



EMS Mass Casualty Incident Plan

2020

Thomas Jefferson EMS Council
EMS Mass Casualty Plan

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1. PREFACE

The goal of the Thomas Jefferson EMS (TJEMS) Council EMS Mass Casualty Plan is to prepare, on a regional basis, for a unified, coordinated and immediate emergency medical services (EMS) response by prehospital and hospital resources to, and the effective emergency medical management of, victims of any type of Mass Casualty Incident (MCI).

This EMS MCI Plan, as most recently amended, will serve as the basis for out-of-hospital responses in the TJEMS region (planning district 10 and Madison County of planning district 9).

Success of the MCI plan depends upon effective cooperation, organization and planning among health care professionals, hospitals, EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning districts which compromise the TJEMS region as provided in the Code of Virginia, § [32.1-111.4:2](#).

2. BASIC DEFINITIONS

2.1 For the purpose of the EMS MCI Plan, the following definitions will apply:

2.1.1 EMS Agency – an entity licensed by the Office of EMS to engage in the business, service, or regular activity, whether or not for profit, of transporting or rendering immediate medical care to persons who are sick, injured, or otherwise incapacitated. Any volunteer, career, private or governmental Emergency Medical Services agency that is licensed by the Commonwealth of Virginia to render prehospital care and provide emergency transportation for the sick and/or injured as described in the Code of Virginia, § [32.1-111.1](#).

2.1.2 EMS Provider – a person who holds a valid certification issued by the Office of EMS.

2.1.3 Mass Casualty Incident (MCI) – sometimes called a Multiple Casualty Incident or Multiple Patient incident, an MCI is an event resulting from a natural, technological or human hazard that causes illness and/or injuries that exceed the Emergency Medical Services (EMS) capabilities of a locality, jurisdiction and/or region.

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2.1.4 MCI Medical Control – that medical care facility, designated by the local healthcare community, which provides remote overall medical direction of the MCI and coordinates the distribution of patients throughout the healthcare community.

2.1.5 Medical Care Facility – any institution, place, building, or agency, whether licensed or required to be licensed by the Board of Health, whether operated for profit or nonprofit and whether privately owned or privately operated or owned and operated by a local government unit, by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical.

2.1.6 Incident command system - a management system designed to enable effective and efficient incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. A basic premise of ICS is that it is widely applicable. It is used to organize both near-term and long-term field-level operations for a broad spectrum of emergencies, from small to complex incidents, both natural and manmade. ICS is used by all levels of government—Federal, State, local, and tribal—as well as by many private sector and nongovernmental organizations. ICS is also applicable across disciplines. It is normally structured to facilitate activities in five major functional areas: command, operations, planning, logistics, and finance and administration.

2.1.7 Virginia S.T.A.R.T. Triage – The Virginia Simple Triage and Rapid Treatment method whereby patients in an MCI are assessed and evaluated based on the severity of injuries and assigned emergency treatment priorities.

3. AUTHORITY

3.1 The Thomas Jefferson EMS Council is one of eleven regional EMS councils established within the Code of Virginia, § [32.1-111.4:2](#). TJEMS is charged by law “with the development and implementation of an efficient and effective regional emergency medical services delivery system” to include the regional coordination of emergency medical disaster planning and response.

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4. SCOPE OF THE EMS MCI PLAN

4.1 The Thomas Jefferson EMS Council region consists of planning district 10 and Madison County from planning district 9. As such, the EMS MCI Plan is applicable to the counties of: Albemarle, Fluvanna, Greene, Louisa, Madison and Nelson and the city of Charlottesville.

4.2 The EMS MCI Plan addresses the EMS mutual aid responses of the regional emergency medical services (EMS) system.

4.3 Mass Casualty Incidents that involve fatalities will be handled in cooperation with the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police and the Virginia Department of Emergency Management.

5. GENERAL PROVISIONS

5.1 The EMS MCI Plan necessitates the following general provisions and assumptions:

5.1.1 The proximity and capabilities of appropriate medical care facilities will be the primary considerations of MCI Medical Control when designating the medical care facilities to which patients are distributed during any local or regional emergency situation that results in the activation of the EMS MCI Plan.

5.1.2 Localities and/or individual EMS agencies will respond with appropriate personnel and equipment as available when the EMS MCI Plan is activated. The response will be dispatched by the local Emergency Communications Center. EMS agencies should not “self-dispatch.”

5.1.3 When considering their responses to activation of the EMS MCI Plan, localities and/or EMS agencies will be expected to maintain emergency medical response capabilities necessary to meet local needs.

5.1.4 Personnel affiliated with all participating EMS agencies and/or jurisdictions will operate during a MCI or under a standard Incident Command System (ICS) as required by Homeland Security Presidential Directive (HSPD)–5, *Management of Domestic Incidents*.

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5.1.5 Hospital and pre-hospital components in the region should participate in training exercises that require use of the MCI Plan. TJEMS will assist with the coordination of these exercises as requested.

6. LEVELS AND CATEGORIES

6.1 EMS MCI's within the TJEMS region will be classified by levels based upon an assessment by EMS providers using the Virginia S.T.A.R.T. Triage System:

6.1.1 **Level 1:** MCI resulting in less than 10 surviving victims.

6.1.2 **Level 2:** MCI resulting in 11 to 25 surviving victims.

6.1.3 **Level 3:** MCI resulting in greater than 25 surviving victims.

7. POTENTIAL INCIDENTS

7.1 Mass Casualty Incidents can occur in varying degrees, at anytime, and in practically any conceivable situation. High risks in the region include:

7.1.1 University of Virginia

7.1.2 North Anna Nuclear Power Plant

7.1.3. Charlottesville-Albemarle Regional Airport

7.1.4 Heavily traveled highways and interstates between populated areas

7.1.5 Freight and passenger rail lines

7.1.6 Light and heavy industrial plants

7.1.7 Local schools, malls, and shopping centers

7.1.8 Severe and unusual weather conditions also prevail throughout the region, including tornados, windstorms, hurricanes and heavy rains, heavy snows usually to the west, sleet and freezing rains and flooding of the rivers.

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7.2 Based on these risks, potential Mass Casualty Incidents in the TJEMS region could include:

- 7.2.1 Multi-family residential structure fires
- 7.2.2 Radioactive substance release
- 7.2.3 Public transportation crash (aircraft, train, bus, *etc.*)
- 7.2.4 Major vehicular accidents with multiple victims
- 7.2.5 Construction and/or industrial and farm accidents including hazardous materials, building collapses with multiple victims
- 7.2.6 River and/or localized flooding, impassable highways, roads and bridges
- 7.2.7 Medical care facility evacuations
- 7.2.8 Acts of terrorism and/or civil disobedience
- 7.2.9 Tornadoes or other severe weather-related events

8. MANAGEMENT GOALS

8.1 Goals of MCI management:

- 8.1.1 Perform the greatest good for the greatest number of people.
- 8.1.2 Make the best possible use of labor, equipment and facility resources.
- 8.1.3 Avoid relocating the MCI to a medical care facility.

9. INCIDENT PRIORITIES

9.1 Priorities of an MCI (or other complex emergency situation):

- 9.1.1 Life safety
- 9.1.2 Incident stabilization
- 9.1.3 Conservation of property and equipment
- 9.1.4 Provide for the safety, accountability and welfare of victims and responders.

10. PARTICIPANTS

10.1 The regional EMS system response to an MCI may involve:

10.1.1 Certified and/or licensed EMS providers at all levels of emergent patient care, from prehospital Basic (BLS) and Advanced (ALS) Life Support to acute medical and surgical treatment nurses and physicians in the hospital setting as well as related healthcare providers, especially those with facilities to care for critically injured or sick patients.

10.1.2 Medical care facilities, in particular those with acute-care or emergency facilities to care for critically injured or sick patients.

10.1.3 Local, state and federal government agencies may include, but not be limited to: the Virginia Department of Emergency Management; the Virginia Department of Health including the Office of Emergency Medical Services, the local Health Districts, the Office of the Chief Medical Examiner; the Virginia Department of State Police; the Virginia Department of Transportation; the Virginia Department of Military Affairs; the U.S. Armed Forces (including the U.S. Coast Guard); the Federal Emergency Management Agency (FEMA); and Local Emergency Planning Committees from jurisdictions within the TJEMS region.

10.1.4 Non-transport and related support components such as the American Red Cross, Salvation Army, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other groups that support EMS and emergency operations.

10.2 The key to successful EMS system response to a MCI is the close cooperation and coordination of these components and the emergency response community through effective communications, planning and training.

11. LOCAL EMERGENCY OPERATIONS PLANS

11.1 It is recognized that each Virginia county and locality has an emergency operations plan. **Whenever possible, regional EMS system response to a MCI should conform to the local emergency operations guidelines and established agreements between Designated Emergency Response Agencies (DERA).**

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11.2 Regional EMS system response planning will be transparent to, and support the health and medical annexes of, local jurisdiction emergency operations plans. Planning guidance in this document will be made available to the local Emergency Services Coordinators to assist them in the preparation and maintenance of their plans. The EMS MCI Plan will be employed in circumstances such as when:

11.2.1 The MCI is of such magnitude that it completely exhausts the EMS resources of one locality.

11.2.2 The MCI crosses local boundaries and exhausts the EMS resources of one or more localities.

11.2.3 A medical care facility must evacuate patients on a temporary basis and transportation requirements exceed the capabilities of the facility, locality and/or region.

11.3 The local Emergency Services Coordinator should be notified as soon as possible that the EMS MCI Plan is activated, or of the possible need.

12. INITIAL RESPONSE TO AN INCIDENT

12.1 The EMS MCI Plan calls for the 5-S approach as taught in the Virginia Mass Casualty Incident management training program:

12.1.1 Assess the scene for **S**afety – determine if providers will be safe.

12.1.2 **S**urvey the Scene – determine the type of incident, number of patients, severity of injuries (category) and best access.

12.1.3 **S**end information and request assistance – contact dispatch with survey information, request resources, activate MCI Plan.

12.1.4 **S**et up scene management structure (ICS) – include extrication, triage, treatment and transportation.

12.1.5 Begin **S**.T.A.R.T. triage of patients.

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13. ACTIVATING THE MCI PLAN

13.1 The MCI Plan can be activated by the following individuals:

13.1.1 The Incident Manager/Incident Commander at the scene of the MCI according to existing local protocol.

13.1.2 The EMS or Emergency Services Coordinator, or that person's representative, of a political subdivision who has authority for the management of the incident.

13.2 It is strongly recommended that the MCI Plan be activated through the local Emergency Communications Center:

13.2.1 The person authorized to request the activation should identify himself/herself and request to activate the MCI Plan. This person should give a brief description of the incident. The information should include time of incident, location; initial numbers of patients involved and re-contact information (call back number, radio designation, etc.).

13.3 Local protocol will dictate the necessity for mutual aid agencies to be notified (DERA's) and the notification of any additional resources.

14. RESPONSIBILITIES – EMS AGENCIES

14.1 Transportation of patients under the authority of the EMS MCI Plan will be performed by licensed EMS agencies in the Thomas Jefferson EMS Council region and from neighboring regions when necessary and available.

14.2 Units and personnel involved in an EMS system response to a MCI will be dispatched through the local emergency communications center.

14.3 Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. Providers who respond in privately-owned vehicles (POV's) will be directed to report to their respective agencies or, at the discretion of the Incident Commander and if they have appropriate EMS Identification, may be directed to the Incident Staging Area.

14.4 All EMS providers and/or agencies responding to a MCI in the TJEMS region agree to operate under the Virginia Mass Casualty Incident

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Management System, and the Virginia START Triage system. The respective regional Patient Care Guidelines are to be utilized by EMS agencies providing patient care at the incident.

14.5 Crew members of EMS units responding to a MCI will be required to carry self-identification and should be prepared to provide proof of affiliation with their agency.

14.6 Crew members of EMS units responding to a MCI will be responsible for maintaining all medical and operational documentation, and for making that documentation available to the appropriate authorities.

15. RESPONSIBILITIES – MEDICAL CARE FACILITIES

15.1 MCI Medical Control – The University of Virginia Medical Center (UVAMC) will serve as primary MCI Medical Control for the TJEMS region in the event of an incident that requires activation of the EMS MCI Plan.

15.1.1 UVAMC may request the Martha Jefferson Hospital act as primary MCI Medical Control for any appropriate reason including better communications, better or closer geographical location to the MCI site, or because of any other circumstances that would be in the best interest of effective patient care.

15.2 MCI Medical Control will activate the appropriate medical care facilities that best can accommodate the scope of the MCI, and which are in the best interests of effective patient care.

15.3 Medical care facilities that are activated under the research of the EMS MCI Plan will provide upon request from MCI Medical Control confirmation or revised information on the numbers of patients they can accommodate in the three START Triage categories: Red, Yellow and Green.

15.4 MCI Medical Control will assign patients to the medical care facilities closest to the site of an MCI and which can provide the appropriate levels of emergent care.

15.5 MCI Medical Control also will be responsible for any on-line medical direction during patient transport to medical care facilities.

15.5.1 In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with the regional patient care guidelines in effect in the region in which the transporting personnel are released to practice as EMS providers.

16. FATALITY and MASS FATALITY INCIDENTS

16.1 By Commonwealth of Virginia Statute, the Chief Medical Examiner is responsible for the medical investigation of sudden, unexpected and violent deaths throughout the Commonwealth. Persons who die under those circumstances require the expeditious and skilled attention of the Medical Examiner.

16.2 It is critical that the Medical Examiner's Office be notified as early as possible in any MCI that involves, or may involve fatalities.

16.2.1 The Office of the Chief Medical Examiner can be reached by calling 804-786-3174.

16.3 An MCI also may be a Mass Fatality Incident.

16.3.1 A Mass Fatality Incident is any situation where there are more bodies than can be handled using local resources. The Chief Medical Examiner may activate the State Funeral Directors Mass Fatalities Plan.

17. STANDARD PRECAUTIONS

17.1 All EMS personnel involved in a response to a MCI will be expected to observe Standard Precautions and other Body Substance Isolation practices as specified by the Centers for Disease Control, OSHA or mandated by their agency. Suspected or actual exposures to communicable diseases or bioterrorism agents will be reported to the appropriate health district as soon as practical. In addition, the infection control officers for the involved EMS agencies and the appropriate hospital infection control personnel should be notified.

18. EMERGENCY COMMUNICATIONS

18.1 The H.E.A.R system will remain the primary method of field-to-hospital communications during a MCI. The VHF system provides a dedicated channel for communications and is recorded for future review. Telephone communications are discouraged due to volume and inconsistencies in cellular coverage.

18.1.1 The H.E.A.R radio frequency (EMS 1, 155.340) is the primary channel for communications between the medical care facility and the EMS Transportation Unit at the incident.

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18.2 The Statewide Mutual Aid frequency (155.205) should be implemented when a MCI event requires the response of EMS agencies from outside the primary jurisdiction of the event. It may also be utilized within a jurisdiction as a tactical channel.

18.3 Unless there is an extreme emergency, ambulance crews **should not** use EMS 1 or the Statewide Mutual Aid frequency for communicating when responding to an incident, or when transporting a patient to a medical care facility from a MCI site. The EMS Transportation Unit Leader will communicate patient information to the receiving facility.

18.4 The use of ten-codes is prohibited. EMS providers will use "plain English" to communicate information during a MCI.

19. CRITICAL INCIDENT STRESS MANAGEMENT

19.1 Critical Incident Stress Management (CISM), a comprehensive, integrated, multi-component crisis intervention system, may be requested as an integral part of any emergency medical response to a MCI. A regional team of certified mental health and peer "debriefers" is available for assistance.

19.1.1 The TJEMS CISM team can be activated through their 24-hour phone number: 434-977-9041.

19.1.2 Other CISM assets can be activated through the Virginia Department of Emergency Management (VDEM) at 804-674-2400 or 1-800-468-8892.

20. VIRGINIA HEALTH and MEDICAL EMERGENCY RESPONSE TEAMS (EMS DISASTER TASK FORCES)

20.1 In a declared state or local emergency, local resources can be supplemented by requesting deployment of state EMS Disaster Task Forces through the EMS Desk in the Virginia Emergency Operations Center (804-674-2400 or 1-800-468-8892).

20.2 EMS Disaster Task Forces can be deployed in three configurations. The requesting jurisdiction should identify the specific configuration needed.

20.2.1. Standard Task Force: Composed of one Basic Life Support (BLS) ambulance, one Advanced Life Support (ALS) ambulance, one heavy-duty or medium-duty rescue truck, and a disaster truck

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or trailer, if available, with a Task Force Commander and minimum of eight (8) EMS providers.

20.2.2 Personnel Package: Composed of standard Task Force staffing with appropriate transportation. Providers carry no equipment other than personal kits.

20.2.3 Augmentation Package: A standard task force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

20.3 EMS Disaster Task Forces are designed to be used as units either to undertake specific tasks or to supplement the needs of the requesting jurisdiction.

20.4 EMS Disaster Task Forces will attempt to arrive supplied for 72 hours, not including water, fuel or expendable supplies.

21. DEACTIVATING THE MCI PLAN

21.1 The Incident Commander will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed at the MCI site.

21.2 MCI Medical Control will deactivate the EMS MCI Plan among medical care facilities when MCI Medical Control is notified by the on-scene Incident Commander that EMS activities are completed at the MCI site or when it is determined that all other patient care issues have been resolved.

22. ANNEXES

A. Forms and Worksheets

1. Patient Count & Distribution Worksheet
2. MCI Patient Tracking Form
3. Prehospital Job Checklists:
 - a. First Unit on Scene Unit
 - b. Incident Commander
 - c. Medical Branch Supervisor
 - d. Staging Area Manager
 - e. Triage Unit Leader
 - f. Treatment Unit Leader
 - g. Red, Yellow (Prime), Green Treatment Area Attendant-in-Charge
 - h. Incident Morgue Attendant-in-Charge
 - i. Medical Supply Coordinator
 - j. Transportation Unit Leader
 - k. Transport Recorder
 - l. Transport Loader
 - m. Medical Communications Coordinator
 - n. Air Operations Group Supervisor (as needed)
 1. Air Operations Annex
 - o. Hospital Driving Directions

23. Patient Count & Distribution Worksheet

Date: _____ Incident Name _____
 Location: _____

Number of Patients Reported by Triage Category					
On-Scene Location	Red (Immediate)	Yellow (Delayed)	Green (Minimal)	Black (Deceased)	Total Number of Victims

Available Transport Units					

Patient Distribution														
ED or Hospital Name														
Capacity (R/Y/G)														
No. of Pts Sent														
ED or Hospital Name														
Capacity (R/Y/G)														
No. of Pts Sent														

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24. MCI Patient Tracking Form

#	Triage Tag No.	Priority (R/Y/G)	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time left Scene	Patient Destination
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2						
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25. Prehospital Job Checklists:

(Following sheets are examples and not exhaustive)

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a. Position: First Unit On-Scene

Mission/Tasks: First unit on scene gives visual size-up, assumes and announces command, and confirms incident location, then performs the 5 S's:

SAFETY assessment. Assess the scene observing for:

- Electrical hazards.
- Flammable liquids.
- Hazardous Materials
- Other life threatening situations.
- Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:

- Type and/or cause of incident.
- Approximate number of patients.
- Severity level of injuries (either Major or Minor).
- Area involved, including problems with scene access.

SEND information:

- Contact dispatch with your size-up information and declare a Multiple or Mass Casualty Incident (Determine level of MCI if able).**
- Request additional resources.**
- Notify the closest hospital / emergency department of the incident.**

SETUP the scene for management of the casualties:

- Establish staging.
- Identify access and egress routes.
- Identify adequate work areas for Triage, Treatment, and Transportation.

START (Simple Triage And Rapid Treatment) and JumpSTART (for pediatric patients).

- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use surveyor's tape to mark patients.
- Move quickly from patient to patient.
- Maintain patient count.
- Provide only minimal treatment.
- Keep moving!
- Remember...Establish COMMAND, SAFETY, SURVEY, SEND, SET-UP AND START/JumpSTART**

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b. Position: Incident Commander

Mission: Responsible for the overall management and coordination of personnel and resources responding to the incident.

Tasks:

- Assumes command and announces name and title to the communications center.
- Dress in identifying vest.
- Identify potentially hazardous situations.
- Assess current situation.
- Estimate number of patients.
- Request additional resources as appropriate.
- Notify closest hospital / emergency department.**
- Establish a visible command post.
- Initiate, maintain and control communications.
- Assign ICS functions.
- Assign and direct resources.
- Track current resources committed.
- Develop, evaluate and revise operational plans.
- Coordinate with other agencies.
- Control and facilitate media.

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c. Position: Medical Branch Supervisor Check List

Mission: To insure that supervision and coordination is provided for extrication triage, treatment, and transportation of all patients.

Tasks:

- Report and provide frequent updates to the INCIDENT COMMANDER or Operations Section Chief. The Medical role may be assumed by the Incident Commander on small incidents.
- Dress in identifying vest.
- Locate in a visible position.
- Assume responsibility of MEDICAL GROUP.
- Coordinate, direct and manage all MEDICAL GROUP operations.
- Account for all personnel assigned to this group.
- Monitor safety and welfare of group personnel.
- Consider relief crews.
- Consider Critical Incident Stress Management (CISM) assistance.
- Appoint and assign Medical Group Supervisor / Unit Leaders and support staff.
- Verify the location of the staging area if needed.

* On small incidents the Incident Commander may assume responsibility for the Medical Group/Branch.

d. Position: Staging Area Manager Check List

Mission: To maintain separate stockpiles of manpower, reserve equipment and expended equipment at a staging area away from the incident.

Tasks:

- Report to INCIDENT COMMANDER (or OPERATIONS CHIEF if appointed)
- Dress in identifying vest.
- Locate in a visible position.
- Establish STAGING AREA in conjunction with INCIDENT COMMAND or Operations Section Chief as needed.
- Provide appropriate staffing, vehicles, equipment, and supplies as requested.
- Maintain status of number and types of resources in staging area.
- Recommend additional staffing, equipment, and resources when necessary.
- Order all personnel to remain with their units until assigned.
- Verify the equipment pool location.
- Control and document all resources entering and leaving the staging area.
- Ensures unimpeded access and egress to and from staging area.
- Coordinate security for staging area.

Helpful Hints

- Maintain communications with OPERATIONS and TRANSPORT.
- Locate and secure buses for use by Transport Group Supervisor/Unit Leader.
- Use a mobile radio when possible to communicate with incoming units.
- Size of incident may require that a separate ambulance staging area be established.
- Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement.

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e. Position: Triage Unit Leader

Mission: To assess and sort casualties to appropriately establish priorities for treatment and transportation.

Tasks:

- Report and provide updates to INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate in a visible position between the incident site and the treatment area.
- If the patients are in imminent danger exists, move all patients out of INCIDENT AREA before establishing TRIAGE.
- Establish controlled pathway from the incident site to the treatment area.
- Direct walking wounded to designated treatment area.
- If START/JumpSTART not yet completed by first arriving crews, appoint triage teams to perform START/JumpSTART using triage ribbons.
 - Obtain a count of accurate count of all victims by triage category (Red/Yellow/Green/Black) & report the count to the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR.
- Continue to use START/JumpSTART algorithms, to continually reassess patients.
- Coordinate the transfer of patients to Treatment Unit Leader.
- Triage all patients upon entry into the Treatment Area
- Appoint "porters" to transport patients via backboards to treatment area. At hazardous materials incidents, requiring decontamination, a team must be assigned to move patients from the warm zone decontamination line to the cold zone treatment area.
- Maintain communications with MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR and other units as needed.

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Helpful Hints

- Continue START/JumpSTART until all patients have been triaged. Have triage teams work in an orderly fashion.
- Remind Treatment Area Attendants-In-Charge to perform secondary triage on all patients in their respective section of the treatment area.
- Move all RED patients to the TREATMENT AREA first, unless tight quarters necessitate moving others first in order to gain access to RED patients.
- Move YELLOW patients next.
- Move GREEN patients to a designated location at the TREATMENT AREA.
- Leave ALL BLACK tagged victims in place unless the remains interfere with the ability to reach the survivors or are in danger of being destroyed.
- Notify that the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR have Incident Command notify the Medical Examiner if black tags are issued.
- Once a triage tag is applied and color identified the triage ribbons may be removed.

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f. Position: Treatment Unit Leader

Mission: Provide patient counts, triage, & treatment to patients awaiting transportation.

Tasks:

- Report and provide updates to the INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate in a visible position.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Designate an Attendant-In-Charge for the Red, Yellow & Green patient care areas
- Ensure that all patients upon entry into the Treatment Area are re-triaged.
- Maintain a count of all victims entering the Treatment Area by triage category.
- Ensure that patients are re-triaged using Secondary Triage and that a triage tags is applied to each as patients upon entry to the respective Red, yellow & Green patient care areas.
- Appoint a MEDICAL SUPPLY COORDINATOR (if needed).
- Working with the Attendants-in-Charge, determine the transportation priority & most appropriate transport method for each patient.
- Maintain contact with the appropriate Attendants-In-Charge of each patient care area (Red Tagged/Immediate, Yellow Tagged/Delayed and Green/Minor.
- Continually reassess each patient's condition and triage status.

Helpful Hints

- Arrange and clearly identify the TREATMENT Area. Identify patient treatment areas for each triage category using colored tarps, flags, tape, chemical lights, etc.
- Have Green/Minor Patients ("Walking Wounded") move to a supervised & controlled area. Isolate emotionally disturbed patients.
- Continuously triage ALL patients. Remove the triage ribbons once triage tags area applied. *Refer to Secondary Triage Decisions.
- Consider establishing specialty patient care teams (i.e. IV teams, bandaging teams, etc).
- Maintain contact with the TRANSPORTATION UNIT LEADER & coordinate the movement of patients to the transportation area based on patient priority.
- Establish "cattle shoots" staffed with triage personnel as "gatekeepers" at entrance to and exit from the TREATMENT AREA to control patient flow.

g. Position: Red, Yellow, or Green Tagged Treatment Area Attendant-In-Charge

Mission: Provide patient counts, triage, and treatment to patients awaiting transportation.

Tasks:

- Report and provide updates to the TREATMENT UNIT LEADER
- Dress in identifying vest.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Clearly identify your treatment area with the appropriate colored flag, tarp, and/or chemical light.
- Ensure that patients are re-triaged upon entry to the treatment area using Secondary Triage and ensure a triage tag is applied to each as patient.
- Maintain accountability of all victims in your treatment area.
- Determine the transportation priority & most appropriate transport method for each patient.
- Report the transportation priority of patients and recommended transport method for each patient to the Treatment Unit Leader.
- Continually reassess each patient's condition and triage status.
- Request the establishment of special patient care teams (e.g. IV team, bandaging team, etc.) as necessary to support the care of your patients.
- Request additional personnel as needed to provide the care for your patients.
- Provide palliative care for catastrophically injured (Yellow Prime) patients until resources allow for their transportation to a hospital.
- Coordinate the relocation of any patient who dies in the treatment area to the Incident Morgue (Black Tagged Treatment Area). Leave all medical devices in place.

Helpful Hints

- Have Green/Minor Patients (“Walking Wounded”) move to a supervised & controlled area.
- Isolate emotionally disturbed patients.
- Remove the triage ribbons once triage tags area applied.

h. Position: Incident Morgue Attendant-In-Charge (Black Tagged Patient Treatment Area)

Mission: To establish and maintain an incident morgue area for deceased persons who die in route to or in the Treatment Area.

Tasks:

- Report to the TREATMENT UNIT LEADER.
- Dress in identifying vest.
- Verify with the TREATMENT UNIT LEADER that the closest Office of the Chief Medical Examiner has been notified of deceased persons:
Richmond: (804) 786-3174
- Secure the area from all unauthorized personnel and provide security to the morgue area with the assistance of Law Enforcement.
- Reassess each patient upon entry to the Incident Morgue / Black Tagged Patient Care Area. Annotate the patient assessment on the triage tag. If the patient does not have a triage tag then attach a completed triage tag to the patient.
- Leave all medical interventions in place (i.e. IV's, bandages, etc.)
- Cover patient(s) with sheets or enclose remains in disaster pouches or similar body bags.
- Ensure that no human or animal remains are moved from the incident site prior to the arrival and approval of the Medical Examiner/chief law enforcement officer.
- Establish a secure morgue area separate from the TREATMENT AREA, and accessible to vehicles (i.e. emergency vehicles, law enforcement).
- With the assistance of Law Enforcement, secure the area from all unauthorized personnel and provide security to the morgue area.
- Coordinate activities with the Medical Examiner's Office, funeral directors, and law enforcement as necessary.
- Maintain accountability of all victims received in the treatment area using the MCI Patient Tracking Form.

Helpful Hints

- The only remains that should be moved to the incident morgue are those whose location is hindering rescue operations, or victims who died in route to, or in the treatment area.
- Do NOT allow photographs in the morgue without the medical examiner's permission.

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i. Position: Medical Supply Coordinator

Mission: Acquire, distribute and maintain the status of medical equipment and supplies.

Tasks:

- Report and provide updates to the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate medical supplies in a central position in the Treatment Area using caution not to block access & egress to and from the Treatment Area.
- Maintain an inventory list of equipment, supplies, and Disaster Medical Support Units (DMSUs) received and distributed. Provide receipts upon request.
- Continually assess status of medical supplies and equipment. Request additional supplies and equipment through the Medical Group Supervisor / Medical Branch Director as needed.
- Distribute medical supplies and equipment to the Patient Care Areas.
- Request personnel to assist in the collection and distribution of supplies and equipment. Consider a need to have a vehicles(s) transport supplies and equipment.

Helpful Hints

- Do NOT strip ambulance of medical supplies & equipment unless absolutely needed to manage the initial phase of the incident.
- Establish a perimeter around the medical supply area to assist in controlling the distribution of supplies and equipment.
- Use the SALTT acronym to request resources.

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j. Position: Transportation Unit Leader

Mission: Track and distribute patients to medical facilities by assigning the mode of transportation & destination for each patient.

Tasks:

- Report and provide updates to the INCIDENT COMMANDER (MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR.)
- Dress in identifying vest.
- Locate in a visible position.
- Verify the Staging Area location.
- Collaborate with the Treatment Unit Leader to determine patient transportation priorities, Emergency Department bed availability & patient destinations using attached Patient Tracking & Distribution Worksheets.
- Communicate transportation resource needs to the MEDICAL GROUP SUPERVISOR / BRANCH DIRECTOR.
- Appoint MEDICAL COMMUNICATIONS COORDINATOR and ensure communications link is established with the Coordinating Emergency Department.
- Appoint TRANSPORT RECORDER for each area of patient egress & ensuring each patient is tracked by triage tag number using the MCI Patient Tracking Form.
- Appoint TRANSPORT LOADERS.
- Inform transport crews of their destination, remind units to return to the Staging Area unless otherwise directed.
- Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient's condition or if they need physician's orders.
- Document patient and unit movements and destination using the MCI Patient Tracking Form.
- Maintain close communications with INCIDENT COMMAND or MEDICAL, TREATMENT, GROUND & AIR OPERATIONS.
- Once the last patient has been transported, and before demobilization, work with the Transport Recorder, Transport Loader, Medical Communications Coordinator and the Coordinating Emergency Department to **account for 100% of the patients/victims.**

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Helpful Hints

- Ensure that transport ambulances are parked to allow easy patient loading and egress without being blocked by other ambulances or require ambulances to back in for patient loading.

k. Position: Transport Recorder

Mission: To assist in ensuring proper documentation of victim/patient and unit movements.

Tasks:

- Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER
- Dress in identifying vest.
- Locate at assigned patient egress point in the TRANSPORT area.
- Document patient transport information on triage tag and collect tag stubs.
- Complete an entry on the MCI Patient Tracking Form (ICS 306 Form) for each patient leaving the Transportation Area.
- Deliver triage tag Transportation Record to MEDICAL COMMUNICATIONS/TRANSPORTATION as directed.

Helpful Hints

- Determine whether or not TRANSPORT will be handling the MEDICAL COMMUNICATIONS role or will the function be assigned to a separate individual.

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I. Position: Transport Loader

Mission: Ensure patients are safely loaded into the assigned vehicle or air ambulance, verify & vehicle destination & travel directions.

Tasks:

- Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Ensure patients selected for transportation are:
 - o Ready for transport
 - o Safely loaded aboard the ambulance or other vehicle designated by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER
- Provide the following information to ambulance personnel:
 - o Inform crews of the destination hospital/Emergency Department.
 - o Provide travel directions to the receiving hospital/Emergency Department
 - o Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient's condition or if they need physician's orders.
 - o Remind crews to return to the Staging Area upon completion of their assignment unless otherwise directed.
- Ensure all patients being loaded have triage tags attached and the transport stub has been removed.
- Maintain close communications with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER and TRANSPORT RECORDER.

Helpful Hints

- Obtain maps or directions to area hospitals for distribution to ambulance crews.
- If the TRANSPORT Area is some distance from TREATMENT, consider using a stretcher from a committed ambulance to move patients to the receiving units.

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m. Position: Medical Communication Coordinator

Mission: To maintain and coordinate medical communications at the incident scene between TRANSPORT GROUP SUPERVISOR/UNIT LEADER and the Designated Coordinating Emergency Department.

Tasks:

- Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Remain in close proximity to the TRANSPORT and TREATMENT areas.
- Establish and maintain a dependable communications link with the designated Coordinating Hospital. The following minimal information should be provided and updated:
 - o Type of incident
 - o Number of patients
 - o Severity of injuries
- Coordinate patient distribution with the Coordinating Emergency Department.
- Report individual patient information to Coordinating Emergency Department as relayed by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
 - o Unit transporting
 - o Destination hospital
 - o Number of patients
 - o Triage tag numbers
 - o Triage category, major injuries and age of patients
- Assist TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER with documentation.

Helpful Hints

- Locate in close physical proximity to the TRANSPORTATION area.
- Maintain contact with designated Coordinating Emergency Department, relaying triage tag number, patient condition and destination.
- Maintain communications with TRANSPORT GROUP SUPERVISOR/UNIT LEADER.

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n. Position: Air Operations Group Supervisor

Mission: To assume responsibility for the coordination, landing, and communication with air ambulance aircraft.

Tasks:

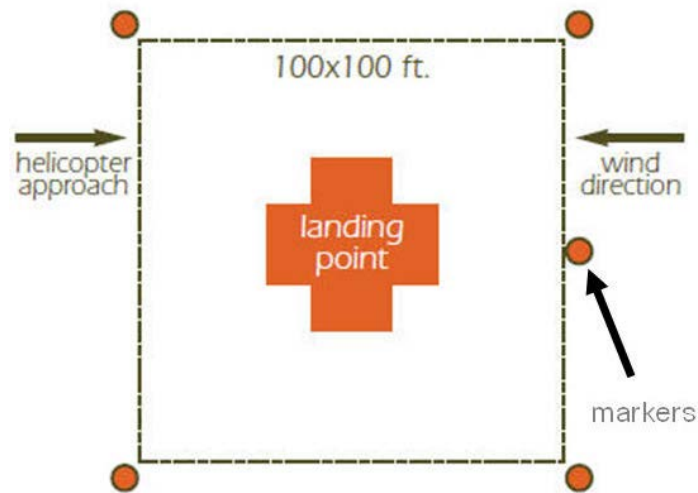
- Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Assign a fire unit and personnel and establish a HELISPOT (a.k.a. landing zone.)
- Secure and maintain a helispot of sufficient size on the most firm and level surface available (less than 5° slope) and clear of debris. Night operations and low visibility conditions require a larger helispot! (See the Helicopter Profiles and Helispot Requirements table for landing area space requirements).
- Locate helispot at least one mile upwind from HAZMAT incident sites when explosives, gases, vapors, or chemicals are in danger of exploding or burning on sites, or when a plume is present. For radioactive materials incidents with no steam or smoke the helispot can be located ¼ mile upwind from the incident site.
- Clearly mark the area with five weighted cones, flares, or beacons.
- Maintain helispot/landing zone security. Request law enforcement assistance if needed.
- Maintain radio contact with incoming helicopters. (All civilian helicopters stationed in Virginia can communicate on the Statewide Mutual Aid channel, VHF 155.205)
- Advise the pilot of the following BEFORE landing:
 - Obstructions at the landing area, as well as "near-by" (e.g. radio or cell towers, antennas, telephone lines, other wires, cranes, tall buildings, etc).
 - Wind direction or ground wind gusts.
 - Location of any HAZMAT incidents, plume location and direction.
 - Relay patient information from the Medical Communication Coordinator to the air ambulance crew (e.g. patient condition, patient weight, and airway status).
 - Coordinate loading and transport of patients with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.

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Helpful Hints

- ✓ Air ambulances will NOT transport contaminated or combative patients.
- ✓ Use of white lights should be avoided.
- ✓ If landing aircraft repeatedly consider using non-flare lighting to mark the helispot.
- ✓ All markers (flashing lights) should be put out and/or cut off before takeoff.
- ✓ Assign personnel to secure helispot after landing.
- ✓ Have fire equipment wet down the helispot if it is extremely dusty.
- ✓ ALWAYS AVOID THE TAIL ROTOR.
- ✓ NEVER APPROACH THE CRAFT DURING LANDING OR TAKE OFF.

Helispot Set-up Diagram



Helispot (Landing Area) Requirements and Safety

The following guidelines should be used to select and establish a helispot for rotary wing aircraft:

- ✓ **Locate an area that is large enough to land a helicopter safely.** The touchdown or landing area should be 60 X 60 feet during the day and 100 X 100 feet at night for most civilian (BK 117) air ambulances such as LifeEvac and Nightingale. The area should be on level, firm ground which is free of overhead obstructions, rocks, and other ground debris. If landing more than one helicopter each aircraft must have its own 100' x 100' box to land in.

NOTE: The size of the landing area varies upon the type of helicopter. U.S. Coast Guard and military helicopters (i.e. JayHawk, SH-60s) require a much larger landing area. Refer to the following table for assistance in determining the appropriate landing area size for U.S. Coast Guard and Department of Defense helicopters.

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1. AIR OPERATIONS

The Incident Commander or Operations Section Chief may establish an Air Operations Branch depending upon the needs of the incident. Air operations at major incidents are complicated. **Flight safety is, and must remain, a vital concern of all personnel involved in air operations.**

The Air Medical Transport Decision

Aero-medical ambulances should be considered when their use can:

- ✓ Decrease transport time from the incident scene to the hospital.
- ✓ Provide advanced critical care not available from ground EMS Units.
- ✓ When special medical resources must be brought to the scene or moved to an intermediate care facility.
- ✓ When ground EMS Units cannot access or egress the scene.
- ✓ Evacuate critical ill patients from the affected disaster area or local hospitals.
- ✓ Provide the Incident Commander with an aerial scene evaluation.

Requesting Air Ambulance Services

The initial request for air ambulance services will follow normal request procedures from the incident commander, via the jurisdiction's dispatch center, to the dispatch center of an air ambulance service provider. *(Add any additional notes needed here)*

Contact the Virginia Emergency Operations Center at 1-800-468-8892 if air ambulance services are needed from providers outside of the jurisdictional/regional area. The Virginia Emergency Operations Center can assist in providing the telephone numbers for other air ambulances service providers such as the Virginia Army National Guard, Virginia Air National Guard, U.S. Coast Guard and the Department of Defense (Air Force, Army, Marine Corp, and Navy).

Airspace Restrictions

Airspace over an MCI is regulated by the Federal Aviation Administration (FAA). Questions or requests concerning the use or restriction of that airspace during an MCI should be directed to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center at 703-771-3470. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other FAA facilities as appropriate. The Virginia EOC at 1-800-468-8832 has access to additional contact information to assist in this function. *(Add any additional notes for the jurisdiction or region here)*

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Aircraft Communications

The primary incident Emergency Communications Center / 911 Dispatch Center normally contacts air ambulance services to request medevac services. The scene helispot (landing area) location, coordinates, control and frequency information will be given to the pilots by their agency's dispatch center when the aircraft is dispatched.

Scene to Aircraft Communications

Ground to helicopter communications. The Virginia Medevac Committee recommends using the VHF Statewide Mutual Aid channel to communicate with air ambulances. Helicopters whose primary base-of-operations are not in Virginia, including those operated by the U.S. Coast Guard and the Department of Defense cannot communicate on 800 MHz channels. However, all of these helicopters can communicate using VHF frequencies. The designated mutual aid VHF frequencies are as follows:

155.205 MHz - Statewide Mutual Aid

154.265 MHz - Peninsulas Mutual Aid Frequency

154.295 MHz - Tidewater Mutual Aid Frequency

Ground to helicopter communications may also be performed on a locally assigned VHF channel that does not interfere with incident communications. Communications may also be established using 800 MHz channels **IF** the responding air ambulances service has that capability.

Aircraft to Aircraft Communications

Helicopter to helicopter communication is accomplished using the 123.025 VHF frequency, allowing pilots to communicate flight or scene hazards to each other.

Communications and Multiple Aircraft Response

The use of multiple aircraft in an incident response brings with it an increased risk of an aircraft related mishap. The Air Operations Branch Director must establish effective and clear communications with each responding aircraft. During landing area operations, all aircraft-ground communications must occur on an assigned and common incident radio frequency, ideally the VHF 155.205 MHz - Statewide Mutual Aid channel as recommended by the Virginia Medevac Committee. Alternate radio communications between aircraft may be accomplished using VHF 123.025 MHz. Assigned frequencies should be documented on the Air Operations Summary Form (ICS 220).

The following multiple aircraft response communications procedure has been recommended for adoption by all agencies involved in air operations at any incident where more than one air ambulance, or aircraft, is responding. This procedure was designated as a "*Best Practice*" by the Virginia Medevac Committee in January 2008:

1. The initial request for medevac services should be made to the jurisdictions primary medevac service provider (air ambulance service).

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2. If requests were made for additional air ambulances or other aircraft to respond to the scene, the requesting emergency communication center must contact the dispatch center for each air ambulance or other aircraft, and advise them that this is a multiple aircraft response.

3. The medevac service provider/air ambulance service's dispatch or communications center should take the following actions after they are notified that another aircraft has been requested to the facility or scene.

- o Contact all other responding aircraft communications centers and advise them of the multiple aircraft response.

- o Inform their prospective aircraft that multiple helicopters or aircraft are responding and replay the following information to the individual flight crews:

- ✓ The number of inbound aircraft
- ✓ The assisting aircraft's name (i.e. LifeEvac, Medflight, etc.)

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o. Hospital Driving Directions

10 closest hospitals in order from the center of Charlottesville, VA
(fill out directions from each scene for hospitals to transport to)

Hospital 1 Name: **UVA Hospital**
Address: **1215 Lee Street; Charlottesville, VA 22908**
Driving Directions:

Hospital 2 Name: **Sentara Martha Jefferson Hospital**
Address: **500 Martha Jefferson Drive; Charlottesville, VA 22911**
Driving Directions:

Hospital 3 Name: **Sentara Martha Jefferson Free Standing ER**
Address: **3263 Proffit Road; Charlottesville, VA 22911**
Driving Directions:

Hospital 4 Name: **Augusta Health**
Address: **78 Medical Center Drive; Fishersville, VA 22939**
Driving Directions:

Hospital 5 Name: **UVA - Novant Health Systems Culpeper Regional
Hospital**
Address: **501 Sunset Lane; Culpeper, VA 22701**
Driving Directions:

Hospital 6 Name: **Sentara Rockingham Memorial Hospital**
Address: **2010 Health Campus Drive; Harrisonburg, VA 22801**
Driving Directions:

Hospital 7 Name: **Henrico Doctor's Hospital Parham**
Address: **7700 East Parham Road; Richmond, VA 23294**
Driving Directions:

Hospital 8 Name: **Henrico Doctor's Hospital Forest**
Address: **1602 Skipworth Road; Richmond, VA 23229**
Driving Directions:

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Hospital 9 Name: **Mary Washington Hospital**
Address: **1001 Sam Perry Boulevard; Fredericksburg, VA 22401**
Driving Directions:

Hospital 10 Name: **Centra Lynchburg General Hospital**
Address: **1901 Tate Springs Rd; Lynchburg, VA 24501**
Driving Directions: