST/MTF Program may be developed or organized by providers, OAs, Regions, or the State. This manual and its figures are designed so that users may make edits based on their specific needs.

The remainder of the manual contains checklists, glossary of terms, acronyms, index, and authorities. Please note that acronyms are used to a great extent throughout this manual. A list of acronyms is located in Section 700.

The contents of this document are not intended as a substitute for required training and good judgment. All Incident Command System (ICS) based emergency operations should make certain that AST members and leaders receive adequate and appropriate training to perform their assigned duties and tasks.

103 PLANNING ASSUMPTIONS AND EXPECTATIONS

- A catastrophic incident, as defined by the National Response Framework (NRF), is any natural or manmade incident, including terrorism that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.
- A multi casualty incident (MCI) or Mass Casualty Event (MCE) can require numerous medical transport resources.
- According to California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, a surge event is a significant healthcare incident or set of circumstances resulting in an excess in demand over capacity and/or capability. A medical transportation surge event is specific to the medical transportation sector.
- The CDMOM further classifies events based upon the degree of response as Level I (OA), Level II (Regional) and Level III (State/Federal).
- An organized response within the framework of NIMS & SEMS and using the ICS is superior to an unorganized response.
- Management of single resources may quickly exceed span of control thresholds, (5-7) whereas the supervision of resources organized in strike team/task force configuration under the ICS is a proven management model.
- Multiple incidents may occur requiring a structured and organized approach to response resources.
- Medical Mutual Aid Assistance is defined in the State Master Mutual Aid (MMA) Agreement for public entities and is an annex to the California Disaster Medical Response Plan (CDMRP). Medical Mutual Aid Assistance is further defined in CDMOM and by agency agreements.
- This plan maybe implemented based upon the need for mobilizing medical transportation assets into an impacted area from non-impacted areas. The resources under this plan are located within OAs and therefore require coordination with the LEMSA and/or the MHOAC Program for the respective OA.
- Self-dispatching of any resource can cause negative consequences in both the sending and the receiving areas.
- All resources must be officially requested through the medical mutual aid system.

- In accordance with executed agreements, assistance may be provided with an expectation of reasonable reimbursement.
- Following an MCI or MCE, the community's primary field medical response will most likely be from the local ambulances and medical first responder entities.
- In accordance with the CDMOM, the LEMSA and/or the MHOAC Program has responsibility for ensuring that local needs are considered when responding to mutual aid request(s).
- Responding ASTs/MTFs shall be integrated into the requesting emergency management structure via ICS and must comply with the directions of the requesting entity.
- ASTs/MTFs may be pre-identified.
- ASTs/MTFs may have a limited amount of equipment, fuel, etc. and thus support for sustained operations must be considered.
- ASTs/MTFs may need local area mapping / direction support.
- Normal communications may be impacted or inefficient.
- All event data will be captured utilizing the Situation Report (SITREP) EF-8, Medical and Public Health OA Branch Report as described in the Interim CDHOM (www.emsa.ca.gov) .
- Resource requests are conducted using the Medical and Health Resource Request Form and processed as described in the Interim CDHOM.
- Patient care will be rendered, as circumstances permit, in accordance with the scope of practice, policies and procedures and medical control of the responders' permitting/accrediting LEMSA.
- Adequate logistical support for incoming ASTs/MTFs should be provided by the receiving MHOAC program/OA.

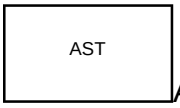
200 ORGANIZATION AND STRUCTURE

This section presents the overall organization and structure of the California AST/MTF program, and each of the key entities, positions, and Roles and Responsibilities (R&Rs) within the system. Figure 1 – Program Organization & Structure, provides a sample of how AST/MTF activation might occur in a multi casualty incident.

201 PRIMARY ORGANIZATION AND STRUCTURE ENTITIES AND POSITIONS

Headings proceeded by a symbol should be referenced alongside Figure 1: Program Organization & Structure on page 14.

AMBULANCE PROVIDER:
An AST/MTF provider agency contributes one or more of the medical resources making up the AST/MTF. Once formed into an AST/MTF, this single medical resource will report directly to the Ambulance Strike Team Leader (ASTL). The team is responsible for medical duties assigned by the ASTL and will ensure that equipment and supplies include those items listed in Section 704 Equipment Standards/Requirements are maintained.



AMBULANCE STRIKE TEAM (AST):
Five properly staffed and equipped medical transport vehicles of the same capabilities and a leader with vehicle, all with like communications equipment.

AST LEAD ENTITY (ASTLE):
The Lead Entity is an ambulance provider or LEMSA who will coordinate and support the development of an AST/MTF; provide an AST Leader; provide an AST/MTF Leader vehicle; and ensure that all of the AST/MTF resources and personnel meet the minimum requirements of the Statewide AST/MTF Program. The ASTLE will, with the authorization of the LEMSA/MHOAC program, coordinate through the Medical Dispatch Center, Operational Area (OAMDC) and/or Medical Dispatch Center, Regional (RMDC).

- An ASTLE is a private or public medical transport provider or LEMSA.
- Responsible for the selection, formation and coordination of ASTs/MTFs.
- Ensures the AST/MTF personnel are trained, equipped and prepared for deployment as an AST/MTF.
- Provides coordination between the requesting agency and the AST.
- Acts as the single point of contact for the AST/MTF.
- Maintains 24 hour per day communications and dispatch capability..

- Ensures proper documentation and tracking of all movement, times, expenditures and costs associated with a deployment.
- Ensures support functions of the resource are met, i.e. housing, sustenance, communications, fuel, etc.

AMBULANCE STRIKE TEAM LEADER (ASTL):
The ASTL manages, supervises, and monitors the AST/MTF while in operation.

- Serves as the point of contact for the AST.
- Reports to an ASTLE prior to check-in with the emergency management structure and post incident release.
- Reports work progress, resource status, and other important information to ASTLE.
- May supervise tactical assignments given to the AST.
- Maintains appropriate incident documentation.
- Coordinates travel to and from the incident.

LOCAL EMERGENCY MEDICAL SERVICES AGENCY (LEMSA):
The agency, department, or office having primary responsibility for administration of emergency medical services in a county.

MEDICAL COMMUNICATIONS COORDINATOR (Med. Comm.):
The Medical Communications Coordinator maintains communications with the patient distribution center or other medical facilities to assure proper patient transportation and destination and coordinates information through the Patient Transportation Group Supervisor and the Transportation Recorder.

MEDICAL DISPATCH CENTER, OPERATIONAL AREA (OAMDC):
A center, designated by the LEMSA in each operational area to serve as the single point of contact within the OA for the acquisition and coordination of EMS medical transport resources during response to disasters.

MEDICAL DISPATCH CENTER, REGIONAL (RMDC):
Designated by the RDMHC in each CAL-EMA mutual aid region, the RMDC serves as the single point of contact within the region for the acquisition and coordination of EMS resources during response to disasters.

MEDICAL HEALTH OPERATIONAL AREA COORDINATOR (MHOAC):
The position filled by designation by the Local Health Officer (LHO) and EMS Agency Administrator, responsible to facilitate development of OA medical/health disaster response plans. In most OAs, the MHOAC implements the OA's disaster medical/health response plan, coordinates the Medical/Health Branch of the OAEOC, coordinates developing OA mutual aid requests for external resources and the OA's

response to external requests, and facilitates the establishment of priorities through the Multi-Agency Coordination Group for Medical/Health requests and response.

MEDICAL TASK FORCE (MTF):
Any combination of resources assembled to support a specific medical mission or operational need. All resource elements within a Task Force must have common communications and a designated leader. Can be pre-identified at the Operational Area based on local or historic need. Most often established at the incident to accomplish a specific mission/task and disbanded upon completion of the mission/task.

OPERATIONAL AREA (OA):
An intermediate level of the State emergency management organization, consisting of a county and all political subdivisions within the county.

OA EMS DISPATCH CENTER (or Local EMS Dispatch Center):
An EMS dispatch center, assigned by the LEMSA, to serve as the single point of contact within the OA for the acquisition and coordination of EMS resources.

PATIENT DISTRIBUTION CENTER, OPERATIONAL AREA (OAPDC):
A function assigned by the LEMSA, to coordinate the distribution of casualties at the operational area level.

PATIENT DISTRIBUTION CENTER, REGIONAL (RPDC):
A function assigned by each RDMHC, to coordinate the distribution of patients at the regional level during disasters.

PATIENT DISTRIBUTION CENTER, STATE (SPDC):
The state level function for coordinating the distribution of patients at the state and federal level during disasters. The SPDC function is performed by the CDPH/EMSA JEOC.

REGIONAL DISASTER and MEDICAL HEALTH COORDINATOR (RDMHC):
At the regional level, EMSA and CDPH jointly appoint a RDMHC, whose responsibilities include supporting the mutual aid requests of the MHOACs for disaster response within the region and providing mutual aid support to other areas of the State in support of the State medical response system. The RDMHC also serves as an information source to the State medical and health response system.

- May designate a Regional Medical Transportation Coordinator (RMTC) to assist with development of the AST/MTF Program.
- Supports the organization of medical transportation assets within the Region.
- Facilitates the development and maintenance of the Regional AST/MTF Program.

FILLED BY RMHCC, RDMHC/S OR DESIGNEE

REGIONAL DISASTER MEDICAL HEALTH SPECIALIST (RDMHS): The RDMHS provides the day-to day planning and coordination of medical and health disaster response in the State's six mutual aid regions. During disasters, the RDMHS may be designated by the RDMHC as the key contact for OAs to request and/or to provide medical and health resources.

202 AST/MTF FORMATION

INCIDENT/PLANNED EVENT

Immediate Need

- Immediate need ambulances are resources prepared to respond within three (3) hours of a request. These ambulances are requested in sufficient quantity to mitigate the emergency. Personnel associated with these resources should be prepared for an extended term incident.

Planned Need:

- Planned need resources have an estimated time of arrival greater than three hours. These ambulances are requested to relieve initial and immediate need ambulances or for tactical needs in the next operational period. These resources are usually requested to relieve first wave resources during the next operational period (12 – 24 hours).

203 AST/MTF NUMBERING SCHEMATIC; TYPING

The AST/MTF numbering schematic has evolved from and is similar to the schematic that is used by the fire service strike team numbering system. This diagram serves as the model for all statewide ASTs and should be used in all cases where an AST is formed.

- Schematic
  - CA-California
  - M-Medical Resource
  - X?? – Three Letter Operational Area Designation (MACS 410-2)
  - # - CAL EMA Mutual Aid Region 1-6
  - # - Sequential Number (01-99)
  - # - Alpha Character Designating the Typing Class:
    - V: Type 1 – Advanced Life Support (ALS)
    - W: Type 2 – Basic Life Support (BLS)
  - # - Unit number within team 1-6

- Schematic for Disaster Medical Support Unit (DMSU)
    - Numbering: State Unit #s – “CA-M-DMSU 1-26”
    - AST/MTF Numbering for DMSU:
        - If used as an ASTL Vehicle, the numbering scheme would be: CA-M-XLA- 101W1 – Leader vehicle is #1 in unit sequence. Remember that this number is placed on the unit when it becomes part of the strike team or MTF.

        - If used as a single asset or additional unit for the strike team, the numbering scheme would be: CA-M-DMSU “1-26”. These numbers are placed on the vehicle permanently.

Each OAMDC shall work with the RDMHS/RMDC to ensure compliance with the numbering convention process.

- It is required that each ambulance of an AST/MTF have placards available so that it can be clearly be identified as a component of an AST/MTF. The placard will be no less than 4 inches in height and 11 inches in length. Where applicable, placards for the AST/MTF will be available in the Disaster Medical Support Unit (DMSU) with the AST Leader Kit. Placement of the placard should be on the lower right corner of the windshield and placed in a manner that it does not have an impact on the driver’s vision and safe operation of the medical resource.

FIGURE 1

Figure 1, Program Organization & Structure provides the structure of the AST/MTF Program within the framework of SEMS. This figure emphasizes the different roles and responsibilities from the State level all the way down the individual AST members. This figure should used in conjunction with the position/entity information in section 200.

FIGURE 1 – PROGRAM ORGANIZATION & STRUCTURE

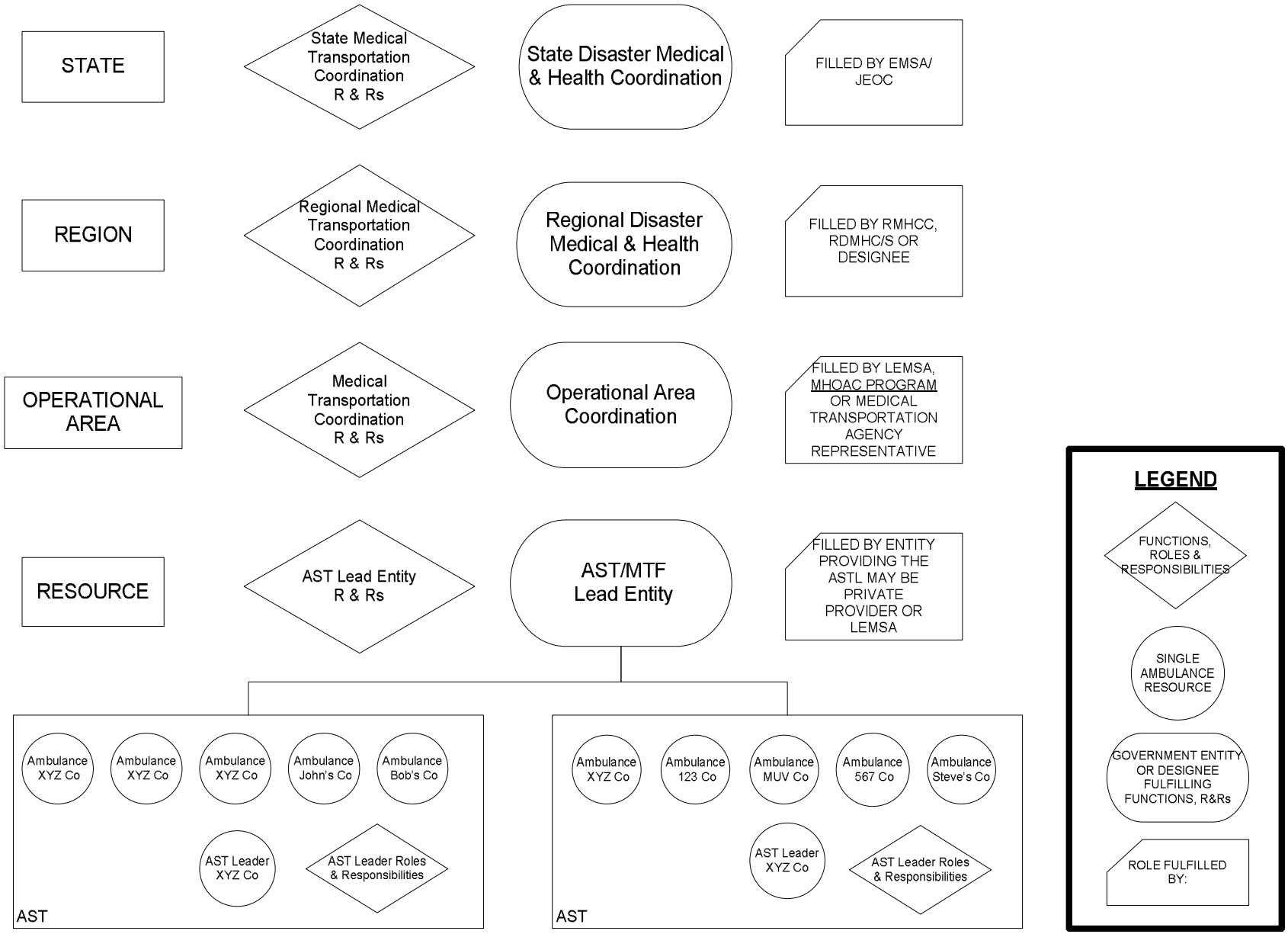


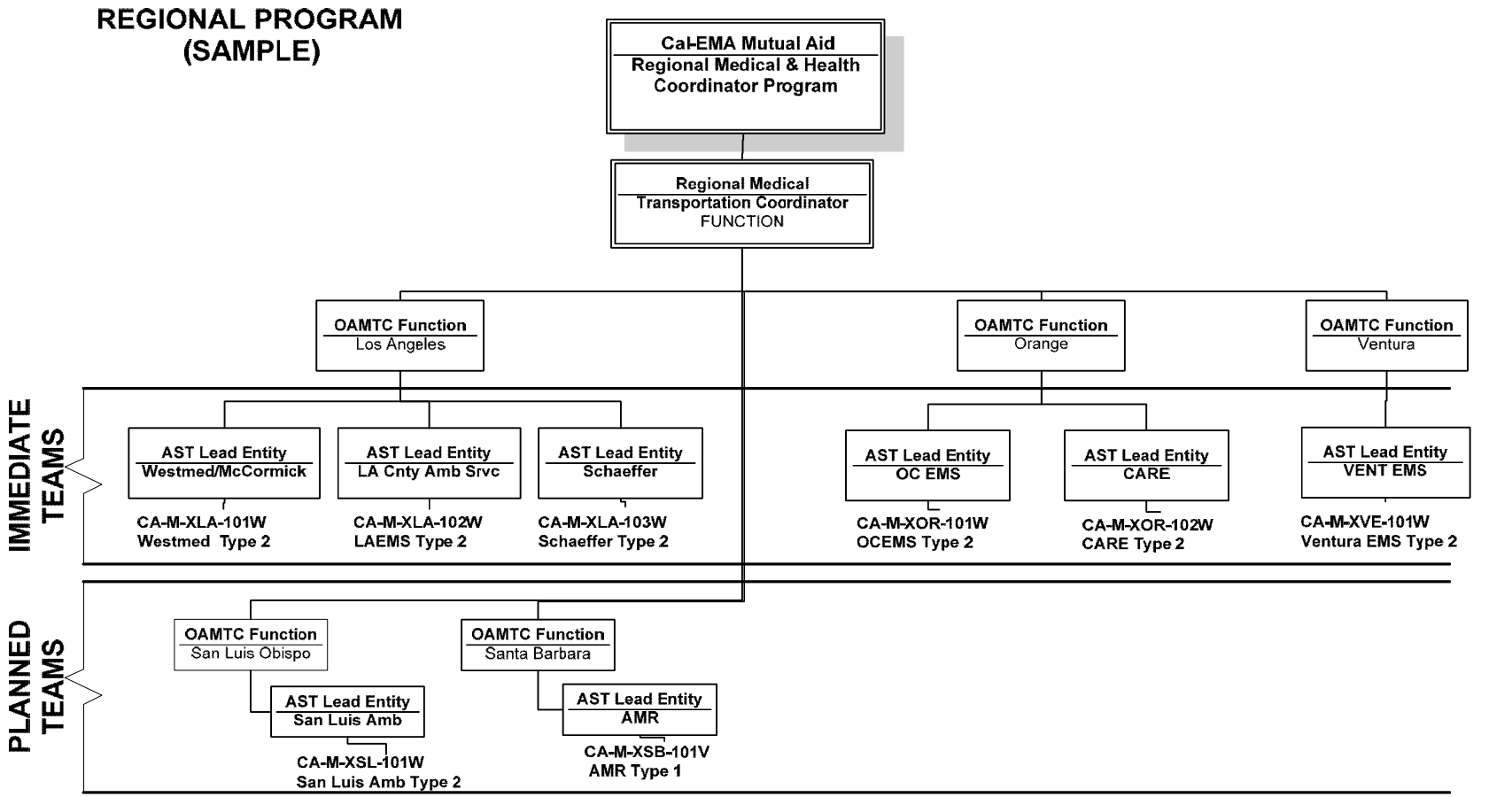
FIGURE 2

Figure 2, Team Configuration provides an AST hierarchy broken down by OA and Immediate/Planned Teams. This figure provides the various functions and roles of the AST/MTF Program, i.e. Coordinator Program/Group, OAMDC, and ASTLE.

The legend contains detailed information in regards the AST Numbering Convention Scheme and the Alpha Ambulance Typing. Please note the following information in reference to the Alpha Ambulance Tying box. Type (Y) and (Z) are pending national review and comment via the process of NIMS Integration Center (NIC).

This sample is based on the five counties of CAL-EMA Mutual Aid Region 1, but it can easily be modified so that it reflects the other CAL-EMA Mutual Aid Regions.

FIGURE 2 – TEAM CONFIGURATION



Numbering Convention Scheme
CA-M-XVE-1001V-(Units 1-6)
CA-California M-Medical Transportation Resource X?? – Operation Area #- OES Mutual Aid Region 1-6 ##- 2 Digit Sequential Team 01-99 # - ALPHA – Typing (V,W, Y, Z) # - Unit number within team 1-6

IMMEDIATE: Pre-Identified, 24-hr Dispatch, Available to RMHCC as a standing order resource.
PLANNED: Assembled upon request, 24-hr Dispatch through AST Lead Entity.
DMSU: Single asset that may be requested to accompany an AST/MTF.

ALPHA AMBULANCE TYPING:
(V): Type 1 ALS
(W) Type 2: BLS
(Y) PENDING
(Z) PENDING
(TF) Medical Task Force

This document is a DRAFT of the CALIFORNIA Ambulance Strike Team Notification, Activation and Organizational Charts. 26 Feb, 2010 **V1.8**

300 OPERATIONS

301 STANDARDIZED FIELD PROTOCOLS

EMSA has adopted the California FIRESCOPE Multi-Casualty Incident response system as the operational standard for response to multi-casualty incidents in California.

302 PATIENT CARE DOCUMENTATION AND PREHOSPITAL CARE REPORTS (PCRs)

All patients shall have the medical condition and care rendered documented. In general, this documentation will occur in one of two forms: triage tags or PCRs. Triage tags may be utilized at multi-casualty incidents where the ratio of patients to care givers and the urgency of the situation precludes the practical use of a PCR. In all other situations, a PCR is indicated. The minimum standard for PCRs is that a hardcopy is left at the receiving hospital. Responders should utilize their PCRs from their permitting/accrediting jurisdiction, or forms provided to them at staging.

303 OPERATIONS PREPARATION, ORDERING AND REQUESTING PROCESS

In advance, and in preparation for an incident and response, the MHOAC Program in each OA will work with ambulance providers to identify resources, both personnel and ambulances, so that they are staffed and stocked with necessary equipment. The MHOAC Program will develop a system by which resources in their area can be identified immediately when needed. At the OA level, law enforcement, fire and rescue, and medical and health representatives should work to avoid redundancy in providing resources.

304 MEDICAL MUTUAL AID

The foundation of California's disaster medical response system is the capacity for jurisdictions to make medical resources available through California's Medical Mutual Aid System and other inter-OA resource sharing procedures. The processes for requesting, mobilizing, tracking, and demobilizing those resources are described below with capabilities and procedures that ensure that medical transport resource needs are

rapidly identified, communicated and responded to. They are consistent with processes for resource requesting described in the Interim CDHOM.

305 AST/MTF ALERT AND NOTICE

Upon notification of a major medical/health disaster, the region may initiate an advisory to the AST resources.

- The EMS dispatch center alerts/notifies the MHOAC Program and/or LEMSA that an incident has occurred.
- The MHOAC Program and/or LEMSA contacts the RPDC, which will carry forward the notification process to both impacted and assisting parties and the EMS Duty Officer.

305.1 AST/MTF INCREASED READINESS ACTIVITIES

Notification of a major medical/health event may place the Region's AST/MTF Resources in an advisory status.

- Advisories may be issued to unaffected OAMDC notifying them of the event.
- In accordance with SEMS, the RDMHC/S Program performs the assessment of available AST/MTF resources.
- In accordance with SEMS, the RDMHS Program are readied to receive request from affected OA.
- RDMHC/S Program monitors and maintains contact with the affected OA to ensure proper progression or de-escalation of AST/MTF Resources.

305.2 AST/MTF PRE-IMPACT ACTIVITIES

The RDMHC Program shall issue situation reports to direct pre-impact activities which may include:

- Readiness of Initial Response Ambulances (teams).
- Conduct the formation of other Planned Need Ambulances (teams).
- Initiate and open the communication pathways between the RMDC and the ASTLE.

306 MEDICAL INCIDENT(S), NOTIFICATION/ACTIVATION

Medical Incidents are defined in CDMOM in Section II. The classifications are:

- Level I Medical Incident – Requires response resources only from within the affected operational area (OA) (or as available from outside the OA through day to day agreements)
- Level II Medical Incident – Requires response resources from or distribution of casualties to other OAs within the mutual aid region of the impacted OA
- Level III Medical Incident – Requires State or federal response resources or distribution of patients beyond the mutual aid region using state or federal systems and resources

307 INCIDENT REQUEST

A request for AST/MTF should be done using the Medical and Health Resource Request Form (Ref: CDMOM/CDHOM/EF8 Medical Health Operations Manual) and should include the following information:

- Required point of contact
  - Name
  - Number
  - Position

- Deliver point of contact
- Priority
- Preferred communication method, i.e., radio, etc
- Deliver Address/Drop Point
- Detailed description of resource/task
- Kind/Type/Quantity of resource request
- Utilization of Form IS 213 RR MH is recommended

308 MOBILIZING RESOURCES

The ASTL should expect the following information:

1. Special instructions as noted in the initial request
2. Instructions to contact the RMDC in the impacted area and the sending MHOAC on arrival and at the time of release.
3. Recommended equipment and personal gear they should carry, based on the anticipated length of the assignment and the situation and resource availability in the affected area.

The requesting RDMHC/S may also ask for a contact telephone number for cancellation of resource while en-route, or for information updates. If the resource is cancelled en-route, the requesting RDMHC/S will advise the sending MHOAC who will revise the status of the resource in CDMN OR EQUIVALENT OR EQUIVALENT to “Canceled”.

309 AST TRAVEL PROCEDURES

The ASTL will:

1. Determine rendezvous point.
2. Introduce team members.
3. Brief the team members on current conditions, safety issues and potential assignments.
4. Determine response route (considering time of day), traffic, food and fueling stops.
5. Make the travel and communication plans, i.e. who leads, who brings up the rear. Identify a travel radio frequency for en-route communications.
6. Conduct a checklist assessment for the AST/MTF readiness and equipment availability.
7. Notify the RMDC, ASTLE , or other designated entity of status and ETA to incident.

All units will maintain contact with the ASTL by radio or phone while en-route to the incident.

If an ambulance unit is unable to respond or maintain status on the AST for any reason (mechanical failure of the ambulance, illness of team members, etc.), then the ASTL will contact the RMDC, ASTLE, or other designated entity. Ambulances and team members are not considered incident resources until the team has checked in at the incident.

310 AT THE INCIDENT

The AST/MTF Leader will check in and report to assigned location or staging area for assignments. The ASTL will be responsible for the following:

1. Maintains and continues using ICS Form 214, (Unit Log), for each vehicle throughout the entire incident.
2. Provides information, including resource order and request number for check in (ICS Form 211).
3. Receives Incident Briefing (ICS Form 205 and 206).
4. Obtains orientation to hospital location(s).
5. Briefs AST team members on incident and their assignments.
6. Determines preferred travel routes and brief team members.
7. Reports for line assignment(s) or to a Staging Area as directed.

311 PROTOCOLS – SCOPE OF PRACTICE

ALS Ambulances:
If dispatched as an ALS ambulance during a response into another operational area, then an EMT-Paramedic (EMT-P) may utilize the Scope of Practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting home LEMSA.

ASTL:
If the ASTL provides any medical care during the incident, they will utilize the Scope of Practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting LEMSA.

BLS Ambulances:
EMT-Basic (EMT-B) who is functioning as an AST/MTF member is able utilize the EMT-B Scope of Practice. However, Optional Scope of Practice may not be performed outside of his/her home jurisdiction, i.e., the LEMSA in which s/he is trained and authorized.

312 INCIDENT SUPPORT

Each incident is unique in terms of scope, demands, duration etc. In general, incident durations may be classified as:

1. Short Term Incidents:
   Incidents which are generally resolved in less than 12 hours. Field, support staff, and administrative staff may be required to work some overtime hours; however, long term staffing of the incident site and other locations is usually not required.

2. Extended Term Incidents:
   Incident lasts 12 to 72 hours and may tax staffing in field settings. Managing extended term incidents may require:
   a. Early release of staff during the first operational period to ensure their future availability.
   b. Establishment of a staff schedule to ensure adequate coverage throughout the incident.
   c. Assessment of need for additional field staff assistance from neighboring LEMSAs.
   d. Provision of advice to field providers to prepare for extended scheduling early in the first operational period.

3. Long Term Incidents:

Long Term Incidents require staffing for more than 72 hours. In addition to the personnel strategies described above for Extended Term Incidents, response agencies may consider:

a. Mutual aid assistance.
b. Acquisition and just-in-time training of staff from other agencies.
c. Assistance from other state and federal response agencies.

Incidents may begin as one type of incident and evolve into another type or present multiple types simultaneously. These shifts may dramatically change the role, responsibility, involvement, and authority of the LEMSA and the OA's medical response.

While the MHOAC program or the OA are responsible for integrating responding ASTs/MTFs and providing logistical support, resources, etc., this capability varies widely across the State. Thus, AST/MTF reporting to the scene of a disaster or other incident, should not expect support services to be in place during the early stages of the incident. For this reason, all AST/MTFs are expected to be self-sufficient for up to 72-hours. The location and magnitude of the disaster will determine the level of support services available. The ASTL may have to utilize commercial services for food, fuel, and supplies until logistical services are established. Obtaining replacement medical supplies during the first few days of a disaster may also prove to be difficult.

The facilities, services, and material at an incident are typically provided by the Logistics Section of the Field Level IC. The ASTL will contact their respective supervisor for instructions on accessing these services.

The ASTL is expected to attend operational shift briefings and keep all personnel on the team informed on conditions, mission assignments, etc. If the individual units of the AST/MTF are assigned to single resource functions, i.e. patient transportation, triage, or treatment, then the ASTL will make contact with the personnel at least once during each Operational Period.

If possible, units within an AST/MTF should stay together unless otherwise directed by the ASTL. At a minimum, all team members will maintain communications with the ASTL. Until incident facilities are established, each AST will have to remain self sufficient.

313 DEMOBILIZATION

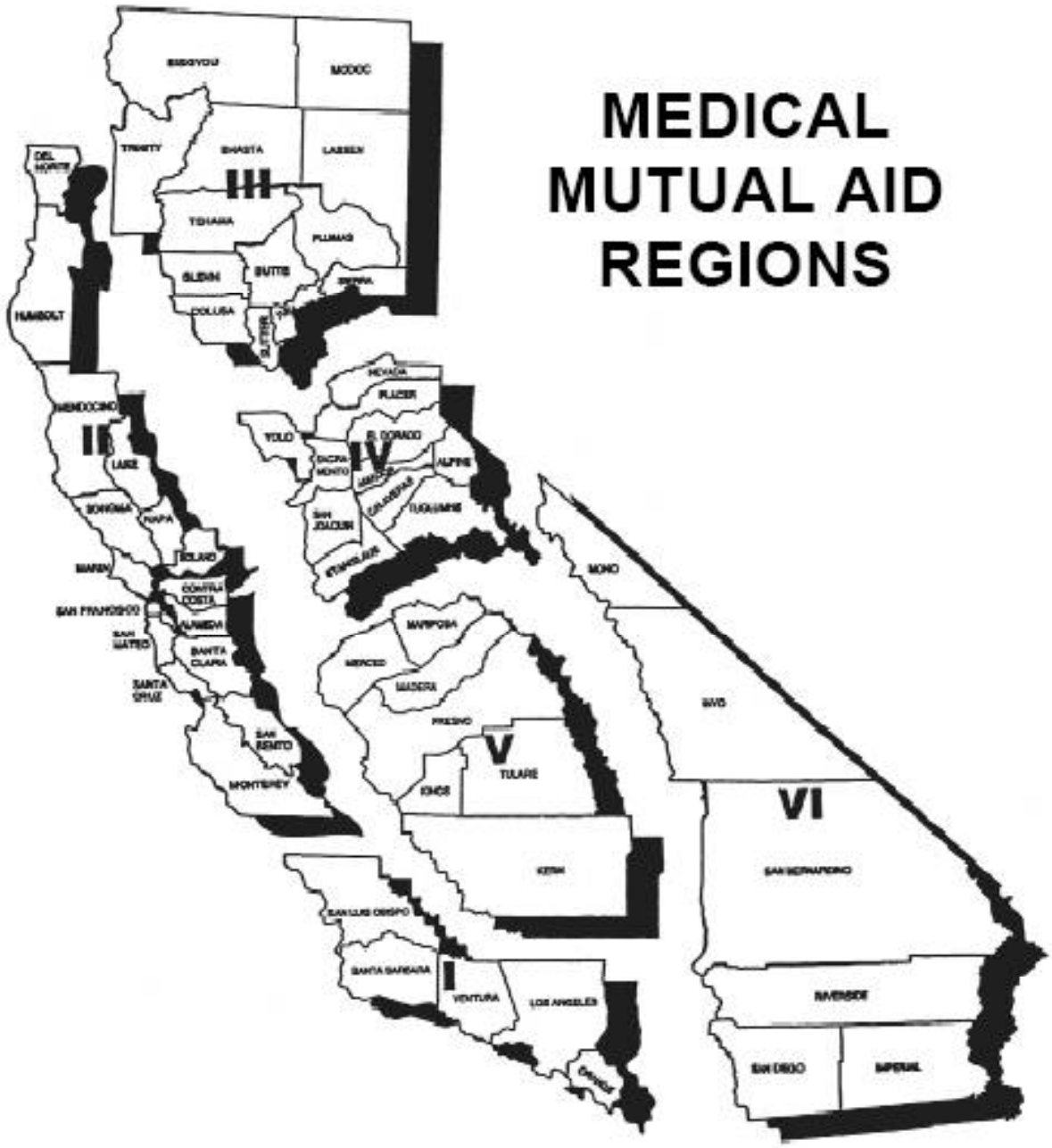
Demobilization and release will take place in accordance with the Incident Demobilization Plan and the ICS Form 221. At no time shall a crew or individual team member leave without being formally released and provided with departure instructions. ASTs should obtain necessary supplies to assure that the ambulances documented through the Demobilization Process, leave in a "state of readiness" whenever possible.

All AST/MTF personnel will receive a debriefing from the ASTL prior to departure from the incident. Vehicles may be inspected for safety by the Ground Support Unit before departing from the Incident. The ASTL will review return travel procedures with AST/MTF members. The ASTL or designee will notify the RMDC of the ambulance release time, travel route, and estimated time of arrival back at home base. The AST/MTF is still a team until they return to their home base(s) and may be reactivated at any time.

It is expected that demobilization as a team will be the standard, and break of teams will be a rare exception. When teams are broken up, remaining units are reassigned under a new mission as single resources, or recombined, again with a new mission, as another strike team.

It is expected that the sending MHOAC/RDMHC and/or the RDMC or ASTLE will coordinate the demobilization status and tracking. All demobilizations, whether of complete teams or single resources will include communication with the home base as to the estimated time of arrival back at home base.

FIGURE 3 – MEDICAL MUTUAL AID REGIONS

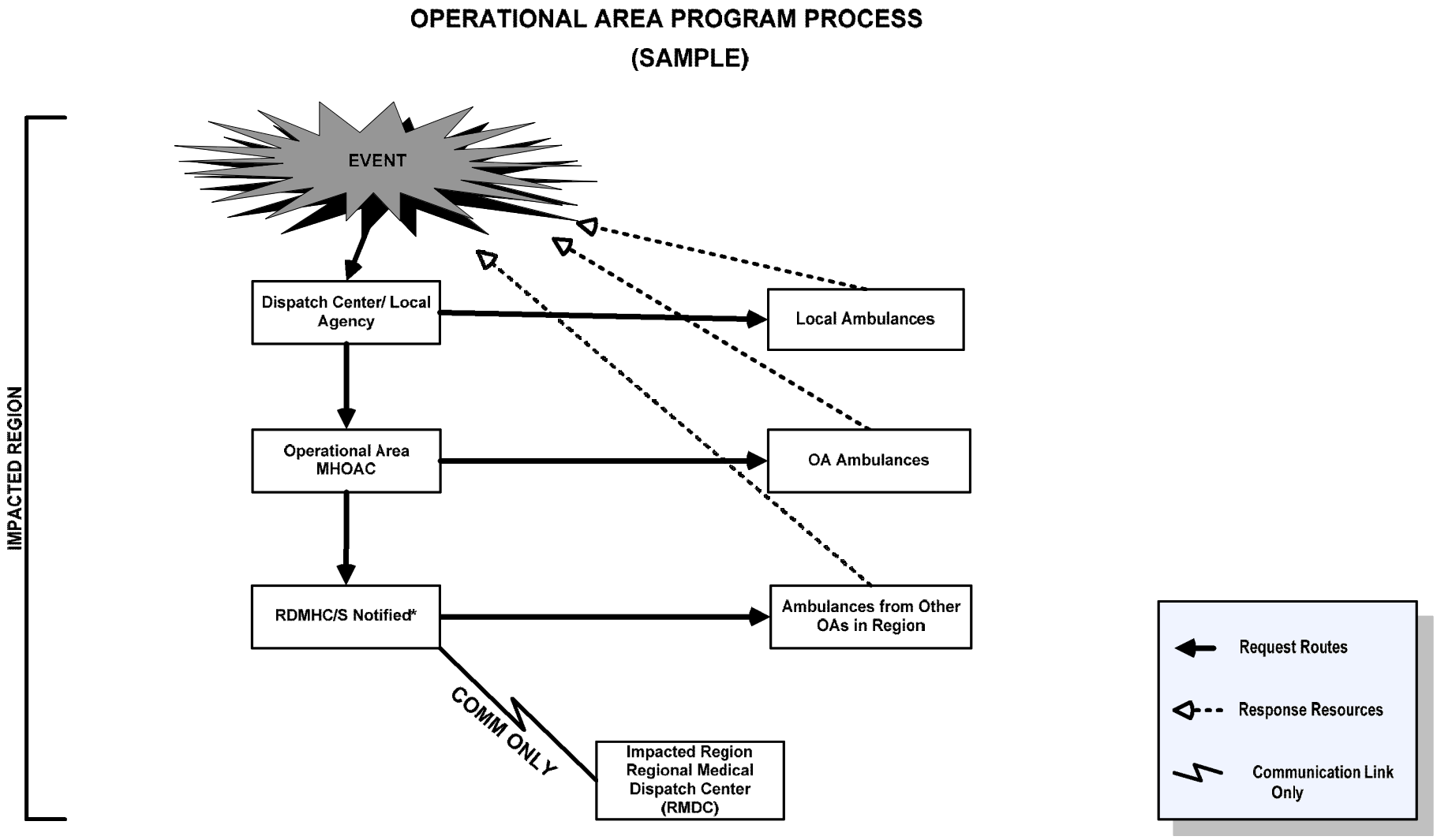


FIGURES 4 & 5

Figure 4 - Operational Area Request for AST/MTF provides the structure of the AST/MTF Program at the OA level. Please note that this chart is to be used as a sample only and individual OAs may vary. This figure shows the interaction between the local and county dispatch centers. The event is the starting point that triggers the AST/MTF request to the Impacted Region's MHOAC Program via the Local Agency/Dispatch Center, i.e. Agency Dispatch. This request is forwarded onto the Impacted Region's RMDC. This is the end point for this particular chart because the request route continues onto Figure 4 with the Regional Program and is outside the scope of the OA.

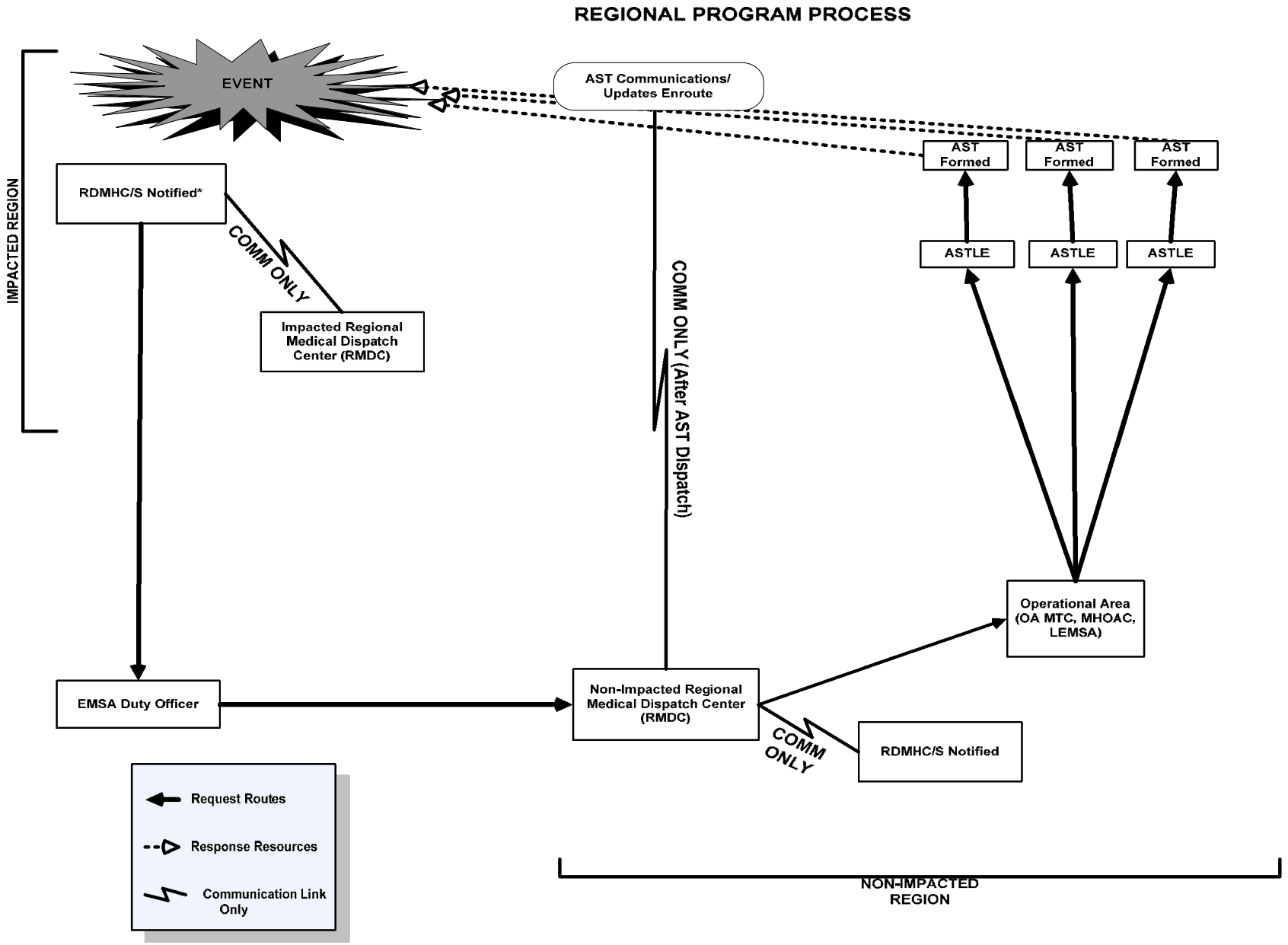
Figure 5 – Regional Request for AST/MTF picks up (at the regional level) where Figure 4 leaves off. This figure is split into two parts with the left side reflecting the "Impacted Region" and the right side the "Non-Impacted Region". The Impacted Region's RMDC requests AST resources from the AST/MTF Requesting Authority. The Non-Impacted RMDC Program receives the alert from the AST Requesting Authority that AST/MTF resources are needed at the event. Subsequently, by means of Standing Orders, the RMDC Program activates OA AST Resources and the MHOAC Program and the ASTLEs coordinate the formation of ASTs/MTFs in the Non-Impacted Region.

FIGURE 4 – OPERATIONAL AREA REQUEST FOR AST/MTF



V1.1

FIGURE 5 – REGIONAL REQUEST FOR AST/MTF



*The RDMHC and the RMDC will be in coordination with each other during the requesting process.

400 COMMUNICATIONS

Communications equipment, protocols, etc. vary within the State. It is the responsibility of each MHOAC and/or the OAMDC to ensure that the minimum communications equipment described below is available to ambulances, ambulance/medical personnel and AST/MTF Leaders. There are three distinct communications needs for AST/MTF:

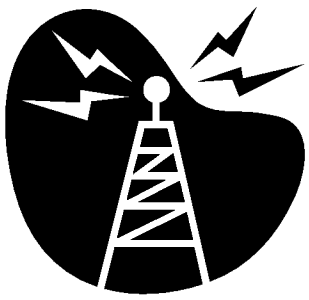
1.) Communications to the RMDC Program
All AST/MTF resources will be equipped with radios and/or cell phones with the ability to communicate to their RMDC from any destination in California. Redundant capabilities are recommended.

2.) Communications in-transit
While en-route to the incident, AST resources must be able to communicate with each other and their respective RMDC. Options for communications in-transit may include CALCORD, cell phones, common radio frequencies, etc.

3.) Communications at the scene
A programmable hand-held radio is better suited for responding to a disaster. It will provide the ability to maintain communications outside of the vehicle and stay in contact with the ASTL. A mobile radio is recommended in addition to the hand-held programmable radio due to the increase in output power with a mobile unit. It is expected that the ASTL be provided with a hand-held programmable radio to communicate with the requesting operation area or incident command staff at the incident.

Ambulances will not communicate directly with receiving facilities unless given special instruction to do so by either the Incident Commander or designee. The Medical Communications Coordinator or Patient Transport Group Supervisor will conduct all communications to and from the hospitals/control facility. For frequency specific information, reference Figure 4: Frequency Channel Plan.

4.) DMSU Resources

ASTL Communications Cache	
	❶ (1) UHF mobile radio (50 watt) preprogrammed with the EMS Statewide Frequencies ❷ (1) VHF mobile radio (50 watt) with EMS Statewide Frequencies ❸ (1) 800 MHz mobile radio (50 watt) preprogrammed with EMS Statewide Frequencies ❹ (6) UHF handheld radios preprogrammed with EMS Statewide Frequencies ❺ Mobile repeater ❻ EMS Statewide Communications Directory

- EMSA hand-held radios are programmed solely by Department of General Services (DGS) Telecommunications Division or the Incident Command Communications Officer. For DMSU-specific communication equipment information, reference the Memorandum of Understanding, For the Transfer of the DMSU.

- DMSU Resources: Radio frequencies will be pre-assigned by the six RMDCs and those frequencies will be preprogrammed into each DMSU radio system by DGS. This preprogramming will ensure that the DMSU will have an established, direct line of communication with its assigned RMDC. This frequency will be a unique frequency governed by the RMDC for which the DMSU is assigned. Refer to Figure 6: Activation and Dispatch for more information regarding this direct communication link between the AST/MTF and the RMDC.

- Non-DMSU Resources: The EMSA holds licenses for statewide communications on UHF Med-net channel 9 (468.950) and channel 10 (467.975). These two channels are the recommended frequencies for both Field and OA levels but other UHF, VHF, and 800 MHz frequencies can be assigned to and utilized by ASTs.

FIGURE 6

Figure 6, AST/MTF Activation & Dispatch depicts the expected events of both the OAMDC, RMDC, RDHMC/S. The communication pathways commence on the right portion of this figure with the AST/MTF Requesting Authority, i.e. the SOC, REOC, or the Joint Emergency Operations Center (JEOC). The alert is designated by a communication link between the RDMHC Program and the SPDC. For specific SPDC activation and dispatch tasks, reference the SPDC Checklist in the Appendix. The AST/MTF Leader(s) will communicate with the SPDC and vice-versa in order to provide updates en-route to the Field Level IC Field Event.

FIGURE 6 – AST/MTF ACTIVATION & DISPATCH

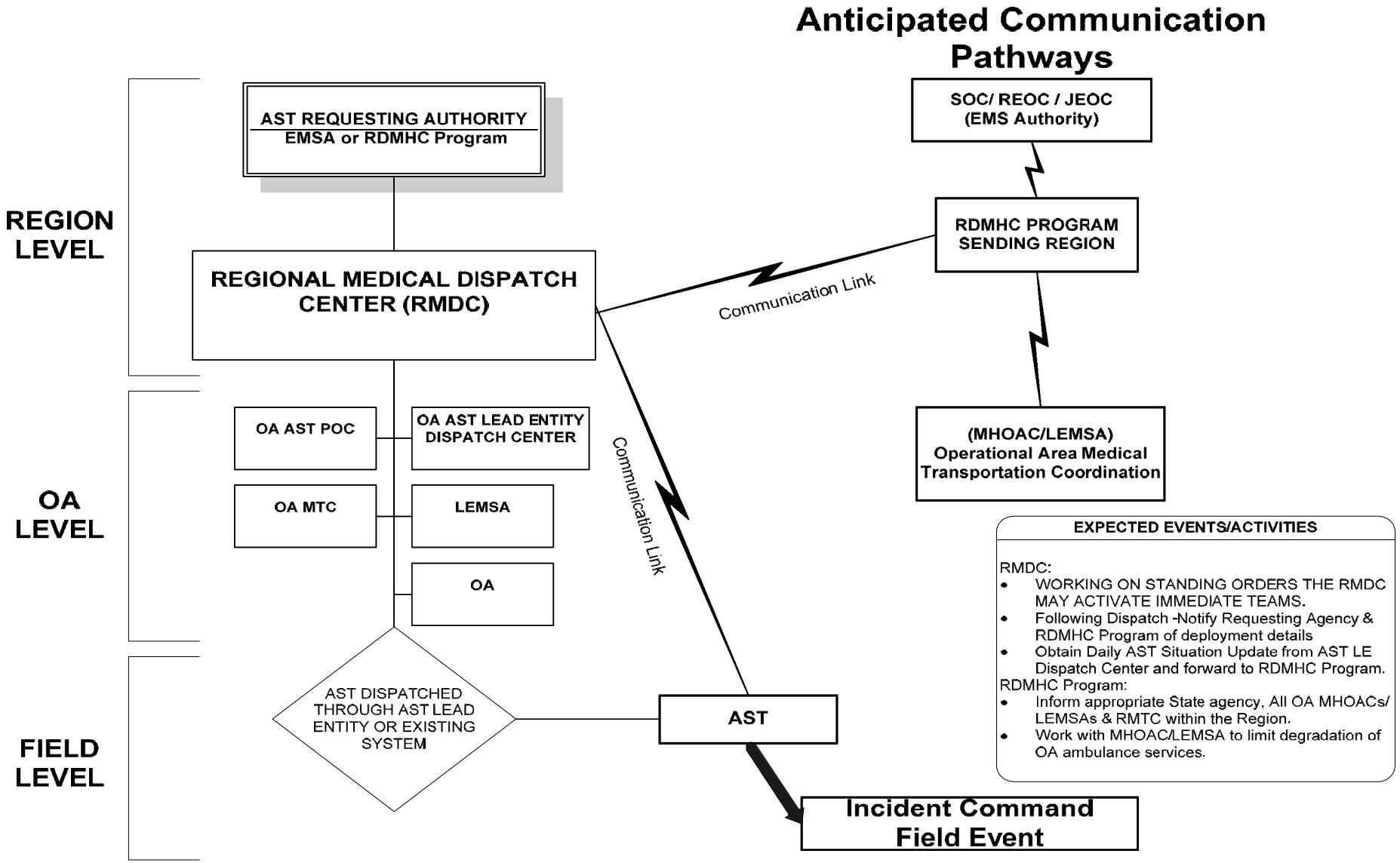
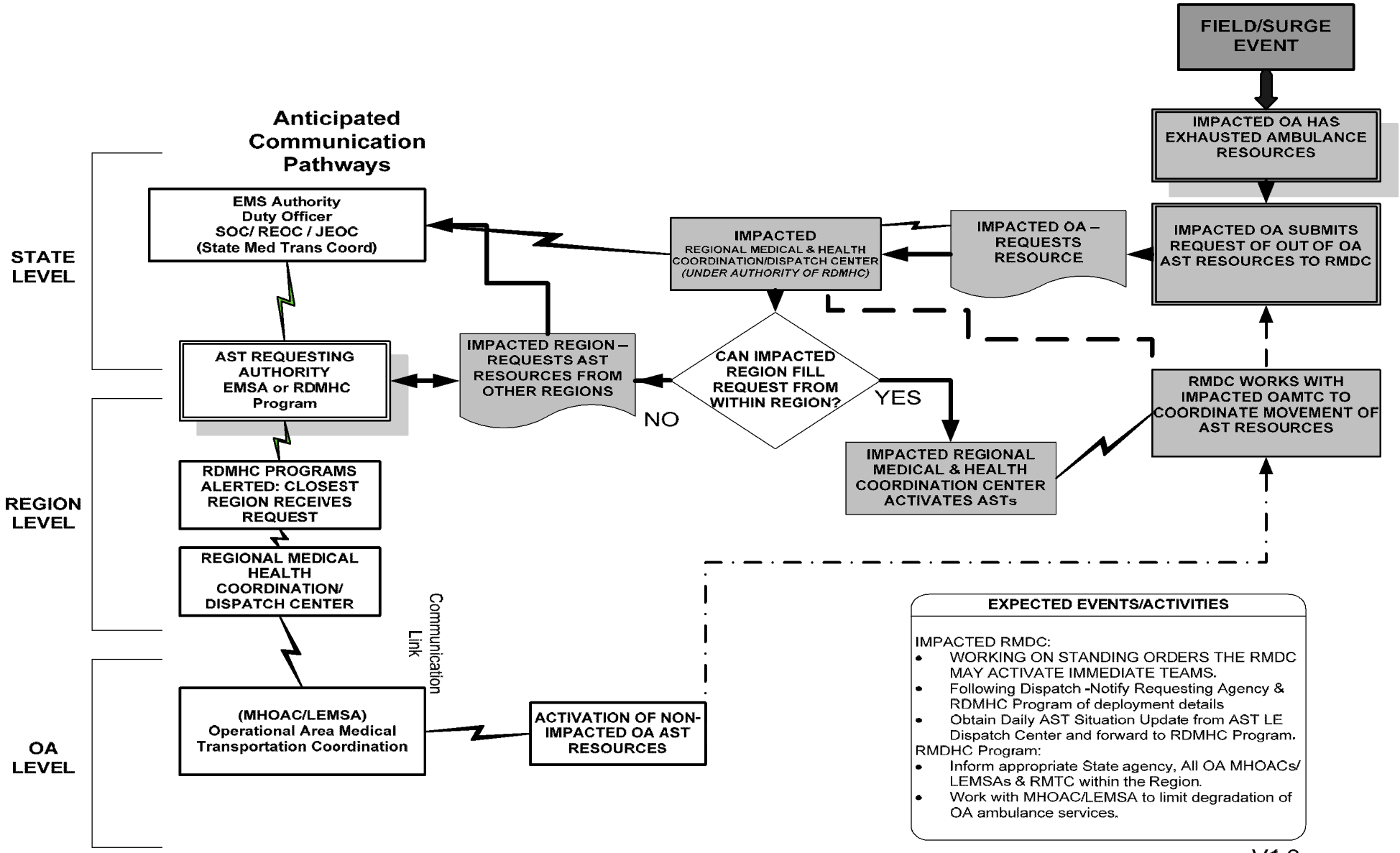


FIGURE 7

Figure 7, Impacted Region Requesting Process shows the complete requesting process starting with the Field/Surge Event. The figure has two primary pathways which diverge at the diamond shaped box which asks the question, “Can Impacted Region Fill Request from within Region?” Depending on the “yes” or “no” response, the requesting process will lead off either to right or left respectively.

FIGURE 7 – IMPACTED REGION REQUESTING PROCESS



500 TRAINING / EDUCATION

The Ambulance Strike Team Leader (ASTL) Training Program and any AST/MTF related training/education shall be in compliance with SEMS and NIMS. The curriculum shall be approved by EMSA, and conducted by a California Approved Pre-Hospital Continuing Education Provider which coordinates with the LEMSA having applicable jurisdiction. In order to advance the AST/MTF Program and ensure NIMS compliance, the following provisions are in operation.

501 AMBULANCE STRIKE TEAM LEADER (ASTL) COURSE

Minimum Prerequisites for the ASTL course are provided below:

- Ambulance operational experience is preferred.
- NIMS 700a
- SEMS (Introductory)
- ICS 100, 200, 300
- Hazardous Materials (HAZMAT) Field Response Operations (FRO)

502 ASTL POSITION TASK BOOK (PTB)

Upon successful completion of an approved ASTL course, the student will receive a Position Task Book and will be designated as an ASTL Trainee (ASTLT) until they submit a completed and approved PTB. The PTB is included as Appendix 715 and can also be downloaded at www.emsa.ca.gov. It is not only useful for the documentation of tasks, but serves as an essential reference for AST deployments. The provider / employer will sign off on the PTB before it is submitted to the LEMSA for approval. If the PTB is approved, the ASTLT will be issued an EMSA authorized certification card by the LEMSA.

This Position Task Book (PTB) has been developed for use in Ambulance Strike Team (AST)/Medical Task Force (MTF) Leader positions in California functioning under the Incident Command System. The PTB lists the performance requirements (tasks) for the specific position in a format that allows a trainee to be evaluated against written guidelines. Successful performance of all tasks, as observed and recorded by an evaluator, will result in a recommendation to the agency that the trainee be certified in that position.

Evaluation and confirmation of the trainee's performance of all the tasks may involve more than one Evaluator and can occur at incidents, planned events, full scale exercises, in classroom simulations, and in other work situations. It is important that

performance be critically evaluated and accurately recorded by each evaluator. All tasks must be evaluated before recommending certification. All bullet statements within a task which require an action (contain an action verb) must be demonstrated before that task can be signed off. Pictures, copies of IAP OR ICS 201s on an incident, exercise plans, and other supporting documents are encouraged.

503 ASTL GRANDFATHER AND COMPARABLE EXPERIENCE

LEMSAs may issue ASTL certification cards to individuals who have completed comparable training or experience. Each ASTL must have completed the ASTL course prior to appointment as an ASTL on an AST/MTF outside of their operational area.

504 APPOINTMENT AS AN ASTL

An ASTL will be appointed by either a LEMSA or ambulance provider. Please note that current EMT certification or paramedic licensure are not perquisites to being an ASTL.

505 ASTL RECERTIFICATION

The original ASTL certification card is valid for 5 years. If the ASTL has not responded to an incident or participated in an exercise within this timeframe, at the discretion of the LEMSA the ASTL may be required to demonstrate core competencies in order to qualify for another certification card.

506 ASTL LISTINGS

The LEMSA maintains a listing of current ASTLs for their respective county or counties.

600 REIMBURSEMENT / RECOVERY

601 REIMBURSEMENT / RECOVERY FOR AST/MTF EMERGENCY RESPONSE

This section will focus on State AST missions and the process to receive reimbursement for region(s) to region(s) deployments. It is the intent of EMSA that ambulance providers only commit their resources as approved by their MHOAC/LEMSA.

602 BILLING FOR STATE AST ACTIVATIONS AND DEPLOYMENTS

Reimbursement procedures should be consistent with EMSA's AST policies and Memorandum of Understanding (MOU) between EMSA and providers participating in the State authorized AST deployment(s).

603 FORMS AND DOCUMENTATION

All providers will be responsible for and will maintain full documentation to substantiate any invoices submitted to EMSA. The following documentation is to be provided to EMSA along with the approved AST invoice:

- Demobilization Checkout (ICS 221)
- Unit Log(s) (ICS 214) for each unit and ASTL to include timekeeping
- Organizational Assignment (ICS 203) if applicable
- Payee Data Record (STD.204)
- Drug-Free Certification (STD.21)

In order to ensure prompt payment to AST participants, the approved AST invoice and all of the supporting documentation must be completed and submitted to: Emergency Medical Services Authority, 1930 9th Street, Sacramento, California, 95811, Attention: Budget Officer.

604 PATIENT TRANSPORTS

EMSA has determined that billing for Patient Transports is permissible and no deduction(s) from the total cost need be made when completing the AST invoice.

605 RATES AND FEE STRUCTURE

Information on the current rates and fee structure can be referenced on the EMSA website.

700 APPENDIXES

701 AMBULANCE STRIKE TEAM/MEDICAL TASK FORCE LEADER

Ambulance Strike Team/Medical Task Force Leader Checklist

Mission: Manage, coordinate, and direct the actions of assigned ambulance crews at a wide variety of emergency situations. This includes maintaining all required records, and ensuring that the logistical needs of all personnel are met during the entire activation of the team

Pre-Event: READINESS

- ○ Notify OAMDC/RMDC of a change in either contact information or eligibility to participate in the Ambulance Strike Team Program. Ensure that equipment meets or exceeds the requirements published in the EMSA #215, equipment includes:
  AST/MTF "Go kit or 72 hour go pack
  AST/MFT Leader Vehicle1

Travel: RENDEZVOUS POINT

- ○ In cooperation with the Ambulance Strike Team Lead Entity or an OAMDC, establish rendezvous point for the formation of the AST/MTF, (if necessary).
- ○ Ensure that all five ambulances make it to the rendezvous point.
- ○ Coordinate safe travel plans to incident location.

Response: BRIEFING

Will include at a minimum the following items:

- ○ General Message and Incident Update
- ○ Introduce self, Ambulance Strike Team Trainee, and identify second in command
- ○ Provide brief overview of known incident information and assignments
- ○ Work, ethic, professionalism, human relations expectations
- ○ Communications
- ○ Identify cell phone numbers, travel and tactical radio frequencies
- ○ Determine radio designators for each AST and ASTT
- ○ Information will normally be exchanged up and down via personnel meetings and chain of command. Exception: Immediate and/or unresolved safety issues
- ○ Ambulance/Staff Readiness
- ○ All medical supplies and spares
- ○ Staff with appropriate uniforms
- ○ Rig for probable assignment
- ○ Utilizing the AST Numbering Schematic, identify each ambulance on the AST/MTF by affixing the EMSA Strike Team Identification Stickers to the windshield2
- ○ Safety

- ○ Review unknown or probable incident hazards, emphasizing lookouts, communications, escape routes, and safety (LCES)
- ○ Identify Medical resources on team
- ○ Personal Protection Equipment (PPE) donned3
- ○ Affirm crew evacuation signals and procedures
- ○ Travel Procedures
- ○ Response urgency, including appropriate use of Code 3
- ○ Travel route, planned stops, reporting location
- ○ Keep formation tight; slowest ambulance in front
- ○ Advise when approaching quarter fuel during travel, at least half fuel at time of deployment
- ○ Fuel payment procedure(s)
- ○ Briefly review essential elements of anticipated tactics (e.g. treatment, triage, transport) empathizing safety and mobility
- ○ Identify members having special experience/qualifications, e.g. bilingual, tactical medic, etc.
- ○ Assignments will primarily be based on crew experience, capability, and readiness
- ○ No freelancing. Personnel will advise the ASTL when their assignments are completed or if they are receiving conflicting orders from Branch, Division/Supervisor, etc.
- ○ Staging means 3-minute maximum ready time, at all times
- ○ Accountability and behavior expectations during unassigned time
- ○ All supply requisitions will go through the AST/MTF Leader or designee
- ○ Patient Flow Rate Formula: Pts/Ambulance multiplied by number of ambulances, divided by average round trip transport time
- ○ If anyone is unable to commit to his or her assignment for at least 96 hours, then advise as soon as possible.
- ○ Provide response and incident updates to the home Regional Medical Health Coordination Center.
- ○ Closing Comments

Post Event: DEMOBILIZATION:

Upon release orders from the Incident Commander, the AST/MTF Leader will:

- ○ Notify AST members that they have been released from the Mutual Aid Incident
- ○ Provide rendezvous location for debriefing
- ○ Conduct Debriefing4
- ○ Contact home State Patient Distribution Center and provide notification that ambulances are available to be put back in service
- ○ Complete all EMSA provided forms for the documentation of all the events that occurred during dispatch and or series of dispatches.
- ○ Submit completed Mutual Aid Incident forms to the Ambulance Strike Team Lead Entity for review prior to submission to the EMSA

Footnotes:

[1] If participating on an Immediate Team, then the MOU, For Transfer of the Disaster Ambulance Support Unit, should be referenced for more information on vehicle and equipment requirements/standards

[2] Sticker contained in the AST/MTF Leader Kit should be placed in the lower right corner of the windshield

[3] May postpone this action until approaching incident

[4] Reference Section 304 for detailed information on Debriefing

702 REGIONAL MEDICAL DISPATCH CENTER CHECKLIST

Regional Medical Dispatch Center (RMDC) Checklist

MISSION: Provide initial need ambulance resources to an impacted county within the region or adjacent region, and coordinate the arrival, tracking and release of out of region immediate and planned need medical resources for Level II and Level III Medical Incidents occurring within the region.

PREPAREDNESS:
- ○ Establish a telephone number and Med-Net radio frequency for medical mutual aid communications with requesting agencies and mobilized resources
- ○ Maintain a list of ambulances, and their dispatch information, which are available in each Operational Area (OA) within the region for rapid deployment to "immediate need" requests. Establish protocols for updating the list when MHOAC/LEMSAs withdraw the availability of some or all of their resources.
- ○ Establish protocols for tracking status and response times of resource responding from outside the region to planned need resource requests, and update their status in California Disaster Medical Network (CDMN or equivalent), including: time of arrival in the region, time on-scene, time released, and estimated time of arrival at home base.
- ○ Establish protocol for out of region medical resources to contact the Regional Disaster Medical/Health Coordinator and Specialists (RDMHC/S) when released from their assignment but prior to beginning travel to their home base, to determine if there are additional assignments. If reassigned, the RDMHC/S records the time and status for their new assignment in CDMN or equivalent.
- ○ Ensure that all regional dispatch staff are trained in the response operations listed below.

RESPONSE: Activation/Notification

Immediate

RECEIVE NOTIFICATION

Receive incident notification from the Medical Health Coordination Center (MHCC), RDMHC/S, or OA EMS Dispatch Center (for in-region incidents) or other source. Complete the Resource Request Form for in-county requests for mutual aid transportation resources, (i.e. requestor, resource requested, when needed, where to report, etc.)

Medical Resource Assessment

Immediate
ASSESS MEDICAL TRANSPORTATION RESOURCES
When requested by the MHCC or RDMHC/S; contact OA EMS Dispatch Center to assess availability of resources to respond to planned need (available in 3 or 4 hours) resource requests.

RELAY MEDICAL TRANSPORTATION AVAILABILITY
Relay status of medical transportation resources within the OAs to the MHCC or RDMHC/S.

Resource Request
Immediate
IMMEDIATE NEED REQUESTS
Relay immediate need requests to appropriate OA EMS Dispatch Centers.
NOTIFY MHOAC/LEMSA FOR MUTUAL AID REQUESTS
Notify the MHCC or RDMHC/S for requests for mutual aid that exceed pre-established thresholds for auto-aid.

Mobilizing Resources
Ongoing
PREPARE RESOURCES FOR MOBILIZATION
Coordinate with the RDMHC/S and OA EMS Dispatch Center to ensure that medical transportation resources are properly assembled; provided with order/request and travel information; and appropriately (Personal Protective Equipment (PPE), communications, (water, etc.) prior to departure.

Resource Tracking
Ongoing
MAINTAIN RESOURCE STATUS
Ensure that CDMN OR EQUIVALENT OR EQUIVALENT resource status information (en route, on-scene, released) for deployed resources is accurate and up-to-date.

Demobilization
Ongoing
RELEASE OF RESOURCES
When resources are released from an incident, coordinate with RDMHC/S to ensure they are not needed elsewhere within region, prior to releasing the resources to return to their home base.
UPDATE CDMN OR EQUIVALENT OR EQUIVALENT
Ensure that CDMN OR EQUIVALENT OR EQUIVALENT resource status information for demobilized resources is accurate and up-to-date.

703 OPERATIONAL AREA PATIENT DISTRIBUTION CENTER (OAPDC)

Operational Area Patient Distribution Center (OAPDC)
Checklist

MISSION:
Coordinate the distribution of casualties within the Operational Area (OA)

PREPAREDNESS:
Enter into agreement or Memorandum of Understanding (MOU) with the local EMS Agencies (LEMSA) to perform the duties of the OAPDC.
Develop and maintain protocols for out-of-OA distribution of patients.
Establish a 24-hour contact point for the OAPDC duty officer.
Appoint an OAPDC supervisor to act as liaison to local receiving facilities and the LEMSA. Notify local receiving facilities and the LEMSA when this position changes and provide updated contact names and telephone numbers.
Maintain an electronic Hospital Alert / Assessment System (HAAS) (e.g., EMSystems, Reddinet, etc.) able to (1) alert hospitals; (2) assess their capability to accept immediate, delayed, and minor patients from a mass casualty incident site; and, (3) assess hospital capabilities using California HAvBED Plus standards.
Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the OA Patient Distribution Plan, California's Medical Mutual Aid Plan, HAAS operations, use of primary and back-up communication systems (radio, telephone, etc.) and patient tracking system(s) in accordance with LEMSA and state protocols.
Maintain multiple redundant communication capabilities between with the OAPDC and all OA receiving facilities. Establish communications failure protocol.
In cooperation with the LEMSA, participate in the development of OA medical/health patient distribution exercises and drills.
Develop and maintain internal protocols, consistent with the California Disaster Medical Operations Manual (CDMOM) and LEMSA policy outlining the facility's role and responsibilities during a patient distribution incident.

Immediate:
RECEIVE NOTIFICATION

For incidents within the OA, the OAPDC may be notified or activated by the EMS Dispatch Center, field personnel, or local hospital. For incidents outside the OA, notification may be received from the LEMSA, Medical/Health Operational Area Coordinator (MHOAC), Regional Patient Distribution Center (RPDC), or Medical Health Coordinator Center (MHCC).
ASSIGN STAFF
When notified of a mass casualty incident, assign staff to coordinate information from the incident and provide information to receiving facilities.

CREATE MASS CASUALTY INCIDENT IN CDMN OR EQUIVALENT
Create a mass casualty incident and alert all hospitals in the OA via HAAS and other systems according to LEMSA policy. If HAAS is unavailable, use back-up communications protocol.
IDENTIFY RECEIVING FACILITIES
Map location of incident and identify receiving facilities to receive patients triaged immediate. Notify the RPDC to use hospitals in an adjacent OA or region.
MAINTAIN COMMUNICATIONS
Maintain communications with the field Med. Comm or other patient information source (e.g. RPDCs, MHOAC, etc.)

ON-GOING:
UPDATE INCIDENT INFORMATION
Update HAAS information when new information is received from the field.

Access Facility Capacities:
Immediate:
RECEIVING FACILITY CAPACITIES
Each receiving facility notified by the OAPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in the HAAS and reports their status to the OAPDC according to local policy.
Ongoing:
MAINTAIN FACILITY STATUS
Update capacities of receiving facilities as patients are assigned to various facilities.

Mass Casualty Incident Communications
Immediate:
LIMITED FIELD COMMUNICATIONS
During response, all EMS radio traffic is routed through the OAPDC, including for non-incident patients (Refer to local policy). Transporting units should not report patient information directly to receiving facilities.
DOCUMENT PATIENT INFORMATION
When notified by the field Med. Comm that patient triage is complete, document patient information on the Patient Destination Worksheet and confirm total number of available transport resources.

Patient Destinations
Immediate:
IMMEDIATE PATIENTS
Distribute immediate patients according to local protocol.
DELAYED PATIENTS
Distribute delayed patients according to local protocol.
AUSTERE CARE
When there are more patients within any triage category than available teams to accept those patients, consider requesting receiving facilities to increase patient capacity;

sending more patients to local teams than standard guidelines recommend; or sending patients beyond the standard transport radius.

NOTIFY FACILITIES OF INCOMING PATIENTS

Notify the receiving facilities of incoming patients.

Ending a Mass Casualty Incident

Ongoing:

FINAL SUMMARY

When all patients are distributed, the OAPDC provides a final summary of the mass casualty incident, including patient destinations, to participating receiving facilities. After providing the summary of the incident, the OAPDC ends the incident and notifies all participating facilities.

MASS CASUALTY INCIDENT CRITIQUE

When the incident is ended, the OAPDC and all participating receiving facilities complete a mass casualty incident critique and file incident paperwork. (Refer to local protocol).

AFTER ACTION REVIEW

The OAPDC supervisor may coordinate an after action review with the LEMSA. (Refer to local protocol).

704 REGIONAL PATIENT DISTRIBUTION CENTER (RPDC)

Regional Patient Distribution Center (RPDC)
Checklist

MISSION:
Coordinate the distribution of patients within the mutual aid region during a mass casualty incident

PREPAREDNESS:
Enter into agreement or Memorandum of Understanding with the Regional Disaster Medical/Health Coordinator and Specialist (RDMHC/S) to perform the duties of the RPD.
Develop and maintain protocols for out-of-region distribution of patients.
Establish a 24-hour contact point for the RPDC duty officer.
Develop and maintain internal protocols, consistent with this document and RDMHC policy outlining the RPDC's role and responsibilities during an incident requiring patient distribution.
Appoint a RPDC Supervisor to act as liaison to the Operational Area Patient Distribution Center (OAPDC), Regional Disaster Medical/Health Coordinator and Specialist (RDMHC/S) and State Patient Distribution Center (SPDC). Notify the SPDC, RDMHC/S, and OAPDCs when this position changes and provide updated contact names and telephone numbers.
Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the region's patient distribution plan, the California Medical Mutual Aid Plan, use of primary and back-up communication systems (radio, telephone, etc.) and patient tracking system(s) in accordance with RDMHC/S and state protocols
Maintain multiple redundant communication capabilities with the SPDC and all OAPDCs within the mutual aid region.
In cooperation with the RDMHC/S, participate in the development of regional medical/health patient distribution exercises and drills.

RESPONSE
Activation / Notification
Immediate:
RECEIVE NOTIFICATION
For incidents within the Region, the RPDC may be notified or activated by OAPDCs, Medical/Health Operational Area Coordinators (MHOAC), and the RDMHC/S. For incidents outside the Region, notification may be received from the RDMHC/S, MHCC, or SPDC.
DISTRIBUTION TO ADJACENT OA
If the impacted county requires distribution of patients to only one adjacent OA, its OAPDC may request the RPDC (and the RPDC, the receiving OA if that OA is located

in an adjacent region) to permit the sending OAPDC. If approved, the RPDC(s) monitors activities but is not directly involved in the distribution of patients.
DISTRIBUTION TO ADJACENT REGION
If receiving facilities in an adjacent region are closer to the incident site than facilities in the impacted region, the RPDC may activate that region's RPDC to coordinate distribution into that region if only one adjacent region is involved. All communications from the adjacent region's RPDC are routed through the impacted RPDC to the impacted OAPDC.
Assign Staff
When notified of a mass casualty incident, assign staff to coordinate information from the incident and provide information to the OAPDCs.
CREATE MASS CASUALTY INCIDENT IN CDMN OR EQUIVALENT
Create a mass casualty incident and alert all hospitals in the region via Hospital Alert/Assessment Systems (HAAS) and other systems according to RDMHC/S policy. If HAAS is unavailable, use back-up communications protocols.

IDENTIFY RECEIVING FACILITIES
Map location of incident and identify receiving facilities to receive patients triaged immediate. Notify the SPDC.
MAINTAIN COMMUNICATIONS
Maintain communications with the OAPDC or other patient information source (e.g. RDMHC/S, SPDC, MHCC, etc.)

Intermediate Extended:
UPDATE INCIDENT INFORMATION
Update HAAS information when new information is received from the field.

Assess OA Capacities
Immediate:
RECEIVING FACILITY CAPACITIES
Each Receiving Facility notified by the RPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in their HAAS and reports their status to the RPDC.
DOCUMENT OA CAPACITIES
Document OA capacities on the Patient Destination Worksheet and confirm total number of available transport resources.
MAINTAIN OA CAPACITIES
Track and update the OA capacities as patients are assigned to OAs and receiving facilities.

Patient Destinations
Immediate:
RECEIVE PATIENT DESTINATIONS

When OA capacities are identified, coordinate the distribution of patients to facilities for each OA in the Region, in coordination with the OAPDCs according to OA patient destination guidelines.

RELAY DESTINATION TO IMPACTED OAPDC

Relay patient destinations to impacted OAPDC. The impacted OAPDC advises the field Med. Comm of the hospital destination.

RELAY PATIENT INFORMATION TO RECEIVING OA

When Med. Comm advises the OAPDC that patients are en-route, the OAPDC will forward the unit number, number of patients, patient triage category and injury type (for immediate only); and ETA to the RPDC. (For a medical facility evacuation, California HAvBED categories are communicated rather than triage category.) The RPDC notifies the receiving OAPDCs which in-turn notifies receiving facilities. Regions that use the same HAAS system may use HAAS for all notifications, as appropriate.

NOTIFY OAPDC OF INCOMING PATIENTS

Notify the OAPDC of patients en route to facilities within the OA.

OUT-OF-REGION INCIDENT

Hospital capability information is generated in the same manner as in-county/regional incidents: from the receiving county's OAPDC to the RPDC and then to the requesting OA, Region, or SPDC. Patient distribution information is transmitted from the impacted RPDC or SPDC, to the receiving RPDC and then to the OAPDC.

Ending a Mass Casualty Incident

Intermediate Extended:

FINAL SUMMARY

When all patients have been distributed, the RPDC provides a final summary of the mass casualty incident to participating OAPDCs and receiving facilities, including patient destinations. After providing the incident summary, the RPDC ends the incident, and notifies all OAPDCs.

AFTER ACTION REVIEW

The RPDC supervisor coordinates an after action review with the RDMHC/S, (Refer to regional protocol).

705 STATE PATIENT DISTRIBUTION CENTER (SPDC)

State Patient Distribution Center (SPDC) Checklist

MISSION:
Coordinate the distribution of patients with the six mutual aid regions in California during a mass casualty incident.

PREPAREDNESS:
Enter into agreement or Memorandum of Understanding with the California EMS Authority to perform the duties of the RPDC.
Develop and maintain protocols for in-state and out-of-state distribution of patients.
Establish a 24-hour contact point for the SPDC duty officer.
Develop and maintain internal protocols, consistent with this document and EMS Authority policy outlining the SPDC's role and responsibilities during an incident requiring patient distribution.
Appoint a SPDC Supervisor to act as liaison to the Regional Patient Distribution Center (RPDC), EMS Authority, and ASPR. Notify EMS Authority, RPDCs and ASPR when this position changes and provide updated contact names and telephone numbers.
Maintain multiple redundant communication capabilities with ASPR and RPDCs.
Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the Region's Patient Distribution Plan. Ensure personnel are trained in the patient distribution plan, California Medical Mutual Aid Plan, California Disaster Medical Network (CDMN OR EQUIVALENT), primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s) in accordance with State protocols.
In cooperation with EMS Authority, participate in the development of state medical/health patient distribution exercises and drills.

RESPONSE:
Activation / Notification
Immediate:
RECEIVE NOTIFICATION
For incidents within the State, the SPDC may be notified or activated by RPDCs, RDMHC/S, and EMS Authority. For incidents outside the state, notification may be received from the EMS Authority, the Medical Health Coordination Center (MHCC), or ASPR.
DISTRIBUTION TO ADJACENT REGIONS
If the impacted region requires distribution of patients to only one adjacent region, it may request the SPDC, (the receiving RPDC if that RPDC is located in an adjacent region) to permit the sending RPDC to coordinate patient distribution directly with the adjacent region's RPDC. If approved the SPDC will monitor activities but is not directly involved in the distribution of patients.
DISTRIBUTION TO ADJACENT STATES

If receiving facilities in an adjacent state are closer to the incident site than in-state facilities, the SPDC may request that state's patient distribution system to coordinate distribution into that state. All communication from the adjacent state's facilities may be routed through the impacted RPDC to the impacted Operational Area Patient Distribution Center (OAPDC).

ASSIGN STAFF

Once notified of a mass casualty incident, assign appropriate staff members to coordinate information from incident, and information provided to RPDCs.

CREATE MASS CASUALTY INCIDENT IN CDMN OR EQUIVALENT

Create a Quick Incident in CDMN OR EQUIVALENT if not already created. Contact the appropriate RPDCs to create a mass casualty incident in the mutual aid region utilizing HAAS to assess emergency department or inpatient bed capacities. If Hospital Alert/Assessment Systems (HAAS) is unavailable, use back-up communications protocols.

IDENTIFY RECEIVING FACILITIES

Map location of incident and identify receiving facilities to receive patients triaged immediate. (If any of those hospitals are located in an adjacent state, notify the appropriate patient distribution authority).

MAINTAIN COMMUNICATIONS

Maintain communications with the RPDC (or other patient information source, e.g., EMS Authority, Medical Health Coordinators and Specialists (RDMHC/S, ASPR, etc.).

Intermediate Extended:

UPDATE INCIDENT INFORMATION

Update the mass casualty incident information in the CDMN OR EQUIVALENT and relay updates to the RPDCs to update local HAAS when new information is received from the field.

Assess OA Capacities

Immediate:

RECEIVING FACILITY CAPACITIES

Each receiving facility notified by the RPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in their HAAS and reports status to the RPDC.

DOCUMENT OA CAPACITIES

Document capacities by mutual aid region on the Patient Destination Worksheet and confirm total number of available transport resources.

Ongoing:

MAINTAIN OA CAPACITIES

Track and update the regional capacities as patients are assigned to various mutual aid regions and OAs.

Patient Destinations

Immediate:

UPDATE INCIDENT INFORMATION

Update the mass casualty incident information in the CDMN OR EQUIVALENT and relay updates to the RPDCs to update local HAAS when new information is received from the field.

RECEIVE PATIENT DESTINATIONS

When region capacities are identified, coordinate the distribution of patients to facilities within each OA within the mutual aid region in coordination with the RPDCs according to receiving OA patient destination guidelines.

RELAY DESTINATIONS TO IMPACTED RPDC

Relay patient destinations to the impacted RPDC. The impacted RPDC advise the OAPDC to notify the field Med. Comm of the hospital destination.

RELAY PATIENT INFORMATION TO RECEIVING OA

When Med. Comm advises the OAPDC that patients are en-route, the OAPDC will forward the unit number; number of patients; patient triage category and injury type (for immediate only); and ETA to the RPDC. (For a medical facility evacuation, California HAvBED Plus categories are communicated rather than triage category). The SPDC notifies the receiving RPDC which in-turn notifies the OAPDC, which then notifies the receiving facility. Regions that use the same HAAS system may use HAAS for all appropriate notifications.

OUT-OF-STATE INCIDENT

Hospital capability information is generated in the same manner as an in-state incident (i.e. from the OA to the RPDC to the SPDC. Patient distribution information is transmitted from the impacted area (or ASPR) to the SPDC, to the receiving RPDC, and then to the OAPDC.

Ending a Mass Casualty Incident:

Intermediate Extended:

FINAL SUMMARY

When all patients have been distributed, the SPDC provides a final summary of the mass casualty incident to participating RPDCs and OAPDCs, including patient destinations. After providing the Summary of the Incident, the SPDC ends the incident and notifies all RPDCs.

AFTER ACTION REVIEW

The SPDC supervisor coordinates an after action review with the EMS Authority and RDMHC/S, (refer to State protocol.)

706 EQUIPMENT STANDARDS/REQUIREMENTS

The equipment that each AST/MTF Member or Leader should have on-hand for participation on an AST/MTF is listed below. This personal equipment supply is also known as a personal "Go" Kit or 72-Hour Go Pack. Special equipment needs for both the AST/MTF ambulances and leader vehicle are also provided.

Personal AST "Go" Kit or 72-Hour Go Pack for AST/MTF Members

Pack to contain the following:

Reflective jacket
Extra uniforms and undergarments
Safety boots
Sunglasses
1-Qt. water bottle/canteen with potable water
Raingear
2 Meals Ready-to-Eat (MREs)
Toilet paper
Personal medications & medical history documentation
Toiletries & other personal items as needed
Sunscreen
DEET
Sleeping bag
Hearing protection (ear plugs)
Photo I.D. and petty cash
Clothing appropriate for climate conditions

Ambulance (Minimum requirements in each category)

Equipment and Supplies to meet minimum scope of practice (ALS or BLS) as determined by Title 13 and Title 22.

Most recently published edition of State Thomas Brothers Map Book
Communications Equipment (see Communication Section)
Fuel & Supply Purchasing (Credit Cards, Cash)
20 Patient Care Reports (PCRs)
20 Disaster Triage Tags
2 pair Work Gloves
2 Safety Helmet with Dust-Proof Safety Goggles
4 HEPA masks and 4 dust filters
2 Flashlights or Headlamps

AST/MTF Leader – Ambulance Vehicle

Equipment and Supplies to meet minimum requirements in Title 13 for a California Highway Patrol (CHP) Vehicle
Most recently published edition of State Thomas Brothers Map Book
Compass
Fuel and Supply Purchasing (Credit Cards, Cash)
Communications Equipment capable of communicating with the team en-route and at the incident
Cell Phone, batteries and charger
FIRESCOPE FOG Manual
2 Sleeping Bags
36 MREs
Potable Water
50 Triage Tags
2 Helmets
2 pairs Work Gloves
2 Flashlights
ICS Forms & Strike Team Leader Kit
100 Patient Care Reports (PCRs)
“Go” Kit or 72-Hour Go Pack as described above

AST/MTF/DMSU
For DMSU-specific minimum equipment information, reference the Standard Operation Procedure (SOP) 1 and the MOU, For the Transfer of the DMSU 2.

Note: When assembling the team and the vehicles, the AST/MTF Leader will make sure there are extra batteries, bulbs, chargers, etc. as needed for all equipment.

Footnotes:
1 The DMSU SOP is contained in the ASTL Kit, which is provided along with each DMSU.
2 Exhibit A – Product Description, DMSU MOU for the transfer of the DMSU.

707 GLOSSARY

Ambulance Strike Team Lead Entity (ASTLE):
A public or private agency that normally coordinates ground medical transportation assets.

Demobilization
The need for medical transport resources has been met and the AST/MTF resources are no longer needed.
Ambulance Strike Team (AST):
A team of five properly staffed and equipped medical transport vehicles of the same capabilities and one team leader with vehicle. All with like communications equipment.

Disaster Medical Support Unit (DMSU): The California EMS Authority and local EMS systems have placed a fleet of vehicles throughout the state equipped to support Ambulance Strike Teams and other disaster medical operations. These vehicles contain medical equipment and supplies, comprehensive communications capabilities and provisions to support response personnel for several days.
Ambulance Strike Team Leader (ASTL): A person that has met the requirements to be an AST Leader and has been designated by the ASTLE as such.

Dispatch
The process of receiving a request for emergency medical assistance and the act of sending an EMS vehicle or air ambulance in response to each request.
Ambulance Strike Team Trainee(ASTLT):
A person that has completed an approved Ambulance Strike Team course but still needs to complete his or her position task book and receive certification as an ASTL.

Emergency Operations Center (EOC) The physical location at which civil jurisdictions coordinate information and resources to support incident management (on-scene operations). An EOC may be a temporary facility or permanently established in a fixed facility.

AST "GO" Kit or 72-Hour Go Pack Minimum equipment needed for AST/MTF Members participating on an AST.

Frequency
The number of cycles, repetitions, or oscillations of a periodic process completed during a unit of time. The frequency of waves in the electromagnetic spectrum (radio waves) is designated in hertz (Hz), kilohertz (KHz or 1,000 Hz), megahertz (MHz or 1000000 Hz). One hertz is equivalent to one cycle per second.
California Emergency Management Agency (CalEMA)
Governor's cabinet office that coordinates overall state agency response to major disasters in support of local government

Immediate Need Ambulances
Immediate need ambulances are resources prepared to respond within three (3) hours of a request.
CalEMA Mutual Aid Region
One of the six geographical areas defined by the CalEMA for the coordination of resources in the event of a disaster or major incident where mutual aid is requested.

Incident Command System (ICS)
A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize filed-level incident management operations.
Local Emergency Medical Services Agency (LEMSA) The agency, department, or office having primary responsibility for administration of emergency medical services in a county.

Mutual Aid
Mutual aid is the voluntary provision of services and facilities by agencies or organizations to assist each other when existing resources prove to be inadequate
Medical Communications Coordinator (Med.Comm) The Medical Communications Coordinator maintains communications with the patient distribution center or other medical facilities to assure proper patient transportation and destination and coordinates information through the Patient Transportation Group Supervisor and the Transportation Recorder.

Operational Area (OA):
An intermediate level of the State emergency medical services organization, consisting of a county and all political subdivisions with the county
Medical Dispatch Center, Operational Area (OAMDC)
A center, designated by the LEMSA in each operational area, to serve as the single point of contact within the OA for the acquisition and coordination of EMS medical transport resources during response to disasters.

Patient Distribution Center, Operational Area (OAPDC)
A function, assigned by the LEMSA, to coordinate the distribution of casualties at the operational area level.
Medical DispatchCenter, Regional (RMDC)
Designated by the RDMHC in each CalEMA mutual aid region, the RMDC serves as the single point of contact within the region for the acquisition and coordination of EMS resources during response to disasters.

Patient Distribution Center, Regional (RPDC): A function assigned by each RDMHC, to coordinate the distribution of patients at the regional level during disasters.

Medical Health Coordination Center (MHCC)

The MHCC is the 24 hour, seven days per week disaster medical response point of contact that assists RDMHC/S with the immediate response to medical disasters by disseminating situation status information, identifying resource needs, and locating immediately needed resources from area near the impacted OA. The MHCC function is activated by contacting the EMS Authority Duty Officer and may be performed by the CDPH/EMSA Joint Emergency Operations Center (JEOC).

Patient Distribution Center, State (SPDC) The state level function for coordinating the distribution of patients at the state and federal level during disasters. The SPDC function is performed by the CDPH/EMSA JEOC.

Medical Health Operational Area Coordinator (MHOAC) The position, filled by designation by the Local Health Officer and EMS Agency Administrator, responsible to facilitate development of OA medical/health disaster response plans. In most OAs, the MHOAC implements the OA's disaster medical/health response plan, coordinates developing OA mutual aid requests for external resources and the OA's response to external requests, and facilitates the establishment of priorities through the Multi-Agency Coordination Group for Medical/Health requests and responses.

Patient Transportation Group Supervisor This position establishes and maintains communications with the Control Facility and directs and coordinates patient loading into ambulances as determined by the Treatment Leader(s). This position may be filled concurrently by the Medical Group Supervisor in the event there are not enough qualified personnel available.

Medical Transportation Surge Event A significant healthcare event or set of circumstances resulting in an excess in demand over capacity and/or capability in the medical transportation sector

Regional Disaster Medical Health Coordinator (RDMHC): The EMS Authority and CDPH jointly appoint the Regional Disaster Medical Health Coordinator (RDMHC) in each of the six mutual aid regions. RDMHC responsibilities include supporting the mutual aid requests of MHOACs for disaster response within the region and providing mutual aid support to other areas of the state in support of the state medical response system. The RDMHC also serves as an information source to the state medical and health response system.

Medical Task Force (MTF):

Any combination (within span of control) of resources (e.g. Ambulances, Rescues, Engines, and Squads) assembled for a medical mission, with common communications and a leader (supervisor).

Regional Disaster Medical Health Specialist (RDMHS) The RDMHS provides the day-to-day planning and coordination of medical and health disaster response in the six mutual aid regions. During disaster response, the RDMHS may be designated by the RDMHC as the key contact for OAs to request and/or to provide medical and health resources.

Resource Typing
The categorization and description of resources that are commonly exchanged in disasters via mutual aid, by capacity and/or capability. Through resource typing, disciplines examine resources and identify the capabilities of the resource's component.

Standardized Emergency Management System (SEMS)
The emergency management system identified in the California Government Code 8607 for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the ICS and is intended to standardize response to emergencies in the state.

Triage Tags
Tags for qualified triage personnel which are normally distributed by the Medical Group Supervisor at the scene. The number of tags distributed should be noted to better assess the actual number of patients

Ultra High Frequency
A range of electromagnetic waves whose frequency is between 300 MHz and 3.0 GHz.

Very High Frequency
A range of electromagnetic waves whose frequency is between 30 MHz to 300 MHz

708 ACRONYMS

ALS

Advanced Life Support
AST

Ambulance Strike Team
AST/MTF

Ambulance Strike Team/Medical Task Force
ASTL

Ambulance Strike Team Leader
ASTLE

Ambulance Strike Team Lead Entity
ASTLT

Ambulance Strike Team Leader Trainee
BLS

Basic Life Support
CAA

California Ambulance Association
CAL EMA

California Emergency Management Agency
CDPH

California Department of Public Health
CHP

California Highway Patrol
DMSU

Disaster Medical Support Unit
EMS

Emergency Medical Services
EMSA

Emergency Medical Services Authority
EMT-B

Emergency Medical Technician, Basic
EMT-P

Emergency Medical Technician, Paramedic
FOG

Field Operations Guide
HAZMAT

Hazardous Materials
IC

Incident Command
ICS

Incident Command System
JEOC

Joint Emergency Operations Center
LEMSA

Local Emergency Medical Services Agency
LHO

Local Health Officer
MCI

Mass Casualty Incident
MHOAC

Medical Health Operational Area Coordinator
MREs

Meals Ready to Eat
MTF

Mobile Task Force
NIMS

National Incident Management System
OA

Operational Area
OAEOC

Operational Area Emergency Operations Center
OAMDC

Operational Area Medical Dispatch Center
OAPDC

Operational Area Patient Distribution Center
PCRs

Patient Care Report
PPE

Personal Protection Equipment
PTB

Position Task Book
RDMHC

Regional Disaster Medical Health Coordinator
RDMHS

Regional Disaster Medical Health Specialist
REOC

Regional Emergency Operations Center
RMDC

Regional Medical Dispatch Center
SEMS

Standardized Emergency Management System
SOC

State Operations Center
SPDC

State Patient Distribution Center
UHF

Ultra High Frequency
VHF

Very High Frequency

709 MULTI-AGENCY COORDINATION SYSTEM, RESOURCE DESIGNATION SYSTEM

Refer to MACS 410-2

710 FIRESCOPE, FIELD OPERATIONS GUIDE

See ICS 420-1A

711 AST NUMBERING SCHEMATIC SAMPLES

Schematic for Ambulance Strike Team (AST)

Team Number: CA-M-XVE-101W (Units 1-6):
Ventura Operational Area Type 2 BLS Strike Team

Team Number: CA-M-XSH-301W (Units 1-6):
Shasta Operational Area Type 2 BLS Strike Team

Team Number: CA-M-XSC-299V (Units 1-6):
Santa Clara Operational Area Type 1 ALS Strike Team

Schematic for Disaster Medical Support Unit (DMSU)

Team Number: CA-M-XVE-101W1 (Units 1-26):
Ventura Operational Area Type 2 BLS & DMSU Strike Team

Team Number: CA-M-XSH-301W2 (Units 1-26):
Shasta Operational Area Type 2 BLS & DMSU Strike Team

Team Number: CA-M-XSC-201V (Units 1-26):
Santa Clara Operational Area Type 1 ALS & DMSU Strike Team

Schematic for Medical Task Force (MTF)

Team Number: CA-M-XVE-101TF (Units 1-6):
Ventura Operational Area Task Force

Team Number: CA-M-XSH-301TF (Units 1-6):
Shasta Operational Area Task Force

Team Number: CA-M-XSC-299TF (Units 1-6):
Santa Clara Operational Area Task Force

712 STATE AST INVOICE AND MOU

Current copies of EMSA's AST MOU, AST Invoice and related information may be reviewed at the EMSA website:
http://www.emsa.ca.gov.

713 ICS FORMS 203, 214, 221

ICS forms and information are available at:
http://www.nwcg.gov/pms/forms/icsforms.htm

714 CDHOM SIT-REP AND MEDICAL HEALTH RESOURCE REQUEST

CDHOM forms and information are available at:
http://www.emsa.ca.gov

715 INDEX

Qualification Card
Ambulance Strike Team / Medical Task Force Leader

Name		Issued
EMS Qualification	LEMSA Location	Expires

This person has met State of California requirements to function as an Ambulance Strike Team / Medical Task Force Leader and should be provided appropriate access and assistance in the performance of those duties.

Approved By	Title	Employer

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