Town of East Hampton, Connecticut

Local Emergency Medical Services Plan

January 2021

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Table of Contents

Appendices:

Appendices Continued:
Sponsor Hospital Medical Oversight Policy for:
-Public Safety Answering Point (PSAP)
-First Responder level of service
-Basic Ambulance level of service
-First Responder supplemental level of service
North Central Region 3 MCI Protocol
Statewide Fire Service Disaster Response Plan
East Hampton Public Schools Emergency Operations Manual (Redacted, original on file at Town Hall)

Purpose Statement

To develop a plan that satisfies the municipality's statutory requirement and provides a comprehensive local EMS plan (LEMSP) that communicates information about the local EMS system to all stakeholders, including municipal and EMS organization leaders, EMS organization members, citizens, regional and State policy makers and planners. To establish methods to monitor how well the EMS system is functioning and frames objectives and methods for improving the EMS system.

A municipality that puts effort and detail into the LEMSP may benefit greatly from both the process and the final product. When the municipal leaders and the EMS organizations meet to discuss the plan, the discussion leads to better organizational relations, improved system knowledge, and multi-dimensional goals and objectives for the town's EMS system development. A municipality that fails to implement a local EMS plan essentially forfeits the ability to proactively manage its local EMS system. The organizations providing EMS services to the municipality will be assessed for their provisions of services under the plan not less than every 5 years. In the absence of a plan, the Department of Public Health Office of Emergency Services will assess them for compliance with applicable statues and regulations which may be much looser standards than what a municipality would choose to have. The updated statues which took effect October 1, 2014 also provide expanded municipal controls for towns that comply with the provisions of the local EMS planning statues. It is, for the aforementioned reasons, in the municipality's best interest to work with its EMS system providers to develop a local EMS plan.

The LEMSP encompasses all components of the EMS system; both statutorily required and recommended "best practices".

Local EMS Planning Statutory Requirement

The required components of the Local EMS Plan are delineated in §CGS 19a–181b, which was comprehensively updated in 2014, and have been addressed in this plan. Additional information regarding the Emergency Medical Services System within the Town of East Hampton has been included so that this plan will be a valuable resource to anyone seeking information about our system.

Municipal Information

Town Contact Information:

Office of the Town Manager
Town of East Hampton
1 Community Drive
East Hampton, CT 06424

Name: David Cox
Phone: 860-267-4468
Email: dcox@easthamptonct.gov
Town Tax Code: 042

Demographic Information:
State Office of Rural Health designation: Non-Rural
Population: 12,959 (2010 census)
Square Miles: 36.8 (Land – 35.6, Water – 1.2)

System Overview

The Emergency Medical Services System for the Town of East Hampton is based upon a multi-tiered response—First Responder, Basic Ambulance, and Paramedic Response. Glastonbury Police Department Dispatch (PSAP) receives 911 calls originating within the Town. The PSAP then dispatches the Ambulance and First Responders via "tone-activated pagers," "alpha-numeric pager", and "I Am Responding" cell phone app. East Hampton Police Department (EHPD) provides First Responder Services. East Hampton Volunteer Fire Department (EHVFD) provides First Responder Supplemental Services. East Hampton Ambulance Association Inc. (EHAA) provides the Basic Ambulance services. Paramedic level service is activated either immediately according to Emergency Medical Dispatch Protocol (EMD) or as requested by EMS responders at the scene. Middlesex Health Paramedics provides paramedic services to the Town. Patients are transported to the most appropriate local primary receiving facility (Emergency Department) as per State Regulation, Patient Care Protocols, and patient request. A comprehensive mutual-aid system implemented automatically by the PSAP helps to assure EMS response during times of "system overload", which is, more requests for emergency response than the system's providers have resources to handle.

Independent Agency Status

The organizations, East Hampton Ambulance Association and Middlesex Health Paramedics, providing each segment of emergency medical service to the Town of East Hampton are incorporated independently of the Town of East Hampton. As such, they are governed by their own corporate boards and by-laws, and operate in compliance with Local, State and Federal laws.

Levels of Emergency Medical Services (§CGS 19a-181b)

Public Safety Answering Point (PSAP):

Glastonbury Police Department Dispatch
2108 Main Street.
P.O. Box 535
Glastonbury, CT 06033

Phone: (860) 652-4222
Contact: Gene Jopeck, Communications Supervisor
Email: gene.jopeck@glastonbury-ct.gov

Written Agreement and Performance Standards required pursuant to §CGS 19a–181b are included in the appendix.

First Responder:

East Hampton Police Department
1 Community Drive
East Hampton, CT 06424

Phone: (860) 267-9544
Contact: Dennis Woessner, Police Chief
Email: dwoessner@easthamptonct.gov

This provider fulfills the requirements outlined in Connecticut Public Act 16-43 and is equipped with and trained in the administration of an opioid antagonist.

Performance Standards required pursuant to §CGS 19a–181b are included in the appendix.
2002 Written agreement with Town attached.

First Responder Supplemental:

East Hampton Volunteer Fire Department
3 Barton Hill Road
East Hampton, CT 06424

Phone: (860) 267-1012
Contact: Greg Voelker, Fire Chief
Email: firechief@easthamptonct.gov

Performance Standards required pursuant to §CGS 19a–181b are included in the appendix.

Basic Ambulance Service:

East Hampton Ambulance Association Inc.
4 Middletown Avenue
P.O. Box 144
East Hampton, CT 06424

Phone: (860) 267-9679
Contact: Donald Scranton, EMS Chief
Email: chief@ehems.org

This provider fulfills the requirements outlined in Connecticut Public Act 16-43 and is equipped with and trained in the administration of an opioid antagonist.

Written Agreement and Performance Standards required pursuant to §CGS 19a–181b are included in the appendix.

Advanced Life Support Providers (Paramedic Level):

Middlesex Health
Middlesex Health Paramedics
28 Crescent Street
Middletown, CT 06415

Phone: (860) 358-6081
Contact: Jim Santacroce, Chief Service / EMS Coordinator
Email: jim.santacroce@midhosp.org

This provider fulfills the requirements outlined in Connecticut Public Act 16-43 and is equipped with and trained in the administration of an opioid antagonist.

Written Agreement and Performance Standards required pursuant to §CGS 19a–181b are included in the appendix.

Mutual Aid Call Arrangements:
PSAP: During system overload, equipment failure, or other situations where the PSAP cannot answer E-911 calls, calls are transferred automatically to another designated PSAP.
Basic Ambulance: East Hampton Ambulance Association Inc. has entered into a mutual aid agreement with multiple organizations. Under most circumstances, the mutual aid will be provided by or given, but not limited to:

Roy B. Pettengill Ambulance Association Inc.
Contact: Mark Merritt, Rescue Captain
Phone: (860) 916-9577
Email: lawnsnstuff@comcast.net

East Haddam Ambulance Association Inc.
Contact: Richard Harmon, EMS Chief
Phone: (860) 639-1287
Email: bozofd393@sbcglobal.net

Colchester Hayward Volunteer Fire Department.
Contact: Sean Shoemaker, Interim Fire/EMS Chief
Phone: (860) 209-6271
Email: firemarshal@colchesterct.gov

First Responder: East Hampton has entered into a mutual aid agreement based on geographical location with one organization as listed:

Haddam Neck Volunteer Fire Department
Contact: Robert McGarry, Fire Chief
Phone: 860-930-8135
Email: chief@hnvfd.com

Subcontracts or Other Agreements for segments of the EMS System:
There is currently no provision of the identified levels of emergency medical services, not otherwise identified above, that are provided under subcontract to the primary EMS providers.

Local System comparison to a Model EMS Plan

The following section provides answers to a series of questions created by the Office of Emergency Medical Services to benchmark the Town of East Hampton's EMS System to a "Model EMS System." As with any model that is designed to represent a "perfect system", the benchmark may not be realistic within the community but provides a goal for this and every community to examine and, if appropriate, strive to achieve.

1) Accident/Injury Prevention and Community Response:

It is estimated that there are approximately 10% of the Town's citizens trained in CPR. The Town was recognized as a Heart Safe Community in 2010, 2016 and 2020 and intends to renew this status as it comes up for renewal. CPR classes are offered to the community throughout the year by the Town Parks and Recreation Department and East Hampton Ambulance Association. There are approximately 25 AEDs throughout town, with most being in public areas or private areas of high population congregation. Additionally, citizens are made aware of AED locations and how to access through CPR classes, school notices and community outreach.

2) Citizens educated in the proper use of 9-1-1:

Very few citizens call East Hampton Ambulance Association directly and if they do, an automatic prompt informs them to call 911 in the event of an emergency. The East Hampton Volunteer Fire Department conducts safety education in the school system during National Fire Prevention Week, either through the firefighters or the Fire Marshal's Office. The children are also invited to tour the fire department and ambulance and learn about some of the functions of the equipment.

3) All streets clearly identifiable, homes and businesses properly numbered:

All public streets are properly identified. Most private streets are identified. Businesses are properly numbered. There are no CT general statues regarding street numbering. The East Hampton Volunteer Fire Department offers low cost reflective numbers to aid in improving residence numbering. Signs can be installed by the homeowner or the fire department can install them to aid with the best location for responders to see.

4) Public Safety Answering Point (PSAP) utilizes Emergency Medical Dispatch:

The PSAP for the Town of East Hampton is Glastonbury Police Department Dispatch. The PSAP presently uses Priority Dispatch ProQA, as its state approved vendor for Emergency Medical Dispatch (EMD) national guidelines Public Act 00-151 required all PSAPs within the state to provide EMD by July 1, 2004 Dispatching protocols and procedures are maintained and implemented by the PSAP through the use of computers.

The PSAP also adheres to an Ongoing System Evaluation of EMD:

- Dispatchers must be certified after a 3 day course by the International Academy of Emergency Medical Dispatch (IAEMD) before delivering EMD.
- Dispatchers must recertify every 2 years and complete 24 hours of continuing education.
- Dispatchers are evaluated by a certified EMS Q&A who rates their performance each month.
- Dispatchers must maintain a compliance rating based off the appropriate category.
- After evaluation, there may be discussion between the two certified Q&A personnel if any discrepancies, and if necessary discusses discrepancies with any dispatcher failing to meet the compliance ratings.
- Manchester Hospital is Glastonbury Police Department Dispatch's Medical oversight who signs off on EMD guidelines given to them by Priority Dispatch/ProQA.
- Problem resolution over EMD Policy and Procedure are resolved at meetings between Glastonbury Police Department Dispatch and Manchester Hospital, if necessary.

5) Rapid deployment of opioid antagonist by EMS responders:

The Town of East Hampton assures rapid deployment of opioid antagonists by equipping and training most levels of EMS responders in the community. This assures that the first arriving EMS unit will able to appropriately treat opioid related emergencies. Currently, East Hampton Volunteer Fire Department as a Supplemental First Responder does not carry an opioid antagonist.

6) EMS First Responder with Primary Service Area assignment for your community:

The East Hampton Police Department is the designated First Responder Service Provider for the Town of East Hampton. The PSA boundary for the East Hampton Police Department is the entire *Town of East Hampton*, bordered on the North by Glastonbury, on the East by Marlborough and Colchester, on the South by Haddam (Haddam Neck) and East Haddam and on the West by Portland.

7) EMS First Responder with a automatic external defibrillator (AED):

The East Hampton Police Department currently maintains designated First Responder vehicles equipped with AED units. The East Hampton Police Department has additional authorization for the following skills/treatments: AED Defibrillation and Naloxone.

8) Supplemental First Responder where necessary to enhance quick emergency medical response, equipped with an AED:

The Town currently has the East Hampton Volunteer Fire Department as a Supplemental First responder. Currently, the East Hampton Volunteer Fire Department responds to all EMS calls of Cardiac Arrest, Unresponsive, Unconscious, or when requested. The East Hampton Volunteer Fire Department responds with an AED on their Rescue truck.

9) Basic Ambulance Service with PSA Assignment for the community:

East Hampton Ambulance Association Inc. is the designated Basic Ambulance Service Provider for the Town of East Hampton. The PSA boundary for East Hampton Ambulance Inc. is the entire *Town of East Hampton*, bordered on the North by Glastonbury, on the East by Marlborough and Colchester, on the South by Haddam (Haddam Neck) and East Haddam and on the West by Portland

The East Hampton Ambulance Association Inc. has Mobile Intensive Care (MIC) authorization for the following additional skills/treatments: Aspirin, AED Defibrillation, Epinephrine Autoinjector and Naloxone.

East Hampton Ambulance Association Inc. has an obligation to service the area of Haddam Neck in the Town of Haddam per a Special Mutual Aid Agreement. In the event of a medical emergency occurring in Haddam Neck, this shall be deemed as a "First Call" for the Town of East Hampton.

10) Basic Ambulance Services is equipped with an AED:

East Hampton Ambulance Association Inc. is authorized to operate two (2) ambulances both equipped with an AED.

11) Paramedic Service with PSA assignment for the community:

The Middlesex Health Paramedic Service is a designated paramedic level responder within the Town of East Hampton, within Middlesex County. The PSA boundary for the Community Hospital Paramedic Service is a multi-town, county-wide PSA that includes the *Town of East Hampton*. The Middlesex Health Paramedic Service is authorized under Connecticut Agency Regulations 19a-179-21 to charge a "Fee for Service." Charges are billed according to all applicable State and Federal rules and regulations.

12) Ongoing EMS System evaluation (i.e.: response times, coverage problems, system effectiveness, and problem resolution, etc.):

a) Medical Quality Assurance and Quality Improvement is conducted through the EMS providers' Sponsor Hospital, pursuant to Connecticut Agencies Regulations §19a-179-12.

Sponsor Hospital for the East Hampton Police Department, East Hampton Volunteer Department, and East Hampton Ambulance Association Inc.:

Middlesex Health

28 Crescent Street
Middletown, CT 06415

Contact: Dr. Michael Zanker
Email: Michael.zanker@midhosp.org

Contact: Jim Santacroce, Chief Service / EMS Coordinator
Email: jim.santacroce@midhosp.org
Phone: (860) 358-6081

b) Staffing and Coverage of each segment of the EMS System:

PSAP: Glastonbury Police Department Dispatch has 24-hour-per-day paid staff assigned to answer E-911 calls and to provide dispatch services to the member organizations.

First Responder: East Hampton Police Department has 24-hour-per-day paid staff assigned to respond to 911 calls and to provide First Responder Services.

Basic Ambulance: East Hampton Ambulance Association Inc. issues tone-activated pagers, alpha numeric pagers to all members, along with a cell phone app "I Am Responding" who then respond as dispatched by the PSAP. This helps to ensure an efficient response. East Hampton Ambulance Association Inc. utilizes an ambulance incentive program in order to assist in the staffing of the ambulances 24-hours-per-day. East Hampton Ambulance does not employ full-time or per-diem personnel to staff the ambulance.

Advanced Life Support Providers: Middlesex Health Paramedic Service has 24-hour-per-day paid personnel to staff their vehicles. The number of vehicles staffed varies according to time of day and distributed appropriately throughout Middlesex County. This is done in order to maintain an efficient, yet cost-effective, level of service.

c) Problem resolution:

Any problem, question, or issue is handled on an individual basis with the appropriate agency(s), and remedied according to the specific needs of the situation.

13) Written mutual-aid agreements for back up to existing EMS responders at all levels:

Definition: "System Overload." System Overload occurs when the requests for assistance exceeds the resources of a specific provider of a segment of the emergency medical services system. Example: If an ambulance service has two ambulances and three calls requesting ambulance service are received within their response area at the same time, the service's ambulances are already committed for the first two calls received. Or there are two ambulances requested and only enough resources to fulfill one request. During system overload, mutual aid is requested from neighboring services to provide assistance in fulfilling any request for service that has exceeded the designated service's resources.

PSAP: Public Safety Answering Points do not enter into traditional mutual aid agreements. Automatic back up is built into the E-911 phone system in Connecticut.

Basic Ambulance: East Hampton Ambulance Association Inc. has written mutual-aid agreements separately with surrounding departments.

First Responder: If East Hampton Police Department is unavailable, there is no current back up first responder service.

Paramedic: If Middlesex Paramedic is unavailable, there is no current written mutual aid agreement with other Paramedic services, but traditionally a Hunters Ambulance Paramedic, or ASM/AETNA paramedic is requested.

14) Written Mass Casualty Plan:

There is not a current written mass casualty plan for the Town currently. The Town currently utilizes the North Central C-MED Region 3 Mass Casualty Incident Protocol produced by the North Central EMS Council.
Fire Service Personnel are instructed in the *Incident Command System* in various fire service courses, which is an integral part of MCI management. Fire Department members received specific training in managing mass casualty incidents and SMART Triage training. Subsequent to the terrorist threats facing the nation, the Town encourages participation in All Hazard planning to include *Bioterrorism/Weapons of Mass Destruction*, Infectious Disease and Pandemic Outbreaks, as feasible for local responders.
The Fire Department currently adheres to the Connecticut Statewide Fire - Rescue Disaster Plan produced by the Connecticut Fire Chief's Association in cooperation with the Commission on Fire Prevention and Control.

15) Mass Casualty Plan Exercise:

East Hampton Volunteer Fire Department, and East Hampton Ambulance Association Inc, plan and execute multi-municipality mass casualty incident exercises and drills every two years as well as participate in other local area towns' mass casualty incident exercises and drills. The Town will continue to encourage participation in MCI exercises.

Potential impediments to response in Suburban EMS

The Town of East Hampton, as well as other suburban communities, faces certain potential impediments that may delay response of the Emergency Medical Services System. The following areas of concern, adapted from the State of Connecticut Emergency Medical Services Plan, are potentially a problem in suburban communities in Connecticut and across the Nation. Citizens and visitors of suburban areas must keep this in mind if they need to access the Emergency Medical Services System in any suburban community.

Unlike rural communities, most of the suburban towns in Connecticut have full-time paid police and/or fire departments. Population density is greater and although many of the problems of the rural community exist in suburban areas, the severity is usually not as great.

CONCERNS:

As described above, many of the suburban communities have full-time paid police departments and in some cases full-time fire departments with transport capabilities. East Hampton has a volunteer staffed Basic Ambulance transport service that may not be fully staffed all the time. Transportation to further care is a critical element of the cardiac "chain of survival" and equally important in other medically life threatening situations.

Although many suburban communities have direct or intercept Paramedic service, the effectiveness of ALS is severely diminished because they don't have a full-time paid ambulance transport service to allow the patient to be transported to further care that is needed in a timely fashion.

Community boundary lines are strictly observed and there is reluctance to coordinate or share public safety resources. This often results in delayed response and increased cost.

There is difficulty with recruiting and retaining volunteer personnel because they must attend EMS initial education and training courses at night and on weekends as well as attend recertification and continuing education courses in order to receive and maintain state certification. This is a significant time commitment in addition to the hours they actually spend "on duty". This is uncompensated time not spent with their families or in pursuing career development. In addition, EMS personnel are frequently working under hazardous conditions.

There is currently no mutual aid agreements or designated backups to the first responder service's in East Hampton if they are unavailable which may delay the critical element of timely care in the event of life threatening situations.

There are no mutual aid agreements with the Town of Portland, only verbal agreements.

Currently mutual aid agreements are based on agreements written in 2002 and are not legally sufficient.

East Hampton Ambulance Association Inc. has a special mutual aid agreement with the Town of Haddam for the Haddam Neck portion of town. An Ambulance call in this area could affect the response and timely care of patient's in the Town of East Hampton

POSSIBLE SOLUTIONS:

Designate a backup First Responder Service and Paramedic Service.

If the community utilizes a volunteer ambulance and staffing for the ambulance is inadequate, consider hiring personnel, contract with a commercial service or form a multi-town EMS system.

Utilize incentive programs to aid volunteer recruitment efforts.

Where possible, encourage Bystander EMS and Public Access Defibrillation

Develop legally sufficient written mutual-aid agreements with surrounding communities and first responder services.

Develop mutual aid agreements with all surroundings towns.

State funded grants programs should be developed to assist communities in improving response times and quality of care.

Communities should study the feasibility of coordinating existing EMS resources and forming multi-town systems if it would result in improved response times and quality of care to the patient.

Develop an EMS plan for each community. Use the State EMS Plan and the Local EMS System Checklist as a guide.

Look into town-funding for EMS.

Look into adopting Haddam Neck area of Haddam to the Town of East Hampton Basic Ambulance PSAR.

EMS System Development Goals and Objectives

Goal: Participate in All-Hazard Preparedness Planning with Regional, State, and Federal agencies.

Objectives:

- Participate in all-hazards exercises with local, county, and regional exercises, inclusive of MCI exercises. Timeframe: Not less than once every 24 months.
- EHAA, EHVFD, EHPD to participate in the Town's response to the annual State Emergency Preparedness and Planning Initiative (EPPI). Timeframe: Annually, as prescribed by the Governor.

Goal: Support the mission of EMS to reduce morbidity and mortality by providing access to time-critical life-saving treatments and procedures.

Objectives:

- EHAA, EHVFD, EHPD to develop response data and clinical data reporting mechanisms to implement the performance measures agreed to with the Town. Timeframe: 12 months.
- EHAA, EHVFD, EHPD to train EMS personnel in the latest CT OEMS Statewide Protocols as they are released. Timeframe: 100% annually.
- Development and/or designate a backup First Responder Service. Timeframe: 3 years.

Goal: Timely, efficient, *cost-effective* delivery of Emergency Medical Service to the visitors and citizens of the Town of East Hampton.

Objectives:

- Maintain criteria to meet Connecticut Department of Public Health "HeartSafe" designation. Timeframe: Renewal every three years based on 2020 renewed certification.
- Evaluate the efficacy of initiatives and incentive programs to promote volunteerism in the East Hampton Volunteer Fire Department and East Hampton Ambulance Association Inc. Timeframe: 3 years.

Goal: Support and encourage the obtaining of Federal, State, and Private Grants.

Objectives:

- Survey community, to identify town residents with grant writing experience and technical expertise then follow up with targeted recruitment. Timeframe: 18 months.
- Conduct annual review of grant criteria for applicable submissions.

Goal: Support EMS programmatic development on the Local, Regional, and State levels.

Objectives:

- Participation of EHAA in the Regional EMS Council and its committees, as deemed appropriate by EHAA leadership. Timeframe: Monthly attendance.
- Participation of EHVFD in the Middlesex County Fire Chiefs Association and its committees as deemed appropriate by EHVFD leadership. Timeframe: Monthly attendance.

Goal: Foster the development of public education.

Objectives:

- Increase community based CPR training and Public-Access Defibrillation. EMS Awareness education by adding additional classes annually. Timeframe 12 months.

Goal: Establish formal, uniform mutual aid agreements.

Objectives:

- Update existing written mutual aid agreements with towns/agencies to ones that are legally sufficient. Timeframe 2 years.
- Establish legally sufficient written mutual aid agreements with surroundings towns where one may only be verbally in place or non-existent for emergency medical services. Timeframe 2 years.
- Establish legally sufficient written mutual aid agreements with Glastonbury Police Department Dispatch to another Dispatch center for operations. Timeframe 3 years.

Goal: Adopt Haddam Neck area of Haddam to the Town of East Hampton Basic Ambulance PSAR.

Objectives:

- Research the feasibility and Adopt Haddam Neck Area of Haddam to East Hampton Ambulance Association's PSAR. Timeframe 3 years.

Goal: Review and Update First Responder Agreements with the Town of East Hampton.

Objectives:

- Update agreements with Town for First Responder services. Timeframe 2 years.

Town Manager closing remarks...

The components of this Local EMS Plan are in a constant state of development. The system as reflected in this plan will change. The Town's objective is to provide our citizens and visitors with the best EMS system possible with the resources we have available to us.
The elected officials and citizens of the Town of East Hampton support our volunteer system. We encourage you to become a volunteer member of East Hampton Volunteer Fire Department or East Hampton Ambulance Association Inc.

David Cox, Town Manager 2/23/21

Local EMS Plan Performance Measures
Basic Ambulance Level of Service PSAR

The following performance measure agreement, required pursuant to Section 19a-181b of the Connecticut General Statutes is being entered into between the East Hampton Ambulance Association Inc (the basic ambulance PSAR) and the Town of East Hampton.

Minimum response data reporting

The basic ambulance PSAR shall report activation and response times in the following format and schedule. Each fractile response category may vary +/- 5% for any given reporting period:

Activation Time means the measure of time from notification to the PSAR that an emergency exists, to the beginning of the response of PSAR personnel.

"Numbers were based on calendar year 2020 responses"

Percentage of responses where activation time was:
Less than or equal to one minute fifty nine seconds: ..... Standard: 31.41%
Greater or equal to two minutes but less than three minutes: ..... Standard: 08.71%
Greater or equal to three minutes but less than four minutes: ..... Standard: 07.62%
Greater or equal to four minutes but less than five minutes: ..... Standard: 09.33%
Greater or equal to five minutes but less than ten minutes: ..... Standard: 42.92%

Exceptions: .....Standard: 28.08%

(Exceptions are outliers in the statistical data. An outlier is a data point that differs significantly from other observations)

Response Time means the total measure of time from notification to the PSAR that an emergency exists, to arrival at the patient's side, *including the activation time.*

Percentage of responses where the response time was:
Less than or equal to four minute fifty nine seconds: ..... Standard: 10.04%
Greater or equal to five minutes but less eight minutes: ..... Standard: 11.91%
Greater or equal to eight minutes but less than twelve minutes: ..... Standard: 22.81%
Greater or equal to twelve minutes but less than twenty minutes: ..... Standard: 40.18%
Greater or equal to twenty minutes but less than thirty minutes: ..... Standard: 12.91%
Greater than thirty minutes: ..... Standard: 02.15%

First call responses:
PSAR must respond to at least fifty percent or more first call responses in any rolling *three-month* period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 50% or greater

PSAR must respond to at least eighty percent or more first call responses, excluding those responses excused by the municipality in any rolling *twelve-month* review period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 80% or greater

Reporting period: The PSAR shall submit written reports based on the total EMS responses quarterly to the Office of the Town Manager.
Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31
The reports shall be generated from data collected from a combination of sources including Glastonbury Police Department Dispatch, ESO Records, and Fire Reporting Software. Reported times are not based on hot and/or cold responses.

The PSAR must meet defined response time standards agreed to with the municipality, excluding those responses excused by the municipality under the criteria listed below.

Delayed response times due to inclement weather or roadway obstructions
Mechanical failure enroute
Unsafe scene or difficult scene access
Second calls (A call that is received while the department is currently responding to another call)

The PSAR's failure to respond to a first call shall be excused by the municipality under the criteria listed below.
Response is halted due to catastrophic weather, in consultation with the Town Manager
Mechanical failure of ambulance
Second calls in town (A call that is received while the department is currently responding to another call)
When the department is already responding to a call in the Haddam Neck portion of the Town of Haddam
When the department is already responding to a call in another town due to mutual aid request

Clinical Measures / Patient Outcomes:

PSAR will generate reports on currently collected e-PCR data points if required to submit data electronically to OEMS.

Reporting period: The PSAR shall submit written reports on currently collected data points quarterly to the Office of the Town Manager. The development of the reporting mechanism for the clinical measurements below will be completed within twelve months of acceptance of this agreement. Subsequent to the development of the reporting mechanism, statistical data will be reported on the following schedule:

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

Performance measures based on 2009 NHTSA EMS Model Performance Measures

Description	Question	Objective	Clinical need addressed
Cardiac Arrest/Chest Pain	Time to initiation of CPR in Cardiac Arrest	Reduce	Survival from Cardiac Arrest
Cardiac Arrest/Chest Pain	What percentage of patients experiencing cardiac arrest experience ROSC prior to transport	Increase Survival Rates	Successful resuscitation from cardiac arrest
Patient Satisfaction With Care	What percentage of patients does your EMS organization survey to measure patient satisfaction?	Increase	Patient satisfaction with care
Pain Assessment	What percentage of patients presenting with signs and symptoms of pain are being assessed for level of pain using a 0-10 scale	Increase	Assessment of Pain
Review Of Services Provided	What percentages of clinical cases are reviewed for adherence to protocol, guidelines and standard of care?	Increase	Appropriate delivery of care
Opiate Overdose Care	What percentage of patients with suspected opioid overdose received Naloxone	Increase rate in appropriate patients	Definitive care for suspected Opioid Overdose

Field Trauma Triage	What percentage of patients who meet the current CT guidelines for field triage criteria for transfer to a trauma center are transported to a trauma center?	Increase rate in appropriate patients	Definitive care for major trauma
Anaphylaxis / Allergy Care	What percentage of patients with suspected anaphylactic reaction received epinephrine	Increase rate in appropriate patients	Definitive care for suspected Anaphylaxis
Opiate Overdose Care	What percentage of patients with suspected opioid overdose received Naloxone	Increase rate in appropriate patients	Definitive care for suspected Opioid Overdose
Review Of Services Provided	What percentages of clinical cases are reviewed for adherence to protocol, guidelines and standard of care?	Increase	Appropriate delivery of care

The provisions of this agreement will be assessed regularly and revised not less than annually or as needed based on results of the clinical findings, system status measurements and state and national recommendations for performance measurements.

This constitutes the entire agreement between the PSAR and the municipality with regard to performance measures of the provision of emergency medical services and supersedes any and all other agreements, verbal or written. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this 23rd day of February, ~~2020~~ 2021.

By: _____
Town Manager
Town of East Hampton

By: _____
Chief
East Hampton Ambulance Association

Town of East Hampton, Connecticut

Local Emergency Medical Services Plan
First Responder Service

Section 19a-181b, requires that each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical service providers and the public safety answering point, as defined in section 28-25 that covers the municipality.

Therefore, based on the recommendations set forth by Public Act 00-151 East Hampton Police Department agrees to provide the following to support the Town of East Hampton, Connecticut Emergency Medical Services:

- Assignment and retention of a Primary Service Area Responder (PSAR) for East Hampton, Connecticut at the First Responder level;
- Have on staff at all times adequate staffing levels to service the first responder level needs of the Town of East Hampton;
- Have on line at all times adequate and functioning equipment to service the medical needs of the Town of East Hampton;
- Have on staff at all times properly trained and educated staff to provide emergency medical care at the EMR level;
- Have the ability to arrive at the scene of any medical emergency within eight (8) minutes from the time of dispatch, 80% of the time;
- Have on record at all times documentation in regards to medical training provided and received;
- Periodic review of data related to performance and adherence to standard operating procedures, protocols and guidelines;
- Provide written requirements of Medical Oversight from Sponsor Hospital;
- Provide a copy of Certificate of Operations;
- And comply with all Mandated Reporting; including but not limited to: Elder Abuse/Neglect (DSS), Child Abuse/Neglect (DCF), Opioid (SWORD), etc.

Accepted by:

Dennis Woessner, Chief
East Hampton Police Department

Date: 02/23/2021

Donald Scranton, Chief
East Hampton Ambulance Association Inc.

Date: 02/23/21

David Cox, Town Manager
Town of East Hampton

Date: 2/23/21

Town of East Hampton, Connecticut

Local Emergency Medical Services Plan
Basic Ambulance Service

Section 19a-181b, requires that each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical service providers and the public safety answering point, as defined in section 28-25 that covers the municipality.

Therefore, based on the recommendations set forth by Public Act 00-151 East Hampton Ambulance Association Inc. agrees to provide the following to support the Town of East Hampton, Connecticut Emergency Medical Services:

- Assignment and retention of a Primary Service Area Responder (PSAR) for East Hampton, Connecticut at the BLS Basic Ambulance level;
- Have on staff at all times adequate staffing levels to service the Basic Ambulance level needs of the Town of East Hampton;
- Have on line at all times adequate and functioning equipment to service the medical needs of the Town of East Hampton;
- Have on staff at all times properly trained and educated staff to provide emergency medical care at the EMR and EMT level;
- Have the ability to arrive at the scene of any medical emergency within seventeen (17) minutes from the time of dispatch, 70% of the time;
- Have on record at all times documentation in regards to medical training provided and received;
- Periodic review of data related to performance and adherence to standard operating procedures, protocols and guidelines;
- Provide written requirements of Medical Oversight from Sponsor Hospital;
- Provide a copy of Certificate of Operations;
- And comply with all Mandated Reporting; including but not limited to: Elder Abuse/Neglect (DSS), Child Abuse/Neglect (DCF), Opioid (SWORD), etc.

Accepted by:

Barbara Moore — 2-23-21

Barbara Moore, President — Date:
East Hampton Ambulance Association Inc., Board of Directors

Donald Scranton, EMS Chief — 02/23/21 Date:
East Hampton Ambulance Association Inc.

David Cox, Town Manager — 2/23/21 Date:
Town of East Hampton

Town of East Hampton, Connecticut

Local Emergency Medical Services Plan
Paramedic Service

Section 19a-181b, requires that each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical service providers and the public safety answering point, as defined in section 28-25 that covers the municipality.

Therefore, based on the recommendations set forth by Public Act 00-151 Middlesex Hospital agrees to provide the following to support the Town of East Hampton, Connecticut Emergency Medical Services:

- Assignment and retention of a Primary Service Area Responder (PSAR) for East Hampton, Connecticut at the Paramedic level;
- Shall endeavor to make available licensed Paramedics for Service twenty-four (24) hours per day, seven (7) days a week to the medical needs of the Town of East Hampton;
- Have on line at all times adequate and functioning equipment to service the Paramedic level needs of the Town of East Hampton;
- Have on staff at all times properly trained and educated staff to provide emergency medical care at the Paramedic level;
- Have the ability to arrive at the scene of any medical emergency within fifteen (15) minutes from the time of dispatch, 90% of the time;
- Have on record at all times documentation in regards to medical training provided and received;
- Periodic review of data related to performance and adherence to standard operating procedures, protocols and guidelines;
- Provide a copy of Certificate of Operations;
- And comply with all Mandated Reporting; including but not limited to: Elder Abuse/Neglect (DSS), Child Abuse/Neglect (DCF), Opioid (SWORD), etc.

Accepted by:

Jim Santacroce, Chief
Middlesex Hospital Emergency Medical Services — Date: 2/23/2021

Donald Scranton, Chief
East Hampton Ambulance Association Inc — Date: 02/23/21

David Cox, Town Manager
Town of East Hampton — Date: 2/23/21

GRANT APPLICATION

This Grant is provided effective as of July 1, 2016 by the Town of East Hampton ("Town") with offices at 20 East High Street, East Hampton, Connecticut to MIDDLESEX HOSPITAL, a Connecticut corporation owning and operating a Connecticut-licensed acute care hospital and other treatment facilities with a business address at 28 Crescent Street Middletown, CT 06457 "Middlesex Hospital".

1. Town will grant to Middlesex Hospital an amount to continue the provision of Paramedic Services as set forth below in Sections 2 and 3. The Grant for the Fiscal Year beginning July 1, 2016 and ending June 30, 2017 shall be $1.00 "per-capita" for the Town of East Hampton as determined by the 2010 U.S. census, to wit, 12,959 persons. The Grant, based on the aforementioned information, shall increase $1.00 at each renewal term as set forth in Section 5. The release of the Grant funds will be based upon receipt of a quarterly invoice from Middlesex Hospital starting on July 1 for the period of July 1 to September 30, 2016; October 1 for the period of October 1 to December 31, 2016; January 1 for the period of January 1 – March 31, 2017; and April 1st for the period of April 1 to June 30, 2017. The Grant shall be paid thirty (30) days after receipt of the invoice. This Grant shall be effective for the entire period beginning July 1, 2016, even if the execution and finalization of this Grant does not occur until on or before July 15, 2016.

2. Middlesex Hospital shall endeavor to make available licensed Paramedics for Services twenty-four (24) hours per day, seven (7) days per week. Town acknowledges that emergency medical service system demands on Middlesex Hospital will at times prevent Middlesex Hospital from responding timely to a East Hampton Volunteer Ambulance Association request. Middlesex Hospital will notify the East Hampton Volunteer Ambulance Association immediately at the time of request when such circumstances exist. In such circumstances, paramedic services will be requested by Middlesex according to its existing mutual aid agreements with other paramedic service providers.

3. Middlesex Hospital shall respond to East Hampton Volunteer Ambulance Association requests to provide Services either at the scene of the medical emergency or by meeting the transporting ambulance *en route* to an acute care medical facility at an agreed intercept point. Services shall be provided by a Middlesex Hospital Paramedic in accordance with the most recent revision to the State of Connecticut ALS Protocols.

4. **Advisory Committee.** An advisory committee composed of EMS service chiefs, municipal chief elected officials or town managers, and Middlesex Hospital representatives will be formed and will meet no less than quarterly to discuss matters related to service and financial performance measures and business in regard to Middlesex Hospital paramedic services, including the amount and calculation of municipal grants.

5. **Reporting.** The town shall receive reports on paramedic use and finances. At the first meeting of the Advisory Committee, the Advisory Committee shall discuss and identify the types

of quality of service delivery metrics to be collected by Middlesex Hospital. At each subsequent quarterly meeting the Advisory Committee shall receive from Middlesex Hospital reports on quality of service delivery, and reports on paramedic use and finances. Reports shall be for the entire service area and broken down by municipality

6. **Term/Termination.** This Grant shall commence on the effective date of this Grant and shall continue for one (1) year. Upon mutual Agreement between the parties in writing this Grant may be renewed for additional one (1) year terms ("each, Renewal Term") under the same terms and conditions, for not more than four (4) subsequent annual one (1) year renewal Terms. The town has the right to terminate this Grant without cause upon thirty (30) days prior written notice to Middlesex Hospital. Middlesex Hospital has the right to terminate this Grant without cause upon thirty (30) days written notice to the town. Upon termination of the Grant, the town shall be entitled to a pro-rated refund, if any, of any payments made to Middlesex Hospital under this Grant. Middlesex Hospital shall be entitled to collect any pro-rated payments from the town, up to the date of termination.

7. **Connecticut Law**. The laws of the State of Connecticut will govern the interpretation and construction of this Grant and the acts or omissions of the parties pursuant to it, without reference to conflicts of law principles. Town expressly consents to the personal jurisdiction of the state courts located in Middlesex Judicial District for the State of Connecticut, and to the United States District Court for the District of Connecticut.

Both parties agree to abide by all local ordinances, and state and federal statutes.

8. **Assignment**. Neither party shall assign this Grant or any rights hereunder without the prior written consent of the other party; provided, however, that Middlesex Hospital may assign this Grant in the event that it is acquired by or merges with another entity, or if all or substantially all of its assets are transferred to another entity.

9. **Payment.** Payment terms are net thirty (30) days upon receipt of the application.

10. **Default.** In the event of a default by either party in carrying out any material obligation hereunder, the other party may terminate this Grant; provided, however, that such right of termination shall only apply if written notice of such default has been given and the defaulting party has not cured such default within thirty (30) days of receipt of such notice.

11. **Independent Contractor.** The Grant does not create any agency relationship between Middlesex Hospital and Town, and both parties are acting hereunder as independent contractors. The parties shall be and act as independent Contractors, under no circumstances shall this Grant be construed as one of agency, partnership, joint venture, or employment between the parties. Each party acknowledges and agrees that it neither has nor will give the appearance or impression of having any legal authority to bind or commit the other party in any way. Neither party grants the other any right to bind it except as otherwise expressly agreed in writing. Each party shall be fully liable for all workers' compensation premiums and liability

insurance, federal, state and local withholding taxes or charges with respect to its respective employees.

12. This Grant is independent of, and shall not supersede, Middlesex Hospital's agreement with East Hampton Volunteer Ambulance Association. The town shall be notified of modification or cancelation of Middlesex Hospital's agreement with the town's BLS provider. All billing for those individuals actually receiving paramedic services from Middlesex Hospital will be governed by, and carried out in accordance with, the Agreement between Middlesex Hospital and the East Hampton Ambulance Association.

13. **Indemnification.** In entering into this Grant with Middlesex Hospital, the Town of East Hampton does not take on any responsibility or liability for the paramedic services provided by Middlesex Hospital. Middlesex Hospital shall indemnify the Town of East Hampton from any lawsuits or claims against East Hampton solely due to the paramedic services provided by Middlesex Hospital.

14. **Notices**. Whenever notice must be given under the provisions of this Grant, such notice must be in writing and will be deemed to have been duly given by (a) hand delivery; or (b) certified mail, return receipt requested, postage prepaid; or (c) telecopier (with written confirmation of receipt), provided that a copy is also mailed by registered mail, return receipt requested, addressed to the parties at their respective address set forth below. The Town and Middlesex Hospital may change the recipients of the notice upon written notice to the other party.

If to Town to:

Town Manager
Town of East Hampton
20 East High Street
East Hampton, CT 06424

If to Middlesex Hospital to:

Middlesex Hospital
28 Crescent Street
Middletown, CT 06457

Attention: Materials Management Dept.

15. **Force Majeure**. No party shall be liable for delay in performance hereunder due to forces beyond its control, including but not limited to acts of God, fires, strikes or other labor disputes, acts of war, acts of terrorism, or intervention by any governmental authority, and each party shall take steps to minimize any such delay. Notwithstanding any of the foregoing, in the event that Town experiences one or more Force Majeure events resulting in delays in performance of thirty (30) days or more in the aggregate, Middlesex Hospital may immediately terminate this Grant and shall have no further liability to Town. In the event that Middlesex Hospital experiences one or more Force Majeure events resulting in delays in performance of thirty (30) days or more in the aggregate, the Town may immediately terminate this Grant and shall have no further liability to Middlesex Hospital.

16. **Severability**. In the event that any portion of these Terms and Conditions is held to be unenforceable, the remainder of the provisions shall continue in full force and effect. In such

event, the parties shall, in good faith, modify these Terms and Conditions so as to achieve as much as can be achieved of the provision that was held unenforceable.

17. **Entire Agreement.** This Grant contains the entire understanding between the parties and supersedes all prior understandings, either oral or in writing, with respect to the subject matter thereof. No amendment, alternation, change, or attempted waiver of any of the provisions of this Grant shall be binding with the written consent of both parties.

18. **Counterparts, Facsimile and PDF Image Copy.** This Grant may be executed in any number of counterparts, each of which when so executed shall be deemed to be an original, and all of which when taken together shall constitute one and the same Grant. The Parties hereto agree that this Grant may be transmitted between them or their respective attorneys by facsimile or PDF image copy. The Parties intend that faxed or PDF signatures constitute original signatures and that a Grant containing the signatures (original, facsimile or PDF) of all the parties is binding on the parties once sent via facsimile or via electronic mail to the opposing party.

IN WITNESS WHEREOF, the said parties have caused this Grant Application to be executed and approved by their duly constituted officers as of day first written above.

Middlesex Hospital

Signature

Vincent Capece Jr.

Print Name

CEO

Title

9/28/16

Date

ACCEPTED BY **Town of East Hampton:**

Signature

Michael Maniscalco

Print Name

Town Manager

Title 9/21/16

Date

FOURTH AMENDMENT TO AGREEMENT

This Fourth Amendment to Agreement (the "Fourth Amendment") is entered into effective July 1, 2020, by and between Middlesex Hospital, a Connecticut corporation owning and operating a Connecticut licensed acute care hospital and other treatment facilities with a main business address at 28 Crescent Street, Middletown, Connecticut 06457 ("Middlesex Hospital") and the Town of East Hampton, with offices at 20 East High Street, East Hampton, Connecticut ("Town").

WITNESSETH

WHEREAS, Middlesex Hospital and Town entered into an Agreement dated July 1, 2016 (the "Agreement") for Middlesex Hospital to continue to provide Paramedic Services to the residents of the Town; and

WHEREAS, Middlesex Hospital desires to continue providing paramedic services to the residents of the town.

WHEREAS, both parties have agreed to amend the Agreement as set forth below.

NOW, THEREFORE, in consideration of the premises and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, parties agree as follows:

1. The Agreement is hereby amended as set forth in the following paragraphs.
2. The term of the Agreement is hereby renewed for an additional one (1) year term July 1, 2020 - June 30, 2021 in accordance with Section 6 of the Agreement.
3. The $1.00 increase as indicated in Section 1 of the Agreement will be waived by Middlesex Hospital to the Town for only the renewal term of July 1, 2020 - June 30, 2021 under this Fourth Amendment.
4. Except as amended by this Fourth Amendment, the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the said parties have caused this Amendment to be executed by their duly constituted officers as of the effective date of this Agreement.

ACCEPTED BY:

Middlesex Hospital

Signature

Vincent G. Capece, Jr

Print Name

President / CEO

Title

04/20/20

Date

Town of East Hampton:

Signature

DAVID E COX

Print Name

TOWN MANAGER.

Title

4/15/2020

Date

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

Office of Emergency Medical Services

STATE DEPARTMENT OF HEALTH SERVICES

OFFICE OF EMERGENCY MEDICAL SERVICES

PRIMARY SERVICE AREA RESPONDER

In accordance with Section 19a-179-4 of the Regulations for Emergency Medical Services:

MIDDLESEX MEMORIAL HOSPITAL is the assigned Primary Service Area Responder at the **MOBILE INTENSIVE CARE-PARAMEDIC** level of emergency care for the geographic area/s as described below:

THE BOUNDARIES OF MIDDLESEX COUNTY, CONNECTICUT

An express condition of licensure or certification as an emergency medical services provider shall be the availability and willingness of the emergency medical service provider to carry out any PSAR assignment made by the OEMS pursuant to this section of these regulations.

This PSAR assignment may be withdrawn when it is determined by the OEMS that it is in the best interest of patient care to do so, or the chief administrative official of the municipality in which the PSA lies can demonstrate to the commissioner that an emergency exists and that the safety, health and welfare of the citizens of the affected area are jeopardized by the performance of the assigned primary service area responder.

November 6, 1989

Thomas Santamauro, Chief
Licensure and Certification
Office of Emergency Medical Services

OEMS 10/89

Phone: 566-7336
150 Washington Street • Hartford, Connecticut 06106

MEMORANDUM OF AGREEMENT
BETWEEN THE
TOWN OF GLASTONBURY
AND THE
TOWN OF EAST HAMPTON FOR
PUBLIC SAFETY DISPATCH SERVICES

This Memorandum of Agreement ("Agreement") is made and entered into on this 12th day of April ("Effective Date"), by and between the Town of Glastonbury, Connecticut ("Glastonbury") and the Town of East Hampton, Connecticut ("East Hampton").

RECITALS

WHEREAS, Connecticut General Statutes, Sections 7-148cc and 7-339a, authorize two (2) or more municipalities to jointly perform any function that each municipality may perform separately upon entering into an Agreement to effect such with other municipalities;

WHEREAS, the Public Safety Dispatch services are now provided to East Hampton by the KX Dispatch Center and KX is scheduled to close effective June 30, 2016;

WHEREAS, East Hampton wishes to have Glastonbury provide Dispatch Services for its Police, Fire, EMS Services and CMED Services, and become the primary Public Safety Answering Point ("PSAP") for East Hampton (collectively, "Dispatch Services") and Glastonbury desires to provide such Dispatch Services to East Hampton;

WHEREAS, Glastonbury is a recognized State of Connecticut 9-1-1 Communication Center and PSAP capable of providing Dispatch Services for law enforcement, fire, and emergency medical services ("EMS") (collectively, "Dispatch Services") to responders and emergency medical dispatch services ("EMD Services") and Coordinated Medical Emergency Direction services ("CMED Services") for municipalities; and

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants herein contained, the parties agree as follows:

Section 1. Purpose of Agreement

The purpose of this Agreement is to set forth the rights, responsibilities, and obligations of the parties to this Agreement.

Section 2. **Obligations of Glastonbury**

Glastonbury shall:

A. Monitor all Police, Fire, and EMS radio frequencies for East Hampton on a twenty-four (24) hour basis.

B. Provide Dispatch Services for all Police, Fire, and EMS calls in accordance with standard protocols and procedures.

C. Provide tactical radio contact and support to Police, Fire, and EMS personnel while such personnel are engaged in the performance of their duties.

D. Act as the PSAP for 9-1-1 calls in the Town of East Hampton.

E. Provide any other public safety communication Dispatch Services mandated by State law or mutually agreed upon by both Glastonbury and East Hampton.

F. Supervise the Glastonbury staff to ensure that:

1. The Glastonbury dispatch center is staffed and operated twenty-four (24) hours a day by trained personnel.

2. Dispatch Services are provided in accordance with standard protocols and procedures.

G. Collect such reasonable Dispatch Services data as may be requested by East Hampton.

H. Answer all incoming 9-1-1 calls in accordance with standard protocols and procedures.

Section 3. **Obligations of East Hampton**

A. East Hampton shall provide to Glastonbury such data and records, as may be reasonably requested by Glastonbury, to enable it to effectively and efficiently provide Dispatch Services.

B. East Hampton shall provide, establish, maintain, and repair, at its sole cost and expense, all equipment necessary for East Hampton Police, Fire, and EMS to effectively communicate with Glastonbury, including back-up systems and equipment.

C. Maintain necessary and appropriate FCC licenses.

Section 4. **Financial Obligations**

A. It is the intent of this Agreement that Operating and Capital costs for Glastonbury to provide Dispatch Services to East Hampton shall be furnished by Glastonbury on a cost neutral-basis.

B. East Hampton shall be responsible for Capital costs for equipment and systems required to establish and maintain effective communication between Glastonbury and East Hampton for Dispatch Services.

C. East Hampton shall be responsible for Operating costs incurred by Glastonbury for providing Dispatch Services to East Hampton. Annual Operating costs are expected to include: wages, employee benefits, payroll costs, insurance, training, overtime, uniforms, and other annual Operating costs as applicable for Glastonbury to provide Dispatch Services to East Hampton. Such Operating costs shall be subject to the collective bargaining process and other factors influencing annual costs for Dispatch staff and Dispatch Services.

D. Each February Glastonbury will provide to East Hampton an estimate of the annual Operating cost for the next following fiscal year.

E. Annual State grants in support of Operating costs for multi-town Dispatch Services shall be received directly by Glastonbury and deducted from annual charges to East Hampton.

F. Should Glastonbury provide Dispatch Services to other communities during the term of this agreement, the cost-sharing process established herein will be amended, as applicable, through discussions between the municipalities receiving such Dispatch Services.

G. Invoices for Dispatch Services shall be furnished to East Hampton on a quarterly basis by Glastonbury for the prior three (3) month period. East Hampton shall forward payment for each quarterly invoice within 30 days of receipt.

Section 5. **Term and Termination**

A. The term of the Agreement shall begin on July 1, 2016 for a five (5) year period ending June 30, 2021 and shall renew for five (5) year terms thereafter unless Glastonbury or East Hampton withdraw from this agreement pursuant to section 5B

B. East Hampton may withdraw from participation in this Agreement upon: (1) giving one years' prior written notice to the Town Manager of Glastonbury of its

intent to terminate, and (2) the adoption of a resolution to that effect by the East Hampton Town Council. Notwithstanding such termination, East Hampton shall complete its financial obligations as set forth in Section 4 for the remainder of that year. Glastonbury may withdraw from participation in this Agreement by providing one years' prior written notice to East Hampton of its intent to terminate.

Section 6. **Indemnification**

A. East Hampton agrees to indemnify and hold Glastonbury, its employees, officers, directors, agents, and representatives harmless from any and all claims, lawsuits, administrative orders, penalties, damages, liabilities, losses, and expenses (including reasonable attorneys' fees and out-of-pocket expenses) incurred by Glastonbury that are caused by East Hampton's breach of its obligations under this Agreement or by the negligence or willful misconduct of East Hampton, its agents, representatives, public officials, employees or contractors.

B. Glastonbury agrees to indemnify and hold East Hampton, its employees, officers, directors, agents, and representatives harmless from any and all claims, lawsuits, administrative orders, penalties, damages, liabilities, losses, and expenses (including reasonable attorneys' fees and out-of-pocket expenses) incurred by East Hampton that are caused by Glastonbury's breach of its obligations under this Agreement or by the negligence or willful misconduct of Glastonbury, its agents, representatives, officers, employees or contractors.

Section 7. **Equipment and Property Ownership and Use**

Regardless of such use, ownership of equipment and property of the Town of Glastonbury shall remain that of the town; and ownership and equipment of property of the Town of East Hampton shall remain that of the Town of East Hampton.

Equipment owned by the Town of East Hampton and directly or indirectly operated by the Town of Glastonbury shall be the responsibility of the Town of East Hampton including but not limited to its operation, housing, maintenance and applicable licensing requirements.

Section 8. Insurance

The Town of Glastonbury and the Town of East Hampton shall agree to maintain in force at all times during the contract the following minimum coverages with carriers approved in the State of Connecticut and with a minimum AM Best's Rating of "A-" VIII.

		(Minimum Limits)
General Liability	Each Occurrence	$1,000,000
	General Aggregate	$2,000,000
	Products/Completed Operations Aggregate	$2,000,000
Automobile Liability	Combined Single Limit Each Accident	$1,000,000
Public Official Liability	Each Wrongful Act	$1,000,000
	Aggregate	$1,000,000
Law Enforcement Liability	Each Wrongful ACT	$1,000,000
	Aggregate	$1,000,000
Umbrella (Excess Liability)	Each Occurrence	$5,000,000
	Aggregate	$5,000,000
Workers' Compensation & Employers' Liability	WC Statutory Limits	
	EL Each Accident	$500,000
	EL Disease Each Employee	$500,000
	EL Disease Policy Limit	$500,000

Each Town must provide original, completed Certificate of Insurance prior to contract issuance and replacement/renewal certificates at least 30 days prior to the expiration date of the policies.

Section 9. Administration of Agreement

A. The person responsible for administering this Agreement for Glastonbury shall be the Town Manager of Glastonbury or his/her designee.

B. The person responsible for administering this Agreement for East Hampton shall be the Town Manager of East Hampton or his/her designee.

C. To effectively provide Dispatch Services pursuant to this Agreement, the Police, Fire, and EMS Chiefs or their designees shall meet on a quarterly basis to review Dispatch Services and resolve any pending matters, as needed. The Glastonbury Police Chief shall be responsible for convening the quarterly meeting. Minutes from these quarterly meetings shall be provided to the Town Manager of Glastonbury and the Town Manager of East Hampton.

The Town of Glastonbury and the Town of East Hampton agree to work to resolve any conflicts between the two communities in a cooperative and amicable manner. Any matters not resolved by the respective Chiefs shall be referred to the Town Manager of Glastonbury and Town Manager of East Hampton. In the event discussion between the respective Chiefs and Town Managers do not result in a resolution of the pending matter, the Town Manager of Glastonbury shall make the final written decision in the pending matter. If the Town of East Hampton disputes the decision of the Town Manager of Glastonbury, the Town of East Hampton shall, within thirty (30) days following written decision by the Town Manager of Glastonbury, demand arbitration, which unless the parties agree otherwise, shall be administered by the American Arbitration Association or such other entity mutually agreed upon by the Town of Glastonbury and Town of East Hampton subject to the use of the procedures of the American Arbitration Association. A demand for arbitration shall be made in writing, and delivered to the Town of Glastonbury and filed with the person or entity administering the arbitration. The award rendered by the arbitrator shall be final and binding and judgment may be entered upon it in accordance with applicable law in any court having jurisdiction thereof.

Section 10. Amendment to the Agreement

A. Any amendment to this Agreement must be approved by the Glastonbury Town Council and East Hampton Town Council.

Section 11. Miscellaneous

A. Assignment. Neither party shall assign or transfer any interest, obligation or duty under this Agreement without the prior written approval of the other party.

B. Modifications and Waivers. This Agreement may not be amended or modified except by written instrument executed by the parties. The failure of the parties to insist upon strict performance of any provision hereof shall not constitute a waiver of, or estoppel against, asserting the right to require such performance in the future, nor shall a waiver or estoppel in any one instance constitute a waiver or estoppel with respect to a later breach of a similar nature or otherwise. The waiver of any of the terms and conditions of this Agreement shall not be construed to be a waiver of any other term or condition of this Agreement.

C. Integration. This Agreement incorporates all the understandings of the parties and supersedes any and all agreements reached by the parties prior to the execution of this Agreement, whether oral or written.

D. Binding on Successors. Glastonbury and East Hampton each binds itself, its successors, assigns, and legal representatives to the other party to this Agreement and to the partners, successors, assigns, and legal representatives of such other party with respect to its rights, duties, and privileges under this Agreement.

E. Severability. In the event that any provision of this Agreement or part thereof is determined to be illegal or otherwise unenforceable by a court of competent jurisdiction, such provision or part thereof shall be modified to the minimum extent necessary to render such provision enforceable and preserve the parties' intent or, if not possible, severed, and in either case the other terms and provisions of this Agreement shall continue in full force and effect.

F. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be an original, but all of which shall constitute one and the same instrument. A facsimile or .pdf copy of a signature or electronic signature of a party hereto shall have the same force and effect and validity as an original signature.

G. Governing Law. This Agreement shall be deemed to be entered into, executed and performed in the State of Connecticut and shall, at all times, be subject to the laws of the State of Connecticut, exclusive of conflict of laws rules.

H. Captions. The captions used herein are inserted only as a matter of convenience and for reference, and in no way define, limit, or describe the scope of the intent of any section or paragraph hereof.

I. Construction. This Agreement shall not be construed against the party preparing it, but shall be construed as if the parties jointly prepared this Agreement, and any uncertainty and ambiguity in drafting shall not be interpreted against any one party.

J. Notice. All notices required under this Agreement shall be in writing, and shall be deemed to have been duly given on the date sent if sent by certified or registered mail return receipt requested, postage prepaid, hand delivered, sent via facsimile, or electronic mail, or on the day following if sent by overnight courier, postage prepaid, and addressed to the party below:

If to Glastonbury: Town Manager
2155 Main Street
Glastonbury, CT 06033

Copy to: Chief of Police
2108 Main Street
Glastonbury, CT 06033

If to East Hampton: Town Manager
20 East High Street
East Hampton, CT 06424

Copy to: Chief of Police
20 East High Street
East Hampton, CT 06424

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the parties hereto have executed or have caused this Agreement to be executed by their duly authorized representatives.

TOWN OF GLASTONBURY, CT

By: _____ 5-17-16
Name: Richard J. Johnson, Town Manager Date

TOWN OF EAST HAMPTON, CT

By: _____ 5/6/16
Name: Michael Maniscalco, Town Manager Date

RECITALS

1. Purpose of Agreement
2. Obligations of Glastonbury
3. Obligations of East Hampton
4. Financial Obligations
5. Term and Termination
6. Indemnification
7. Insurance
8. Administration of Agreement
9. Amendment to Agreement
10. Miscellaneous

East Hampton Ambulance Association Inc.
4 Middletown Avenue
P.O. Box 144
East Hampton, CT 06424
Neighbors Helping Neighbors Since 1953

Ambulance Mutual Aid Agreement

This agreement is between East Hampton Ambulance Association Inc. and Colchester Hayward Volunteer Fire Department for the purpose of providing Mutual Aid Ambulance service.

Colchester Hayward Volunteer Fire Department agrees to respond with an ambulance to its best abilities when requested to the Town of East Hampton, Connecticut.

East Hampton Ambulance Association Inc. agrees to respond with an ambulance to its best abilities when requested to the Town of Colchester, Connecticut.

This agreement shall be in effect 24 hours per day, 365 days per year. This agreement will become effective on January 1st, 2021 at 0000 hours. At any time, either party may withdraw from this agreement so long as 30 days written notice to the other party via US Mail is provided.

By affixing my signature, I understand and accept the above agreement and its conditions.

Accepted By:

Sean Shoemaker, Interim Fire/EMS Chief
Colchester Hayward Vol Fire Department

1/19/21
Date

Donald Scranton, EMS Chief
East Hampton Ambulance Association Inc.

1/19/21
Date

East Hampton Ambulance Association Inc.
4 Middletown Avenue
P.O. Box 144
East Hampton, CT 06424
Neighbors Helping Neighbors Since 1953

Ambulance Mutual Aid Agreement

This agreement is between East Hampton Ambulance Association Inc. and East Haddam Ambulance Association Inc. for the purpose of providing Mutual Aid Ambulance service.

East Haddam Ambulance Association Inc. agrees to respond with an ambulance to its best abilities when requested to the Town of East Hampton, Connecticut.

East Hampton Ambulance Association Inc. agrees to respond with an ambulance to its best abilities when requested to the Town of East Haddam, Connecticut.

This agreement shall be in effect 24 hours per day, 365 days per year. This agreement will become effective on January 1st, 2021 at 0000 hours. At any time, either party may withdraw from this agreement so long as 30 days written notice to the other party via US Mail is provided.

By affixing my signature, I understand and accept the above agreement and its conditions.

Accepted By:

Richard Harmon, EMS Chief
East Haddam Ambulance Association Inc.

01/23/2021
Date

Donald Scranton, EMS Chief
East Hampton Ambulance Association Inc.

01/23/2021
Date

East Hampton Ambulance Association Inc.
4 Middletown Avenue
P.O. Box 144
East Hampton, CT 06424
Neighbors Helping Neighbors Since 1953

Ambulance Mutual Aid Agreement

This agreement is between East Hampton Ambulance Association Inc. and Roy B. Pettengill Ambulance Association Inc for the purpose of providing Mutual Aid Ambulance service.

Roy B. Pettengill Ambulance Association Inc. agrees to respond with an ambulance to its best abilities when requested to the Town of East Hampton, Connecticut.

East Hampton Ambulance Association Inc. agrees to respond with an ambulance to its best abilities when requested to the Town of Marlborough, Connecticut.

This agreement shall be in effect 24 hours per day, 365 days per year. This agreement will become effective on January 1st, 2021 at 0000 hours. At any time, either party may withdraw from this agreement so long as 30 days written notice to the other party via US Mail is provided.

By affixing my signature, I understand and accept the above agreement and its conditions.

Accepted By:

Mark Merritt, Rescue Captain
Roy B. Pettengill Ambulance Association Inc.

2/3/2021
Date

Donald Scranton, EMS Chief
East Hampton Ambulance Association Inc.

2/3/2021
Date

EMS Mutual Aid Agreement

This agreement is entered into between the EMS Organizations listed on the attached signatures page that executes and adopts the terms and conditions contained herein based on the following facts:

Purpose:
An automatic aid agreement for EMS organizations where one service agrees to respond automatically in return for the other jurisdiction agreeing to respond to another area in return. For assistance when they need additional staffing and equipment to a specific problem at a specific time. This mutual aid can be long or short term, with the latter being the more common. An example of long-term aid would be EMS units being sent to a large incident that goes on for many days. Short term would be an event lasting less than eight (8) hours.

This agreement is only for special occurrences, not to augment normal staffing. Departments must staff for the normal activities during a given time, day, and day of week. When other than normal situations occur and the staffing levels and\or equipment are no longer sufficient to deal with a specific incident, the requesting service will elicit mutual aid assistance from the other. This assistance is given gratis to the receiving jurisdiction for the duration of the specific incident.

Each service will make every attempt to supply additional staffing and/or equipment when requested. In the event that any party feels that they are being exclusively utilized to augment the services of another without equal retribution, grounds may exist for termination of the mutual aid agreement in accordance with this contract.

WHEREAS, the State of Connecticut is geographically vulnerable to hurricanes, flooding, ice storms and other natural and technologic disasters that could have caused severe disruption of emergency medical services; and

WHEREAS, the Parties to this Agreement recognize that additional human resources and equipment may be needed to mitigate further damage and restore vital services to the citizens of the affected community should such disasters occur; and

WHEREAS, to provide the most effective mutual aid possible, each agency, intends to foster communications between the personnel of the other agencies, exchange of information and development of plans and procedures to implement this Agreement;

NOW, THEREFORE, the Parties agree to agree as follows:

SECTION 1. DEFINITIONS

A. "AGREEMENT" means the EMS Mutual Aid Agreement.
B. "REQUESTING PARTY" means the participating EMS entity requesting aid in the event of an emergency. Each service must coordinate requests for state or federal emergency response assistance through its county.
C. "ASSISTING PARTY" means the participating EMS entity furnishing equipment, services and/or human Resources to the requesting Party.
D. "AUTHORIZED REPRESENTATIVE" means an employee of a participating EMS entity or 911 center contracted with the Requesting Party authorized to request, offer or provide assistance under the terms of this Agreement.
E. "AGENCY" means the participating entity.

F. "EMERGENCY" means any occurrence or condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could result in placing the patient's health in jeopardy; cause serious impairment to bodily functions; or cause serious dysfunction of any bodily organ or part.

G. "DISASTER" means any natural, technological, or civil emergency that causes damage of sufficient severity and magnitude to result in a proclamation of a local emergency by a city/county, a declaration of a State of Emergency by the Governor, or a disaster declaration by the President of the United States.

H. "MAJOR DISASTER" means a disaster that will likely to exceed local capabilities and require a broad range of state and federal assistance.

I. "PARTICIPATING AGENCY" – Any service which executes this mutual aid agreement and supplies a completed executed copy to the Agency.

J. "PERIOD OF ASSISTANCE" – the period of time beginning with the departure of any personnel and equipment of the assisting Party from any point for the purpose of traveling to the Requesting Party in order to provide assistance and ending upon the return of all personnel and equipment of the Assisting Party, after providing the assistance requested, to their residence or regular place of work, whichever occurs first. The period of assistance shall not include any portion of the trip to the requesting Party or the return trip from the Requesting Party during which the personnel of the Assisting Party are engaged in a course of conduct not reasonably necessary for their safe arrival at or return from the Requesting Party.

K. "WORK OR WORK-RELATED PERIOD" - any period of time in which either the personnel or equipment of the Assisting Party are being used by the Requesting Party to provide assistance and for which the requesting Party will reimburse the Assisting Party. Specifically included within such period of time are rest breaks when the personnel of the Assisting Party will return to active work within a reasonable time. Specifically excluded from such period of time are breakfast, lunch, and dinner breaks.

Nothing should be derived from the above statement that excludes Assisting Party personnel from being considered "on the job" for purposes of workers' compensation injuries or accidents during these periods.

SECTION 2. PROCEDURES

When a Participating Agency either becomes affected by an emergency, disaster, or major disaster, Participating Agency or its Authorized Representative may request emergency related mutual aid assistance by orally communicating a request for mutual aid assistance to Assisting Party or to the Agency.
Mutual aid shall not be requested by Participating Agency or its Authorized Representative unless resources available within the stricken area are deemed inadequate by that Participating Agency. Municipalities shall coordinate requests for state or federal assistance with their county Emergency Management Agencies. All requests for mutual aid shall be transmitted by the Authorized Representative or the Director of the Local Emergency Management Agency. Request for assistance may be communicated either to the Agency or directly to an Assisting Party.

A. REQUESTS DIRECTLY TO ASSISTING PARTY: The Requesting Party may directly contact the Authorized Representative of the Assisting Party and shall provide them with the information in paragraph C below. All communications shall be conducted directly

between the Requesting and Assisting Party. Each party shall be responsible for keeping the Agency advised of the status of the response activities. The Agency shall not be responsible for costs associated with such direct requests or assistance unless it so elects. However, the Agency may provide, by rule, for reimbursement of eligible expenses from a Disaster Assistance fund.

B. REQUESTS ROUTED THROUGH, OR ORIGINATING FROM, THE AGENCY: The Requesting Party may directly contact the Agency, in which case it shall provide the Agency with the information in paragraph C below. The Agency may then contact other Participating Governments on behalf of the Requesting Party and coordinate the provision of mutual aid. The Agency shall not be responsible for costs associated with such indirect requests for assistance, unless the Agency so indicates in writing at the time it transmits the request to the Assisting Party. In no event shall the Agency be responsible for costs associated with assistance in the absence of appropriated funds. In all cases, the party receiving the mutual aid shall be primarily responsible for the costs incurred by any Assisting Party providing assistance pursuant to the provisions of this Agreement.

C. REQUIRED INFORMATION: Each request for assistance shall be accompanied by the following information, to the extent known:

1. A general description of the situation;
2. The amount and type of personnel, equipment, materials, and supplies needed and a reasonable estimate of the length of time they will be needed; a specific place for a representative of the requesting Party to meet the personnel and equipment of any Assisting party. This information may be provided by any available means.

D. ASSESSMENT OF AVAILABILITY OF RESOURCES AND ABILITY TO RENDER ASSISTANCE: When contacted by a Requesting Party or the Agency, the Authorized Representatives of any Participating Agency agree to assess their agencies situation to determine available personnel, equipment and other resources. All Participating Agencies shall render assistance to the extent personnel, equipment and resources are available. Each Participating Agency agrees to render assistance in accordance with the terms of this Agreement to the fullest extent possible. When the Authorized Representative determines that his Participating Agency has available personnel, equipment or other resources, they shall so notify the requesting Party or the Agency, whichever communicated the request. The Agency shall, upon response from sufficient Participating Parties to meet the needs of the Requesting Party, notify the authorized representative of the Requesting Party and provide them with the information to the extent known. The Assisting Party shall acknowledge receipt regarding the assistance to be rendered, setting forth the information transmitted in the request, and shall transmit it by the quickest practical means to the Requesting Party or the Agency, as applicable.

E. SUPERVISION AND CONTROL: The personnel, equipment and resources of any Assisting Party shall remain under operational control of the Requesting Party for the area in which they are serving. Direct supervision and control of said personnel, equipment and resources shall remain with the designated personnel of the Assisting Party. Representatives of the Requesting Party shall assign work tasks to the personnel of the Assisting Party. The designated personnel of the Assisting Party shall have the

responsibility and authority for assigning work and establishing work schedules for the personnel of the Assisting Party, based on task or mission assignments provided by the Requesting Party and the Agency. The designated personnel of the Assisting Party shall: maintain daily personnel time records, material records and a log of equipment hours; be responsible for the operation and maintenance of the equipment and other resources furnished by the Assisting Party; and shall report work progress to the requesting Party. The Assisting Party's personnel and other resources shall remain subject to recall by the Assisting Party at any time, subject to reasonable notice to the Requesting Party and the Agency. At least twenty-four (24) hours advance notification of the intent to terminate mission shall be provided to the Requesting Party, unless such notice is not practicable, in which case such notice as is reasonable shall be provided.

G. FOOD; HOUSING; SELF-SUFFICIENCY - Unless specifically instructed otherwise, the Requesting Party shall have the responsibility of providing food and housing for the personnel of the Assisting Party from the time of their arrival at the designated location to the time of their departure. However, Assisting Party personnel and equipment should be, to the greatest extent possible, self-sufficient for operations in areas stricken by emergencies or disasters. The Requesting Party may specify only self-sufficient personnel and resources in its request for assistance.

H. RIGHTS AND PRIVILEGES - Whenever the employees of the Assisting Party are rendering outside aid pursuant to this Agreement, such employees shall have the powers, duties, rights, privileges, and immunities, and shall receive the compensation, incidental to their employment.

I. COMMUNICATIONS: Unless specifically instructed otherwise, the requesting Party shall, during long term events, have the responsibility for coordinating communications between the personnel of the Assisting Party and the Requesting Party. Assisting Party personnel should be prepared to furnish communications equipment sufficient to maintain communications among their respective operating units.

SECTION 3. REIMBURSABLE EXPENSES

The terms and conditions governing reimbursement for any assistance provided under this Agreement shall be in accordance with the following provisions, unless otherwise agreed upon by the Requesting and Assisting Parties and specified in the written acknowledgment executed in accordance with Section 2D of this Agreement. The Requesting Party shall be ultimately responsible for reimbursement of all eligible expenses. The Assisting Party shall submit reimbursement documentation to the Requesting Party.

A. PERSONNEL - During the period of assistance, the Assisting Party shall continue to pay its employees according to its then prevailing ordinances, rules, and regulations. The Requesting party shall reimburse, if reimbursed by the State of Connecticut or the Federal Emergency Management Agency (FEMA), the Assisting Party for all direct and indirect payroll costs and expenses including travel expenses incurred during the period of assistance, including, but not limited to, employee pensions and benefits as provided by Generally Accepted Accounting Principles (GAAP). However, the Requesting Party shall not be responsible for reimbursing any amounts paid or due as benefits to employees of the Assisting Party due to personal injury or death occurring while such

employees are engaged in rendering aid under this agreement. Both the Requesting Party and the Assisting Party shall be responsible for payment of such benefits only to their own employees.

B. EQUIPMENT - The Assisting Party shall be reimbursed by the Requesting Party, if reimbursed by the State of Connecticut or the FEMA, for the use of its equipment during the period of assistance according to either a pre-established local or state hourly rate or according to the actual replacement, operation, and maintenance expenses incurred. For those instances in which costs are reimbursed by the FEMA, the eligible direct costs shall be determined in accordance with 44 CFR 206.228. The Assisting Party shall pay, if reimbursed by the State of Connecticut or the FEMA, for all repairs to its equipment as determined necessary by its on-site supervisor(s) to maintain such equipment in safe and operational condition. At the request of the Assisting Party, fuels, miscellaneous supplies, and minor repairs may be provided by the Requesting Party, if practical. The total equipment charges to the requesting Party shall be reduced by the total value of the fuels, supplies, and repairs furnished by the Requesting Party and by the amount of any insurance proceeds received by the Assisting Party.

C. MATERIALS AND SUPPLIES - The Assisting Party shall be reimbursed, if the requesting party is reimbursed by the State of Connecticut or the Federal Emergency management Agency, for all materials and supplies furnished by it and used or damaged during the period of assistance, except for the costs of equipment, fuel and maintenance materials, labor and supplies, which shall be included in the equipment rate established in 3.B. above, unless such damage is caused by gross negligence, willful and wanton misconduct, intentional misuse, or recklessness of the Assisting Party's personnel. The Assisting Party's Personnel shall use reasonable care under the circumstances in the operation and control of all materials and supplies used by them during the period of assistance. The measure of reimbursement shall be determined in accordance with 44 CFR 206.228. In the alternative, the Parties may agree that the Requesting Party will replace, with like kind and quality as determined by the Assisting Party, the materials and supplies used or damaged. If such an agreement is made, it shall be reduced to writing and transmitted to the Agency.

D. RECORD KEEPING - The Assisting Party shall maintain records and submit invoices for reimbursement by the requesting party or the Agency using format used or required by FEMA publications, including 44 CFR part 13 and applicable Office of Management and Budget Circulars. Requesting Party and Agency finance personnel shall provide information, directions, and assistance for record keeping to Assisting Party personnel.

E. PAYMENT - Unless otherwise mutually agreed in the written acknowledgment executed in accordance with paragraph 2.I. or a subsequent written addendum to the acknowledgment, the reimbursable expenses with an itemized Notice as soon as practicable after the expenses are incurred, but not later than sixty (60) days following the period of assistance, unless the deadline for identifying damage is extended in accordance with 44 CFR part 206. The Requesting Party shall pay the bill or advise of any disputed items, not later than sixty (60) days following the billing date. These time frames may be modified by mutual agreement. This shall not preclude an Assisting Party or Requesting Party from assuming or donating, in whole or in part, the costs associated

with any loss, damage, expense or use of personnel, equipment and resources provided to a Requesting Party.

F. PATIENT BILLING PRACTICES - The services providing care for patient s outside of their assigned PSA here by agree to honor the current billing practices and contracts within the specified PSA that the service is provided. The Assisting Party will maintain a separate billing system and submit claims for re-imbursement for all patients treated by the Assisting Party.

SECTION 4. IMMUNITY
To the extent permitted by law, the Parties shall not be liable for actions to the extent provided by Section 33-15-21(a). This immunity may be waived by the Parties in a manner provided by law to the extent that adequate insurance coverage is in effect.

SECTION 5. LENGTH OF TIME FOR EMERGENCY
The duration of such Local emergency declared by the Requesting Party is limited to seven (7) days. It may be extended, if necessary, in seven (7) day increments.

SECTION 6. TERM
This Agreement shall be in effect for one (3) years from the date hereof and shall automatically be renewed in successive one (3) year terms unless terminated upon sixty (60) days advance written notice by the participating organization. Notice of such termination shall be made in writing and shall be served personally or by registered mail by either party. Notice of termination shall not relieve the withdrawing Party from obligations incurred hereunder prior to the effective date of the withdrawal and shall not be effective until sixty (60) days after notice thereof has been set by any Participating Party.

SECTION 7. EFFECTIVE DATE OF THIS AGREEMENT
This Agreement shall be in full force and effect upon approval by the Participating Agency and upon proper execution hereof.

SECTION 8. ANNUAL RENEWAL CYCLE
This agreement shall be renewed on an annual basis.

SECTION 9. SEVERABILITY; EFFECT ON OTHER AGREEMENTS
Should any portion, section, or subsection of this Agreement be held to be invalid by a court of competent jurisdiction, that fact shall not affect or invalidate any other portion, section or subsection; and the remaining portions of this Agreement shall remain in full force and affect without regard to the section, portion, or subsection or power invalidated.

EMS Agency: **Haddam Ambulance**	EMS Agency: **East Hampton Ambulance**
Title/Name: **D.Dole - Chief**	Title/Name: **D.Scranton - Chief**
Date	Date April 7th, 2019
Signature	Signature *Donald Scranton*

Special Automatic Mutual Aid Agreement

This agreement designates the East Hampton Ambulance as the first due ambulance to the Haddam Neck portion of the town of Haddam. Due to the geographical location of Haddam Neck, East Hampton can provide a timelier response to this area.

Haddam Ambulance will continue to maintain the ambulance PSAR for this area, and work with Haddam Neck Fire Department and East Hampton Ambulance as necessary to assure proper emergency medical services are provided to the area.

Valley Shore Emergency Communications will manage dispatching the proper resources to this area based on designated preplans and response guides.

This agreement is effective immediately and will remain in effect until rescinded by either agency.

EMS Agency: **Haddam Ambulance**
Title/Name: **D.Dole - Chief**
Date MAY 1, 2019
Signature

EMS Agency: **East Hampton Ambulance**
Title/Name: **D.Scranton - Chief**
Date Apr
Signature [redacted]

:c: Haddam Neck Fire Chief

Special Automatic Mutual Aid Agreement

This agreement designates the East Hampton Ambulance as the first due ambulance to the Haddam Neck portion of the town of Haddam. Due to the geographical location of Haddam Neck, East Hampton can provide a timelier response to this area.

Haddam Ambulance will continue to maintain the ambulance PSAR for this area, and work with Haddam Neck Fire Department and East Hampton Ambulance as necessary to assure proper emergency medical services are provided to the area.

Valley Shore Emergency Communications will manage dispatching the proper resources to this area based on designated preplans and response guides.

This agreement is effective immediately and will remain in effect until rescinded by either agency.

EMS Agency: **Haddam Ambulance**
Title/Name: **D.Dole - Chief**
Date
Signature

EMS Agency: **East Hampton Ambulance**
Title/Name: **D.Scranton - Chief**
Date April 7th, 2019
Signature Donald Scranton

cc: Haddam Neck Fire Chief

EMS Agency: **Haddam Ambulance**

Title/Name: **D.Dole - Chief**

Date MAY 1ST, 2019

Signature

EMS Agency: **East Hampton Ambulance**

Title/Name: **D.Scranton - Chief**

Date Ap[redacted]

Signature [redacted]

Automatic Mutual Aid Agreement for Medical Calls Between East Hampton Police Department And Haddam Neck Volunteer Fire Department

This agreement is established in order to better serve the citizens of East Hampton and Haddam Neck. As there is often confusion on the part of people calling for emergency assistance in the vicinity of the East Hampton and Haddam town boundary as to their exact location the East Hampton Police Department and Haddam Neck Volunteer Fire Department agree that the Haddam Neck Volunteer Fire Department will be dispatched on automatic mutual aid to any medical call in the following area of East Hampton:

All above street number 80 Middle Haddam Road
All of Shad Row
All of Knowles Road
All of Moodus road
All of School House Lane (both sides)
All above street number 80 Hog Hill Road
All of Terp Road
All of Ox Yoke Circle
All Hurd Park Road
All Haddam Neck Road
All of Wilkes Road
All of Green Road
All of Whippoorwill Hollow Road
All of Pine Brook Road
All of Sexton Hill Road
All above street number 249 Wopowog Road
All above street number 285 Young Street
All of Hurd state park.

This agreement becomes effective when signed by the Chiefs of each department. It remains in effect until canceled in writing by either department.

_____ _____

Matthew Reimondo — Date
Chief
East Hampton Police Department

_____ _____

Robert McGarry — Date
Chief
Haddam Neck Volunteer Fire Department

Automatic Mutual Aid Agreement for Medical Calls Between East Hampton Police Department And Haddam Neck Volunteer Fire Department

This agreement is established in order to better serve the citizens of East Hampton and Haddam Neck. As there is often confusion on the part of people calling for emergency assistance in the vicinity of the East Hampton and Haddam town boundary as to their exact location the East Hampton Police Department and Haddam Neck Volunteer Fire Department agree that the Haddam Neck Volunteer Fire Department will be dispatched on automatic mutual aid to any medical call in the following area of East Hampton:

All above street number 80 Middle Haddam Road
All of Shad Row
All of Knowles Road
All of Moodus road
All of School House Lane (both sides)
All above street number 80 Hog Hill Road
All of Terp Road
All of Ox Yoke Circle
All Hurd Park Road
All Haddam Neck Road
All of Wilkes Road
All of Green Road
All of Whippoorwill Hollow Road
All of Pine Brook Road
All of Sexton Hill Road
All above street number 249 Wopowog Road
All above street number 285 Young Street
All of Hurd state park.

This agreement becomes effective when signed by the Chiefs of each department. It remains in effect until canceled in writing by either department.

Sean Cox
Chief
East Hampton Police Department

03/20/17
Date

Robert McGarry
Chief
Haddam Neck Volunteer Fire Department

3/20/17
Date

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF OPERATION

FOR

EAST HAMPTON POLICE DEPARTMENT
1 COMMUNITY DRIVE
EAST HAMPTON, CT 06424-1002

The above referenced service is hereby certified at the First Responder level of service beginning 10/01/2020 and ending 09/30/2021. This certificate demonstrates compliance with the following criteria:

Applicant has met the minimum standards of the Department of Public Health in the areas of training, equipment and personnel. Applicant has demonstrated its suitability to provide first responder services.

A copy of this certificate shall be displayed prominently in the above stated operational headquarters of each location from which the provider is granted to operate under this certificate.

Dated: September 09, 2020

Deidre S. Gifford, MD, MPH
Acting Commissioner

Phone: (860) 509-8100
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12EMS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF OPERATION

FOR

EAST HAMPTON FIRE DEPARTMENT
3 BARTON HILL RD
EAST HAMPTON, CT 06424-1102

The above referenced service is hereby certified at the Supplemental Responder level of service beginning 10/01/2020 and ending 09/30/2021. This certificate demonstrates compliance with the following criteria:

Applicant has met the minimum standards of the Department of Public Health in the areas of training, equipment and personnel. Applicant has demonstrated its suitability to provide first responder services.

A copy of this certificate shall be displayed prominently in the above stated operational headquarters of each location from which the provider is granted to operate under this certificate.

Dated: September 18, 2020

Deidre S. Gifford, MD, MPH
Acting Commissioner

Phone: (860) 509-8100
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12EMS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF OPERATION C042B1

FOR

EAST HAMPTON AMBULANCE ASSN.
4 MIDDLETOWN AVE
EAST HAMPTON, CT 06424-1730

Is hereby authorized to operate **2** vehicle(s) in a BA category beginning **10/01/2020** and ending **09/30/2021**.

Of the **2** authorized vehicles, the certificate holder will be permitted to equip and use not more than **2** ambulance(s), **0** invalid coach(es), as defined by Chapter 368d, Section 19a-175 of the Connecticut General Statutes, and **0** as non-transporting emergency medical service vehicle(s) as defined in Section 19a-180-1(b)(4) of the Regulations of Connecticut State Agencies. The applicant is also authorized to operate **0** branch locations. Addresses of the authorized branch locations are on file in the Department of Public Health.

Applicant has furnished evidence of financial responsibility as required by Section 19a-180 of the Connecticut General Statutes, as amended

Applicant has met the minimum standards of the State Department of Public Health in the areas of training, equipment and personnel for operation of an emergency medical service or is presently operating under a waiver of certain provisions of the regulations

Applicant has demonstrated its suitability to provide emergency medical service.

A copy of this certificate shall be displayed prominently in the above stated operational headquarters and at each location from which the provider is granted to operate under this certificate.

Dated: September 09, 2020

Deidre S. Gifford, MD, MPH
Acting Commissioner

Phone: (860) 509-8100
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12EMS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

LICENSE – **L083P1**

FOR

MIDDLESEX HOSPITAL
28 CRESCENT ST
MIDDLETOWN, CT 06457-3654

The above organization is hereby authorized to operate **10** vehicle(s) in a FR/MIC-P category beginning **01/01/2021** and ending **12/31/2021**.

The licensed ambulance service, which the licensee is authorized to operate, shall consist of the provision of all forms of medical service allowed by law through the use of the following ambulance vehicles:

> Of the **10** authorized vehicles, the licensee will be permitted to equip and use not more than **3** ambulance(s), **0** invalid coach(es), as defined by Chapter 368d, Section 19a-175 of the Connecticut General Statutes, and **7** as non-transporting emergency medical service vehicle(s) as defined in Section 19a-180-1(b)(4) of the Regulations of Connecticut State Agencies. Licensee is also authorized to operate **2** branch locations. Addresses of the authorized branch locations are on file in the Department of Public Health.

This license is transferable only with the prior approval of the Department of Public Health and is issued subject to payment of such fees as required by law, compliance by licensee with all motor vehicle laws and statutes of the State of Connecticut, and orders as the Department of Public Health may from time to time promulgate. The licensee above-named is permitted by this license to operate emergency medical service from its principal place of business indicated above.

A copy of this certificate shall be displayed prominently in the above stated operational headquarters and at each location from which the provider is granted to operate under this certificate.
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Dated: December 16, 2020

Deidre S. Gifford, MD, MPH
Acting Commissioner

Phone: (860) 509-8100
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12EMS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Billing Service Agreement

This Agreement, effective November 1, 2019, is made between Shared Response Health Systems, LLC, (SRHS) and East Hampton Ambulance Association, Inc.. (EHAMP) for setting forth the terms and conditions under which SRHS will perform billing and collection services for professional services rendered. It will remain in force until October 31, 2020 at which time the Agreement will automatically renew for consecutive periods of 12 months. This Agreement may be canceled by either party for just and reasonable cause with 60-day notice in writing to the other.

RESPONSIBILITIES OF SRHS

SRHS will provide the following:

Input of all data from run forms and applicable attachments into ESO software to process billing as completed on ESO Suites upon lock and QA by EHAMP.

Electronic claims submission to insurance carriers within three (3) days of date of service. Paper billing to all other carriers.

Generation and mailing of patient statements for four (4) months, with proper dunning messages, if so desired by EHAMP.

Tracking of Medicare bundle bill to process payments due by EHAMP.

Transfer of delinquent accounts to outside collection agency designated by EHAMP once deemed delinquent at 120 days, if so desired.

Collection and posting of all receivables within three (3) days of receipt. SRHS shall make bank deposits to the bank approved by EHAMP.

Customer service support to EHAMP, third party payers, and patients from 8:00 a.m. to 4:30 p.m., Monday through Friday.

SRHS assumes all labor, telephone, paper and postage charges as directly related to the above responsibilities.

Generation of month end reports within five (5) business days of each calendar month end/quarter end/year end close. Additional reports will be generated per request of EHAMP.

SRHS will provide up to two (2) staff training sessions per year upon request by EHAMP to inform staff of current documentation requirements and related reimbursement.

SRHS will make every effort to obtain necessary patient signatures as required by law whenever a patient was unable to sign at the time of service.

RESPONSIBILITIES OF EAST HAMPTON AMBULANCE ASSOCIATION, INC..

Provide SRHS with all applicable provider numbers for reimbursement.

Provide SRHS with associated Paramedic bundle bill agreements, and any updates as amended.

Notification of nature and level of call, and proper patient demographic information. All reasonable efforts to secure the patient and/or responsible party signature are the responsibility of EHAMP.

Notification of any/all patient and insurance payments received weekly by EHAMP.

Monthly fees to be promptly paid to SRHS within fifteen (15) calendar days of the calendar month end.

EHAMP will reimburse SRHS for ESO related charges as assumed through the agreement with Middlesex County agencies and paid for by SRHS.

COMPENSATION

EHAMP will pay SRHS a nine percent (9%) commission on all cash collected by SRHS, payments received by client.

CONFIDENTIALITY

SRHS and EHAMP acknowledge that all materials and information which have or will come into our possession or knowledge in connection with this Agreement, or the performance hereto, including all documents, reports, and material developed during the term of this Agreement, are deemed to be confidential information, which disclosure to or use by unauthorized parties could be damaging.

Therefore, SRHS and EHAMP agree to hold such material and information in the strictest confidence and not to make use therefore other than for performance of this Agreement, except as specifically agreed upon in this or other Agreements between or among the parties. SRHS and EHAMP will use our best efforts to prevent the disclosure of such information to any unauthorized party. It is expressly understood that the obligation referred to in this paragraph is a continuing obligation and that it extends beyond the terms of the Agreement.

CONNECTICUT CONTRACT

This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

ASSIGNMENT

This Agreement may not be assigned by either party without the prior written consent of the other party. However, subject to the limitation on assignment, this Agreement shall extend to and be equally binding upon the successors and assigns of each party.

INDEPENDENT CONTRACTOR

For purposes of this Agreement, SRHS and EHAMP are and will act at all times as independent contractors. Nothing contained in this Agreement establishes or constitutes or will be construed as establishing or constituting a partnership or agency or employment agreement between SRHS and EHAMP. Nor does this Agreement establish or constitute a joint venture between SRHS and EHAMP. Each party is responsible for its own acts/omissions and is not responsible for the act/omission of the other party.

INTEGRATED AGREEMENT

This Agreement shall be the complete and total understanding of the parties and shall not be amended except in writing executed by both parties hereto.

NOTICES

Any notices required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent certified or registered mail to SRHS at:

Shared Response Health Systems, LLC
195 Route 80
Killingworth, CT 06419

ATTENTION: Sandra Castlevetro

And to EHAMP at:

East Hampton Ambulance Association, Inc..
PO Box 114
East Hampton, CT 06424-0114

ATTENTION: Donald Scranton, Chief of Service

Or to any address as either SRHS or East Hampton Ambulance Association, Inc.. designate by notice to the other.

IN WITNESS THEREOF, the parties have executed this Agreement the date and year first written above.

Sandra Castlevetro, Managing Member
Shared Response Health Systems, LLC

10/10/2019
Date

Donald Scranton, Chief of Service
East Hampton Ambulance Association, Inc..

10/10/2019
Date

ADVANCED LIFE SUPPORT INTERCEPT AGREEMENT
BETWEEN
EAST HAMPTON AMBULANCE ASSOCIATION
AND
MIDDLESEX HOSPITAL

This Advance Life Support Intercept Agreement (the "Agreement") is made as of this Twelveth day of December, 2012, (the "Effective Date") by and between the East Hampton Ambulance Association ("EHAA"), a Connecticut corporation having a place of business at 4 Middletown Ave, East Hampton, Connecticut, 06424 and Middlesex Hospital, a non-stock corporation having a place of business at 28 Crescent Street, Middletown, CT 06457, and its Emergency Medical Service Paramedics ("MHEMS")

WHEREAS, EHAA is licensed and qualified to provide basic life support ("BLS") ambulance transportation within its Primary Service Area ("PSA"); and,

WHEREAS, EHAA requires access to Advanced Life Support ("ALS") capability to serve certain critically ill patients within the PSA; and,

WHEREAS, MHEMS is licensed, qualified, staffed with Paramedics and is willing to provide ALS intercept services to EHAA ("Services"); and,

WHEREAS, EHAA and MHEMS wish to enter into an arrangement for provision of Services to patients transported by EHAA;

NOW THEREFORE, in consideration of the mutual covenants and agreements set forth herein, the parties agree as follows:

1. MHEMS shall endeavor to make available licensed Paramedics for Services twenty-four (24) hours per day, seven (7) days per week. EHAA acknowledges that emergency medical service system demands on MHEMS will at times prevent MHEMS from responding timely to a EHAA request. MHEMS will notify EHAA immediately at the time of request when such circumstances exist. In such circumstances, paramedic services will be requested by MHEMS according to its existing mutual aid agreements with other paramedic service providers.

2. MHEMS shall respond to EHAA requests to provide Services either at the scene of the medical emergency or by meeting the transporting ambulance *en route* to an acute care medical facility at an agreed intercept point. Services shall be provided by an MHEMS Paramedic in accordance with the most recent revision of the State of Connecticut ALS Protocols.

3. If Services are initiated for the EHAA transported patient, a MHEMS Paramedic shall accompany the patient and the crew on board the EHAA ambulance to the acute care facility and shall remain until patient care responsibilities are transferred to the acute care medical facility's personnel.

4. From time to time, the MHEMS Paramedic in performing an assessment on a EHAA patient will determine, based upon MHEMS prehospital treatment guidelines, that the patient may be safely transported by EHAA to the acute care medical facility without a MHEMS Paramedic in the ambulance. MHEMS will document such assessments using "emsCharts", and billing for such assessments will be as stated in paragraph 8.

5. MHEMS shall provide to EHAA upon request evidence of current licensure to provide Services. Such evidence shall include the license issued by the State of Connecticut and either an authorizing letter from the Regional Council for MHEMS to provide the ALS services or a letter from Middlesex Hospital agreeing to provide MHEMS with medical control.

6. EHAA shall provide to MHEMS upon request evidence of its licensure, that it is a Medicare Provider in good standing and its Medicare Provider Number. The affected party will provide the other party timely notice of any changes in licensure, good standing or Medicare Provider Number. Also, EHAA will provide MHEMS with EHAA's current Medicare allowable rates upon execution of this Agreement and within thirty (30) days of Medicare publishing new rates.

7. MHEMS and EHAA shall each be responsible for obtaining necessary demographic and billing information on transported patients. MHEMS and EHAA shall bill and collect for patient transports not covered by Medicare only for their respective component of the emergency response. MHEMS shall bill third party payors and self-pay patients for Services at the then current Paramedic Intercept rate authorized by the State of Connecticut Department of Public Health and EHAA shall bill third party payors and self-pay patients the BLS transport rate authorized by the State of Connecticut Department of Public Health.

8. Notwithstanding anything in the paragraph 6 above, MHEMS and EHAA agree that EHAA shall bill the Advanced Level Paramedic Intercept fee portion of a bundled bill to Medicare Part B, Medicare HMO Replacement Plans, Veteran's Administration, and Federal Blue Cross for MHEMS Services rendered to Medicare Beneficiaries and employees of the Federal Blue Cross Program as transported by EHAA. This includes any fees associated with ALS Assessments, as stated in paragraph 4 above. MHEMS and EHAA agree that MHEMS may not bill Medicare or the Federal Blue Cross programs directly for Services rendered hereunder.

9. MHEMS and EHAA agree that EHAA shall bill the Advanced Level Paramedic Intercept fee portion as an additional line item (A0432) in addition to the BLS charge to Connecticut Medicaid. EHAA shall reimburse MHEMS the allowable rate (currently $130.07) upon receipt of a statement from the MHEMS billing agent.

10. MHEMS shall submit weekly to EHAA, or the EHAA billing agent, a Claim for Services. The Claim shall include a listing of the Paramedic responses during that period with the name of the patient and date of each call for Service, and a copy of the Paramedic Patient Care Report (PCR) or Non-transport Report, as appropriate, for each call. Both Reports will include time of call, address of pick-up or intercept location, acute care medical facility destination, and level of call. MHEMS understands that any call submitted to EHAA more than thirty (30) days after the date of Service may not be billable by EHAA and as a result not payable to MHEMS by EHAA.

11. Within thirty (30) days after EHAA receives payment from Medicare, EHAA shall remit to MHEMS, or the MHEMS billing agent, One Hundred Percent (100%) of the difference between the then current Medicare allowable rate for basic life support-emergency and the Medicare allowable rate for the applicable advanced level care for the ambulance transport, either ALS-1 emergency or ALS-2, as applicable to the call. The EHAA will bill Medicare Beneficiaries, Federal Blue Cross programs, or their secondary insurers the patient's co-payments. Within thirty (30) days after EHAA receiving such co-payments, EHAA shall remit to MHEMS, or the MHEMS billing agent, the amount received in excess of EHAA's customary BLS co-payment.

12. MHEMS, or the MHEMS billing agent, will provide EHAA with a monthly statement as of the end of the month within ten (10) days of the end of each month for the Services for which MHEMS has not received payment from EHAA. EHAA will provide MHEMS, or the MHEMS billing agent, a monthly report as of the end of the month within ten (10) days of the end of each month giving billing and collection detail for each Medicare-covered and Federal Blue Cross program call for which MHEMS has provided Services. The parties agree to meet as necessary to resolve issues of billing, documentation, or reconciliation of amounts owed to MHEMS by EHAA within ten (10) days of Notice of such dispute by the aggrieved party.

13. EHAA shall provide MHEMS, or the MHEMS billing agent, a contact name and phone number for the EHAA billing agent. EHAA authorizes MHEMS, or the MHEMS billing agent, to contact the EHAA billing agent if the patient accounts receivables age is 60 days or greater.

14. EHAA shall be responsible for the errors/omissions of the EHAA billing agent and for delayed or incorrect level of service bundle bill charges, provided that MHEMS, or the MHEMS billing agent, provides MDF evidence of the MHEMS billing agent's proper and timely submission of Patient Care Reports and Non-Transport Forms for the disputed claims. In these instances, MHEMS shall also provide EHAA evidence of acknowledgement of receipt of said forms by the EHAA billing agent.

15. The relationship between Middlesex Hospital and EHAA shall be that of independent contractors. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Agreement.

16. Middlesex Hospital will indemnify, defend and hold harmless EHAA, from any and all suits, claims, losses, damages or injuries to persons or property and any costs and expenses incurred in connection therewith, including reasonable attorney's fees, caused by the negligent and/or willful acts, errors or omissions of Middlesex Hospital its directors, officers, employees or agents.

17. EHAA will indemnify, defend and hold harmless Middlesex Hospital its directors, officers, employees and agents from any and all suits, claims losses, damages or injuries to persons or property and all costs and expenses incurred in connection therewith, including reasonable attorney's fees, caused by the negligent and/or willful acts, errors or omissions of EHAA, its directors, officers, employees or agents.

18. Each party shall give the other party prompt written notice of any claim, threatened or made, or suit instituted against it which could result in a claim for indemnification.

19. Each party, at its sole expense, shall maintain professional liability and comprehensive general liability insurance to meet their respective obligations hereunder in at least the following amounts: one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. Both parties shall provide the other party upon request with certificates of insurance evidencing all of the aforementioned coverage.

20. The term of this Agreement shall be for one (1) year from the Effective Date, unless terminated as provided herein. This Agreement shall be automatically extended for successive one-year periods following the initial term unless either party notifies the other of its intent not to renew at least ninety (90) days before the end of the initial term or any extension term then in effect.

21. Either party may terminate this Agreement for any reason by giving ninety (90) days written notice to the other party.

22. In the event of a default by either party in carrying out any material obligation hereunder, the other party may terminate this Agreement; provided, however, that such right of termination shall only apply if written notice of such default has been given and the defaulting party has not cured such default within thirty (30) days of receipt of such notice.

23. This Agreement will immediately terminate if either party ceases to be licensed or certified, as applicable, as a provider of ambulance transport services. In the event that there is a change in the applicable statutes or regulations that, in the opinion of counsel for either party, would cause the billing arrangement herein to be in violation of Medicare regulations, the parties agree to immediately suspend billing Medicare under the terms of this Agreement until the Agreement is modified to be in compliance with such new regulations.

24. All notices or demands made in connection with this Agreement given to or made upon either party shall be in writing and shall be deemed to have been given if mailed by

certified mail, hand delivered or sent via reputable commercial courier to the party at the following address, as may be modified from time to time by written notice:

East Hampton Ambulance Association:	Middlesex Hospital / MHEMS:
P.O. Box 144	Middlesex Hospital Paramedics
East Hampton, CT 06424	28 Crescent Street
	Middletown, CT 06457
Attention: Chief of Service	Attention: EMS Manager

25. This Agreement contains the entire agreement of the parties related to the subject matter hereof, and supersedes all prior understandings, agreements, and documentation relating to the subject hereof. No modification of or amendment to this Agreement shall be binding unless agreed to in writing and executed by both parties.

26. If any provision of this Agreement or portion of such provision or the application thereof to any person or circumstance shall to any extent be held invalid or unenforceable, the remainder of this Agreement (or the remainder of such provision) and the application thereof to other persons or circumstances shall not be affected thereby.

27. This Agreement may not be assigned without the prior written consent of both parties.

28. This Agreement shall be governed by the laws of the State of Connecticut and the parties agree that the venue for any disputes arising hereunder shall be in the courts of that state.

29. The failure of a party to insist upon strict adherence to any term of this Agreement on any occasion shall not be considered a waiver or deprive that party of the right thereafter to that term or any other term of this Agreement.

IN WITNESS WHEREOF, the parties have hereto have set their hands by their fully authorized representatives:

East Hampton Ambulance Association

Thomas Donnelly
Signature

Thomas Donnelly
Printed Name

Chief
Title

12/8/12
Date

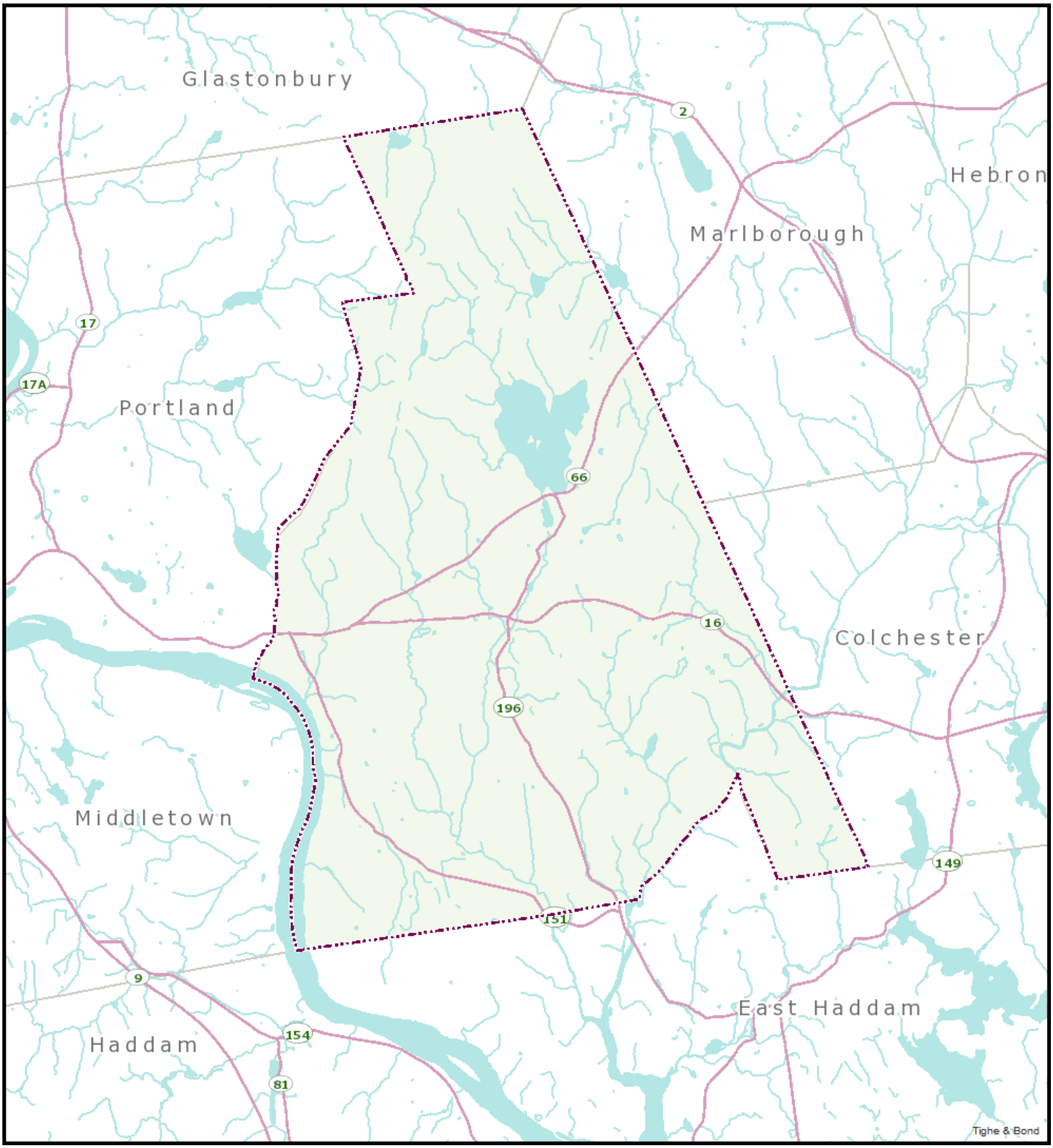
Middlesex Hospital

Susan Martin
Signature

Susan Martin
Printed Name

Vice President, Finance
Title

12/12/12
Date



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Scale: 1"=8000'

Scale is approximate

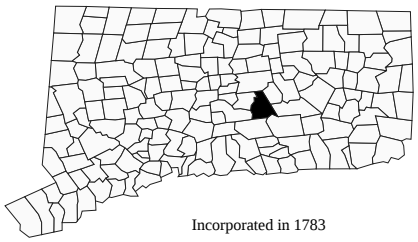
The information depicted on this map is for planning purposes only. It is not adequate for legal boundary definition, regulatory interpretation, or parcel-level analyses.

East Hampton, Connecticut

CERC Town Profile 2019 *Produced by Connecticut Data Collaborative*

Town Hall
20 East High Street
East Hampton, CT 06424
(860) 267-4468

Belongs To
Middlesex County
LMA Hartford
Lower CT River Valley Planning Area



Incorporated in 1783

Demographics

Population

	Town	County	State
2000	13,352	155,071	3,405,565
2010	12,959	165,676	3,574,097
2013-2017	12,890	164,110	3,594,478
2020	13,757	170,518	3,604,591
'17 - '20 Growth / Yr	2.1%	1.3%	0.1%

	Town	County	State
Land Area (sq. miles)	36	369	4,842
Pop./Sq. Mile (2013-2017)	362	444	742
Median Age (2013-2017)	46	45	41
Households (2013-2017)	4,941	66,599	1,361,755
Med. HH Inc. (2013-2017)	$99,104	$81,673	$73,781

	Town	State
Veterans (2013-2017)	1,042	180,111

Race/Ethnicity (2013-2017)

	Town	County	State
White Non-Hisp	11,598	138,523	2,446,049
Black Non-Hisp	181	8,046	350,820
Asian Non-Hisp	335	4,780	154,910
Native American Non-Hisp	55	156	5,201
Other/Multi-Race Non-Hisp	228	2,993	84,917
Hispanic or Latino	493	9,612	551,916

	Town	County	State
Poverty Rate (2013-2017)	5.7%	7.2%	10.1%

Educational Attainment (2013-2017)

	Town		State	
High School Graduate	2,412	26%	673,582	27%
Associates Degree	1,039	11%	188,481	8%
Bachelors or Higher	3,634	39%	953,199	38%

Age Distribution (2013-2017)

	0-4		5-14		15-24		25-44		45-64		65+		Total	
Town	505	4%	1,720	13%	1,279	10%	2,755	21%	4,666	36%	1,965	15%	12,890	100%
County	7,042	4%	17,570	11%	20,717	13%	36,566	22%	52,019	32%	30,196	18%	164,110	100%
State	186,188	5%	432,367	12%	495,626	14%	872,640	24%	1,031,900	29%	575,757	16%	3,594,478	100%

Economics

Business Profile (2018)

Sector	Units	Employment
Total - All Industries	257	2,019
23 - Construction	30	152
31-33 - Manufacturing	12	83
44-45 - Retail Trade	27	323
62 - Health Care and Social Assistance	20	265
72 - Accommodation and Food Services	18	222
Total Government	19	498

Top Five Grand List (2018)

	Amount
Eversource	$20,987,760
Landmark East Hampton LLC	$7,521,320
Connecticut Natural Gas Corp	$3,507,610
Hampton 66 LLC	$3,500,000
Global Self Storage LW	$2,673,480
Net Grand List (SFY 2016-2017)	$1,123,511,268

Major Employers (2018)

Town of East Hampton
Cobalt Lodge
Eversource Energy
Stop & Shop Supermarket
American Distilling

Education

2018-2019 School Year

	Grades	Enrollment
East Hampton School District	PK-12	1869

Smarter Balanced Test Percent Above Goal (2017-2018)

	Grade 3		Grade 4		Grade 8	
	Town	State	Town	State	Town	State
Math	56.6%	53.8%	68.5%	51.3%	46.5%	43.0%
ELA	61.5%	53.1%	67.1%	54.9%	61.3%	56.1%

Pre-K Enrollment (PSIS)

	2018-2019
East Hampton School District	54

Rate of Chronic Absenteeism (2017-2018)

	All
Connecticut	10.7%
East Hampton School District	6.2%

4-Year Cohort Graduation Rate (2017-2018)

	All	Female	Male
Connecticut	88.3%	91.8%	85.1%
East Hampton School District	94.7%	93.0%	96.4%

Public vs Private Enrollment (2013-2017)

	Town	County	State
Public	94.3%	87.0%	86.8%
Private	5.7%	13.0%	13.2%

profiles.ctdata.org

East Hampton, Connecticu

CERC Town Profile 2019

Connecticut Economic Resource Center

Government

Government Form: Council - Manager

Total Revenue (2017)	$48,160,877	Total Expenditures (2017)	$47,459,555	Annual Debt Service (2017)	$2,881,468
Tax Revenue	$33,583,829	Education	$34,672,028	As % of Expenditures	6.1%
Non-tax Revenue	$14,577,048	Other	$12,787,527	Eq. Net Grand List (2017)	$1,605,563,611
Intergovernmental	$13,949,064	Total Indebtedness (2017)	$33,763,238	Per Capita	$124,453
Per Capita Tax (2017)	$2,574	As % of Expenditures	71.1%	As % of State Average	82.4%
As % of State Average	87.8%	Per Capita	$2,617	Moody's Bond Rating (2017)	Aa3
		As % of State Average	104.1%	Actual Mill Rate (2017)	29.44
				Equalized Mill Rate (2017)	20.68
				% of Net Grand List Com/Ind (2017)	5.5%

Housing/Real Estate

Housing Stock (2013-2017)

	Town	County	State
Total Units	5,541	75,938	1,507,711
% Single Unit (2013-2017)	85.2%	70.8%	59.2%
New Permits Auth (2017)	22	237	4,547
As % Existing Units	0.4%	0.3%	0.3%
Demolitions (2017)	0	25	1,403
Home Sales (2017)	166	1,191	21,880
Median Price	$261,400	$283,700	$270,100
Built Pre-1950 share	26.4%	25.1%	29.3%
Owner Occupied Dwellings	4,287	49,088	906,798
As % Total Dwellings	86.8%	73.7%	66.6%
Subsidized Housing (2018)	177	6,619	167,879

Distribution of House Sales (2017)

	Town	County	State
Less than $100,000	2	35	536
$100,000-$199,999	35	145	5,237
$200,000-$299,999	70	405	6,681
$300,000-$399,999	44	329	3,863
$400,000 or More	15	277	5,563

Rental (2013-2017)

	Town	County	State
Median Rent	$1,166	$1,132	$1,123
Cost-burdened Renters	30.2%	50.8%	52.3%

Labor Force

	Town	County	State
Residents Employed	7,526	89,811	1,827,070
Residents Unemployed	261	3,267	78,242
Unemployment Rate	3.4%	3.5%	4.1%
Self-Employed Rate	8.8%	11.2%	10.0%
Total Employers	257	5,433	122,067
Total Employed	2,019	68,827	1,673,867

Connecticut Commuters (2015)

Commuters Into Town From:		Town Residents Commuting To:	
East Hampton, CT	617	Hartford, CT	816
Colchester, CT	96	East Hampton, CT	617
Marlborough, CT	79	Middletown, CT	599
Portland, CT	67	East Hartford, CT	286
Middletown, CT	65	Glastonbury, CT	272
East Haddam, CT	46	Rocky Hill, CT	183
Glastonbury, CT	41	Farmington, CT	160

Quality of Life

Crime Rates (per 100,000 residents) (2017)

	Town	State
Property	434	1,777
Violent	36	228

Disengaged Youth (2013-2017)

	Town	State
Female	3.3%	4.2%
Male	0.0%	5.6%

	Town
Library circulation per capita	6.41

Distance to Major Cities

	Miles
Hartford	17
Providence	59
Boston	94
New York City	97
Montreal	281

Residential Utilities

Electric Provider
Eversource Energy
(800) 286-2000

Gas Provider
CNG Corp
(860) 727-3000

Water Provider
Connecticut Water Company
(800) 286-5700

Cable Provider
Comcast Middletown
(800) 266-2278

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

September 21, 2020

David Cox, Manager
Town of East Hampton
East Hampton Town Hall
1 Community Drive
East Hampton, CT 06424

Dear Mr. Cox:

On behalf of the Connecticut Department of Public Health and the American Heart Association, congratulations to your community for having met the renewal requirements of a designated HEARTSafe community.

This three-year re-designation, effective September 14, 2020, recognizes your community's continued commitment to provide improved cardiac response and care to the residents of your community utilizing the "Chain of Survival" of early 9-1-1 access, cardiopulmonary resuscitation, defibrillation and advanced care.

We commend you on your efforts to continue to save lives and improve the health of your community.

Sincerely,

Deidre S. Gifford

Deidre S. Gifford, MD, MPH
Acting Commissioner

Connecticut Department of Public Health

Phone: (860) 509-7975 • Fax: (860) 730-8384
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

State of Connecticut
Department of Public Health

The Office of Emergency Medical Services

In recognition of community efforts to improve survival from sudden cardiac arrest,
the town of

East Hampton

has met the criteria for re-designation as a

HEARTSafe Community

Presented this 14th day of September, 2020

Deidre S. Gifford, MD, MPH
Acting Commissioner

ProQA Paramount Medical Response Codes Protocol Version 13.0.997 NAE-STD Created: 15 March 2017 Updated:					This column to be used to define Agency CAD code if it varies from ProQA's default CAD code
	These two fields		These two fields		
Determinant Descriptor	ProQA Code	Suffix Code	Response Text	CAD Code	
1. Abdominal Pain / Problems					
Abdominal pain	01A01		Alpha	1A01	
Testicle or groin pain (male)	01A02		Alpha	1A02	
Override	01C00		Charlie	1C00	
SUSPECTED aortic aneurysm (tearing/ripping pain) ≥ 50	01C01		Charlie	1C01	
Diagnosed aortic aneurysm	01C02		Charlie	1C02	
Fainting or near fainting ≥ 50	01C03		Charlie	1C03	
Females with fainting or near fainting 12–50	01C04		Charlie	1C04	
Males with pain above navel ≥ 35	01C05		Charlie	1C05	
Females with pain above navel ≥ 45	01C06		Charlie	1C06	
Override	01D00		Delta	1D00	
Not alert	01D01		Delta	1D01	
Ashen or gray color reported ≥ 50	01D02		Delta	1D02	
2. Allergies (Reactions) / Envenomations (Stings, Bites)					
No difficulty breathing or swallowing (rash, hives, or itching may be present)	02A01		Alpha	2A01	
Spider bite	02A02		Alpha	2A02	
Override	02B00		Bravo	2B00	
	02B00	I	Bravo	2B00I	
	02B00	M	Bravo	2B00M	
Unknown status/Other codes not applicable	02B01		Bravo	2B01	
	02B01	I	Bravo	2B01I	
	02B01	M	Bravo	2B01M	
Override	02C00		Charlie	2C00	
	02C00	I	Charlie	2C00I	
	02C00	M	Charlie	2C00M	
Difficulty breathing or swallowing	02C01		Charlie	2C01	
	02C01	I	Charlie	2C01I	
	02C01	M	Charlie	2C01M	
History of severe allergic reaction	02C02		Charlie	2C02	
	02C02	I	Charlie	2C02I	
	02C02	M	Charlie	2C02M	
Override	02D00		Delta	2D00	
	02D00	I	Delta	2D00I	
	02D00	M	Delta	2D00M	
Not alert	02D01		Delta	2D01	
	02D01	I	Delta	2D01I	
	02D01	M	Delta	2D01M	
DIFFICULTY SPEAKING BETWEEN BREATHS	02D02		Delta	2D02	
	02D02	I	Delta	2D02I	
	02D02	M	Delta	2D02M	
SWARMING attack (bees, wasps, hornets, etc.)	02D03		Delta	2D03	
	02D03	I	Delta	2D03I	
	02D03	M	Delta	2D03M	
Snakebite	02D04		Delta	2D04	
	02D04	I	Delta	2D04I	
	02D04	M	Delta	2D04M	
Override	02E00		Echo	2E00	
	02E00	I	Echo	2E00I	
	02E00	M	Echo	2E00M	
INEFFECTIVE BREATHING	02E01		Echo	2E01	
	02E01	I	Echo	2E01I	
	02E01	M	Echo	2E01M	
3. Animal Bites / Attacks					
NOT DANGEROUS body area	03A01		Alpha	3A01	
NON-RECENT (≥ 6hrs) injuries (without priority symptoms)	03A02		Alpha	3A02	

Suffix I - Injection administered or advised
Suffix M - Medication administered or advised

SUPERFICIAL injuries	03A03		Alpha	3A03	
Override	03B00		Bravo	3B00	
POSSIBLY DANGEROUS body area	03B01		Bravo	3B01	
SERIOUS hemorrhage	03B02		Bravo	3B02	
Unknown status/Other codes not applicable	03B03		Bravo	3B03	
Override	03D00		Delta	3D00	
Arrest	03D01		Delta	3D01	
Unconscious	03D02		Delta	3D02	
Not alert	03D03		Delta	3D03	
Chest or Neck injury (with difficulty breathing)	03D04		Delta	3D04	
DANGEROUS body area	03D05		Delta	3D05	
Large animal	03D06		Delta	3D06	
EXOTIC animal	03D07		Delta	3D07	
MAULING or multiple animals	03D08		Delta	3D08	
Attack in progress	03D09		Delta	3D09	
4. Assault / Sexual Assault / Stun Gun					
Marked (*) NOT DANGEROUS body area with deformity	04A01	A	Alpha	4A01A	
	04A01	S	Alpha	4A01S	
	04A01	T	Alpha	4A01T	
NOT DANGEROUS body area	04A02	A	Alpha	4A02A	
	04A02	S	Alpha	4A02S	
	04A02	T	Alpha	4A02T	
NON-RECENT (≥ 6hrs) injuries (without priority symptoms)	04A03	A	Alpha	4A03A	
	04A03	S	Alpha	4A03S	
	04A03	T	Alpha	4A03T	
Override	04B00	A	Bravo	4B00A	
	04B00	S	Bravo	4B00S	
	04B00	T	Bravo	4B00T	
POSSIBLY DANGEROUS body area	04B01	A	Bravo	4B01A	
	04B01	S	Bravo	4B01S	
	04B01	T	Bravo	4B01T	
SERIOUS hemorrhage	04B02	A	Bravo	4B02A	
	04B02	S	Bravo	4B02S	
	04B02	T	Bravo	4B02T	
Unknown status/Other codes not applicable	04B03	A	Bravo	4B03A	
	04B03	S	Bravo	4B03S	
	04B03	T	Bravo	4B03T	
Override	04D00	A	Delta	4D00A	
	04D00	S	Delta	4D00S	
	04D00	T	Delta	4D00T	
Arrest	04D01	A	Delta	4D01A	
	04D01	S	Delta	4D01S	
	04D01	T	Delta	4D01T	
Unconscious	04D02	A	Delta	4D02A	
	04D02	S	Delta	4D02S	
	04D02	T	Delta	4D02T	
Not alert	04D03	A	Delta	4D03A	
	04D03	S	Delta	4D03S	
	04D03	T	Delta	4D03T	
Chest or Neck injury (with difficulty breathing)	04D04	A	Delta	4D04A	
	04D04	S	Delta	4D04S	
	04D04	T	Delta	4D04T	
Multiple victims	04D05	A	Delta	4D05A	
	04D05	S	Delta	4D05S	
	04D05	T	Delta	4D05T	
5. Back Pain (Non-Traumatic or Non-Recent Trauma)					
NON-TRAUMATIC back pain	05A01		Alpha	5A01	
NON-RECENT (≥ 6hrs) traumatic back pain (without priority symptoms)	05A02		Alpha	5A02	
Override	05C00		Charlie	5C00	
SUSPECTED aortic aneurysm (tearing/ripping pain) ≥ 50	05C01		Charlie	5C01	
Diagnosed aortic aneurysm	05C02		Charlie	5C02	
Fainting or near fainting ≥ 50	05C03		Charlie	5C03	
Difficulty breathing	05C04		Charlie	5C04	
Override	05D00		Delta	5D00	
Not alert	05D01		Delta	5D01	
Ashen or gray color reported ≥ 50	05D02		Delta	5D02	

Suffix A - Assault
Suffix S - Sexual assault
Suffix T - Stun gun

6. Breathing Problems						Suffix A - Asthma Suffix E - COPD (Emphysema/Chronic bronchitis) Suffix O - Other lung problems
Abnormal breathing	06C01		Charlie	6C01		
	06C01	A	Charlie	6C01A		
	06C01	E	Charlie	6C01E		
	06C01	O	Charlie	6C01O		
Tracheostomy (no obvious distress)	06C02		Charlie	6C02		
	06C02	A	Charlie	6C02A		
	06C02	E	Charlie	6C02E		
	06C02	O	Charlie	6C02O		
Override	06D00		Delta	6D00		
	06D00	A	Delta	6D00A		
	06D00	E	Delta	6D00E		
	06D00	O	Delta	6D00O		
Not alert	06D01		Delta	6D01		
	06D01	A	Delta	6D01A		
	06D01	E	Delta	6D01E		
	06D01	O	Delta	6D01O		
DIFFICULTY SPEAKING BETWEEN BREATHS	06D02		Delta	6D02		
	06D02	A	Delta	6D02A		
	06D02	E	Delta	6D02E		
	06D02	O	Delta	6D02O		
CHANGING COLOR	06D03		Delta	6D03		
	06D03	A	Delta	6D03A		
	06D03	E	Delta	6D03E		
	06D03	O	Delta	6D03O		
Clammy or cold sweats	06D04		Delta	6D04		
	06D04	A	Delta	6D04A		
	06D04	E	Delta	6D04E		
	06D04	O	Delta	6D04O		
Tracheostomy (obvious distress)	06D05		Delta	6D05		
	06D05	A	Delta	6D05A		
	06D05	E	Delta	6D05E		
	06D05	O	Delta	6D05O		
Override	06E00		Echo	6E00		
	06E00	A	Echo	6E00A		
	06E00	E	Echo	6E00E		
	06E00	O	Echo	6E00O		
INEFFECTIVE BREATHING	06E01		Echo	6E01		
	06E01	A	Echo	6E01A		
	06E01	E	Echo	6E01E		
	06E01	O	Echo	6E01O		
7. Burns (Scalds) / Explosion (Blast)						Suffix E - Explosion Suffix F - Fire present Suffix W - Fireworks
Burns < 18% body area	07A01		Alpha	7A01		
	07A01	E	Alpha	7A01E		
	07A01	F	Alpha	7A01F		
	07A01	W	Alpha	7A01W		
Fire alarm (unknown situation)	07A02		Alpha	7A02		
	07A02	E	Alpha	7A02E		
	07A02	F	Alpha	7A02F		
	07A02	W	Alpha	7A02W		
MINOR burns	07A03		Alpha	7A03		
	07A03	E	Alpha	7A03E		
	07A03	F	Alpha	7A03F		
	07A03	W	Alpha	7A03W		
Sunburn	07A04		Alpha	7A04		
	07A04	E	Alpha	7A04E		
	07A04	F	Alpha	7A04F		
	07A04	W	Alpha	7A04W		
NON-RECENT (≥ 6hrs) burns/injuries (without priority symptoms)	07A05		Alpha	7A05		
	07A05	E	Alpha	7A05E		
	07A05	F	Alpha	7A05F		
	07A05	W	Alpha	7A05W		
Override	07B00		Bravo	7B00		
	07B00	E	Bravo	7B00E		
	07B00	F	Bravo	7B00F		
	07B00	W	Bravo	7B00W		

Blast injuries (without priority symptoms)	07B01		Bravo	7B01	
	07B01	E	Bravo	7B01E	
	07B01	F	Bravo	7B01F	
	07B01	W	Bravo	7B01W	
Unknown status/Other codes not applicable	07B02		Bravo	7B02	
	07B02	E	Bravo	7B02E	
	07B02	F	Bravo	7B02F	
	07B02	W	Bravo	7B02W	
Override	07C00		Charlie	7C00	
	07C00	E	Charlie	7C00E	
	07C00	F	Charlie	7C00F	
	07C00	W	Charlie	7C00W	
Fire with persons reported inside	07C01		Charlie	7C01	
	07C01	E	Charlie	7C01E	
	07C01	F	Charlie	7C01F	
	07C01	W	Charlie	7C01W	
Difficulty breathing	07C02		Charlie	7C02	
	07C02	E	Charlie	7C02E	
	07C02	F	Charlie	7C02F	
	07C02	W	Charlie	7C02W	
Burns ≥ 18% body area	07C03		Charlie	7C03	
	07C03	E	Charlie	7C03E	
	07C03	F	Charlie	7C03F	
	07C03	W	Charlie	7C03W	
SIGNIFICANT FACIAL burns	07C04		Charlie	7C04	
	07C04	E	Charlie	7C04E	
	07C04	F	Charlie	7C04F	
	07C04	W	Charlie	7C04W	
Override	07D00		Delta	7D00	
	07D00	E	Delta	7D00E	
	07D00	F	Delta	7D00F	
	07D00	W	Delta	7D00W	
Multiple victims	07D01		Delta	7D01	
	07D01	E	Delta	7D01E	
	07D01	F	Delta	7D01F	
	07D01	W	Delta	7D01W	
Arrest	07D02		Delta	7D02	
	07D02	E	Delta	7D02E	
	07D02	F	Delta	7D02F	
	07D02	W	Delta	7D02W	
Unconscious	07D03		Delta	7D03	
	07D03	E	Delta	7D03E	
	07D03	F	Delta	7D03F	
	07D03	W	Delta	7D03W	
Not alert	07D04		Delta	7D04	
	07D04	E	Delta	7D04E	
	07D04	F	Delta	7D04F	
	07D04	W	Delta	7D04W	
DIFFICULTY SPEAKING BETWEEN BREATHS	07D05		Delta	7D05	
	07D05	E	Delta	7D05E	
	07D05	F	Delta	7D05F	
	07D05	W	Delta	7D05W	
Override	07E00		Echo	7E00	
	07E00	E	Echo	7E00E	
	07E00	F	Echo	7E00F	
	07E00	W	Echo	7E00W	
Person on fire	07E01		Echo	7E01	
	07E01	E	Echo	7E01E	
	07E01	F	Echo	7E01F	
	07E01	W	Echo	7E01W	
8. Carbon Monoxide / Inhalation / HAZMAT / CBRN					
Carbon monoxide detector alarm (scene contact without priority symptoms)	08O01		Omega	8O01	
Carbon monoxide detector alarm (alarm only, no scene contact)	08O02		Omega	8O02	
Override	08B00		Bravo	8B00	
	08B00	C	Bravo	8B00C	
	08B00	B	Bravo	8B00B	
	08B00	R	Bravo	8B00R	

Suffix C - Chemical
Suffix B - Biological
Suffix R - Radiological
Suffix N - Nuclear
Suffix G - Smell of gas/fumes
Suffix M - Carbon monoxide
Suffix S - Suicide attempt (only carbon monoxide)

	08B00	N	Bravo	8B00N	
	08B00	G	Bravo	8B00G	
	08B00	M	Bravo	8B00M	
	08B00	S	Bravo	8B00S	
	08B00	T	Bravo	8B00T	
	08B00	U	Bravo	8B00U	
Alert without difficulty breathing	08B01		Bravo	8B01	
	08B01	C	Bravo	8B01C	
	08B01	B	Bravo	8B01B	
	08B01	R	Bravo	8B01R	
	08B01	N	Bravo	8B01N	
	08B01	G	Bravo	8B01G	
	08B01	M	Bravo	8B01M	
	08B01	S	Bravo	8B01S	
	08B01	T	Bravo	8B01T	
	08B01	U	Bravo	8B01U	
Override	08C00		Charlie	8C00	
	08C00	C	Charlie	8C00C	
	08C00	B	Charlie	8C00B	
	08C00	R	Charlie	8C00R	
	08C00	N	Charlie	8C00N	
	08C00	G	Charlie	8C00G	
	08C00	M	Charlie	8C00M	
	08C00	S	Charlie	8C00S	
	08C00	T	Charlie	8C00T	
	08C00	U	Charlie	8C00U	
Alert with difficulty breathing	08C01		Charlie	8C01	
	08C01	C	Charlie	8C01C	
	08C01	B	Charlie	8C01B	
	08C01	R	Charlie	8C01R	
	08C01	N	Charlie	8C01N	
	08C01	G	Charlie	8C01G	
	08C01	M	Charlie	8C01M	
	08C01	S	Charlie	8C01S	
	08C01	T	Charlie	8C01T	
	08C01	U	Charlie	8C01U	
Override	08D00		Delta	8D00	
	08D00	C	Delta	8D00C	
	08D00	B	Delta	8D00B	
	08D00	R	Delta	8D00R	
	08D00	N	Delta	8D00N	
	08D00	G	Delta	8D00G	
	08D00	M	Delta	8D00M	
	08D00	S	Delta	8D00S	
	08D00	T	Delta	8D00T	
	08D00	U	Delta	8D00U	
Arrest	08D01		Delta	8D01	
	08D01	C	Delta	8D01C	
	08D01	B	Delta	8D01B	
	08D01	R	Delta	8D01R	
	08D01	N	Delta	8D01N	
	08D01	G	Delta	8D01G	
	08D01	M	Delta	8D01M	
	08D01	S	Delta	8D01S	
	08D01	T	Delta	8D01T	
	08D01	U	Delta	8D01U	
Unconscious	08D02		Delta	8D02	
	08D02	C	Delta	8D02C	
	08D02	B	Delta	8D02B	
	08D02	R	Delta	8D02R	
	08D02	N	Delta	8D02N	
	08D02	G	Delta	8D02G	
	08D02	M	Delta	8D02M	
	08D02	S	Delta	8D02S	
	08D02	T	Delta	8D02T	
	08D02	U	Delta	8D02U	
Not alert	08D03		Delta	8D03	
	08D03	C	Delta	8D03C	

Suffix T - Suicide attempt (other toxic substances)
Suffix U - Unknown

	08D03	B	Delta	8D03B	
	08D03	R	Delta	8D03R	
	08D03	N	Delta	8D03N	
	08D03	G	Delta	8D03G	
	08D03	M	Delta	8D03M	
	08D03	S	Delta	8D03S	
	08D03	T	Delta	8D03T	
	08D03	U	Delta	8D03U	
DIFFICULTY SPEAKING BETWEEN BREATHS	08D04		Delta	8D04	
	08D04	C	Delta	8D04C	
	08D04	B	Delta	8D04B	
	08D04	R	Delta	8D04R	
	08D04	N	Delta	8D04N	
	08D04	G	Delta	8D04G	
	08D04	M	Delta	8D04M	
	08D04	S	Delta	8D04S	
	08D04	T	Delta	8D04T	
	08D04	U	Delta	8D04U	
Multiple victims	08D05		Delta	8D05	
	08D05	C	Delta	8D05C	
	08D05	B	Delta	8D05B	
	08D05	R	Delta	8D05R	
	08D05	N	Delta	8D05N	
	08D05	G	Delta	8D05G	
	08D05	M	Delta	8D05M	
	08D05	S	Delta	8D05S	
	08D05	T	Delta	8D05T	
	08D05	U	Delta	8D05U	
Unknown status/Other codes not applicable	08D06		Delta	8D06	
	08D06	C	Delta	8D06C	
	08D06	B	Delta	8D06B	
	08D06	R	Delta	8D06R	
	08D06	N	Delta	8D06N	
	08D06	G	Delta	8D06G	
	08D06	M	Delta	8D06M	
	08D06	S	Delta	8D06S	
	08D06	T	Delta	8D06T	
	08D06	U	Delta	8D06U	
9. Cardiac or Respiratory Arrest / Death					
EXPECTED DEATH unquestionable (x through z)	09O01	x	Omega	9O01x	
	09O01	y	Omega	9O01y	
	09O01	z	Omega	9O01z	
Override	09B00	x	Bravo	9B00x	
	09B00	y	Bravo	9B00y	
	09B00	z	Bravo	9B00z	
OBVIOUS DEATH unquestionable (a through h)	09B01	a	Bravo	9B01a	
	09B01	b	Bravo	9B01b	
	09B01	c	Bravo	9B01c	
	09B01	d	Bravo	9B01d	
	09B01	e	Bravo	9B01e	
	09B01	f	Bravo	9B01f	
	09B01	g	Bravo	9B01g	
	09B01	h	Bravo	9B01h	
Override	09D00		Delta	9D00	
	09D00	a	Delta	9D00a	
	09D00	b	Delta	9D00b	
	09D00	c	Delta	9D00c	
	09D00	d	Delta	9D00d	
	09D00	e	Delta	9D00e	
	09D00	f	Delta	9D00f	
	09D00	g	Delta	9D00g	
	09D00	h	Delta	9D00h	
	09D00	x	Delta	9D00x	
	09D00	y	Delta	9D00y	
	09D00	z	Delta	9D00z	
INEFFECTIVE BREATHING	09D01		Delta	9D01	
OBVIOUS or EXPECTED DEATH questionable (a through h; x through z)	09D02		Delta	9D02	

Suffix x - Terminal illness
Suffix y - DNR (Do Not Resuscitate) Order
Suffix z - Condition "z" (user-defined)
Suffix a - Cold and stiff in a warm environment
Suffix b - Decapitation
Suffix c - Decomposition
Suffix d - Incineration
Suffix e - NON-RECENT death
Suffix f - Severe injuries obviously incompatible with life
Suffix g - Condition "g" (user-defined)
Suffix h - Condition "h" (user-defined)

	09D02	a	Delta	9D02a	
	09D02	b	Delta	9D02b	
	09D02	c	Delta	9D02c	
	09D02	d	Delta	9D02d	
	09D02	e	Delta	9D02e	
	09D02	f	Delta	9D02f	
	09D02	g	Delta	9D02g	
	09D02	h	Delta	9D02h	
	09D02	x	Delta	9D02x	
	09D02	y	Delta	9D02y	
	09D02	z	Delta	9D02z	
Override	09E00		Echo	9E00	
	09E00	a	Echo	9E00a	
	09E00	b	Echo	9E00b	
	09E00	c	Echo	9E00c	
	09E00	d	Echo	9E00d	
	09E00	e	Echo	9E00e	
	09E00	f	Echo	9E00f	
	09E00	g	Echo	9E00g	
	09E00	h	Echo	9E00h	
	09E00	x	Echo	9E00x	
	09E00	y	Echo	9E00y	
	09E00	z	Echo	9E00z	
Not breathing at all	09E01		Echo	9E01	
UNCERTAIN BREATHING	09E02		Echo	9E02	
Hanging	09E03		Echo	9E03	
Strangulation	09E04		Echo	9E04	
Suffocation	09E05		Echo	9E05	
10. Chest Pain / Chest Discomfort (Non-Traumatic)					
Breathing normally < 35	10A01		Alpha	10A01	
Override	10C00		Charlie	10C00	
Abnormal breathing	10C01		Charlie	10C01	
Cocaine	10C02		Charlie	10C02	
Breathing normally ≥ 35	10C03		Charlie	10C03	
Override	10D00		Delta	10D00	
Not alert	10D01		Delta	10D01	
DIFFICULTY SPEAKING BETWEEN BREATHS	10D02		Delta	10D02	
CHANGING COLOR	10D03		Delta	10D03	
Clammy or cold sweats	10D04		Delta	10D04	
Heart attack or angina history	10D05		Delta	10D05	
11. Choking					
Not choking now (can talk or cry, is alert and breathing normally)	11A01	F	Alpha	11A01F	
	11A01	O	Alpha	11A01O	
	11A01	C	Alpha	11A01C	
	11A01	M	Alpha	11A01M	
	11A01	U	Alpha	11A01U	
Override	11D00	F	Delta	11D00F	
	11D00	O	Delta	11D00O	
	11D00	C	Delta	11D00C	
	11D00	M	Delta	11D00M	
	11D00	U	Delta	11D00U	
Abnormal breathing (PARTIAL obstruction)	11D01	F	Delta	11D01F	
	11D01	O	Delta	11D01O	
	11D01	C	Delta	11D01C	
	11D01	M	Delta	11D01M	
	11D01	U	Delta	11D01U	
Not alert	11D02	F	Delta	11D02F	
	11D02	O	Delta	11D02O	
	11D02	C	Delta	11D02C	
	11D02	M	Delta	11D02M	
	11D02	U	Delta	11D02U	
Override	11E00	F	Echo	11E00F	
	11E00	O	Echo	11E00O	
	11E00	C	Echo	11E00C	
	11E00	M	Echo	11E00M	
	11E00	U	Echo	11E00U	

Suffix F - Food
Suffix O - Object/Toy
Suffix C - Candy/Sweets/Gum
Suffix M - Milk/Liquid (non-toxic)
Suffix U - Unknown

COMPLETE obstruction/INEFFECTIVE BREATHING	11E01		Echo	11E01	
	11E01	F	Echo	11E01F	
	11E01	O	Echo	11E01O	
	11E01	C	Echo	11E01C	
	11E01	M	Echo	11E01M	
	11E01	U	Echo	11E01U	
12. Convulsions / Seizures					
Not seizing now and effective breathing verified (known seizure disorder)	12A01	E	Alpha	12A01E	
Not seizing now and effective breathing verified (seizure disorder unknown)	12A02		Alpha	12A02	
Not seizing now and effective breathing verified (≤ 6, confirmed no seizure disorder)	12A03		Alpha	12A03	
FOCAL/ABSENCE seizure (alert)	12A04		Alpha	12A04	
	12A04	E	Alpha	12A04E	
Impending seizure (aura)	12A05		Alpha	12A05	
	12A05	E	Alpha	12A05E	
Override	12B00		Bravo	12B00	
	12B00	E	Bravo	12B00E	
Effective breathing not verified < 35	12B01		Bravo	12B01	
	12B01	E	Bravo	12B01E	
Override	12C00		Charlie	12C00	
	12C00	E	Charlie	12C00E	
FOCAL/ABSENCE seizure (not alert)	12C01		Charlie	12C01	
	12C01	E	Charlie	12C01E	
Pregnancy	12C02		Charlie	12C02	
	12C02	E	Charlie	12C02E	
Diabetic	12C03		Charlie	12C03	
	12C03	E	Charlie	12C03E	
Not seizing now and effective breathing verified (> 6, confirmed no seizure disorder)	12C04		Charlie	12C04	
History of STROKE or brain tumor	12C05		Charlie	12C05	
	12C05	E	Charlie	12C05E	
OVERDOSE/POISONING (ingestion)	12C06		Charlie	12C06	
	12C06	E	Charlie	12C06E	
ATYPICAL seizure	12C07		Charlie	12C07	
	12C07	E	Charlie	12C07E	
Override	12D00		Delta	12D00	
	12D00	E	Delta	12D00E	
Not breathing (after Key Questioning)	12D01		Delta	12D01	
	12D01	E	Delta	12D01E	
CONTINUOUS or MULTIPLE seizures	12D02		Delta	12D02	
	12D02	E	Delta	12D02E	
AGONAL/INEFFECTIVE BREATHING	12D03		Delta	12D03	
	12D03	E	Delta	12D03E	
Effective breathing not verified ≥ 35	12D04		Delta	12D04	
	12D04	E	Delta	12D04E	
13. Diabetic Problems					
Alert and behaving normally	13A01		Alpha	13A01	
Override	13C00		Charlie	13C00	
	13C00	C	Charlie	13C00C	
Not alert	13C01		Charlie	13C01	
	13C01	C	Charlie	13C01C	
Abnormal behavior	13C02		Charlie	13C02	
	13C02	C	Charlie	13C02C	
Abnormal breathing	13C03		Charlie	13C03	
	13C03	C	Charlie	13C03C	
Override	13D00		Delta	13D00	
	13D00	C	Delta	13D00C	
Unconscious	13D01		Delta	13D01	
	13D01	C	Delta	13D01C	
14. Drowning / Near Drowning / Diving / SCUBA Accident					
Alert and breathing normally (no injuries and out of water)	14A01		Alpha	14A01	
	14A01	D	Alpha	14A01D	
	14A01	F	Alpha	14A01F	
	14A01	I	Alpha	14A01I	
	14A01	S	Alpha	14A01S	
	14A01	W	Alpha	14A01W	

Suffix E - Epileptic or Previous seizure diagnosis

Suffix C - Combative or aggressive

Suffix D - DIVING injury (not underwater)
Suffix F - Floodwater rescue
Suffix I - Ice rescue
Suffix S - SCUBA accident (not underwater)
Suffix W - SWIFT water rescue

Override	14B00		Bravo	14B00	
	14B00	D	Bravo	14B00D	
	14B00	F	Bravo	14B00F	
	14B00	I	Bravo	14B00I	
	14B00	S	Bravo	14B00S	
	14B00	W	Bravo	14B00W	
Alert and breathing normally (injuries or in water)	14B01		Bravo	14B01	
	14B01	D	Bravo	14B01D	
	14B01	F	Bravo	14B01F	
	14B01	I	Bravo	14B01I	
	14B01	S	Bravo	14B01S	
	14B01	W	Bravo	14B01W	
OBVIOUS DEATH (submersion ≥ 6hrs)	14B02		Bravo	14B02	
Unknown status/Other codes not applicable	14B03		Bravo	14B03	
Override	14C00		Charlie	14C00	
	14C00	D	Charlie	14C00D	
	14C00	F	Charlie	14C00F	
	14C00	I	Charlie	14C00I	
	14C00	S	Charlie	14C00S	
	14C00	W	Charlie	14C00W	
Alert with abnormal breathing	14C01		Charlie	14C01	
	14C01	D	Charlie	14C01D	
	14C01	F	Charlie	14C01F	
	14C01	I	Charlie	14C01I	
	14C01	S	Charlie	14C01S	
	14C01	W	Charlie	14C01W	
Override	14D00		Delta	14D00	
	14D00	D	Delta	14D00D	
	14D00	F	Delta	14D00F	
	14D00	I	Delta	14D00I	
	14D00	S	Delta	14D00S	
	14D00	W	Delta	14D00W	
Unconscious	14D01		Delta	14D01	
	14D01	D	Delta	14D01D	
	14D01	F	Delta	14D01F	
	14D01	I	Delta	14D01I	
	14D01	S	Delta	14D01S	
	14D01	W	Delta	14D01W	
Underwater (SPECIALIZED rescue)	14D02		Delta	14D02	
Stranded (SPECIALIZED rescue)	14D03		Delta	14D03	
	14D03	D	Delta	14D03D	
	14D03	F	Delta	14D03F	
	14D03	I	Delta	14D03I	
	14D03	S	Delta	14D03S	
	14D03	W	Delta	14D03W	
Just resuscitated and/or defibrillated (external)	14D04		Delta	14D04	
	14D04	D	Delta	14D04D	
	14D04	F	Delta	14D04F	
	14D04	I	Delta	14D04I	
	14D04	S	Delta	14D04S	
	14D04	W	Delta	14D04W	
Not alert	14D05		Delta	14D05	
	14D05	D	Delta	14D05D	
	14D05	F	Delta	14D05F	
	14D05	I	Delta	14D05I	
	14D05	S	Delta	14D05S	
	14D05	W	Delta	14D05W	
Suspected neck injury	14D06		Delta	14D06	
	14D06	D	Delta	14D06D	
	14D06	F	Delta	14D06F	
	14D06	I	Delta	14D06I	
	14D06	S	Delta	14D06S	
	14D06	W	Delta	14D06W	
Override	14E00		Echo	14E00	
	14E00	D	Echo	14E00D	
	14E00	F	Echo	14E00F	
	14E00	I	Echo	14E00I	
	14E00	S	Echo	14E00S	

	14E00	W	Echo	14E00W	
Arrest (out of water)	14E01		Echo	14E01	
	14E01	D	Echo	14E01D	
	14E01	F	Echo	14E01F	
	14E01	I	Echo	14E01I	
	14E01	S	Echo	14E01S	
	14E01	W	Echo	14E01W	
Underwater (DOMESTIC rescue)	14E02		Echo	14E02	
15. Electrocution / Lightning					
Alert and breathing normally	15C01	E	Charlie	15C01E	
	15C01	L	Charlie	15C01L	
Override	15D00	E	Delta	15D00E	
	15D00	L	Delta	15D00L	
Multiple victims	15D01	E	Delta	15D01E	
	15D01	L	Delta	15D01L	
Unconscious	15D02	E	Delta	15D02E	
	15D02	L	Delta	15D02L	
Not disconnected from power	15D03	E	Delta	15D03E	
Power not off or hazard present	15D04	E	Delta	15D04E	
EXTREME FALL (≥ 30ft/10m)	15D05	E	Delta	15D05E	
	15D05	L	Delta	15D05L	
LONG FALL	15D06	E	Delta	15D06E	
	15D06	L	Delta	15D06L	
Not alert	15D07	E	Delta	15D07E	
	15D07	L	Delta	15D07L	
Abnormal breathing	15D08	E	Delta	15D08E	
	15D08	L	Delta	15D08L	
Unknown status/Other codes not applicable	15D09	E	Delta	15D09E	
	15D09	L	Delta	15D09L	
Override	15E00	E	Echo	15E00E	
	15E00	L	Echo	15E00L	
NOT BREATHING/INEFFECTIVE BREATHING	15E01	E	Echo	15E01E	
	15E01	L	Echo	15E01L	
16. Eye Problems / Injuries					
MODERATE eye injuries	16A01		Alpha	16A01	
MINOR eye injuries	16A02		Alpha	16A02	
MEDICAL eye problems	16A03		Alpha	16A03	
Override	16B00		Bravo	16B00	
SEVERE eye injuries	16B01		Bravo	16B01	
Override	16D00		Delta	16D00	
Not alert	16D01		Delta	16D01	
17. Falls					
Marked (*) NOT DANGEROUS body area with deformity	17A01		Alpha	17A01	
	17A01	A	Alpha	17A01A	
	17A01	E	Alpha	17A01E	
	17A01	G	Alpha	17A01G	
	17A01	J	Alpha	17A01J	
	17A01	P	Alpha	17A01P	
NOT DANGEROUS body area	17A02		Alpha	17A02	
	17A02	A	Alpha	17A02A	
	17A02	E	Alpha	17A02E	
	17A02	G	Alpha	17A02G	
	17A02	J	Alpha	17A02J	
	17A02	P	Alpha	17A02P	
NON-RECENT (≥ 6hrs) injuries (without priority symptoms)	17A03		Alpha	17A03	
	17A03	A	Alpha	17A03A	
	17A03	E	Alpha	17A03E	
	17A03	G	Alpha	17A03G	
	17A03	J	Alpha	17A03J	
	17A03	P	Alpha	17A03P	
PUBLIC ASSIST (no injuries and no priority symptoms)	17A04		Alpha	17A04	
	17A04	A	Alpha	17A04A	
	17A04	E	Alpha	17A04E	
	17A04	G	Alpha	17A04G	
	17A04	J	Alpha	17A04J	

Suffix E - Electrocution
Suffix L - Lightning

Suffix A - Accessibility concerns/difficulty
Suffix E - Environmental problems (rain, heat, cold)
Suffix G - On the ground or floor
Suffix J - Jumper (suicide attempt)
Suffix P - Public place (street, parking garage, market)

	17A04	P	Alpha	17A04P	
Override	17B00		Bravo	17B00	
	17B00	A	Bravo	17B00A	
	17B00	E	Bravo	17B00E	
	17B00	G	Bravo	17B00G	
	17B00	J	Bravo	17B00J	
	17B00	P	Bravo	17B00P	
POSSIBLY DANGEROUS body area	17B01		Bravo	17B01	
	17B01	A	Bravo	17B01A	
	17B01	E	Bravo	17B01E	
	17B01	G	Bravo	17B01G	
	17B01	J	Bravo	17B01J	
	17B01	P	Bravo	17B01P	
SERIOUS hemorrhage	17B02		Bravo	17B02	
	17B02	A	Bravo	17B02A	
	17B02	E	Bravo	17B02E	
	17B02	G	Bravo	17B02G	
	17B02	J	Bravo	17B02J	
	17B02	P	Bravo	17B02P	
Unknown status/Other codes not applicable	17B03		Bravo	17B03	
	17B03	A	Bravo	17B03A	
	17B03	E	Bravo	17B03E	
	17B03	G	Bravo	17B03G	
	17B03	J	Bravo	17B03J	
	17B03	P	Bravo	17B03P	
Override	17D00		Delta	17D00	
	17D00	A	Delta	17D00A	
	17D00	E	Delta	17D00E	
	17D00	G	Delta	17D00G	
	17D00	J	Delta	17D00J	
	17D00	P	Delta	17D00P	
EXTREME FALL (≥ 30ft/10m)	17D01		Delta	17D01	
	17D01	A	Delta	17D01A	
	17D01	E	Delta	17D01E	
	17D01	G	Delta	17D01G	
	17D01	J	Delta	17D01J	
	17D01	P	Delta	17D01P	
Arrest	17D02		Delta	17D02	
	17D02	A	Delta	17D02A	
	17D02	E	Delta	17D02E	
	17D02	G	Delta	17D02G	
	17D02	J	Delta	17D02J	
	17D02	P	Delta	17D02P	
Unconscious	17D03		Delta	17D03	
	17D03	A	Delta	17D03A	
	17D03	E	Delta	17D03E	
	17D03	G	Delta	17D03G	
	17D03	J	Delta	17D03J	
	17D03	P	Delta	17D03P	
Not alert	17D04		Delta	17D04	
	17D04	A	Delta	17D04A	
	17D04	E	Delta	17D04E	
	17D04	G	Delta	17D04G	
	17D04	J	Delta	17D04J	
	17D04	P	Delta	17D04P	
Chest or Neck injury (with difficulty breathing)	17D05		Delta	17D05	
	17D05	A	Delta	17D05A	
	17D05	E	Delta	17D05E	
	17D05	G	Delta	17D05G	
	17D05	J	Delta	17D05J	
	17D05	P	Delta	17D05P	
LONG FALL	17D06		Delta	17D06	
	17D06	A	Delta	17D06A	
	17D06	E	Delta	17D06E	
	17D06	G	Delta	17D06G	
	17D06	J	Delta	17D06J	
	17D06	P	Delta	17D06P	

18. Headache					
Breathing normally	18A01		Alpha	18A01	
Override	18B00		Bravo	18B00	
Unknown status/Other codes not applicable	18B01		Bravo	18B01	
Override	18C00		Charlie	18C00	
	18C00	C	Charlie	18C00C	
	18C00	D	Charlie	18C00D	
	18C00	E	Charlie	18C00E	
	18C00	F	Charlie	18C00F	
	18C00	G	Charlie	18C00G	
	18C00	H	Charlie	18C00H	
	18C00	I	Charlie	18C00I	
	18C00	J	Charlie	18C00J	
	18C00	K	Charlie	18C00K	
	18C00	L	Charlie	18C00L	
	18C00	M	Charlie	18C00M	
	18C00	U	Charlie	18C00U	
	18C00	X	Charlie	18C00X	
	18C00	Y	Charlie	18C00Y	
	18C00	Z	Charlie	18C00Z	
Not alert	18C01		Charlie	18C01	
	18C01	C	Charlie	18C01C	
	18C01	D	Charlie	18C01D	
	18C01	E	Charlie	18C01E	
	18C01	F	Charlie	18C01F	
	18C01	G	Charlie	18C01G	
	18C01	H	Charlie	18C01H	
	18C01	I	Charlie	18C01I	
	18C01	J	Charlie	18C01J	
	18C01	K	Charlie	18C01K	
	18C01	L	Charlie	18C01L	
	18C01	M	Charlie	18C01M	
	18C01	U	Charlie	18C01U	
	18C01	X	Charlie	18C01X	
	18C01	Y	Charlie	18C01Y	
	18C01	Z	Charlie	18C01Z	
Abnormal breathing	18C02		Charlie	18C02	
	18C02	C	Charlie	18C02C	
	18C02	D	Charlie	18C02D	
	18C02	E	Charlie	18C02E	
	18C02	F	Charlie	18C02F	
	18C02	G	Charlie	18C02G	
	18C02	H	Charlie	18C02H	
	18C02	I	Charlie	18C02I	
	18C02	J	Charlie	18C02J	
	18C02	K	Charlie	18C02K	
	18C02	L	Charlie	18C02L	
	18C02	M	Charlie	18C02M	
	18C02	U	Charlie	18C02U	
	18C02	X	Charlie	18C02X	
	18C02	Y	Charlie	18C02Y	
	18C02	Z	Charlie	18C02Z	
Speech problems	18C03	C	Charlie	18C03C	
	18C03	D	Charlie	18C03D	
	18C03	E	Charlie	18C03E	
	18C03	F	Charlie	18C03F	
	18C03	G	Charlie	18C03G	
	18C03	H	Charlie	18C03H	
	18C03	I	Charlie	18C03I	
	18C03	J	Charlie	18C03J	
	18C03	K	Charlie	18C03K	
	18C03	L	Charlie	18C03L	
	18C03	M	Charlie	18C03M	
	18C03	U	Charlie	18C03U	
	18C03	X	Charlie	18C03X	
	18C03	Y	Charlie	18C03Y	
	18C03	Z	Charlie	18C03Z	

Suffix C - PARTIAL evidence of stroke (< T hours)
Suffix D - PARTIAL evidence of stroke (≥ T hours)
Suffix E - PARTIAL evidence of stroke (Unknown hours)
Suffix F - STRONG evidence of stroke (< T hours)
Suffix G - Greater than "T" hours since the symptoms started
Suffix H - STRONG evidence of stroke (≥ T hours)
Suffix I - STRONG evidence of stroke (Unknown hours)
Suffix J - CLEAR evidence of stroke (< T hours)
Suffix K - CLEAR evidence of stroke (≥ T hours)
Suffix L - Less than "T" hours since the symptoms started
Suffix M - CLEAR evidence of stroke (Unknown hours)
Suffix U - Unknown when the symptoms started
Suffix X - No test evidence of stroke (< T hours)
Suffix Y - No test evidence of stroke (≥ T hours)
Suffix Z - No test evidence of stroke (Unknown hours)

Sudden onset of severe pain	18C04	C	Charlie	18C04C	
	18C04	D	Charlie	18C04D	
	18C04	E	Charlie	18C04E	
	18C04	F	Charlie	18C04F	
	18C04	G	Charlie	18C04G	
	18C04	H	Charlie	18C04H	
	18C04	I	Charlie	18C04I	
	18C04	J	Charlie	18C04J	
	18C04	K	Charlie	18C04K	
	18C04	L	Charlie	18C04L	
	18C04	M	Charlie	18C04M	
	18C04	U	Charlie	18C04U	
	18C04	X	Charlie	18C04X	
	18C04	Y	Charlie	18C04Y	
	18C04	Z	Charlie	18C04Z	
Numbness	18C05	C	Charlie	18C05C	
	18C05	D	Charlie	18C05D	
	18C05	E	Charlie	18C05E	
	18C05	F	Charlie	18C05F	
	18C05	G	Charlie	18C05G	
	18C05	H	Charlie	18C05H	
	18C05	I	Charlie	18C05I	
	18C05	J	Charlie	18C05J	
	18C05	K	Charlie	18C05K	
	18C05	L	Charlie	18C05L	
	18C05	M	Charlie	18C05M	
	18C05	U	Charlie	18C05U	
	18C05	X	Charlie	18C05X	
	18C05	Y	Charlie	18C05Y	
	18C05	Z	Charlie	18C05Z	
Paralysis	18C06	C	Charlie	18C06C	
	18C06	D	Charlie	18C06D	
	18C06	E	Charlie	18C06E	
	18C06	F	Charlie	18C06F	
	18C06	G	Charlie	18C06G	
	18C06	H	Charlie	18C06H	
	18C06	I	Charlie	18C06I	
	18C06	J	Charlie	18C06J	
	18C06	K	Charlie	18C06K	
	18C06	L	Charlie	18C06L	
	18C06	M	Charlie	18C06M	
	18C06	U	Charlie	18C06U	
	18C06	X	Charlie	18C06X	
	18C06	Y	Charlie	18C06Y	
	18C06	Z	Charlie	18C06Z	
Change in behavior (≤ 3hrs)	18C07	C	Charlie	18C07C	
	18C07	D	Charlie	18C07D	
	18C07	E	Charlie	18C07E	
	18C07	F	Charlie	18C07F	
	18C07	G	Charlie	18C07G	
	18C07	H	Charlie	18C07H	
	18C07	I	Charlie	18C07I	
	18C07	J	Charlie	18C07J	
	18C07	K	Charlie	18C07K	
	18C07	L	Charlie	18C07L	
	18C07	M	Charlie	18C07M	
	18C07	U	Charlie	18C07U	
	18C07	X	Charlie	18C07X	
	18C07	Y	Charlie	18C07Y	
	18C07	Z	Charlie	18C07Z	
19. Heart Problems / A.I.C.D.					
Heart rate ≥ 50 bpm and < 130 bpm (without priority symptoms)	19A01		Alpha	19A01	
Chest pain/discomfort < 35 (without priority symptoms)	19A02		Alpha	19A02	
Override	19C00		Charlie	19C00	
Firing of A.I.C.D.	19C01		Charlie	19C01	
Abnormal breathing	19C02		Charlie	19C02	
Chest pain/discomfort ≥ 35	19C03		Charlie	19C03	

Cardiac history	19C04		Charlie	19C04	
Cocaine	19C05		Charlie	19C05	
Heart rate < 50 bpm or ≥ 130 bpm (without priority symptoms)	19C06		Charlie	19C06	
Unknown status/Other codes not applicable	19C07		Charlie	19C07	
Override	19D00		Delta	19D00	
Not alert	19D01		Delta	19D01	
DIFFICULTY SPEAKING BETWEEN BREATHS	19D02		Delta	19D02	
CHANGING COLOR	19D03		Delta	19D03	
Clammy or cold sweats	19D04		Delta	19D04	
Just resuscitated and/or defibrillated (external)	19D05		Delta	19D05	
20. Heat / Cold Exposure					
Alert	20A01	H	Alpha	20A01H	
	20A01	C	Alpha	20A01C	
Override	20B00	H	Bravo	20B00H	
	20B00	C	Bravo	20B00C	
Change in skin color	20B01	H	Bravo	20B01H	
	20B01	C	Bravo	20B01C	
Unknown status/Other codes not applicable	20B02	H	Bravo	20B02H	
	20B02	C	Bravo	20B02C	
Override	20C00	H	Charlie	20C00H	
	20C00	C	Charlie	20C00C	
Heart attack or angina history	20C01	H	Charlie	20C01H	
	20C01	C	Charlie	20C01C	
Override	20D00	H	Delta	20D00H	
	20D00	C	Delta	20D00C	
Not alert	20D01	H	Delta	20D01H	
	20D01	C	Delta	20D01C	
Multiple victims (with priority symptoms)	20D02	H	Delta	20D02H	
	20D02	C	Delta	20D02C	
21. Hemorrhage / Lacerations					
NOT DANGEROUS hemorrhage	21A01	M	Alpha	21A01M	
	21A01	T	Alpha	21A01T	
MINOR hemorrhage	21A02	M	Alpha	21A02M	
	21A02	T	Alpha	21A02T	
Override	21B00	M	Bravo	21B00M	
	21B00	T	Bravo	21B00T	
POSSIBLY DANGEROUS hemorrhage	21B01	M	Bravo	21B01M	
	21B01	T	Bravo	21B01T	
SERIOUS hemorrhage	21B02	M	Bravo	21B02M	
	21B02	T	Bravo	21B02T	
Bleeding disorder	21B03	M	Bravo	21B03M	
	21B03	T	Bravo	21B03T	
Blood thinners	21B04	M	Bravo	21B04M	
	21B04	T	Bravo	21B04T	
Override	21C00	M	Charlie	21C00M	
	21C00	T	Charlie	21C00T	
Hemorrhage through TUBES	21C01	M	Charlie	21C01M	
	21C01	T	Charlie	21C01T	
Hemorrhage of dialysis fistula	21C02	M	Charlie	21C02M	
	21C02	T	Charlie	21C02T	
Hemorrhage from varicose veins	21C03	M	Charlie	21C03M	
	21C03	T	Charlie	21C03T	
Override	21D00	M	Delta	21D00M	
	21D00	T	Delta	21D00T	
Arrest	21D01	M	Delta	21D01M	
	21D01	T	Delta	21D01T	
Unconscious	21D02	M	Delta	21D02M	
	21D02	T	Delta	21D02T	
Not alert	21D03	M	Delta	21D03M	
	21D03	T	Delta	21D03T	
DANGEROUS hemorrhage	21D04	M	Delta	21D04M	
	21D04	T	Delta	21D04T	
Abnormal breathing	21D05	M	Delta	21D05M	
	21D05	T	Delta	21D05T	
22. Inaccessible Incident / Other Entrapments (Non-Traffic)					

Suffix H - Heat exposure
Suffix C - Cold exposure

Suffix M - MEDICAL
Suffix T - TRAUMA

Suffix A - Above ground

No longer trapped (no injuries)	22A01		Alpha	22A01	
	22A01	A	Alpha	22A01A	
	22A01	B	Alpha	22A01B	
	22A01	M	Alpha	22A01M	
	22A01	X	Alpha	22A01X	
	22A01	Y	Alpha	22A01Y	
Override	22B00		Bravo	22B00	
	22B00	A	Bravo	22B00A	
	22B00	B	Bravo	22B00B	
	22B00	M	Bravo	22B00M	
	22B00	X	Bravo	22B00X	
	22B00	Y	Bravo	22B00Y	
No longer trapped (unknown injuries)	22B01		Bravo	22B01	
	22B01	A	Bravo	22B01A	
	22B01	B	Bravo	22B01B	
	22B01	M	Bravo	22B01M	
	22B01	X	Bravo	22B01X	
	22B01	Y	Bravo	22B01Y	
PERIPHERAL ENTRAPMENT only	22B02		Bravo	22B02	
	22B02	A	Bravo	22B02A	
	22B02	B	Bravo	22B02B	
	22B02	M	Bravo	22B02M	
	22B02	X	Bravo	22B02X	
	22B02	Y	Bravo	22B02Y	
Unknown status (investigation)/Other codes not applicable	22B03		Bravo	22B03	
	22B03	A	Bravo	22B03A	
	22B03	B	Bravo	22B03B	
	22B03	M	Bravo	22B03M	
	22B03	X	Bravo	22B03X	
	22B03	Y	Bravo	22B03Y	
Override	22D00		Delta	22D00	
	22D00	A	Delta	22D00A	
	22D00	B	Delta	22D00B	
	22D00	M	Delta	22D00M	
	22D00	X	Delta	22D00X	
	22D00	Y	Delta	22D00Y	
Mechanical/Machinery/Object ENTRAPMENT	22D01		Delta	22D01	
	22D01	A	Delta	22D01A	
	22D01	B	Delta	22D01B	
	22D01	M	Delta	22D01M	
	22D01	X	Delta	22D01X	
	22D01	Y	Delta	22D01Y	
Trench collapse	22D02		Delta	22D02	
	22D02	A	Delta	22D02A	
	22D02	B	Delta	22D02B	
	22D02	M	Delta	22D02M	
	22D02	X	Delta	22D02X	
	22D02	Y	Delta	22D02Y	
Structure collapse	22D03		Delta	22D03	
	22D03	A	Delta	22D03A	
	22D03	B	Delta	22D03B	
	22D03	M	Delta	22D03M	
	22D03	X	Delta	22D03X	
	22D03	Y	Delta	22D03Y	
Confined space ENTRAPMENT	22D04		Delta	22D04	
	22D04	A	Delta	22D04A	
	22D04	B	Delta	22D04B	
	22D04	M	Delta	22D04M	
	22D04	X	Delta	22D04X	
	22D04	Y	Delta	22D04Y	
Inaccessible terrain situation	22D05		Delta	22D05	
	22D05	A	Delta	22D05A	
	22D05	B	Delta	22D05B	
	22D05	M	Delta	22D05M	
	22D05	X	Delta	22D05X	
	22D05	Y	Delta	22D05Y	
Mudslide/Avalanche	22D06		Delta	22D06	
	22D06	A	Delta	22D06A	

Suffix B - Below ground
Suffix M - Multiple victims
Suffix X - Both Above ground and Multiple victims
Suffix Y - Both Below ground and Multiple victims

	22D06	B	Delta	22D06B	
	22D06	M	Delta	22D06M	
	22D06	X	Delta	22D06X	
	22D06	Y	Delta	22D06Y	
23. Overdose / Poisoning (Ingestion)					
POISONING (without priority symptoms)	23O01		Omega	23O01	
	23O01	A	Omega	23O01A	
	23O01	I	Omega	23O01I	
	23O01	V	Omega	23O01V	
	23O01	W	Omega	23O01W	
Override	23B00		Bravo	23B00	
	23B00	A	Bravo	23B00A	
	23B00	I	Bravo	23B00I	
	23B00	V	Bravo	23B00V	
	23B00	W	Bravo	23B00W	
OVERDOSE (without priority symptoms)	23B01		Bravo	23B01	
	23B01	A	Bravo	23B01A	
	23B01	I	Bravo	23B01I	
	23B01	V	Bravo	23B01V	
	23B01	W	Bravo	23B01W	
Override	23C00		Charlie	23C00	
	23C00	A	Charlie	23C00A	
	23C00	I	Charlie	23C00I	
	23C00	V	Charlie	23C00V	
	23C00	W	Charlie	23C00W	
Not alert	23C01		Charlie	23C01	
	23C01	A	Charlie	23C01A	
	23C01	I	Charlie	23C01I	
	23C01	V	Charlie	23C01V	
	23C01	W	Charlie	23C01W	
Abnormal breathing	23C02		Charlie	23C02	
	23C02	A	Charlie	23C02A	
	23C02	I	Charlie	23C02I	
	23C02	V	Charlie	23C02V	
	23C02	W	Charlie	23C02W	
Antidepressants (tricyclic)	23C03		Charlie	23C03	
	23C03	A	Charlie	23C03A	
	23C03	I	Charlie	23C03I	
	23C03	V	Charlie	23C03V	
	23C03	W	Charlie	23C03W	
Cocaine, methamphetamine (or derivatives)	23C04		Charlie	23C04	
	23C04	A	Charlie	23C04A	
	23C04	I	Charlie	23C04I	
	23C04	V	Charlie	23C04V	
	23C04	W	Charlie	23C04W	
Narcotics (heroin, morphine, methadone, OxyContin, etc.)	23C05		Charlie	23C05	
	23C05	A	Charlie	23C05A	
	23C05	I	Charlie	23C05I	
	23C05	V	Charlie	23C05V	
	23C05	W	Charlie	23C05W	
Acid or alkali (lye)	23C06		Charlie	23C06	
	23C06	A	Charlie	23C06A	
	23C06	I	Charlie	23C06I	
	23C06	V	Charlie	23C06V	
	23C06	W	Charlie	23C06W	
Unknown status/Other codes not applicable	23C07		Charlie	23C07	
	23C07	A	Charlie	23C07A	
	23C07	I	Charlie	23C07I	
	23C07	V	Charlie	23C07V	
	23C07	W	Charlie	23C07W	
Poison Control request for response	23C08		Charlie	23C08	
	23C08	A	Charlie	23C08A	
	23C08	I	Charlie	23C08I	
	23C08	V	Charlie	23C08V	
	23C08	W	Charlie	23C08W	
Override	23D00		Delta	23D00	
	23D00	A	Delta	23D00A	

Suffix A - Accidental
Suffix I - Intentional
Suffix V - Violent or combative
Suffix W - Weapons

	23D00	I	Delta	23D00I	
	23D00	V	Delta	23D00V	
	23D00	W	Delta	23D00W	
Unconscious	23D01		Delta	23D01	
	23D01	A	Delta	23D01A	
	23D01	I	Delta	23D01I	
	23D01	V	Delta	23D01V	
	23D01	W	Delta	23D01W	
CHANGING COLOR	23D02		Delta	23D02	
	23D02	A	Delta	23D02A	
	23D02	I	Delta	23D02I	
	23D02	V	Delta	23D02V	
	23D02	W	Delta	23D02W	
24. Pregnancy / Childbirth / Miscarriage					Suffix M - Multiple birth
Waters broken (no contractions or presenting parts)	24O01		Omega	24O01	
	24O01	M	Omega	24O01M	
Override	24A00		Alpha	24A00	
	24A00	M	Alpha	24A00M	
1st TRIMESTER hemorrhage or MISCARRIAGE	24A01		Alpha	24A01	
	24A01	M	Alpha	24A01M	
Override	24B00		Bravo	24B00	
	24B00	M	Bravo	24B00M	
Labor (delivery not imminent, ≥ 6 months/24 weeks)	24B01		Bravo	24B01	
	24B01	M	Bravo	24B01M	
Unknown status/Other codes not applicable	24B02		Bravo	24B02	
	24B02	M	Bravo	24B02M	
Override	24C00		Charlie	24C00	
	24C00	M	Charlie	24C00M	
2nd TRIMESTER hemorrhage or MISCARRIAGE	24C01		Charlie	24C01	
	24C01	M	Charlie	24C01M	
1st TRIMESTER SERIOUS hemorrhage	24C02		Charlie	24C02	
	24C02	M	Charlie	24C02M	
Abdominal pain/cramping (< 6 months/24 weeks and no fetus or tissue)	24C03		Charlie	24C03	
	24C03	M	Charlie	24C03M	
Baby born (no complications)	24C04		Charlie	24C04	
	24C04	M	Charlie	24C04M	
Override	24D00		Delta	24D00	
	24D00	M	Delta	24D00M	
BREECH or CORD	24D01		Delta	24D01	
	24D01	M	Delta	24D01M	
Head visible/out	24D02		Delta	24D02	
	24D02	M	Delta	24D02M	
IMMINENT delivery (≥ 6 months/24 weeks)	24D03		Delta	24D03	
	24D03	M	Delta	24D03M	
3rd TRIMESTER hemorrhage	24D04		Delta	24D04	
	24D04	M	Delta	24D04M	
HIGH RISK complications	24D05		Delta	24D05	
	24D05	M	Delta	24D05M	
Baby born (complications with baby)	24D06		Delta	24D06	
	24D06	M	Delta	24D06M	
Baby born (complications with mother)	24D07		Delta	24D07	
	24D07	M	Delta	24D07M	
25. Psychiatric / Abnormal Behavior / Suicide Attempt					Suffix V - Violent Suffix W - Weapons Suffix B - Both Violent and Weapons
Non-suicidal and alert	25A01		Alpha	25A01	
	25A01	V	Alpha	25A01V	
	25A01	W	Alpha	25A01W	
	25A01	B	Alpha	25A01B	
Suicidal (not threatening) and alert	25A02		Alpha	25A02	
	25A02	V	Alpha	25A02V	
	25A02	W	Alpha	25A02W	
	25A02	B	Alpha	25A02B	
Override	25B00		Bravo	25B00	
	25B00	V	Bravo	25B00V	
	25B00	W	Bravo	25B00W	
	25B00	B	Bravo	25B00B	
SERIOUS hemorrhage	25B01		Bravo	25B01	

	25B01	V	Bravo	25B01V	
	25B01	W	Bravo	25B01W	
	25B01	B	Bravo	25B01B	
Non-SERIOUS or MINOR hemorrhage	25B02		Bravo	25B02	
	25B02	V	Bravo	25B02V	
	25B02	W	Bravo	25B02W	
	25B02	B	Bravo	25B02B	
THREATENING SUICIDE	25B03		Bravo	25B03	
	25B03	V	Bravo	25B03V	
	25B03	W	Bravo	25B03W	
	25B03	B	Bravo	25B03B	
Jumper (threatening)	25B04		Bravo	25B04	
	25B04	V	Bravo	25B04V	
	25B04	W	Bravo	25B04W	
	25B04	B	Bravo	25B04B	
Near hanging, strangulation, or suffocation (alert without difficulty breathing)	25B05		Bravo	25B05	
	25B05	V	Bravo	25B05V	
	25B05	W	Bravo	25B05W	
	25B05	B	Bravo	25B05B	
Unknown status/Other codes not applicable	25B06		Bravo	25B06	
	25B06	V	Bravo	25B06V	
	25B06	W	Bravo	25B06W	
	25B06	B	Bravo	25B06B	
Override	25D00		Delta	25D00	
	25D00	V	Delta	25D00V	
	25D00	W	Delta	25D00W	
	25D00	B	Delta	25D00B	
Not alert	25D01		Delta	25D01	
	25D01	V	Delta	25D01V	
	25D01	W	Delta	25D01W	
	25D01	B	Delta	25D01B	
DANGEROUS hemorrhage	25D02		Delta	25D02	
	25D02	V	Delta	25D02V	
	25D02	W	Delta	25D02W	
	25D02	B	Delta	25D02B	
Near hanging, strangulation, or suffocation (alert with difficulty breathing)	25D03		Delta	25D03	
	25D03	V	Delta	25D03V	
	25D03	W	Delta	25D03W	
	25D03	B	Delta	25D03B	
26. Sick Person (Specific Diagnosis)					
(THIS CODE NOT IN USE)	26O01		Omega	26O01	
Boils	26O02		Omega	26O02	
Bumps (non-traumatic)	26O03		Omega	26O03	
Can't sleep	26O04		Omega	26O04	
Can't urinate (without abdominal pain)	26O05		Omega	26O05	
Catheter (urinary – in/out without hemorrhaging)	26O06		Omega	26O06	
Constipation	26O07		Omega	26O07	
Cramps/Spasms/Joint pain (in extremities and non-traumatic)	26O08		Omega	26O08	
Cut-off ring request	26O09		Omega	26O09	
Deafness	26O10		Omega	26O10	
Defecation/Diarrhea	26O11		Omega	26O11	
Earache	26O12		Omega	26O12	
Enema	26O13		Omega	26O13	
Gout	26O14		Omega	26O14	
Hemorrhoids/Piles	26O15		Omega	26O15	
Hepatitis	26O16		Omega	26O16	
Hiccups	26O17		Omega	26O17	
Itching	26O18		Omega	26O18	
Nervous	26O19		Omega	26O19	
Object stuck (nose, ear, vagina, rectum, penis)	26O20		Omega	26O20	
Object swallowed (without choking or difficulty breathing, can talk)	26O21		Omega	26O21	
Painful urination	26O22		Omega	26O22	
Penis problems/pain	26O23		Omega	26O23	
Rash/Skin disorder (without difficulty breathing or swallowing)	26O24		Omega	26O24	
Sexually transmitted disease (STD)	26O25		Omega	26O25	
Sore throat (without difficulty breathing or swallowing)	26O26		Omega	26O26	
Toothache (without jaw pain)	26O27		Omega	26O27	

Wound infected (focal or surface)	26O28		Omega	26O28	
Override	26A00		Alpha	26A00	
No priority symptoms (complaint conditions 2–12 not identified)	26A01		Alpha	26A01	
Blood pressure abnormality (asymptomatic)	26A02		Alpha	26A02	
Dizziness/Vertigo	26A03		Alpha	26A03	
Fever/Chills	26A04		Alpha	26A04	
General weakness	26A05		Alpha	26A05	
Nausea	26A06		Alpha	26A06	
New onset of immobility	26A07		Alpha	26A07	
Other pain (non-OMEGA-level)	26A08		Alpha	26A08	
Transportation only	26A09		Alpha	26A09	
Unwell/Ill	26A10		Alpha	26A10	
Vomiting	26A11		Alpha	26A11	
Possible meningitis	26A12		Alpha	26A12	
Override	26B00		Bravo	26B00	
Unknown status/Other codes not applicable	26B01		Bravo	26B01	
Override	26C00		Charlie	26C00	
ALTERED LEVEL OF CONSCIOUSNESS	26C01		Charlie	26C01	
Abnormal breathing	26C02		Charlie	26C02	
Sickle cell crisis/Thalassemia	26C03		Charlie	26C03	
Autonomic dysreflexia/hyperreflexia	26C04		Charlie	26C04	
Override	26D00		Delta	26D00	
Not alert	26D01		Delta	26D01	
27. Stab / Gunshot / Penetrating Trauma					
NON-RECENT (≥ 6hrs) PERIPHERAL wounds (without priority symptoms)	27A01	S	Alpha	27A01S	
	27A01	G	Alpha	27A01G	
	27A01	P	Alpha	27A01P	
	27A01	I	Alpha	27A01I	
	27A01	X	Alpha	27A01X	
	27A01	Y	Alpha	27A01Y	
Override	27B00	S	Bravo	27B00S	
	27B00	G	Bravo	27B00G	
	27B00	P	Bravo	27B00P	
	27B00	I	Bravo	27B00I	
	27B00	X	Bravo	27B00X	
	27B00	Y	Bravo	27B00Y	
NON-RECENT (≥ 6hrs) single CENTRAL wound	27B01	S	Bravo	27B01S	
	27B01	G	Bravo	27B01G	
	27B01	P	Bravo	27B01P	
	27B01	I	Bravo	27B01I	
	27B01	X	Bravo	27B01X	
	27B01	Y	Bravo	27B01Y	
Known single PERIPHERAL wound	27B02	S	Bravo	27B02S	
	27B02	G	Bravo	27B02G	
	27B02	P	Bravo	27B02P	
	27B02	I	Bravo	27B02I	
	27B02	X	Bravo	27B02X	
	27B02	Y	Bravo	27B02Y	
SERIOUS hemorrhage	27B03	S	Bravo	27B03S	
	27B03	G	Bravo	27B03G	
	27B03	P	Bravo	27B03P	
	27B03	I	Bravo	27B03I	
	27B03	X	Bravo	27B03X	
	27B03	Y	Bravo	27B03Y	
Unknown status/Other codes not applicable	27B04	S	Bravo	27B04S	
	27B04	G	Bravo	27B04G	
	27B04	P	Bravo	27B04P	
	27B04	I	Bravo	27B04I	
	27B04	X	Bravo	27B04X	
	27B04	Y	Bravo	27B04Y	
OBVIOUS DEATH	27B05	S	Bravo	27B05S	
	27B05	G	Bravo	27B05G	
	27B05	P	Bravo	27B05P	
	27B05	I	Bravo	27B05I	
	27B05	X	Bravo	27B05X	
	27B05	Y	Bravo	27B05Y	
Override	27D00	S	Delta	27D00S	

Suffix S - Stab
Suffix G - Gunshot
Suffix P - Penetrating wound (not IMPALED now)
Suffix I - IMPALED currently
Suffix X - Self-inflicted GSW (intentional)
Suffix Y - Self-inflicted knife/stab wound (intentional)

	27D00	G	Delta	27D00G	
	27D00	P	Delta	27D00P	
	27D00	I	Delta	27D00I	
	27D00	X	Delta	27D00X	
	27D00	Y	Delta	27D00Y	
Arrest	27D01	S	Delta	27D01S	
	27D01	G	Delta	27D01G	
	27D01	P	Delta	27D01P	
	27D01	I	Delta	27D01I	
	27D01	X	Delta	27D01X	
	27D01	Y	Delta	27D01Y	
Unconscious	27D02	S	Delta	27D02S	
	27D02	G	Delta	27D02G	
	27D02	P	Delta	27D02P	
	27D02	I	Delta	27D02I	
	27D02	X	Delta	27D02X	
	27D02	Y	Delta	27D02Y	
Not alert	27D03	S	Delta	27D03S	
	27D03	G	Delta	27D03G	
	27D03	P	Delta	27D03P	
	27D03	I	Delta	27D03I	
	27D03	X	Delta	27D03X	
	27D03	Y	Delta	27D03Y	
CENTRAL wounds	27D04	S	Delta	27D04S	
	27D04	G	Delta	27D04G	
	27D04	P	Delta	27D04P	
	27D04	I	Delta	27D04I	
	27D04	X	Delta	27D04X	
	27D04	Y	Delta	27D04Y	
Multiple wounds	27D05	S	Delta	27D05S	
	27D05	G	Delta	27D05G	
	27D05	P	Delta	27D05P	
	27D05	I	Delta	27D05I	
	27D05	X	Delta	27D05X	
	27D05	Y	Delta	27D05Y	
Multiple victims	27D06	S	Delta	27D06S	
	27D06	G	Delta	27D06G	
	27D06	P	Delta	27D06P	
	27D06	I	Delta	27D06I	
	27D06	X	Delta	27D06X	
	27D06	Y	Delta	27D06Y	
28. Stroke (CVA) / Transient Ischemic Attack (TIA)					
Breathing normally < 35	28A01	C	Alpha	28A01C	
	28A01	D	Alpha	28A01D	
	28A01	E	Alpha	28A01E	
	28A01	F	Alpha	28A01F	
	28A01	G	Alpha	28A01G	
	28A01	H	Alpha	28A01H	
	28A01	I	Alpha	28A01I	
	28A01	J	Alpha	28A01J	
	28A01	K	Alpha	28A01K	
	28A01	L	Alpha	28A01L	
	28A01	M	Alpha	28A01M	
	28A01	U	Alpha	28A01U	
	28A01	X	Alpha	28A01X	
	28A01	Y	Alpha	28A01Y	
	28A01	Z	Alpha	28A01Z	
Override	28C00	C	Charlie	28C00C	
	28C00	D	Charlie	28C00D	
	28C00	E	Charlie	28C00E	
	28C00	F	Charlie	28C00F	
	28C00	G	Charlie	28C00G	
	28C00	H	Charlie	28C00H	
	28C00	I	Charlie	28C00I	
	28C00	J	Charlie	28C00J	
	28C00	K	Charlie	28C00K	

Suffix C - PARTIAL evidence of stroke (< T hours)
Suffix D - PARTIAL evidence of stroke (≥ T hours)
Suffix E - PARTIAL evidence of stroke (Unknown hours)
Suffix F - STRONG evidence of stroke (< T hours)
Suffix G - Greater than "T" hours since the symptoms started
Suffix H - STRONG evidence of stroke (≥ T hours)
Suffix I - STRONG evidence of stroke (Unknown hours)
Suffix J - CLEAR evidence of stroke (< T hours)
Suffix K - CLEAR evidence of stroke (≥ T hours)
Suffix L - Less than "T" hours since the symptoms started
Suffix M - CLEAR evidence of stroke (Unknown hours)
Suffix U - Unknown when the symptoms started
Suffix X - No test evidence of stroke (< T hours)
Suffix Y - No test evidence of stroke (≥ T hours)
Suffix Z - No test evidence of stroke (Unknown hours)

	28C00	L	Charlie	28C00L	
	28C00	M	Charlie	28C00M	
	28C00	U	Charlie	28C00U	
	28C00	X	Charlie	28C00X	
	28C00	Y	Charlie	28C00Y	
	28C00	Z	Charlie	28C00Z	
Not alert	28C01	C	Charlie	28C01C	
	28C01	D	Charlie	28C01D	
	28C01	E	Charlie	28C01E	
	28C01	F	Charlie	28C01F	
	28C01	G	Charlie	28C01G	
	28C01	H	Charlie	28C01H	
	28C01	I	Charlie	28C01I	
	28C01	J	Charlie	28C01J	
	28C01	K	Charlie	28C01K	
	28C01	L	Charlie	28C01L	
	28C01	M	Charlie	28C01M	
	28C01	U	Charlie	28C01U	
	28C01	X	Charlie	28C01X	
	28C01	Y	Charlie	28C01Y	
	28C01	Z	Charlie	28C01Z	
Abnormal breathing	28C02	C	Charlie	28C02C	
	28C02	D	Charlie	28C02D	
	28C02	E	Charlie	28C02E	
	28C02	F	Charlie	28C02F	
	28C02	G	Charlie	28C02G	
	28C02	H	Charlie	28C02H	
	28C02	I	Charlie	28C02I	
	28C02	J	Charlie	28C02J	
	28C02	K	Charlie	28C02K	
	28C02	L	Charlie	28C02L	
	28C02	M	Charlie	28C02M	
	28C02	U	Charlie	28C02U	
	28C02	X	Charlie	28C02X	
	28C02	Y	Charlie	28C02Y	
	28C02	Z	Charlie	28C02Z	
Sudden speech problems	28C03	C	Charlie	28C03C	
	28C03	D	Charlie	28C03D	
	28C03	E	Charlie	28C03E	
	28C03	F	Charlie	28C03F	
	28C03	G	Charlie	28C03G	
	28C03	H	Charlie	28C03H	
	28C03	I	Charlie	28C03I	
	28C03	J	Charlie	28C03J	
	28C03	K	Charlie	28C03K	
	28C03	L	Charlie	28C03L	
	28C03	M	Charlie	28C03M	
	28C03	U	Charlie	28C03U	
	28C03	X	Charlie	28C03X	
	28C03	Y	Charlie	28C03Y	
	28C03	Z	Charlie	28C03Z	
Sudden weakness or numbness (one side)	28C04	C	Charlie	28C04C	
	28C04	D	Charlie	28C04D	
	28C04	E	Charlie	28C04E	
	28C04	F	Charlie	28C04F	
	28C04	G	Charlie	28C04G	
	28C04	H	Charlie	28C04H	
	28C04	I	Charlie	28C04I	
	28C04	J	Charlie	28C04J	
	28C04	K	Charlie	28C04K	
	28C04	L	Charlie	28C04L	
	28C04	M	Charlie	28C04M	
	28C04	U	Charlie	28C04U	
	28C04	X	Charlie	28C04X	
	28C04	Y	Charlie	28C04Y	
	28C04	Z	Charlie	28C04Z	
Sudden paralysis or facial droop (one side)	28C05	C	Charlie	28C05C	
	28C05	D	Charlie	28C05D	

	28C05	E	Charlie	28C05E	
	28C05	F	Charlie	28C05F	
	28C05	G	Charlie	28C05G	
	28C05	H	Charlie	28C05H	
	28C05	I	Charlie	28C05I	
	28C05	J	Charlie	28C05J	
	28C05	K	Charlie	28C05K	
	28C05	L	Charlie	28C05L	
	28C05	M	Charlie	28C05M	
	28C05	U	Charlie	28C05U	
	28C05	X	Charlie	28C05X	
	28C05	Y	Charlie	28C05Y	
	28C05	Z	Charlie	28C05Z	
Sudden loss of balance or coordination	28C06	C	Charlie	28C06C	
	28C06	D	Charlie	28C06D	
	28C06	E	Charlie	28C06E	
	28C06	F	Charlie	28C06F	
	28C06	G	Charlie	28C06G	
	28C06	H	Charlie	28C06H	
	28C06	I	Charlie	28C06I	
	28C06	J	Charlie	28C06J	
	28C06	K	Charlie	28C06K	
	28C06	L	Charlie	28C06L	
	28C06	M	Charlie	28C06M	
	28C06	U	Charlie	28C06U	
	28C06	X	Charlie	28C06X	
	28C06	Y	Charlie	28C06Y	
	28C06	Z	Charlie	28C06Z	
Sudden vision problems	28C07	C	Charlie	28C07C	
	28C07	D	Charlie	28C07D	
	28C07	E	Charlie	28C07E	
	28C07	F	Charlie	28C07F	
	28C07	G	Charlie	28C07G	
	28C07	H	Charlie	28C07H	
	28C07	I	Charlie	28C07I	
	28C07	J	Charlie	28C07J	
	28C07	K	Charlie	28C07K	
	28C07	L	Charlie	28C07L	
	28C07	M	Charlie	28C07M	
	28C07	U	Charlie	28C07U	
	28C07	X	Charlie	28C07X	
	28C07	Y	Charlie	28C07Y	
	28C07	Z	Charlie	28C07Z	
Sudden onset of severe headache	28C08	C	Charlie	28C08C	
	28C08	D	Charlie	28C08D	
	28C08	E	Charlie	28C08E	
	28C08	F	Charlie	28C08F	
	28C08	G	Charlie	28C08G	
	28C08	H	Charlie	28C08H	
	28C08	I	Charlie	28C08I	
	28C08	J	Charlie	28C08J	
	28C08	K	Charlie	28C08K	
	28C08	L	Charlie	28C08L	
	28C08	M	Charlie	28C08M	
	28C08	U	Charlie	28C08U	
	28C08	X	Charlie	28C08X	
	28C08	Y	Charlie	28C08Y	
	28C08	Z	Charlie	28C08Z	
STROKE history	28C09	C	Charlie	28C09C	
	28C09	D	Charlie	28C09D	
	28C09	E	Charlie	28C09E	
	28C09	F	Charlie	28C09F	
	28C09	G	Charlie	28C09G	
	28C09	H	Charlie	28C09H	
	28C09	I	Charlie	28C09I	
	28C09	J	Charlie	28C09J	
	28C09	K	Charlie	28C09K	
	28C09	L	Charlie	28C09L	

	28C09	M	Charlie	28C09M	
	28C09	U	Charlie	28C09U	
	28C09	X	Charlie	28C09X	
	28C09	Y	Charlie	28C09Y	
	28C09	Z	Charlie	28C09Z	
TIA (mini-stroke) history	28C10	C	Charlie	28C10C	
	28C10	D	Charlie	28C10D	
	28C10	E	Charlie	28C10E	
	28C10	F	Charlie	28C10F	
	28C10	G	Charlie	28C10G	
	28C10	H	Charlie	28C10H	
	28C10	I	Charlie	28C10I	
	28C10	J	Charlie	28C10J	
	28C10	K	Charlie	28C10K	
	28C10	L	Charlie	28C10L	
	28C10	M	Charlie	28C10M	
	28C10	U	Charlie	28C10U	
	28C10	X	Charlie	28C10X	
	28C10	Y	Charlie	28C10Y	
	28C10	Z	Charlie	28C10Z	
Breathing normally ≥ 35	28C11	C	Charlie	28C11C	
	28C11	D	Charlie	28C11D	
	28C11	E	Charlie	28C11E	
	28C11	F	Charlie	28C11F	
	28C11	G	Charlie	28C11G	
	28C11	H	Charlie	28C11H	
	28C11	I	Charlie	28C11I	
	28C11	J	Charlie	28C11J	
	28C11	K	Charlie	28C11K	
	28C11	L	Charlie	28C11L	
	28C11	M	Charlie	28C11M	
	28C11	U	Charlie	28C11U	
	28C11	X	Charlie	28C11X	
	28C11	Y	Charlie	28C11Y	
	28C11	Z	Charlie	28C11Z	
Unknown status/Other codes not applicable	28C12	C	Charlie	28C12C	
	28C12	D	Charlie	28C12D	
	28C12	E	Charlie	28C12E	
	28C12	F	Charlie	28C12F	
	28C12	G	Charlie	28C12G	
	28C12	H	Charlie	28C12H	
	28C12	I	Charlie	28C12I	
	28C12	J	Charlie	28C12J	
	28C12	K	Charlie	28C12K	
	28C12	L	Charlie	28C12L	
	28C12	M	Charlie	28C12M	
	28C12	U	Charlie	28C12U	
	28C12	X	Charlie	28C12X	
	28C12	Y	Charlie	28C12Y	
	28C12	Z	Charlie	28C12Z	
29. Traffic / Transportation Incidents					
No injuries (confirmed for all persons up to 4)	29O01		Omega	29O01	
	29O01	V	Omega	29O01V	
	29O01	U	Omega	29O01U	
	29O01	Y	Omega	29O01Y	
	29O01	X	Omega	29O01X	
Override	29A00		Alpha	29A00	
	29A00	V	Alpha	29A00V	
	29A00	U	Alpha	29A00U	
	29A00	Y	Alpha	29A00Y	
	29A00	X	Alpha	29A00X	
1st party caller with injury to NOT DANGEROUS body area	29A01		Alpha	29A01	
	29A01	V	Alpha	29A01V	
	29A01	U	Alpha	29A01U	
	29A01	Y	Alpha	29A01Y	
	29A01	X	Alpha	29A01X	

Suffix V - Multiple patients
Suffix U - Unknown number of patients
Suffix Y - Multiple patients and Additional response required
Suffix X - Unknown number of patients and Additional response required
Suffix a - Aircraft
Suffix b - Bus
Suffix c - Subway/Metro
Suffix d - Train
Suffix e - Watercraft
Suffix f - Multi-vehicle (≥ 10) pile-up
Suffix g - Street car/Tram/Light rail
Suffix h - Vehicle vs. building
Suffix k - All-terrain/Snowmobile
Suffix l - Auto vs. bicycle/Auto vs. motorcycle
Suffix m - Auto vs. pedestrian
Suffix n - Ejection

No injuries reported (unconfirmed or ≥ 5 persons involved)	29A02		Alpha	29A02	
	29A02	V	Alpha	29A02V	
	29A02	U	Alpha	29A02U	
	29A02	Y	Alpha	29A02Y	
	29A02	X	Alpha	29A02X	
Override	29B00		Bravo	29B00	
	29B00	V	Bravo	29B00V	
	29B00	U	Bravo	29B00U	
	29B00	Y	Bravo	29B00Y	
	29B00	X	Bravo	29B00X	
Injuries	29B01		Bravo	29B01	
	29B01	V	Bravo	29B01V	
	29B01	U	Bravo	29B01U	
	29B01	Y	Bravo	29B01Y	
	29B01	X	Bravo	29B01X	
SERIOUS hemorrhage	29B02		Bravo	29B02	
	29B02	V	Bravo	29B02V	
	29B02	U	Bravo	29B02U	
	29B02	Y	Bravo	29B02Y	
	29B02	X	Bravo	29B02X	
Other hazards	29B03		Bravo	29B03	
	29B03	V	Bravo	29B03V	
	29B03	U	Bravo	29B03U	
	29B03	Y	Bravo	29B03Y	
	29B03	X	Bravo	29B03X	
LOW MECHANISM (1st or 2nd party caller)	29B04		Bravo	29B04	
	29B04	V	Bravo	29B04V	
	29B04	U	Bravo	29B04U	
	29B04	Y	Bravo	29B04Y	
	29B04	X	Bravo	29B04X	
Unknown status/Other codes not applicable	29B05		Bravo	29B05	
	29B05	V	Bravo	29B05V	
	29B05	U	Bravo	29B05U	
	29B05	Y	Bravo	29B05Y	
	29B05	X	Bravo	29B05X	
Override	29D00		Delta	29D00	
	29D00	V	Delta	29D00V	
	29D00	U	Delta	29D00U	
	29D00	Y	Delta	29D00Y	
	29D00	X	Delta	29D00X	
MAJOR INCIDENT (a through h)	29D01	a	Delta	29D01a	
	29D01	b	Delta	29D01b	
	29D01	c	Delta	29D01c	
	29D01	d	Delta	29D01d	
	29D01	e	Delta	29D01e	
	29D01	f	Delta	29D01f	
	29D01	g	Delta	29D01g	
	29D01	h	Delta	29D01h	
HIGH MECHANISM (k through t)	29D02	k	Delta	29D02k	
	29D02	l	Delta	29D02l	
	29D02	m	Delta	29D02m	
	29D02	n	Delta	29D02n	
	29D02	o	Delta	29D02o	
	29D02	p	Delta	29D02p	
	29D02	q	Delta	29D02q	
	29D02	r	Delta	29D02r	
	29D02	s	Delta	29D02s	
	29D02	t	Delta	29D02t	
HIGH VELOCITY impact	29D03		Delta	29D03	
	29D03	V	Delta	29D03V	
	29D03	U	Delta	29D03U	
	29D03	Y	Delta	29D03Y	
	29D03	X	Delta	29D03X	
HAZMAT	29D04		Delta	29D04	
	29D04	V	Delta	29D04V	
	29D04	U	Delta	29D04U	
	29D04	Y	Delta	29D04Y	
	29D04	X	Delta	29D04X	

Suffix o - Personal watercraft
Suffix p - Rollovers
Suffix q - Vehicle off bridge/height
Suffix r - Possible death at scene
Suffix s - Sinking vehicle/Vehicle in floodwater
Suffix t - Train/Light rail vs. pedestrian

Pinned (trapped) victim	29D05		Delta	29D05	
	29D05	V	Delta	29D05V	
	29D05	U	Delta	29D05U	
	29D05	Y	Delta	29D05Y	
	29D05	X	Delta	29D05X	
Arrest	29D06		Delta	29D06	
	29D06	V	Delta	29D06V	
	29D06	U	Delta	29D06U	
	29D06	Y	Delta	29D06Y	
	29D06	X	Delta	29D06X	
Unconscious	29D07		Delta	29D07	
	29D07	V	Delta	29D07V	
	29D07	U	Delta	29D07U	
	29D07	Y	Delta	29D07Y	
	29D07	X	Delta	29D07X	
Not alert with noisy breathing (abnormal)	29D08		Delta	29D08	
	29D08	V	Delta	29D08V	
	29D08	U	Delta	29D08U	
	29D08	Y	Delta	29D08Y	
	29D08	X	Delta	29D08X	
Not alert with normal breathing	29D09		Delta	29D09	
	29D09	V	Delta	29D09V	
	29D09	U	Delta	29D09U	
	29D09	Y	Delta	29D09Y	
	29D09	X	Delta	29D09X	
30. Traumatic Injuries (Specific)					
Marked (*) NOT DANGEROUS body area with deformity	30A01		Alpha	30A01	
NOT DANGEROUS body area	30A02		Alpha	30A02	
NON-RECENT (≥ 6hrs) injuries (without priority symptoms)	30A03		Alpha	30A03	
Override	30B00		Bravo	30B00	
POSSIBLY DANGEROUS body area	30B01		Bravo	30B01	
SERIOUS hemorrhage	30B02		Bravo	30B02	
Unknown body area (remote patient location)	30B03		Bravo	30B03	
Override	30D00		Delta	30D00	
Arrest	30D01		Delta	30D01	
Unconscious	30D02		Delta	30D02	
Not alert	30D03		Delta	30D03	
Chest or Neck injury (with difficulty breathing)	30D04		Delta	30D04	
HIGH VELOCITY impact/MASS injury	30D05		Delta	30D05	
31. Unconscious / Fainting (Near)					
Fainting episode(s) and alert ≥ 35 (without cardiac history)	31A01		Alpha	31A01	
Fainting episode(s) and alert < 35 (with cardiac history)	31A02		Alpha	31A02	
Fainting episode(s) and alert < 35 (without cardiac history)	31A03		Alpha	31A03	
Override	31C00		Charlie	31C00	
Alert with abnormal breathing	31C01		Charlie	31C01	
Fainting episode(s) and alert ≥ 35 (with cardiac history)	31C02		Charlie	31C02	
Females 12–50 with abdominal pain	31C03		Charlie	31C03	
Override	31D00		Delta	31D00	
Unconscious – AGONAL/INEFFECTIVE BREATHING	31D01		Delta	31D01	
Unconscious – Effective breathing	31D02		Delta	31D02	
Not alert	31D03		Delta	31D03	
CHANGING COLOR	31D04		Delta	31D04	
Override	31E00		Echo	31E00	
INEFFECTIVE BREATHING	31E01		Echo	31E01	
32. Unknown Problem (Person Down)					
Standing, sitting, moving, or talking	32B01		Bravo	32B01	
Medical Alarm (Alert) notifications (no patient information)	32B02		Bravo	32B02	
Unknown status/Other codes not applicable	32B03		Bravo	32B03	
Caller's language not understood (no interpreter in center)	32B04		Bravo	32B04	
Override	32D00		Delta	32D00	
LIFE STATUS QUESTIONABLE	32D01		Delta	32D01	
33. Transfer / Interfacility / Palliative Care					
ACUITY I (no priority symptoms)	33A01	T	Alpha	33A01T	
	33A01	P	Alpha	33A01P	

Suffix T - Transfer/Interfacility
Suffix P - Palliative Care

ACUITY II (no priority symptoms)	33A02	T	Alpha	33A02T	
	33A02	P	Alpha	33A02P	
ACUITY III (no priority symptoms)	33A03	T	Alpha	33A03T	
	33A03	P	Alpha	33A03P	
Override	33C00	T	Charlie	33C00T	
	33C00	P	Charlie	33C00P	
Not alert (acute change)	33C01	T	Charlie	33C01T	
	33C01	P	Charlie	33C01P	
Abnormal breathing (acute onset)	33C02	T	Charlie	33C02T	
	33C02	P	Charlie	33C02P	
Significant hemorrhage	33C03	T	Charlie	33C03T	
	33C03	P	Charlie	33C03P	
Shock	33C04	T	Charlie	33C04T	
	33C04	P	Charlie	33C04P	
Possible acute heart problems or MI (heart attack)	33C05	T	Charlie	33C05T	
	33C05	P	Charlie	33C05P	
Severe pain	33C06	T	Charlie	33C06T	
	33C06	P	Charlie	33C06P	
Emergency response requested	33C07	T	Charlie	33C07T	
	33C07	P	Charlie	33C07P	
Override	33D00	T	Delta	33D00T	
	33D00	P	Delta	33D00P	
Suspected cardiac or respiratory arrest	33D01	T	Delta	33D01T	
	33D01	P	Delta	33D01P	
Just resuscitated and/or defibrillated (external)	33D02	T	Delta	33D02T	
	33D02	P	Delta	33D02P	
34. ACN (Automatic Crash Notification)					
No injuries (refer to Police)	34O01		Omega	34O01	
Override	34A00		Alpha	34A00	
NOT DANGEROUS injuries (1st party & single occupant)	34A01		Alpha	34A01	
Override	34B00		Bravo	34B00	
Injuries involved	34B01		Bravo	34B01	
Multiple victims (one unit)	34B02		Bravo	34B02	
Multiple victims (additional units)	34B03		Bravo	34B03	
Airbag/Other Automatic Sensor (no voice)	34B04		Bravo	34B04	
Unknown situation/Other codes not applicable	34B05		Bravo	34B05	
Override	34D00		Delta	34D00	
HIGH MECHANISM (h through n)	34D01	h	Delta	34D01h	
	34D01	i	Delta	34D01i	
	34D01	j	Delta	34D01j	
	34D01	k	Delta	34D01k	
	34D01	l	Delta	34D01l	
	34D01	m	Delta	34D01m	
	34D01	n	Delta	34D01n	
Unconscious or Not alert	34D02		Delta	34D02	
NOT BREATHING/INEFFECTIVE BREATHING	34D03		Delta	34D03	
LIFE STATUS QUESTIONABLE	34D04		Delta	34D04	
36. Pandemic / Epidemic / Outbreak (Surveillance or Triage)					
Chest pain/discomfort < 35 with single flu symptom	36A01	S	Alpha	36A01S	
	36A01	A	Alpha	36A01A	
	36A01	B	Alpha	36A01B	
	36A01	C	Alpha	36A01C	
Chest pain/discomfort < 35 with multiple flu symptoms	36A02	S	Alpha	36A02S	
	36A02	A	Alpha	36A02A	
	36A02	B	Alpha	36A02B	
	36A02	C	Alpha	36A02C	
Flu symptoms only (cough, fever, chills, sweats, sore throat, vomiting, diarrhea, unusual total b	36A03	S	Alpha	36A03S	
	36A03	A	Alpha	36A03A	
	36A03	B	Alpha	36A03B	
	36A03	C	Alpha	36A03C	
Override	36C00	S	Charlie	36C00S	
	36C00	A	Charlie	36C00A	
	36C00	B	Charlie	36C00B	
	36C00	C	Charlie	36C00C	
Abnormal breathing with single flu symptom or Asthma/COPD	36C01	S	Charlie	36C01S	

Suffix h - Auto vs. bicycle
Suffix i - Auto vs. motorcycle
Suffix j - Auto vs. pedestrian
Suffix k - Ejection
Suffix l - Pinned
Suffix m - Rollover
Suffix n - Vehicle off bridge/height

Suffix S - Level 0 (surveillance only)
Suffix A - Level 1 (low triage)
Suffix B - Level 2 (moderate triage)
Suffix C - Level 3 (high triage)

	36C01	A	Charlie	36C01A	
	36C01	B	Charlie	36C01B	
	36C01	C	Charlie	36C01C	
Abnormal breathing with multiple flu symptoms	36C02	S	Charlie	36C02S	
	36C02	A	Charlie	36C02A	
	36C02	B	Charlie	36C02B	
	36C02	C	Charlie	36C02C	
Chest pain/discomfort ≥ 35 with single flu symptom	36C03	S	Charlie	36C03S	
	36C03	A	Charlie	36C03A	
	36C03	B	Charlie	36C03B	
	36C03	C	Charlie	36C03C	
Chest pain/discomfort ≥ 35 with multiple flu symptoms	36C04	S	Charlie	36C04S	
	36C04	A	Charlie	36C04A	
	36C04	B	Charlie	36C04B	
	36C04	C	Charlie	36C04C	
HIGH RISK conditions	36C05	S	Charlie	36C05S	
	36C05	A	Charlie	36C05A	
	36C05	B	Charlie	36C05B	
	36C05	C	Charlie	36C05C	
Override	36D00	S	Delta	36D00S	
	36D00	A	Delta	36D00A	
	36D00	B	Delta	36D00B	
	36D00	C	Delta	36D00C	
INEFFECTIVE BREATHING with flu symptoms	36D01	S	Delta	36D01S	
	36D01	A	Delta	36D01A	
	36D01	B	Delta	36D01B	
	36D01	C	Delta	36D01C	
DIFFICULTY SPEAKING BETWEEN BREATHS with flu symptoms	36D02	S	Delta	36D02S	
	36D02	A	Delta	36D02A	
	36D02	B	Delta	36D02B	
	36D02	C	Delta	36D02C	
Not alert with flu symptoms	36D03	S	Delta	36D03S	
	36D03	A	Delta	36D03A	
	36D03	B	Delta	36D03B	
	36D03	C	Delta	36D03C	
CHANGING COLOR with flu symptoms	36D04	S	Delta	36D04S	
	36D04	A	Delta	36D04A	
	36D04	B	Delta	36D04B	
	36D04	C	Delta	36D04C	
37. Interfacility Evaluation / Transfer					
EVALUATION	37A01		Alpha	37A01	
	37A01	A	Alpha	37A01A	
	37A01	S	Alpha	37A01S	
	37A01	B	Alpha	37A01B	
TRANSFER level I	37A02		Alpha	37A02	
	37A02	A	Alpha	37A02A	
	37A02	S	Alpha	37A02S	
	37A02	B	Alpha	37A02B	
TRANSFER level II	37A03		Alpha	37A03	
	37A03	A	Alpha	37A03A	
	37A03	S	Alpha	37A03S	
	37A03	B	Alpha	37A03B	
TRANSFER level III	37A04		Alpha	37A04	
	37A04	A	Alpha	37A04A	
	37A04	S	Alpha	37A04S	
	37A04	B	Alpha	37A04B	
Override	37B00		Bravo	37B00	
	37B00	A	Bravo	37B00A	
	37B00	S	Bravo	37B00S	
	37B00	B	Bravo	37B00B	
EVALUATION	37B01		Bravo	37B01	
	37B01	A	Bravo	37B01A	
	37B01	S	Bravo	37B01S	
	37B01	B	Bravo	37B01B	
TRANSFER	37B02		Bravo	37B02	
	37B02	A	Bravo	37B02A	
	37B02	S	Bravo	37B02S	

Suffix A - Additional personnel
Suffix S - Special equipment
Suffix B - Both Additional personnel & Special equipment

	37B02	B	Bravo	37B02B	
Override	37C00		Charlie	37C00	
	37C00	A	Charlie	37C00A	
	37C00	S	Charlie	37C00S	
	37C00	B	Charlie	37C00B	
Acute onset of priority symptom(s)	37C01		Charlie	37C01	
	37C01	A	Charlie	37C01A	
	37C01	S	Charlie	37C01S	
	37C01	B	Charlie	37C01B	
Suspected acute heart problems or MI (heart attack)	37C02		Charlie	37C02	
	37C02	A	Charlie	37C02A	
	37C02	S	Charlie	37C02S	
	37C02	B	Charlie	37C02B	
Suspected STROKE (≤ "T" hours)	37C03		Charlie	37C03	
	37C03	A	Charlie	37C03A	
	37C03	S	Charlie	37C03S	
	37C03	B	Charlie	37C03B	
Medication management required	37C04		Charlie	37C04	
	37C04	A	Charlie	37C04A	
	37C04	S	Charlie	37C04S	
	37C04	B	Charlie	37C04B	
Emergency response requested	37C05		Charlie	37C05	
	37C05	A	Charlie	37C05A	
	37C05	S	Charlie	37C05S	
	37C05	B	Charlie	37C05B	
EVALUATION	37C06		Charlie	37C06	
	37C06	A	Charlie	37C06A	
	37C06	S	Charlie	37C06S	
	37C06	B	Charlie	37C06B	
TRANSFER level I	37C07		Charlie	37C07	
	37C07	A	Charlie	37C07A	
	37C07	S	Charlie	37C07S	
	37C07	B	Charlie	37C07B	
TRANSFER level II	37C08		Charlie	37C08	
	37C08	A	Charlie	37C08A	
	37C08	S	Charlie	37C08S	
	37C08	B	Charlie	37C08B	
TRANSFER level III	37C09		Charlie	37C09	
	37C09	A	Charlie	37C09A	
	37C09	S	Charlie	37C09S	
	37C09	B	Charlie	37C09B	
Override	37D00		Delta	37D00	
	37D00	A	Delta	37D00A	
	37D00	S	Delta	37D00S	
	37D00	B	Delta	37D00B	
NOT BREATHING/INEFFECTIVE BREATHING	37D01		Delta	37D01	
	37D01	A	Delta	37D01A	
	37D01	S	Delta	37D01S	
	37D01	B	Delta	37D01B	
EVALUATION	37D02		Delta	37D02	
	37D02	A	Delta	37D02A	
	37D02	S	Delta	37D02S	
	37D02	B	Delta	37D02B	
TRANSFER	37D03		Delta	37D03	
	37D03	A	Delta	37D03A	
	37D03	S	Delta	37D03S	
	37D03	B	Delta	37D03B	
38. Advanced SEND (Medical Miranda)					
NOT DANGEROUS body area	38A01		Alpha	38A01	
	38A01	H	Alpha	38A01H	
	38A01	C	Alpha	38A01C	
Minor injuries	38A02		Alpha	38A02	
	38A02	H	Alpha	38A02H	
	38A02	C	Alpha	38A02C	
Minor illness	38A03		Alpha	38A03	
	38A03	H	Alpha	38A03H	
	38A03	C	Alpha	38A03C	

Suffix H - Lights-and-siren response requested
Suffix C - Routine response requested

MINOR hemorrhage	38A04		Alpha	38A04	
	38A04	H	Alpha	38A04H	
	38A04	C	Alpha	38A04C	
Chest pain/discomfort < 35 (without priority symptoms)	38A05		Alpha	38A05	
	38A05	H	Alpha	38A05H	
	38A05	C	Alpha	38A05C	
Fall (ground level)	38A06		Alpha	38A06	
	38A06	H	Alpha	38A06H	
	38A06	C	Alpha	38A06C	
Override	38B00		Bravo	38B00	
	38B00	H	Bravo	38B00H	
	38B00	C	Bravo	38B00C	
POSSIBLY DANGEROUS body area	38B01		Bravo	38B01	
	38B01	H	Bravo	38B01H	
	38B01	C	Bravo	38B01C	
SERIOUS hemorrhage	38B02		Bravo	38B02	
	38B02	H	Bravo	38B02H	
	38B02	C	Bravo	38B02C	
Tasered	38B03		Bravo	38B03	
	38B03	H	Bravo	38B03H	
	38B03	C	Bravo	38B03C	
Unknown status (TRAUMA)	38B04		Bravo	38B04	
	38B04	H	Bravo	38B04H	
	38B04	C	Bravo	38B04C	
Override	38C00		Charlie	38C00	
	38C00	H	Charlie	38C00H	
	38C00	C	Charlie	38C00C	
Chest pain/discomfort ≥ 35	38C01		Charlie	38C01	
	38C01	H	Charlie	38C01H	
	38C01	C	Charlie	38C01C	
Childbirth	38C02		Charlie	38C02	
	38C02	H	Charlie	38C02H	
	38C02	C	Charlie	38C02C	
Seizure	38C03		Charlie	38C03	
	38C03	H	Charlie	38C03H	
	38C03	C	Charlie	38C03C	
STROKE	38C04		Charlie	38C04	
	38C04	H	Charlie	38C04H	
	38C04	C	Charlie	38C04C	
Serious illness	38C05		Charlie	38C05	
	38C05	H	Charlie	38C05H	
	38C05	C	Charlie	38C05C	
Unknown status (MEDICAL)	38C06		Charlie	38C06	
	38C06	H	Charlie	38C06H	
	38C06	C	Charlie	38C06C	
Override	38D00		Delta	38D00	
	38D00	H	Delta	38D00H	
	38D00	C	Delta	38D00C	
Reported EXCITED DELIRIUM	38D01		Delta	38D01	
	38D01	H	Delta	38D01H	
	38D01	C	Delta	38D01C	
HIGH VELOCITY impact	38D02		Delta	38D02	
	38D02	H	Delta	38D02H	
	38D02	C	Delta	38D02C	
Critical injuries	38D03		Delta	38D03	
	38D03	H	Delta	38D03H	
	38D03	C	Delta	38D03C	
Multiple victims	38D04		Delta	38D04	
	38D04	H	Delta	38D04H	
	38D04	C	Delta	38D04C	
Unconscious	38D05		Delta	38D05	
	38D05	H	Delta	38D05H	
	38D05	C	Delta	38D05C	
Not alert	38D06		Delta	38D06	
	38D06	H	Delta	38D06H	
	38D06	C	Delta	38D06C	
Difficulty breathing	38D07		Delta	38D07	
	38D07	H	Delta	38D07H	

	38D07	C	Delta	38D07C	
45. Specialized Unscheduled Up-Care Transport					
Unscheduled transport	45A01		Alpha	45A01	
	45A01	a	Alpha	45A01a	
	45A01	b	Alpha	45A01b	
	45A01	c	Alpha	45A01c	
	45A01	d	Alpha	45A01d	
	45A01	e	Alpha	45A01e	
	45A01	f	Alpha	45A01f	
	45A01	g	Alpha	45A01g	
	45A01	h	Alpha	45A01h	
	45A01	i	Alpha	45A01i	
	45A01	j	Alpha	45A01j	
	45A01	k	Alpha	45A01k	
Override	45B00		Bravo	45B00	
	45B00	a	Bravo	45B00a	
	45B00	b	Bravo	45B00b	
	45B00	c	Bravo	45B00c	
	45B00	d	Bravo	45B00d	
	45B00	e	Bravo	45B00e	
	45B00	f	Bravo	45B00f	
	45B00	g	Bravo	45B00g	
	45B00	h	Bravo	45B00h	
	45B00	i	Bravo	45B00i	
	45B00	j	Bravo	45B00j	
	45B00	k	Bravo	45B00k	
SERIOUS hemorrhage	45B01		Bravo	45B01	
Override	45C00		Charlie	45C00	
	45C00	a	Charlie	45C00a	
	45C00	b	Charlie	45C00b	
	45C00	c	Charlie	45C00c	
	45C00	d	Charlie	45C00d	
	45C00	e	Charlie	45C00e	
	45C00	f	Charlie	45C00f	
	45C00	g	Charlie	45C00g	
	45C00	h	Charlie	45C00h	
	45C00	i	Charlie	45C00i	
	45C00	j	Charlie	45C00j	
	45C00	k	Charlie	45C00k	
Acute change in LOC	45C01		Charlie	45C01	
Acute SOB (shortness of breath)	45C02		Charlie	45C02	
Suspected MI (heart attack)	45C03		Charlie	45C03	
Other suspected acute heart conditions	45C04		Charlie	45C04	
Suspected STROKE (≤ "T" hours)	45C05		Charlie	45C05	
Acute surgical emergency	45C06		Charlie	45C06	
Unscheduled transport (ALS medications/equipment)	45C07		Charlie	45C07	
	45C07	a	Charlie	45C07a	
	45C07	b	Charlie	45C07b	
	45C07	c	Charlie	45C07c	
	45C07	d	Charlie	45C07d	
	45C07	e	Charlie	45C07e	
	45C07	f	Charlie	45C07f	
	45C07	g	Charlie	45C07g	
	45C07	h	Charlie	45C07h	
	45C07	i	Charlie	45C07i	
	45C07	j	Charlie	45C07j	
	45C07	k	Charlie	45C07k	
Override	45D00		Delta	45D00	
	45D00	a	Delta	45D00a	
	45D00	b	Delta	45D00b	
	45D00	c	Delta	45D00c	
	45D00	d	Delta	45D00d	
	45D00	e	Delta	45D00e	
	45D00	f	Delta	45D00f	
	45D00	g	Delta	45D00g	
	45D00	h	Delta	45D00h	
	45D00	i	Delta	45D00i	

Suffix a - Abdominal Pain / Problems
Suffix b - Allergies (Reactions) / Envenomations (Stings, Bites)
Suffix c - Back Pain (Non-Traumatic or Non-Recent Trauma)
Suffix d - Convulsions / Seizures
Suffix e - Diabetic Problems
Suffix f - Eye Problems / Injuries
Suffix g - Falls
Suffix h - Headache
Suffix i - Hemorrhage / Lacerations (Minor)
Suffix j - Traumatic Injuries (Non-Trauma Center)
Suffix k - Unconscious / Fainting (Near)

	45D00	j	Delta	45D00j	
	45D00	k	Delta	45D00k	
NOT BREATHING/INEFFECTIVE BREATHING	45D01		Delta	45D01	
Trauma Center criteria	45D02		Delta	45D02	
Emergency response requested	45D03		Delta	45D03	
Unscheduled transport (CCT equipment)	45D04		Delta	45D04	
	45D04	a	Delta	45D04a	
	45D04	b	Delta	45D04b	
	45D04	c	Delta	45D04c	
	45D04	d	Delta	45D04d	
	45D04	e	Delta	45D04e	
	45D04	f	Delta	45D04f	
	45D04	g	Delta	45D04g	
	45D04	h	Delta	45D04h	
	45D04	i	Delta	45D04i	
	45D04	j	Delta	45D04j	
	45D04	k	Delta	45D04k	
Unscheduled transport (CCP equipment)	45D05		Delta	45D05	
	45D05	a	Delta	45D05a	
	45D05	b	Delta	45D05b	
	45D05	c	Delta	45D05c	
	45D05	d	Delta	45D05d	
	45D05	e	Delta	45D05e	
	45D05	f	Delta	45D05f	
	45D05	g	Delta	45D05g	
	45D05	h	Delta	45D05h	
	45D05	i	Delta	45D05i	
	45D05	j	Delta	45D05j	
	45D05	k	Delta	45D05k	
Unscheduled transport (NICU equipment)	45D06		Delta	45D06	
	45D06	a	Delta	45D06a	
	45D06	b	Delta	45D06b	
	45D06	c	Delta	45D06c	
	45D06	d	Delta	45D06d	
	45D06	e	Delta	45D06e	
	45D06	f	Delta	45D06f	
	45D06	g	Delta	45D06g	
	45D06	h	Delta	45D06h	
	45D06	i	Delta	45D06i	
	45D06	j	Delta	45D06j	
	45D06	k	Delta	45D06k	
46. Scheduled Interfacility Transfer (Routine)					
IMMEDIATE	46A01		Alpha	46A01	
SCHEDULED	46A02		Alpha	46A02	
PRESCHEDULED	46A03		Alpha	46A03	
Override	46B00		Bravo	46B00	
IMMEDIATE (BLS medications/equipment)	46B01		Bravo	46B01	
SCHEDULED (BLS medications/equipment)	46B02		Bravo	46B02	
PRESCHEDULED (BLS medications/equipment)	46B03		Bravo	46B03	
Override	46C00		Charlie	46C00	
IMMEDIATE (ALS medications/equipment)	46C01		Charlie	46C01	
SCHEDULED (ALS medications/equipment)	46C02		Charlie	46C02	
PRESCHEDULED (ALS medications/equipment)	46C03		Charlie	46C03	
Override	46D00		Delta	46D00	
IMMEDIATE (CCT equipment)	46D01		Delta	46D01	
SCHEDULED (CCT equipment)	46D02		Delta	46D02	
PRESCHEDULED (CCT equipment)	46D03		Delta	46D03	
IMMEDIATE (CCP equipment)	46D04		Delta	46D04	
SCHEDULED (CCP equipment)	46D05		Delta	46D05	
PRESCHEDULED (CCP equipment)	46D06		Delta	46D06	
IMMEDIATE (NICU equipment)	46D07		Delta	46D07	
SCHEDULED (NICU equipment)	46D08		Delta	46D08	
PRESCHEDULED (NICU equipment)	46D09		Delta	46D09	
47. Mental Health Transfer					
IMMEDIATE	47A01		Alpha	47A01	
SCHEDULED	47A02		Alpha	47A02	

PRESCHEDULED	47A03		Alpha	47A03	
Override	47B00		Bravo	47B00	
IMMEDIATE (BLS medications/equipment)	47B01		Bravo	47B01	
SCHEDULED (BLS medications/equipment)	47B02		Bravo	47B02	
PRESCHEDULED (BLS medications/equipment)	47B03		Bravo	47B03	
Override	47C00		Charlie	47C00	
IMMEDIATE (ALS medications/equipment)	47C01		Charlie	47C01	
SCHEDULED (ALS medications/equipment)	47C02		Charlie	47C02	
PRESCHEDULED (ALS medications/equipment)	47C03		Charlie	47C03	
Override	47D00		Delta	47D00	
IMMEDIATE (CCT equipment)	47D01		Delta	47D01	
SCHEDULED (CCT equipment)	47D02		Delta	47D02	
PRESCHEDULED (CCT equipment)	47D03		Delta	47D03	
IMMEDIATE (CCP equipment)	47D04		Delta	47D04	
SCHEDULED (CCP equipment)	47D05		Delta	47D05	
PRESCHEDULED (CCP equipment)	47D06		Delta	47D06	
48. Air EMS/Scene Transfer					
Air referral	48O01	A	Omega	48O01A	
	48O01	P	Omega	48O01P	
	48O01	N	Omega	48O01N	
EMS request	48S01	A	ELSEd	48S01A	
	48S01	P	ELSEd	48S01P	
	48S01	N	ELSEd	48S01N	
EMD request	48S02	A	ELSEd	48S02A	
	48S02	P	ELSEd	48S02P	
	48S02	N	ELSEd	48S02N	
Mutual aid request	48S03	A	ELSEd	48S03A	
	48S03	P	ELSEd	48S03P	
	48S03	N	ELSEd	48S03N	
Weather check	48S04	A	ELSEd	48S04A	
	48S04	P	ELSEd	48S04P	
	48S04	N	ELSEd	48S04N	
Override	48D00	A	Delta	48D00A	
	48D00	P	Delta	48D00P	
	48D00	N	Delta	48D00N	
Single-engine rotary	48D01	A	Delta	48D01A	
	48D01	P	Delta	48D01P	
	48D01	N	Delta	48D01N	
Dual-engine rotary	48D02	A	Delta	48D02A	
	48D02	P	Delta	48D02P	
	48D02	N	Delta	48D02N	
Single-engine fixed turbo	48D03	A	Delta	48D03A	
	48D03	P	Delta	48D03P	
	48D03	N	Delta	48D03N	
Dual-engine fixed turbo	48D04	A	Delta	48D04A	
	48D04	P	Delta	48D04P	
	48D04	N	Delta	48D04N	
Fixed jet	48D05	A	Delta	48D05A	
	48D05	P	Delta	48D05P	
	48D05	N	Delta	48D05N	
Override	48E00	A	Echo	48E00A	
	48E00	P	Echo	48E00P	
	48E00	N	Echo	48E00N	
Single-engine rotary	48E01	A	Echo	48E01A	
	48E01	P	Echo	48E01P	
	48E01	N	Echo	48E01N	
Dual-engine rotary	48E02	A	Echo	48E02A	
	48E02	P	Echo	48E02P	
	48E02	N	Echo	48E02N	
Single-engine fixed turbo	48E03	A	Echo	48E03A	
	48E03	P	Echo	48E03P	
	48E03	N	Echo	48E03N	
Dual-engine fixed turbo	48E04	A	Echo	48E04A	
	48E04	P	Echo	48E04P	
	48E04	N	Echo	48E04N	
Fixed jet	48E05	A	Echo	48E05A	
	48E05	P	Echo	48E05P	

Suffix A - Adult
Suffix P - Pediatric
Suffix N - Neonate

	48E05	N	Echo	48E05N	
49. Air Interfacility Transfer					
Air	49O01	A	Omega	49O01A	
	49O01	P	Omega	49O01P	
	49O01	N	Omega	49O01N	
Ground	49O02	A	Omega	49O02A	
	49O02	P	Omega	49O02P	
	49O02	N	Omega	49O02N	
EMS request	49S01	A	ELSEd	49S01A	
	49S01	P	ELSEd	49S01P	
	49S01	N	ELSEd	49S01N	
EMD request	49S02	A	ELSEd	49S02A	
	49S02	P	ELSEd	49S02P	
	49S02	N	ELSEd	49S02N	
Airport request	49S03	A	ELSEd	49S03A	
	49S03	P	ELSEd	49S03P	
	49S03	N	ELSEd	49S03N	
Hospital request	49S04	A	ELSEd	49S04A	
	49S04	P	ELSEd	49S04P	
	49S04	N	ELSEd	49S04N	
Other agency request	49S05	A	ELSEd	49S05A	
	49S05	P	ELSEd	49S05P	
	49S05	N	ELSEd	49S05N	
Weather check	49S06	A	ELSEd	49S06A	
	49S06	P	ELSEd	49S06P	
	49S06	N	ELSEd	49S06N	
Override	49A00	A	Alpha	49A00A	
	49A00	P	Alpha	49A00P	
	49A00	N	Alpha	49A00N	
Single-engine rotary	49A01	A	Alpha	49A01A	
	49A01	P	Alpha	49A01P	
	49A01	N	Alpha	49A01N	
Dual-engine rotary	49A02	A	Alpha	49A02A	
	49A02	P	Alpha	49A02P	
	49A02	N	Alpha	49A02N	
Single-engine fixed turbo	49A03	A	Alpha	49A03A	
	49A03	P	Alpha	49A03P	
	49A03	N	Alpha	49A03N	
Dual-engine fixed turbo	49A04	A	Alpha	49A04A	
	49A04	P	Alpha	49A04P	
	49A04	N	Alpha	49A04N	
Fixed jet	49A05	A	Alpha	49A05A	
	49A05	P	Alpha	49A05P	
	49A05	N	Alpha	49A05N	
Ground	49A06	A	Alpha	49A06A	
	49A06	P	Alpha	49A06P	
	49A06	N	Alpha	49A06N	
Override	49B00	A	Bravo	49B00A	
	49B00	P	Bravo	49B00P	
	49B00	N	Bravo	49B00N	
Single-engine rotary	49B01	A	Bravo	49B01A	
	49B01	P	Bravo	49B01P	
	49B01	N	Bravo	49B01N	
Dual-engine rotary	49B02	A	Bravo	49B02A	
	49B02	P	Bravo	49B02P	
	49B02	N	Bravo	49B02N	
Single-engine fixed turbo	49B03	A	Bravo	49B03A	
	49B03	P	Bravo	49B03P	
	49B03	N	Bravo	49B03N	
Dual-engine fixed turbo	49B04	A	Bravo	49B04A	
	49B04	P	Bravo	49B04P	
	49B04	N	Bravo	49B04N	
Fixed jet	49B05	A	Bravo	49B05A	
	49B05	P	Bravo	49B05P	
	49B05	N	Bravo	49B05N	
Ground	49B06	A	Bravo	49B06A	
	49B06	P	Bravo	49B06P	

Suffix A - Adult
Suffix P - Pediatric
Suffix N - Neonate

	49B06	N	Bravo	49B06N	
Override	49C00	A	Charlie	49C00A	
	49C00	P	Charlie	49C00P	
	49C00	N	Charlie	49C00N	
Single-engine rotary	49C01	A	Charlie	49C01A	
	49C01	P	Charlie	49C01P	
	49C01	N	Charlie	49C01N	
Dual-engine rotary	49C02	A	Charlie	49C02A	
	49C02	P	Charlie	49C02P	
	49C02	N	Charlie	49C02N	
Single-engine fixed turbo	49C03	A	Charlie	49C03A	
	49C03	P	Charlie	49C03P	
	49C03	N	Charlie	49C03N	
Dual-engine fixed turbo	49C04	A	Charlie	49C04A	
	49C04	P	Charlie	49C04P	
	49C04	N	Charlie	49C04N	
Fixed jet	49C05	A	Charlie	49C05A	
	49C05	P	Charlie	49C05P	
	49C05	N	Charlie	49C05N	
Ground	49C06	A	Charlie	49C06A	
	49C06	P	Charlie	49C06P	
	49C06	N	Charlie	49C06N	
Override	49D00	A	Delta	49D00A	
	49D00	P	Delta	49D00P	
	49D00	N	Delta	49D00N	
Single-engine rotary	49D01	A	Delta	49D01A	
	49D01	P	Delta	49D01P	
	49D01	N	Delta	49D01N	
Dual-engine rotary	49D02	A	Delta	49D02A	
	49D02	P	Delta	49D02P	
	49D02	N	Delta	49D02N	
Single-engine fixed turbo	49D03	A	Delta	49D03A	
	49D03	P	Delta	49D03P	
	49D03	N	Delta	49D03N	
Dual-engine fixed turbo	49D04	A	Delta	49D04A	
	49D04	P	Delta	49D04P	
	49D04	N	Delta	49D04N	
Fixed jet	49D05	A	Delta	49D05A	
	49D05	P	Delta	49D05P	
	49D05	N	Delta	49D05N	
Ground	49D06	A	Delta	49D06A	
	49D06	P	Delta	49D06P	
	49D06	N	Delta	49D06N	
Override	49E00	A	Echo	49E00A	
	49E00	P	Echo	49E00P	
	49E00	N	Echo	49E00N	
Single-engine rotary	49E01	A	Echo	49E01A	
	49E01	P	Echo	49E01P	
	49E01	N	Echo	49E01N	
Dual-engine rotary	49E02	A	Echo	49E02A	
	49E02	P	Echo	49E02P	
	49E02	N	Echo	49E02N	
Single-engine fixed turbo	49E03	A	Echo	49E03A	
	49E03	P	Echo	49E03P	
	49E03	N	Echo	49E03N	
Dual-engine fixed turbo	49E04	A	Echo	49E04A	
	49E04	P	Echo	49E04P	
	49E04	N	Echo	49E04N	
Fixed jet	49E05	A	Echo	49E05A	
	49E05	P	Echo	49E05P	
	49E05	N	Echo	49E05N	
Ground	49E06	A	Echo	49E06A	
	49E06	P	Echo	49E06P	
	49E06	N	Echo	49E06N	

AMPDS™ v13.0, NAE-std, 150529

Response Determinant Methodology

NON-LINEAR RESPONSE LEVELS

Ω

CAPABILITY: BLS ⟷ ALS

RESPONSE TIME: COLD (Single) ↕ HOT (Multiple)

A	C
B	D

E

In establishing **local** routine vs. emergency **response assignments** to match each MPDS code, consider the following:

1. **Will time make a difference in the outcome?**
2. **How much time-leeway exists for that type of problem?**
3. **How much time can be saved driving in lights-and-siren mode?**
4. **When the patient gets to the hospital, will the time saved be significant compared with the time spent waiting for care such as X-rays, lab tests, etc.?**

All actual response assignments and emergency modes are predetermined by local **Medical Control** and **EMS Administration.**

Legend of Symbols

Notifications

- Police
- Fire
- Electrical
- HAZMAT
- Poison Control

Directors & Warnings

- Mandatory AGONAL BREATHING Detector use
- Consider AGONAL BREATHING Detector use
- Critical EMD Information
- Add Suffix to Determinant Code
- Go to PDIs, then DLS Links
- Unconscious or Arrest
- INEFFECTIVE BREATHING & Not Alert
- Send & go to PDIs
- Send, PDIs & return to questioning
- Send & return to questioning
- Take pulse & return to sequence
- Use the Stroke Diagnostic & return to questioning
- Narcan/Naloxone Admin. Instructions
- CC Chief Complaint
- KQ Key Question
- Vehicle in Water
- Shunt, Go To
- AED Support
- Scene Safety
- Routine Disconnect
- Urgent Disconnect
- Stay on Line
- Cooling & Flushing
- Avulsed Tooth
- Person in Water
- ✔ Verify
- ✔ Confirm
- < Less than
- > Greater than
- ≤ Less than or equal to
- ≥ Greater than or equal to
- Control Bleeding

The INTERNATIONAL ACADEMY EMD Protocol

Priority Dispatch

MEDICAL DIRECTOR AUTHORIZATION FOR ADVANCED MEDICAL PRIORITY DISPATCH IMPLEMENTATION

Local medical authority must define and authorize the following conditions and responses for each of the corresponding Chief Complaints and situations.

Note: This information must be entered on manual cardsets (if used) and entered into the ProQA Configuration Utility

PROTOCOL #9 – CARDIAC OR RESPIRATORY ARREST / DEATH

MD Initials

jc **Protocol 9: Define / authorize Obvious Death Criteria for code 9-B-1, D-2**

- [x] a. Cold and stiff in a warm environment
- [x] b. Decapitation
- [x] c. Decomposition
- [x] d. Incineration
- [x] e. NON-RECENT death
- [x] f. Severe injuries obviously incompatible with life
- [x] g. Locally defined condition "g"
  Transection
- [ ] h. Locally defined condition "h"

_____ **Protocol 9: Define / authorize Expected Death Criteria for code 9-O-1, D-2**

- [ ] x. Known terminal illness
- [ ] y. DNR (Do Not Resuscitate) Order
- [ ] z. Locally defined condition "z"

MD Initials

_____ **Protocol 9; Define / authorize EMS response for Obvious Death (9-B-1)**

Response: _____

_____ **Protocol 9; Define / authorize EMS response for Expected Death (9-O-1)**

Response: _____

_____ **Protocol 9; Define / authorize EMS response for Obvious or Expected death (9-D-2)**

Response: _____

PROTOCOL #14 – DROWNING / NEAR DROWNING / DIVING / SCUBA ACCIDENT

_____ **Protocol 14; Review and authorize usage of condition Obvious Death (Submersion ≥ 6hrs) (14-B-2)**

_____ **Protocol 14; Define / authorize EMS response for condition Obvious Death (Submersion ≥ 6hrs (14-B-2)**

Response: _____

PROTOCOL #18 – HEADACHE

jc **Protocol 18; Define and authorize Stroke Treatment Time Window (suffix: T)**

"T" = Time window set by Medical Control: ≤ 24 hrs

PROTOCOL #24 – PREGNANCY / CHILDBIRTH / MISCARRIAGE

MD Initials

jc **Protocol 24; Define and authorize High Risk Complications for Code 24-D-5**

- ☑ Premature birth (24-36 weeks)
- ☑ Multiple birth (≥ 24 weeks)
- ☑ Bleeding disorder
- ☑ Blood thinners
- ☑ Cervical cerclage (stitch)
- ☑ Placenta abruption
- ☑ Placenta Previa
- ☑ Other (as approved by Medical Director)

☐ Caller reports high risk pregnancy/pregnancy complications _____

☐ _____

_____ **Protocol 24; Review and authorize usage of Omega Referral for Code 24-O-1 (Waters broken, no contractions or presenting parts)**

_____ **Protocol 24; Define/authorize EMS response for Omega Referral Code 24-O-1)**

Response: _____

PROTOCOL #28 – STROKE (CVA) / TRANSIENT ISCHEMIC ATTACK (TIA)

jc **Protocol 28; Define and authorize Stroke Treatment Time Window (suffix: T)**

"T" = Time window set by Medical Control: ≤ 24 hrs

jc **Protocol 28; Authorize launch of Stroke Diagnostic Tool AFTER dispatch**

PROTOCOL #33 – TRANSFER / INTERFACILITY / PALLIATIVE CARE

MD Initials

_____ **Protocol 33 - Define acuity levels for codes 33-A-1, 33-A-2, 33-A-3**

Acuity Level A-I

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Acuity Level A-II

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Acuity Level A-III

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MD Initials

_____ **Protocol 33; Define and authorize EMS Response for Codes 33-A-1, 33-A-2, 33-A-3**

☐ Response 33-A-1: _____

☐ Response 33-A-2: _____

☐ Response 33-A-3: _____

PROTOCOL #34 - ACN (AUTOMATIC CRASH NOTIFICATION)

jc ____ **Protocol 34; Review and authorize use of Automatic Crash Notification Protocol**

PROTOCOL #36 – PANDEMIC / EPIDEMIC / OUTBREAK (SURVEILLANCE OR TRIAGE)

jc ____ **Protocol 36; Review and authorize use of Pandemic / Epidemic / Outbreak (Surveillance or Triage) Protocol**

PROTOCOL #37 – INTERFACILITY / EVALUATION / TRANSFER

_____ **Protocol 37; Define and authorize the minimum qualifications of medical personnel defined as NURSE or DOCTOR**

- ☐ Medical Doctor (MD)
- ☐ Physician Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ _____ Other (Approved by Medical Director)
- ☐ _____ Other (Approved by Medical Director)

_____ **Protocol 37; Define and authorize Stroke Treatment Time Window (suffix: T)**

"T" = Time window set by Medical Control: _____

OTHER SETTINGS AND AUTHORIZATIONS

ASPIRIN DIAGNOSTIC & INSTRUCTION TOOL

jc____ **Review and authorize use of ASA administration**

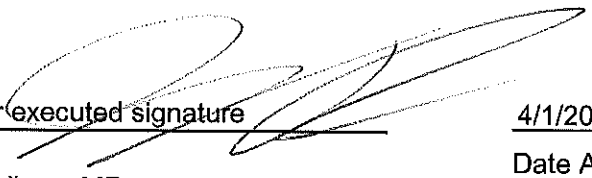
CARDIAC ARREST CPR COMPRESSIONS PATHWAYS

jc____ **Review and authorize one of the compressions pathways for the treatment of adult cardiac arrest of non-respiratory etiology (check one)**

- ☐ **Compressions 1st**
- ☑ **Compressions Only**

I have reviewed each of the items above and completed all applicable authorizations and protocol definitions required to implement the Advanced Medical Priority Dispatch System in:

Glastonbury Police Department



Electronic or executed signature

4/1/2019

Date Approved

Dr. James Castellone, MD

EMD Program Medical Director

Eastern CT Health Network

MIDDLESEX SPONSOR HOSPITAL
MEDICAL DIRECTION REQUIREMENTS and AGREEMENT
MOBILE INTENSIVE CARE SERVICES

Mobile Intensive Care Service is defined as "the organized provision of intensive, complex pre-hospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider" according to Connecticut Department of Public Health regulation 19a-179-1. Medical Control and Direction is a privilege extended to an Emergency Medical Service that wishes to provide patient care. The purpose of this document is to define the various levels of medical control that may be attained and to clarify the responsibilities and obligations that service agencies and individuals must agree to in order to obtain and/or maintain medical direction through Middlesex Hospital (MH).

The Middlesex Hospital EMS Medical Director will be Board Certified in Emergency Medicine, and have an expressed interest in EMS. The EMS Medical Director will be selected for the position after review and interview by the EMS Manager and Emergency Department Chairman.

Middlesex Hospital will make available educational opportunities to all sponsored service members from time to time, and those opportunities will be posted and communicated by email and or direct mailings. If a service has requested a case review or presentation and the resources are available, Sponsor Hospital will provide a liaison to address the request. In addition, several provider meetings will be held annually in order for Sponsor Hospital representatives to meet with chief officers and Service Education Coordinators (SEC). Topics of discussion can include treatment guideline updates, training updates and announcements, facility updates and issues, paramedic response and updates. These meetings will be announced in advance by email and direct mailings.

The Middlesex Hospital Basic Life Support Guidelines are reviewed on a regular basis and any changes are communicated to the service chiefs and each SEC.

Each individual wishing to obtain or maintain MH Mobile Intensive Care (MIC) medical direction authorization must:

1) Maintain a certification of EMR, EMT, EMT-A or licensure as a Paramedic, or MD issued by the State of Connecticut.

2) Be affiliated with a service that is authorized by the State of Connecticut to provide care at the defibrillation level.

Each service intending to obtain or maintain MH medical direction shall:

1) Designate a service education coordinator (SEC) (see section 4).

2) Grant access to paper patient care forms and/or electronic PCR program for quality review by Sponsor Hospital

3) Provide training requested by MH Medical Direction.

4) Provide Middlesex Hospital EMS Department Basic Life Support Guidelines or current guidelines being supported by Middlesex Sponsor Hospital to their members and provide proof of distribution when requested.

5) Annually submit an updated personnel roster when presenting the Connecticut MIC Hospital Agreement for medical control signatures.

6) Assure each member seeking or holding MH medical direction is certified or licensed by the State of Connecticut and is in good standing.

7) Assure each member seeking or holding MH medical direction has received training at the AED level, is trained on department equipment, and is proficient with the MH Sponsor Hospital Guidelines involving AED use and deployment.

8) Assure each EMT member seeking or holding MH medical direction at the MIC EpiPen Auto-Injector level has received EpiPen training, is trained on the location and storage of department EpiPens, and is proficient with the MH Sponsor Hospital Guidelines involving EpiPen use and deployment. ***For MIC-EPI services only.***

SECTION 1: Defibrillation Level

In order to receive and maintain MH Medical Direction for defibrillation, each service shall, at the minimum, be required to be authorized by the State of Connecticut to provide care at the defibrillation level.

The service shall:

1) Appoint a SEC.

2) Require the SEC to maintain personnel rosters on site at the place of business recognized by the State of Connecticut Department of Public Health. Personnel files shall have at a minimum, copies of each service member's certification or license.

3) Review 100% cardiac arrest cases to ensure that all documentation is completed and submitted to MH as instructed on MH's defibrillation data collection form.

4) Perform annual quality assurance checks and maintain/file results on site.

SECTION 2: EMT-B Standing Orders/Epi-Pen

In order to receive and maintain MH Medical Direction for EMT-B Standing Orders/Epi-Pen, each service shall, at the minimum, provide care at the defibrillation level as authorized by the State of Connecticut, maintain the MH Medical Direction requirements for providing defibrillation level care, and appoint a SEC.

A State of Connecticut EMT, EMT-A, or Paramedic may administer all medications per the "Connecticut State BLS Guidelines" as amended by MH Medical Direction. EMR's are not authorized, per State of Connecticut regulations, to provide care at the EMT-B level.

The service requirements for receiving and maintaining EMT-B Standing Orders/Epi-Pen include all of the requirements for defibrillation ***plus***:

1. All cases in which EMT-B Standing Orders/Epi-Pen were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Epi-Pen Guideline and deployment of the Epi-Pen annually with their EMT-B member's.

SECTION 3: Narcan

In order to receive and maintain MH Medical Direction for Narcan on standing order for EMR/EMT level, each service shall inform MH Medical Direction of the desire to carry Narcan and provide Narcan education to all certified or licensed members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT/EMR Standing Orders/Narcan were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Opiate Overdose Guideline and deployment of Narcan annually with their EMT/EMR members.

SECTION 4: Aspirin

In order to receive and maintain MH Medical Direction for Aspirin on standing order for EMT level, each service shall inform MH Medical Direction of the desire to carry Aspirin and provide Aspirin education to all EMT members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT Standing Orders/Aspirin were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Chest Pain Guideline and deployment of Aspirin annually with their EMT member's.

SECTION 5: Continuous Quality Improvement (CQI)

To provide proper oversight and assure quality care is being provided to all patients, MH Sponsor Hospital will review patient care reports, first responder forms, and cases of interest on a regular and ongoing basis. Quality review will be done by the MH EMS Coordinator, EMS Quality Coordinator, or designee. The CQI process will include:

1. Review of a percentage of patient care reports per quarter based on service call volume.
2. 100% review of cases involving cardiac arrest; AED use; Epi-Pen deployment; aspirin administration; Narcan administration.
3. Provide feedback to members via electronic charting software, or via email. Any findings that would result in actions including an investigation will involve the Chief of Service.
4. Educational opportunities for remediation, prevention and enhancement of the patient care system will be made available.

SECTION 6: Service Education Coordinator

To be selected and maintain MH Medical Direction designation as a SEC, the individual must meet all of the following:

1. Have experience as an EMT, EMT-A, Paramedic, or MD. EMS-I preferred, but not necessary.
2. Be in good standing with Sponsor Hospital.

The SEC's responsibilities shall include, but is not limited to:

1. Maintaining personnel files which shall include:

   a) Copies of current State of Connecticut EMR, EMT, EMT-I, Paramedic, RN, or MD certifications/licenses

   b) Provide copies of protocols to service members and provide proof of distribution when requested.

2. Maintaining Service files, which shall include:

   a) Current personnel rosters (includes level of certification/license).

   b) Maintains/files copies of SAED maintenance records.

   c) Maintains and files copies of all patient care reports.

It is the responsibility of the service to notify MH Medical Direction of any change in a service's SEC status.

SECTION 7: Suspension of Medical Direction

Suspension of MH Medical Direction for a service may occur for any one of, but not limited to, the following:

1) In the interest of patient care in accordance with Connecticut Department of Public Health regulations section 19a-179-15(b).

2) Failure to grant Sponsor Hospital access to patient care forms including electronic patient care records (ePCR).

Suspension of MH Medical Direction for an individual may occur for any one of, but not limited to, the following:

1) In the interest of patient care in accordance with Connecticut Department of Public Health regulations section 19a-179-15(b).

2) Consistent pattern of deficiencies noted on quality checks, CQI review, and/or mandatory training.

3) Failure to follow current State of Connecticut recertification guidelines.

SECTION 8: Agreement

Before any service operates under the above MH Medical Direction requirements, they shall be required to sign this MH Medical Direction agreement.

Agreement

We East Hampton Police Department have read, understand, and
(name of organization)
agree to follow the above requirements.

Approved:

Vincent G. Capece, Jr.	Vincent Capece	8/31/15
Middlesex Hospital CEO (print)	Middlesex Hospital CEO (sign)	Date
Michael Zanker, M.D.		8/31/15
MH EMS Medical Director (print)	MH EMS Medical Director (sign)	Date
James J. Santacroce		8/20/15
MH EMS Manager (print)	MH EMS Manager (sign)	Date
Sean Cox		08-11-15
Chief of Service (print)	Chief of Service (sign)	Date

Please send all MH Medical Direction correspondence to the following address:

Jim Santacroce
EMS Manager
28 Crescent St
Middletown, CT 06457
Phone: 860-358-6081
Fax: 860-358-4444
jim.santacroce@midhosp.org

MIDDLESEX SPONSOR HOSPITAL
MEDICAL DIRECTION REQUIREMENTS and AGREEMENT
MOBILE INTENSIVE CARE SERVICES

Mobile Intensive Care Service is defined as "the organized provision of intensive, complex pre-hospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider" according to Connecticut Department of Public Health regulation 19a-179-1. Medical Control and Direction is a privilege extended to an Emergency Medical Service that wishes to provide patient care. The purpose of this document is to define the various levels of medical control that may be attained and to clarify the responsibilities and obligations that service agencies and individuals must agree to in order to obtain and/or maintain medical direction through Middlesex Hospital (MH).

The Middlesex Hospital EMS Medical Director will be Board Certified in Emergency Medicine, and have an expressed interest in EMS. The EMS Medical Director will be selected for the position after review and interview by the EMS Manager and Emergency Department Chairman.

Middlesex Hospital will make available educational opportunities to all sponsored service members from time to time, and those opportunities will be posted and communicated by email and or direct mailings. If a service has requested a case review or presentation and the resources are available, Sponsor Hospital will provide a liaison to address the request. In addition, several provider meetings will be held annually in order for Sponsor Hospital representatives to meet with chief officers and Service Education Coordinators (SEC). Topics of discussion can include treatment guideline updates, training updates and announcements, facility updates and issues, paramedic response and updates. These meetings will be announced in advance by email and direct mailings.

The Middlesex Hospital Basic Life Support Guidelines are reviewed on a regular basis and any changes are communicated to the service chiefs and each SEC.

Each individual wishing to obtain or maintain MH Mobile Intensive Care (MIC) medical direction authorization must:

1) Maintain a certification of EMR, EMT, EMT-A or licensure as a Paramedic, or MD issued by the State of Connecticut.

2) Be affiliated with a service that is authorized by the State of Connecticut to provide care at the defibrillation level.

Each service intending to obtain or maintain MH medical direction shall:

1) Designate a service education coordinator (SEC) (see section 4).

2) Grant access to paper patient care forms and/or electronic PCR program for quality review by Sponsor Hospital

3) Provide training requested by MH Medical Direction.

4) Provide Middlesex Hospital EMS Department Basic Life Support Guidelines or current guidelines being supported by Middlesex Sponsor Hospital to their members and provide proof of distribution when requested.

5) Annually submit an updated personnel roster when presenting the Connecticut MIC Hospital Agreement for medical control signatures.

6) Assure each member seeking or holding MH medical direction is certified or licensed by the State of Connecticut and is in good standing.

7) Assure each member seeking or holding MH medical direction has received training at the AED level, is trained on department equipment, and is proficient with the MH Sponsor Hospital Guidelines involving AED use and deployment.

8) Assure each EMT member seeking or holding MH medical direction at the MIC EpiPen Auto-Injector level has received EpiPen training, is trained on the location and storage of department EpiPens, and is proficient with the MH Sponsor Hospital Guidelines involving EpiPen use and deployment. ***For MIC-EPI services only.***

SECTION 1: Defibrillation Level

In order to receive and maintain MH Medical Direction for defibrillation, each service shall, at the minimum, be required to be authorized by the State of Connecticut to provide care at the defibrillation level.

The service shall:

1) Appoint a SEC.

2) Require the SEC to maintain personnel rosters on site at the place of business recognized by the State of Connecticut Department of Public Health. Personnel files shall have at a minimum, copies of each service member's certification or license.

3) Review 100% cardiac arrest cases to ensure that all documentation is completed and submitted to MH as instructed on MH's defibrillation data collection form.

4) Perform annual quality assurance checks and maintain/file results on site.

SECTION 2: EMT-B Standing Orders/Epi-Pen

In order to receive and maintain MH Medical Direction for EMT-B Standing Orders/Epi-Pen, each service shall, at the minimum, provide care at the defibrillation level as authorized by the State of Connecticut, maintain the MH Medical Direction requirements for providing defibrillation level care, and appoint a SEC.

A State of Connecticut EMT, EMT-A, or Paramedic may administer all medications per the "Connecticut State BLS Guidelines" as amended by MH Medical Direction. EMR's are not authorized, per State of Connecticut regulations, to provide care at the EMT-B level.

The service requirements for receiving and maintaining EMT-B Standing Orders/Epi-Pen include all of the requirements for defibrillation ***plus***:

1. All cases in which EMT-B Standing Orders/Epi-Pen were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Epi-Pen Guideline and deployment of the Epi-Pen annually with their EMT-B member's.

SECTION 3: Narcan

In order to receive and maintain MH Medical Direction for Narcan on standing order for EMR/EMT level, each service shall inform MH Medical Direction of the desire to carry Narcan and provide Narcan education to all certified or licensed members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT/EMR Standing Orders/Narcan were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Opiate Overdose Guideline and deployment of Narcan annually with their EMT/EMR members.

SECTION 4: Aspirin

In order to receive and maintain MH Medical Direction for Aspirin on standing order for EMT level, each service shall inform MH Medical Direction of the desire to carry Aspirin and provide Aspirin education to all EMT members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT Standing Orders/Aspirin were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Chest Pain Guideline and deployment of Aspirin annually with their EMT member's.

SECTION 5: Continuous Quality Improvement (CQI)

To provide proper oversight and assure quality care is being provided to all patients, MH Sponsor Hospital will review patient care reports, first responder forms, and cases of interest on a regular and ongoing basis. Quality review will be done by the MH EMS Coordinator, EMS Quality Coordinator, or designee. The CQI process will include:

1. Review of a percentage of patient care reports per quarter based on service call volume.

2. 100% review of cases involving cardiac arrest; AED use; Epi-Pen deployment; aspirin administration; Narcan administration.

3. Provide feedback to members via electronic charting software, or via email. Any findings that would result in actions including an investigation will involve the Chief of Service.

4. Educational opportunities for remediation, prevention and enhancement of the patient care system will be made available.

SECTION 6: Service Education Coordinator

To be selected and maintain MH Medical Direction designation as a SEC, the individual must meet all of the following:

1. Have experience as an EMT, EMT-A, Paramedic, or MD. EMS-I preferred, but not necessary.

2. Be in good standing with Sponsor Hospital.

The SEC's responsibilities shall include, but is not limited to:

1. Maintaining personnel files which shall include:

   a) Copies of current State of Connecticut EMR, EMT, EMT-I, Paramedic, RN, or MD certifications/licenses

   b) Provide copies of protocols to service members and provide proof of distribution when requested.

2. Maintaining Service files, which shall include:

   a) Current personnel rosters (includes level of certification/license).

   b) Maintains/files copies of SAED maintenance records.

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It is the responsibility of the service to notify MH Medical Direction of any change in a service's SEC status.

SECTION 7: Suspension of Medical Direction

Suspension of MH Medical Direction for a service may occur for any one of, but not limited to, the following:

1) In the interest of patient care in accordance with Connecticut Department of Public Health regulations section 19a-179-15(b).

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Suspension of MH Medical Direction for an individual may occur for any one of, but not limited to, the following:

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3) Failure to follow current State of Connecticut recertification guidelines.

SECTION 8: Agreement

Before any service operates under the above MH Medical Direction requirements, they shall be required to sign this MH Medical Direction agreement.

Agreement

We East Hampton Volunteer Ambulance have read, understand, and
(name of organization)
agree to follow the above requirements.

Approved:

Vincent G. Capece, Jr.		3/10/15
Middlesex Hospital CEO (print)	Middlesex Hospital CEO (sign)	Date
Michael Zanker, M.D.		3/10/15
MH EMS Medical Director (print)	MH EMS Medical Director (sign)	Date
James J. Santacroce		3/9/2015
MH EMS Manager (print)	MH EMS Manager (sign)	Date
Thomas Donnelly	Thomas Donnelly	3-1-15
Chief of Service (print)	Chief of Service (sign)	Date

Please send all MH Medical Direction correspondence to the following address:

Jim Santacroce
EMS Manager
28 Crescent St
Middletown, CT 06457
Phone: 860-358-6081
Fax: 860-358-4444
jim.santacroce@midhosp.org

MIDDLESEX SPONSOR HOSPITAL
MEDICAL DIRECTION REQUIREMENTS and AGREEMENT
MOBILE INTENSIVE CARE SERVICES

Mobile Intensive Care Service is defined as "the organized provision of intensive, complex pre-hospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider" according to Connecticut Department of Public Health regulation 19a-179-1. Medical Control and Direction is a privilege extended to an Emergency Medical Service that wishes to provide patient care. The purpose of this document is to define the various levels of medical control that may be attained and to clarify the responsibilities and obligations that service agencies and individuals must agree to in order to obtain and/or maintain medical direction through Middlesex Hospital (MH).

The Middlesex Hospital EMS Medical Director will be Board Certified in Emergency Medicine, and have an expressed interest in EMS. The EMS Medical Director will be selected for the position after review and interview by the EMS Manager and Emergency Department Chairman.

Middlesex Hospital will make available educational opportunities to all sponsored service members from time to time, and those opportunities will be posted and communicated by email and or direct mailings. If a service has requested a case review or presentation and the resources are available, Sponsor Hospital will provide a liaison to address the request. In addition, several provider meetings will be held annually in order for Sponsor Hospital representatives to meet with chief officers and Service Education Coordinators (SEC). Topics of discussion can include treatment guideline updates, training updates and announcements, facility updates and issues, paramedic response and updates. These meetings will be announced in advance by email and direct mailings.

The Middlesex Hospital Basic Life Support Guidelines are reviewed on a regular basis and any changes are communicated to the service chiefs and each SEC.

Each individual wishing to obtain or maintain MH Mobile Intensive Care (MIC) medical direction authorization must:

1) Maintain a certification of EMR, EMT, EMT-A or licensure as a Paramedic, or MD issued by the State of Connecticut.

2) Be affiliated with a service that is authorized by the State of Connecticut to provide care at the defibrillation level.

Each service intending to obtain or maintain MH medical direction shall:

1) Designate a service education coordinator (SEC) (see section 4).

2) Grant access to paper patient care forms and/or electronic PCR program for quality review by Sponsor Hospital

3) Provide training requested by MH Medical Direction.

4) Provide Middlesex Hospital EMS Department Basic Life Support Guidelines or current guidelines being supported by Middlesex Sponsor Hospital to their members and provide proof of distribution when requested.

5) Annually submit an updated personnel roster when presenting the Connecticut MIC Hospital Agreement for medical control signatures.

6) Assure each member seeking or holding MH medical direction is certified or licensed by the State of Connecticut and is in good standing.

7) Assure each member seeking or holding MH medical direction has received training at the AED level, is trained on department equipment, and is proficient with the MH Sponsor Hospital Guidelines involving AED use and deployment.

8) Assure each EMT member seeking or holding MH medical direction at the MIC EpiPen Auto-Injector level has received EpiPen training, is trained on the location and storage of department EpiPens, and is proficient with the MH Sponsor Hospital Guidelines involving EpiPen use and deployment. ***For MIC-EPI services only.***

SECTION 1: Defibrillation Level

In order to receive and maintain MH Medical Direction for defibrillation, each service shall, at the minimum, be required to be authorized by the State of Connecticut to provide care at the defibrillation level.

The service shall:

1) Appoint a SEC.

2) Require the SEC to maintain personnel rosters on site at the place of business recognized by the State of Connecticut Department of Public Health. Personnel files shall have at a minimum, copies of each service member's certification or license.

3) Review 100% cardiac arrest cases to ensure that all documentation is completed and submitted to MH as instructed on MH's defibrillation data collection form.

4) Perform annual quality assurance checks and maintain/file results on site.

SECTION 2: EMT-B Standing Orders/Epi-Pen

In order to receive and maintain MH Medical Direction for EMT-B Standing Orders/Epi-Pen, each service shall, at the minimum, provide care at the defibrillation level as authorized by the State of Connecticut, maintain the MH Medical Direction requirements for providing defibrillation level care, and appoint a SEC.

A State of Connecticut EMT, EMT-A, or Paramedic may administer all medications per the "Connecticut State BLS Guidelines" as amended by MH Medical Direction. EMR's are not authorized, per State of Connecticut regulations, to provide care at the EMT-B level.

The service requirements for receiving and maintaining EMT-B Standing Orders/Epi-Pen include all of the requirements for defibrillation ***plus***:

1. All cases in which EMT-B Standing Orders/Epi-Pen were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Epi-Pen Guideline and deployment of the Epi-Pen annually with their EMT-B member's.

SECTION 3: Narcan

In order to receive and maintain MH Medical Direction for Narcan on standing order for EMR/EMT level, each service shall inform MH Medical Direction of the desire to carry Narcan and provide Narcan education to all certified or licensed members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT/EMR Standing Orders/Narcan were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Opiate Overdose Guideline and deployment of Narcan annually with their EMT/EMR members.

SECTION 4: Aspirin

In order to receive and maintain MH Medical Direction for Aspirin on standing order for EMT level, each service shall inform MH Medical Direction of the desire to carry Aspirin and provide Aspirin education to all EMT members of the department as outlined by CT DPH OEMS.

1. All cases in which EMT Standing Orders/Aspirin were used shall be included for submission to MH Medical Direction.

2. Each service is strongly encouraged to review the Chest Pain Guideline and deployment of Aspirin annually with their EMT member's.

SECTION 5: Continuous Quality Improvement (CQI)

To provide proper oversight and assure quality care is being provided to all patients, MH Sponsor Hospital will review patient care reports, first responder forms, and cases of interest on a regular and ongoing basis. Quality review will be done by the MH EMS Coordinator, EMS Quality Coordinator, or designee. The CQI process will include:

1. Review of a percentage of patient care reports per quarter based on service call volume.

2. 100% review of cases involving cardiac arrest; AED use; Epi-Pen deployment; aspirin administration; Narcan administration.

3. Provide feedback to members via electronic charting software, or via email. Any findings that would result in actions including an investigation will involve the Chief of Service.

4. Educational opportunities for remediation, prevention and enhancement of the patient care system will be made available.

SECTION 6: Service Education Coordinator

To be selected and maintain MH Medical Direction designation as a SEC, the individual must meet all of the following:

1. Have experience as an EMT, EMT-A, Paramedic, or MD. EMS-I preferred, but not necessary.

2. Be in good standing with Sponsor Hospital.

The SEC's responsibilities shall include, but is not limited to:

1. Maintaining personnel files which shall include:

   a) Copies of current State of Connecticut EMR, EMT, EMT-I, Paramedic, RN, or MD certifications/licenses

   b) Provide copies of protocols to service members and provide proof of distribution when requested.

2. Maintaining Service files, which shall include:

   a) Current personnel rosters (includes level of certification/license).

   b) Maintains/files copies of SAED maintenance records.

   c) Maintains and files copies of all patient care reports.

It is the responsibility of the service to notify MH Medical Direction of any change in a service's SEC status.

SECTION 7: Suspension of Medical Direction

Suspension of MH Medical Direction for a service may occur for any one of, but not limited to, the following:

1) In the interest of patient care in accordance with Connecticut Department of Public Health regulations section 19a-179-15(b).

2) Failure to grant Sponsor Hospital access to patient care forms including electronic patient care records (ePCR).

Suspension of MH Medical Direction for an individual may occur for any one of, but not limited to, the following:

1) In the interest of patient care in accordance with Connecticut Department of Public Health regulations section 19a-179-15(b).

2) Consistent pattern of deficiencies noted on quality checks, CQI review, and/or mandatory training.

3) Failure to follow current State of Connecticut recertification guidelines.

SECTION 8: Agreement

Before any service operates under the above MH Medical Direction requirements, they shall be required to sign this MH Medical Direction agreement.

Agreement

We EAST HAMPTON VOL. FIRE DEPT. have read, understand, and
(name of organization)
agree to follow the above requirements.

Approved:

Vincent G. Capece, Jr.		10/18/15
Middlesex Hospital CEO (print)	Middlesex Hospital CEO (sign)	Date
Michael Zanker, M.D.		10/8/15
MH EMS Medical Director (print)	MH EMS Medical Director (sign)	Date
James J. Santacroce		10/6/2015
MH EMS Manager (print)	MH EMS Manager (sign)	Date
GREGORY VOELKLER		09/29/2015
Chief of Service (print)	Chief of Service (sign)	Date

Please send all MH Medical Direction correspondence to the following address:

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North Central C-MED

Region 3 Mass Casualty Incident Protocol

Pre-Hospital

North Central CT EMS Council
P.O. Box 1833
120 Holcomb Street
Hartford, CT 06144-1833

Business Phone: 860-769-6055
CMED Phone: 860-769-6051
Business Fax: 860-286-3034
Email: info@NorthCentralCTEMS.org

January 2009

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Special thanks to:

Dr. Steven C. Wolf, M.D., Chairman for the Department of Emergency Medicine, Saint Francis Care
Brenda Murphy, Chief Medical Officer, East Hartford Fire Department
Dave Koscuk, EMT-P, EMSI, Captain of Clinical Services, New Britain EMS
Scott A. Woods, EMS Service Chief, Newington Volunteer Ambulance Corps, Inc.

Table of Contents

North Central CMED System

Purpose

North Central CMED's utmost concern is to provide pre-hospital and hospital users with the most efficient and reliable communications system possible.

This information is designed to familiarize you with North Central CMED's procedures during a Multi-Casualty Incident, and is intended to assist with your communication needs if such an incident occurs.

Any questions or concerns regarding these guidelines should be addressed directly to North Central Connecticut EMS Council Management.

Introduction to the Mass Casualty Incident

"Multi-Casualty and "Mass Casualty" traditionally are interchangeable terms in Connecticut. Connecticut's Term references an incident that meets locally defined thresholds in accordance with the jurisdiction emergency response plan.

- Large numbers of injured persons
- Large multi-agency response teams
- Inherently hazardous environments
- High stress environments

Local disaster plans identify the specific formula for each jurisdiction; knowing the local criteria is crucial to early recognition and declaration of MCI

What is a Mass Casualty?

FEMA Mass Casualty Incident Definition
Mass casualty incidents are incidents resulting from man-made or natural causes resulting in illness or injuries that exceed or overwhelm the EMS and hospital capabilities of a locality, jurisdiction, or region. A mass casualty incident is likely to impose a sustained demand for health and medical services rather than the short, intense peak demand for these services typical of multiple casualty Incidents.

What is a Multi-Casualty Incident?

FEMA Multi-Casualty Incident Definition
Multi-casualty incidents are incidents involving multiple victims that can be managed, with heightened response (including mutual aid if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities for one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents.

MCI Threshold Definition

The point at which the number of patients at an MCI and the severity of their conditions are beyond the ability of available resources to provide adequate care.

The day-to-day EMS response is designed to assure scene safety and to triage, treat and transport no more than a few patients. If day-to-day procedures were followed at the scene of a large number of casualties, several problems could occur with scene management, triage, treatment, and transport.

The threshold formula is….

 # Ambulances within 15 minutes X 2 victims +1 would constitute an MCI declaration for that community
Example: 6 ambulances X 2 victims = 12 victims
12 victims + 1 = 13 (MCI declaration)

MCI Threshold = 13 victims

If the numbers of victims exceeds the threshold, but few, if any, appear to be seriously injured, consideration should be given to **not** declaring an MCI.

North Central Region Threshold

"For Area Hospital Notification Only"

Field units are required to notify North Central CMED of incidents involving:

- **Three ambulances to any incident**
- **Three critical (red) victims and/or**
- **Ten victims**

MCI LEVELS

The establishment of MCI levels is to automatically trigger operational movement of resources without the CMED communicator needing special authority/direction. In theory the EMS officer would declare an MCI (level 1-4) and CMED following established protocol would automatically deploy resources as outlined:

Level 1 MCI (11-20 victims)

- 10 Ambulances (no need to specify ALS v BLS)
- 2 EMS Supervisors
- 1 Local MCI equipment resource

Level 2 MCI (21-50 victims)

- 15 ambulances
- 3 EMS Supervisors
- 1 Regional MCI trailer
- Consider 1 bus
- RED Plan Notification

Level 3 MCI (51-100 victims)

- 20 Ambulances
- Consider 2 buses
- 5 EMS Supervisors
- 1 Regional MCI Trailer
- RED Plan Notification

Level 4 MCI (>100 victims)

- 20 Ambulances (per 100 victims)
- Consider 2 Buses (per 100 victims)
- 5 EMS Supervisors (per 100 victims)
- 1 Regional MCI trailer (per 100 victims)
- RED Plan Notification

Hazardous Materials (HAZMAT) Weapons of Mass Destruction (WMD)

HAZMAT, CBRNE/WMD incidents will often require the use of local or regional HAZMAT teams.

FIRST UNIT ON THE SCENE

First unit on scene gives visual size-up, assumes and announces command, and confirms incident location, then…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 CMED with your size-up information.
- Request additional resources.

SETUP the scene for management of the casualties:

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

SMART triage:

- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use SMART Triage tags 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 SMART.

Radio Procedures

It is essential that proper radio etiquette is used during transmissions to CMED. Unit to unit communications should be left to a minimum. Use plain language, avoid jargon and codes. Transmissions shall be professional, brief and concise.

When calling a unit or station, identify the unit or station being called then your I.D. Speak clearly into the microphone and build in pauses when giving reports to confirm the other party receives the message.

Notification to CMED for Declared Mass Casualty Incident

Upon declaration of an MCI, per protocol, CMED will confirm receipt of notification, alert area agencies and notify all hospitals in the North Central Region of the developing MCI with a simultaneous broadcast. CMED will **not** forward information to other agencies, hospitals, etc… until the incident is declared an MCI.

The **Medical Branch Director/Medical Group Supervisor** will request a CMED channel assignment. Once assigned, the **Medical Branch Director/the Medical Group Supervisor** will determine and communicate to CMED the following information:

1. **Name/Title of the Medical Group Supervisor on scene.**
2. **Name/Title of the Patient Transportation Unit Leader/Ambulance Coordinator**
3. **Nature of the Incident (cause of situation).**
4. **Exact Location (town & street).**
5. **MCI Level (1-4)**
6. **Estimated number of victims. (Number of known injuries and estimated possible casualties).**
7. **Number of ambulances requested to the scene (if CMED is requested to perform mutual aid call out) and if an MCI trailer is needed.**
8. **Exact ambulance staging area and contact information**

CMED Notification to Hospitals for Declared Mass Casualty Incident

Upon confirmation and receipt of declared MCI by the **Medical Branch Director/ Medical Group Supervisor** on scene, CMED will notify all hospitals in the North Central region of the developing mass casualty incident with a simultaneous broadcast, and telephone communications as necessary.

Patients will be sorted according to SMART criteria of red, yellow, green. Upon receiving direction from the **Medical Group Supervisor**, CMED will contact all area hospitals to determine red, yellow, and green capabilities.

During the incident, CMED will provide periodic updates to the hospitals in the affected area. ***These hospitals should report any changes in their status during an incident that may affect scene management, directly to CMED.***

CMED will notify hospitals when ambulances depart the scene of an MCI. The following information will be reported for each transport:

- **Ambulance number and destination hospital**
- **Patient SMART Tag**
- **Triage color**

- **Age and sex of patient(s)**
- **Nature of injury**
- **ETA**

Incidents involving more than 10 patients CMED will notify Colchester Communications (MEDNET Control) of the incident.

Use of MED Channels during Mass Casualty Incident

MED Channels are used to facilitate your direction requests to CMED. MED channels will not be used as an "EMS ground frequency" or an uninterrupted direct link to any hospital. EMS units responding to an MCI are to sign on with CMED on MED 10. Units will then be directed to the assigned MCI MED channel.

MCI Channel Assignment

To maintain a sound communication system, CMED will authorize up to three MED channels to be used during an MCI.

MCI Command and Control Channel

This channel will be utilized for communications between the **Medical Branch Director/Supervisor** and CMED. This channel will be used to:

- Coordinate between scene and CMED
- Update CMED with established casualties
- Update CMED with escalation of the incident
- Update scene as to hospital bed availability

MCI Transportation Channel

This channel will be used by the **Patient Transportation Unit Leader/Medical Communications Coordinator** during MCI operations. The Patient Transportation Unit Leader should give concise patient SMART Tag reports to CMED for hospital notification. This will prevent ambulances from lengthy individual reports. This channel will be used to:

- Request mutual aid
- Coordination of arriving units (directions, new information, staging, etc…)
- Update scene of mutual aid status
- Provide patient reports to CMED
- Provide transportation information to CMED

Note: Entry notifications to the hospitals will be made by CMED. **The Patient Transportation Unit Leader/Medical Communications Coordinator** should give CMED patient reports which include: Ambulance number and hospital destination, SMART Tag number and color, age and sex, nature of injury, and ETA will be documented on the CMED patient tracking form.

MCI Channel Assignment

MCI Additonal Channel

Depending upon the nature and scope of the MCI, North Central CMED may assign a third MED channel. Use of this channel will be determined after discussion between the CMED Center and the **Medical Branch Director.** Examples for channel use are listed below and are not all inclusive:

- Forward Movement of Patients
- Ambulance Strike Team Request
- Governmental agency requests
- Supply requests
- Stockpile request
- Further scene coordination
- Communication link between medical control hospital and medical control officer on scene. (This will be a non-repeaterized channel).

MEDNET (CT EMS Communications Network) Notification

CMED will notify various communications centers and appropriate public safety agencies via MEDNET, as necessary.

Mutual Aid

Mutual Aid is the process by which resources from one town/service area are deployed to respond to request for service in another town or service area. Mutual aid is used in the following circumstances:

1. There are more calls in a town service area than the primary responder can handle
2. There is need for additional resources above what the town/service provider can provide at a single incident
3. A mass casualty situation has occurred
4. The primary service has failed to initiate a response within established response parameters

As North Central CMED is not the primary dispatch center for any EMS service, they will have no role in mutual aid callout until such time as they are requested to assist in procuring mutual aid or when a MCI declaration occurs. In either instance, at the time of the request, North Central CMED will become the sole agency with the exception of pre-planned Special Operations to request additional units and responses. During Special Operations, it is the responsibility of the EMS Commander to advise CMED of the number of transport units on scene. At the time of the request North Central CMED should be provided with a turnover of agencies requested and responding, their unit numbers, clinical levels and ETA.

North Central CMED as part of the Statewide MEDNET System is responsible for mobilizing EMS assets in its service area for response to major incidents through out the State of Connecticut. Pending completion of the Department of Public Health EMS Mobilization Plan, North Central CMED and its client EMS Provider Services will be guided by the following principles when requested to provide mutual aid in other areas of the State (outside of Region 3).

1. Only 25% of the on duty ambulance/paramedic units available in the North Central CMED Service area at the time of the request will be allocated to an out of region incident.
2. Upon a state DPH request for North Central CMED service area EMS assets, all EMS provider services will be requested to staff all of their available response units, to ensure coverage in Region 3.
3. At no time will on duty ambulance/paramedic units fall below 75% due to responses requested by the State, other regions or other CMED's.
4. EMS providers will refrain from deploying assets from their service areas to other areas of the State except as may be directed by North Central CMED.

Hospital Distribution

As a general rule, in the case of an emergency, EMS transports patients to the closest geographic hospital. Sometimes, EMS and hospital conditions makes it more appropriate to take the patient to a hospital that is not the closest.

This point-of-entry plan addresses circumstances when, because of the health of the system, the system would benefit from distributing patients to a more distant hospital(s) emergency department. North Central CMED will monitor the overall status of the EMS and hospital systems. In the event of an MCI or other high volume incident or incidents, North Central CMED will assign hospital destinations to transport units.

Staging Areas

All responding EMS units should go directly to the assigned STAGING AREA and await further instructions. Do not leave the staging area until you are instructed to do so by the **Medical Branch Director/Medical Group Supervisor** or the direction of North Central CMED.

Patient Dispersal from the Scene

Patients will be sorted according to SMART Tag criteria of RED/YELLOW/GREEN/BLACK. Upon receiving direction from the the Medical Branch Director/Medical Group Supervisor, CMED will contact all area hospitals to determine RED/YELLOW/GREEN capabilities.

- Red: Priority 1
  Life-threatening but treatable injuries requiring immediate medical attention

- Yellow: Priority 2
  Potentially serious injuries, but are stable enough to wait a short while for urgent medical treatment

- Green: Priority 3
  Injuries that can wait for longer periods of time for delayed treatment

- Black/Blue: Dead/Expectant
  Dead or (expectant still with life signs but injuries are incompatible with survival in austere conditions

To assure hospital capabilities have not reached capacity, transporting units will be assigned hospital destination by North Central CMED.

Patient Dispersal to Receiving Hospitals

Purpose

The purpose of this protocol is to assure that the treatment of patients at the scene of a mass casualty incident and transportation to receiving hospitals is done in accordance with accepted medical and communication standards. ***Radio traffic should be kept at a minimum.*** In accordance with the statewide program of Mass Casualty Care in Connecticut, patients requiring advanced life support will have effective medical control communications providing guidance for, advanced life support care without the need for individual orders, alternative transportation for patients receiving advance life support when insufficient MICU unit are available, and assurance

that trauma patients are taken to appropriate trauma centers. Communications to hospitals and requests for medical control will be processed through the individual that has assumed responsibility for the EMS function at the scene of an incident.

Scene Management

Upon arrival at the scene of a mass casualty incident, the EMS provider sets up EMS scene control and designates and the Medical Branch Director/Medical Group Supervisor per their Mass Casualty Incident Plan. Whenever possible CMED should be advised of the incident's scope. CMED will alert the hospitals closet to the incident's scene. During the incident, CMED will provide periodic updates to the hospitals in the affected area. These hospitals should report any changes in their status during an incident that may affect scene management, directly to CMED.

Medical Control / Communication at the Scene

All EMS personnel providing treatment at the scene of a declared Mass Casualty Incident will follow standing orders protocols**. It is not necessary to contact medical control of the individual service. Standing ALS orders will apply during a declared Mass Casualty Incident.** If communication to medical control is necessary, CMED will provide a MED channel for the designated **Treatment Officer.** The Sponsor Hospital nearest the incident will be designated as the **Medical Control Hospital.** This should **not** be considered an "open patch." The Treatment Officer should establish communication with CMED first to assure that a physician is online.

Med control policy

MEDICAL DIRECTION DURING A MASS CASUALTY INCIDENT

In order to reduce radio congestion and allow scene personnel to accomplish their tasks during a declared mass casualty incident, all regional protocols will revert to standing orders during this time. However, medical personnel cannot function beyond the scope of their training or above the authorized level of the service with which the personnel are responding. All patients treated under standing orders must have this documented on the PCR.

Nevertheless, scene personnel are encouraged to contact on line medical direction as needed to aid in the treatment efforts

After Action Reporting

The EMS Section of Region 3 Emergency Support Function (ESF)-8 will make itself available to facilitate an After Action Report of any MCI within Region 3. The After Action Report may be requested by the incident agency/town, the Region 3 Medical Advisory Committee (MAC), the Region 3 EMS Council or North Central CMED.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

J. Robert Galvin, M.D., M.P.H., M.B.A.
Commissioner

M. Jodi Rell
Governor

Date: August 28, 2008

To: Regional Communication Centers
CMED Centers
EMS Service Chiefs
Fire Departments

From: J. Robert Galvin, M.D., M.P.H., M.B.A. J Robert Galvin MD MPH MBA
Commissioner

Re: Deployment Strategy for MCI Trailers

In a joint effort between the Department of Public Health and the Department of Emergency Management and Homeland Security, 5 regional Mass Casualty Incident Trailers have been deployed throughout the state to be utilized during large-scale events.

These trailers contain items such as immobilization and splinting supplies, trauma supplies and dressings, airway management and oxygen along with various miscellaneous items.

Attached please find the deployment protocol for these trailers, which outline the process for requesting this asset. Should you have any questions, please contact Leonard Guercia, Operations Branch Chief at (860) 509-7975 or via email at Leonard.guercia@ct.gov.

Thank you for your on-going support of our preparedness efforts.

PHONE: (860) 509-7101 FAX: (860) 509-7111
410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308

REGIONAL MASS CASUALTY SUPPORT TRAILER

DEPLOYMENT PROCEDURE

GENERAL

The Connecticut Department of Public Health, in cooperation with the Connecticut Department of Emergency Management and Homeland Security (DEMHS), has partnered to deploy five (5) regional mass casualty supply trailers. These units contain a cache of durable and disposable medical equipment that can be used to support large-scale incidents, when local EMS supply resources have been, or are expected to be, exhausted. Each trailer has been stocked with primarily basic life support equipment, is designed to provide medical supplies and equipment to treat approximately 100 patients, and are pre-positioned in each of the five (5) DEMHS / EMS regions through a voluntary arrangement with the following EMS service providers:

Region 1	Wilton Volunteer Ambulance
Region 2	American Medical Response (AMR) of CT, New Haven
Region 3	New Britain EMS, New Britain
Region 4	American Ambulance Service, Norwich
Region 5	Danbury Fire Department

ACTIVATION / DEPLOYMENT

The Regional Mass Casualty Support Trailers are available to any local jurisdiction requiring the medical supply resources available on the units. In the event of a multi-casualty incident (MCI), the local Incident Command, Medical Branch Director (if so authorized by the IC), or Medical Group Supervisor (if so authorized by the IC) can initiate the request either directly through their local communications center, or through their local C-MED, for deployment of the regional MCI trailer to a designated staging location. The local communications center /CMED will then direct dial the designated Coordinated Medical Emergency Dispatch (CMED) center in the affected region. Those designated CMED centers are identified as follows:

Region 1	Southwest CMED	(203) 338-0762
Region 2	South Central CMED	(203) 499-5600
Region 3	North Central CMED	(860) 769-6051
Region 4	Norwich CMED	(860) 886-1463
Region 5	Northwest Public Safety	(203) 758-0050

C-MED shall dispatch the closest unit to the incident. Based on the totality of the circumstances, and in accordance with any established regional protocols, the designated C-MED may choose to either place a second unit on stand-by or deploy the second unit as a redundant response in case there are factors preventing the original unit from completing the assigned mission. The second unit can also be deployed for additional equipment if required. Upon contact with the most appropriate hosting location's dispatch center, CMED will relay the following information:

a) Requesting agency
b) Incident location
c) Incident type
d) Estimated number of casualties
e) Special hazards or any safety concerns
f) Designated staging location to report to for assignment

MCI trailer deployment
8/28/08 DPH

The designated C-MED will contact **Incident Command**, the **Medical Branch Director** or the **Medical Group Supervisor** via C-MED radio, or by phone through their local communications center, and inform them of an estimated time of arrival to the staging area as soon as the host EMS service provider have reported to C-MED that they are en-route with the staffed regional MCI trailer. The host EMS service provider is required to deploy the regional MCI trailer within 30 minutes of activation in the event of an emergency. It is important to note that the closest regional MCI trailer may not necessarily be from the affected Region. The designated C-MED shall verify the closest unit.

The designated C-MED will also contact the Department of Public Health at (860) 509-8000. In addition, the designated C-MED will notify each of the other four designated C-MED centers via direct phone line, MEDNET, or MEDSAT.

In instances where the Medical Branch Director or Medical Group Supervisor is authorized to call for resources, Incident Command must be informed that additional resources are being deployed to the incident. The Treatment Unit Leader should also be made aware that equipment has been requested, estimated arrival time, and where it is to be staged.

STAFFING

The EMS service providers /communities that host the regional MCI supply trailers are contracted to provide staffing throughout the incident. The trailer shall not be deployed to an incident, to include drills and exercises, without being staffed by at least two (2) personnel from the host agency. Staff responding with the trailers shall not be assigned to any other tasks. They are solely responsible for the operation of the trailer, including inventory control / equipment distribution, and completing demobilization procedures. Other emergency response personnel operating on the scene of a multi-casualty incident may assist the trailer operators with equipment distribution and demobilization only. **Note: Under no circumstances shall the requesting jurisdiction send a representative directly to the trailer location and transport the trailer to the designated staging location.**

ON-SITE OPERATIONS

Upon arrival, trailer staff will liaison with Medical Branch Director, Medical Group Supervisor, or Treatment Unit Leader. The regional MCI trailer should be deployed between the treatment area and transport /loading area.

a) Site location requirement of 30' X 30'
b) Trailer staff must remain with the trailer at all times

Trailer Staff will deploy requested equipment to the treatment area(s) for medical treatment activities. They will maintain records of all medical and other supplies utilized that will need to be replaced, and will note any equipment failures or malfunctions at the conclusion.

DEMOBILIZATION

Upon completion of an assigned mission, the designated CMED center shall be notified by the host EMS service provider if the trailer is out of service due to mechanical failure, or cannot be re-deployed secondary to a depleted supply cache. They will in turn notify the Department of Public Health at (860) 509-8000 and each of the other four designated CMED centers via direct phone line, MEDNET, or MEDSAT, that the regional MCI trailer has been de-mobilized, and whether or not it is back in service.

MCI trailer deployment
8/28/08 DPH

Red Plan Activation

The purpose of the Regional Emergency Deployment Plan (RED Plan) is to provide a framework for member communities and agencies to collaborate in planning, communication information sharing and coordination activities before, during, and after a regional emergency.

*The Red Plan does not supersede existing emergency operations plans or procedures that CMED currently has in place but works in coordination with the RED Plan***.**

RED Plan Incident/Event Status Levels

- **Level One** – Single agency/community
- **Level Two** – Regular mutual aid event
- **Level Three** – Region resources activated through the RED Plan (Standard Regional Incident-SRI)
- **Level Four** – Regional and State resources activated (Disruptive Regional Incident- DRI)
- **Level Five** – Regional, State and Federal Resources activated (Major Regional Incident – MRI)

Notification and RED Plan Activation

Key decision makers, subject matter experts, and RESF chairpersons are notified of a potential or actual incident through Regional Integrated Communication System (RICS). "RICS" is the regional radio designation for the Regional Integrated Communication System headquartered at **Central Connecticut State University Campus Police Department.**

RICS Activation Format:

- A designated authority or incident commander (or agency's dispatcher) calls RICS at 860-832-3477 anytime 24/7 and requests specific resources or the activation of the RED Plan where RCC will anticipate resource needs without a specific request.

- RICS will broadcast the message over the "intercity" radio frequency.
- RICS will notify the chairperson of each RESF of the situation/event and provide the contact number in the message for the chairperson of RESF5 Emergency Management or the designated back-up official.

Medical Branch Incident Command Structure

Medical Branch Incident Command Structure

Medical Branch Director
The Medical Branch is responsible for the implementation of the Incident Action Plan with the Medical Branch. The Branch Director reports to the Operations Sections Chief and supervises medical group(s) and the Patient Transportation function (unit or group). Patient Transportation may be upgraded from a unit to a Group based on the size and complexity of the incident.

Medical Group Supervisor
The Medical Group Supervisor reports to the Medical Branch Director and Supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader and Medical supply Coordinator. The Medical Group Supervisor establishes command and controls activities within the medical group.

Triage Unit Leader
The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Personnel/Litter Bearers and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. When triage is completes, the Unit leader may be reassigned as needed.

Triage Personnel
Triage Personnel report to the Triage Unit Leader. Triage Personnel triage, tag, and assign patients to appropriate treatment areas.

Morgue Manager
The Morgue Manager Reports to the Triage Unit Leader and assumes responsibility for morgue area functions.

Treatment Unit Leader/Group Supervisor
The Treatment Unit Leader reports to the Medical Group Supervisor and supervises Treatment Managers and the Treatment Dispatch Manager. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport and directs movement of patients to loading location(s).

The Treatment Unit Leader reports to the medical group supervisor and appoints Immediate- (Priority 1) Treatment Area Manager, Urgent- (Priority 2) Treatment Area Manager, Delayed- (Priority 3) Treatment Area Manager.

Immediate (Priority 1) Treatment Area Manager
The Immediate –priority 1 Treatment Area Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to the immediate- priority 1 Treatment Area.

Urgent (Priority 2) Area Manager
The Urgent-priority 2 Treatment Area Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to the Urgent-priority 2 Treatment Area.

Delayed (Priority 3) Area Manager
The Delayed-priority 3 Treatment Area Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to the delayed-priority 3 Treatment Area.

Treatment Dispatch Manager

The Treatment Dispatch Manager reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader (or group supervisor if established), the area to appropriate receiving treatment facilities.

Patient Transportation Unit Leader / Group Supervisor

The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ambulance Coordinator. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination. The Patient transportation function may be initially established as a unit and upgraded to a group based on incident size and complexity.

Medical Communications Coordinator

The Medical Communications Coordinator reports to the Patient Transportation Unit Leader / Group Supervisor, and maintains communications with the local CMED to monitor status of available bed to assure proper patient transportation.

Ambulance Coordinator

The Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the ambulance staging area(s), and dispatches ambulances as requested.

Medical Supply Coordinator

The Medical Supply Coordinator reports to the Medical Group Supervisor acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group.

Checklists

for use in Connecticut Multi-Casualty Incident Responses
April 11, 2001
Developed by the Connecticut Mass Casualty Care Committee
Approved by the Connecticut EMS Advisory Board
Revised August 30, 2007 to conform to the NIMS

Checklists are presented for each of the following:

Medical Branch Director
Medical Group Supervisor
Triage Unit Leader and Triage Personnel
Morgue Manager
Treatment Unit Leader
Treatment Dispatch Manager
Immediate (Priority 1) Area Manager
Urgent (Priority 2) Area Manager
Delayed (Priority 3) Area Manager
Patient Transportation Unit Leader or Group Supervisor
Medical Communication Coordinator
Ambulance Coordinator
Medical Supply Coordinator

Medical Branch Director

Appointed by and reports to: Operations Section Chief or Incident Commander
Supervises: All Medical Functions

The Medical Branch Director is also responsible for the functions of the Medical Group Supervisor and the Medical Supply Coordinator until the size of the incident requires expansion. If expanded, the Medical Branch Director should appoint the Medical Group Supervisor and the Medical Supply Coordinator.

- ☐ Review Group assignments for effectiveness of current operations and modify as needed.
- ☐ Provide input to Operations Section Chief for the Incident Action Plan.
- ☐ Supervise Branch activities and confer with the Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.
- ☐ Report to Operations Section Chief on Branch Activities.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to: Date:
Incident Name:

Medical Group Supervisor

Appointed by and reports to: Medical Branch Director or Incident Commander
Supervises: Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, Medical Supply Coordinator

If hazard exists, the Incident Commander may order patients evacuated, or many control hazards before allowing EMS to enter.

- ☐ Identify the type of incident.
- ☐ Estimate the number of victims and their injuries.
- ☐ Coordinate with the command post for site security, traffic and EMS access, including location of any staging areas.
- ☐ Establish Medical Group with assigned personnel, request additional personnel and resources sufficient to handle the magnitude of the incident.
- ☐ Designate Unit Leaders and Treatment Area locations as appropriate.
- ☐ Isolate Delayed Treatment Area and Morgue from Immediate and Urgent Treatment Areas.
- ☐ Request law enforcement/coroner involvement as needed.
- ☐ Determine amount and types of additional medical resources and supplies needed to hand the magnitude of the incident. (backboards, litters, stretchers, medical caches)
- ☐ Ensure activation of hospital alert system via CMED with an estimate of casualties.
- ☐ Direct and/or supervise on-scene personnel from agencies such as the coroner's office, Red Cross, law enforcement, ambulance companies, public health agencies, and hospital volunteers.
- ☐ Identify problems and reassign resources as needed.
- ☐ Give periodic reports to the *Incident Commander.*
- ☐ Maintain Unit/Activity Log (ICS 214).

Notes:

Position assigned to:

Incident Name: Date:

Triage Unit Leader

Appointed by and reports to: Medical Branch Director
Supervises: Triage Personnel, Litter Bearers, Morgue Manager

- ☐ Develop organization sufficient to handle assignment.
- ☐ Inform Medical Group Supervisor of resource needs.
- ☐ Assign and supervise triage personnel.
- ☐ Implement triage process.
- ☐ Coordinate movement of patients from the triage area to the appropriate treatment area.
- ☐ Give periodic classification reports to the *Medical Group Supervisor*
- ☐ Maintain Unit/Activity Log (ICS 214)

Notes:

Position assigned to: Date:
Incident Name:

Triage Personnel

Appointed by and reports to: Triage Unit Leader

- ☐ Report to designated on-scene triage location.
- ☐ Triage and tag injured patients based on RPM. Color classify patients and report classification count to Triage Unit Leader.
- ☐ Direct movement of patients to proper treatment areas.
- ☐ Provide appropriate basic life-saving treatment to patients prior to movement as incident conditions dictate.
- ☐ Report classification totals to the *Triage Unit Leader*.

Notes:

Position assigned to: Date:
Incident Name:

Morgue Manager

Appointed by and reports to: Triage Unit Leader

- ☐ Assess resource/supply needs and order as needed.
- ☐ Coordinate all morgue activities.
- ☐ Keep area off limits to all but authorized personnel.
- ☐ Coordinate with law enforcement and assist the Coroner or Medical Examiner representative.
- ☐ Keep identity of deceased persons confidential.
- ☐ Maintain appropriate documentation.

Notes:

Position assigned to:

Incident Name Date:

Treatment Unit Leader

Appointed by and reports to: Medical Branch Director
Supervises: All Treatment Area Managers
The Treatment Unit Leader is also responsible for the functions of the Treatment Dispatch Manager until the size of the incident requires expansion. If expanded, the Treatment Unit Leader should appoint a Treatment Dispatch Manager.

- ☐ Develop organization sufficient to handle assignment.
- ☐ Direct and supervise Treatment Dispatch, Immediate, Urgent, and Delayed Treatment Areas.
- ☐ Mark boundary lines for the red and yellow patients to be located.
- ☐ Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- ☐ Request sufficient medical caches and supplies as necessary.
- ☐ Establish communications and coordination with Patient Transportation Unit Leader.
- ☐ Ensure continual triage of patients throughout treatment areas.
- ☐ Direct movement of patients to ambulance loading area(s).
- ☐ Give periodic reports to the Medical Branch Director.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Treatment Dispatch Manager

Appointed by and reports to: Treatment Unit Leader

- ☐ Establish communications with the Immediate, Urgent, and Delayed Treatment Managers.
- ☐ Establish communications with the Patient Transportation Unit Leader.
- ☐ Verify that patients are prioritized for transportation.
- ☐ Advise the Medical Communications Coordinator of patient readiness and priority for transport.
- ☐ Coordinate transportation of patients with Medical Communications Coordinator.
- ☐ Assure that appropriate patient tracking information is recorded.
- ☐ Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Immediate Treatment Area Manager

Priority 1

Appointed by and reports to: Treatment Unit Leader

- ☐ Request or establish medical teams as necessary.
- ☐ Assign treatment personnel to patients received in the Immediate Treatment Area.
- ☐ Ensure treatment of patients triaged to Immediate Treatment Area.
- ☐ Assure that patients are prioritized for transportation.
- ☐ Coordinate transportation of patients with Treatment Dispatch Manager.
- ☐ Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- ☐ Assure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date

Urgent Area Treatment Manager
Priority 2

Appointed by and reports to: Treatment Unit Leader

- ☐ Request or establish medical teams as necessary.
- ☐ Assign treatment personnel to patients received in the Immediate Treatment Area.
- ☐ Ensure treatment of patients triaged to Immediate Treatment Area.
- ☐ Coordinate transportation of patients with Treatment Dispatch Manager.
- ☐ Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- ☐ Assure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Delayed Treatment Area Manager

Priority 3

Appointed by and reports to: Treatment Unit Leader

- ☐ Request or establish medical teams as necessary.
- ☐ Assign treatment personnel to patients received in the Immediate Treatment Area.
- ☐ Ensure treatment of patients triaged to Immediate Treatment Area.
- ☐ Assure that patients are prioritized for transportation.
- ☐ Coordinate transportation of patients with Treatment Dispatch Manager.
- ☐ Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- ☐ Assure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Patient Transportation Unit Leader or Group Supervisor

Appointed by and reports to: Medical Group Supervisor
Supervises: Medical Communications Coordinator, Ambulance Coordinator

- ☐ Ensure the establishment of communications with hospital(s).
- ☐ Designate ambulance staging areas.
- ☐ Direct the off-incident transportation of patients as determined by treatment need and system status.
- ☐ Assure that patient information and destination are recorded.
- ☐ Establish communications with Ambulance Coordinator.
- ☐ Request additional ambulances as required.
- ☐ Notify Ambulance Coordinator of ambulance requests.
- ☐ Coordinate requests for air ambulance transportation through the Air Operations Branch Director if appointed.
- ☐ Coordinate the establishment of Air Ambulance Helispots with the Medical Branch Director, Medical Group Supervisor or Air Operations Branch Director.
- ☐ Gives periodic reports to the *Medical Group Supervisor.*
- ☐ Maintain Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date

Medical Communications Coordinator

Appointed by and reports to: Patient Transportation Unit Leader or Group Supervisor

- ☐ Establish communications with CMED for hospital alerting.
- ☐ Determine and maintain current status of hospital/medical facility availability and capability.
- ☐ Receive basic patient information and condition from Treatment Dispatch Manager.
- ☐ Coordinate patient destination with CMED.
- ☐ Communicate patient transportation needs to Ambulance Coordinators based upon requests from the Treatment Dispatch Manager.
- ☐ Communicate patient air ambulance transportation needs to the Air Operations Branch Director or Medical Group Supervisor based on requests from the treatment area managers or Treatment Dispatch Manager.
- ☐ Maintain appropriate records and Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Ambulance Coordinator

Appointed by and reports to: Patient Transportation Unit Leader

- ☐ Establish appropriate staging area for ambulances.
- ☐ Establish routes of travel for ambulances for incident operations.
- ☐ Establish and maintain communications with the Air Operations Branch Director if assigned regarding Air Ambulance transportation assignments.
- ☐ Establish and maintain communications with Medical Communications Coordinator and Treatment Dispatch Manager.
- ☐ Provide ambulances upon request from the Medical Communications Coordinator.
- ☐ Assure that necessary equipment is available in the ambulance for patient needs during transportation.
- ☐ Establish contact with ambulance providers at the scene.
- ☐ Request additional transportation resources as appropriate.
- ☐ Provide an inventory of medical supplies available in the ambulance staging area for use at the scene.
- ☐ Maintain records as required and Unit/Activity Log (ICS Form 214).

Notes:

Position assigned to:

Incident Name: Date:

Medical Supply Coordinator

Appointed by and reports to: Medical Branch Director or Medical Group Supervisor

- ☐ Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.*
- ☐ Request additional medical supplies.*
- ☐ Distribute medical supplies to Treatment and Triage Units.
- ☐ Maintain Unit/Activity Log (ICS Form 214).
- ☐ *If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.

Notes:

Position assigned to: Date:

Incident Name:

CMED Radio Frequencies

Med -1	463.000/468.000 MHZ
Med -2	463.025/468.025 MHZ
Med -3	463.050/468.050 MHZ
Med -4	463.075/468.075 MHZ
Med -5	463.100/468.100 MHZ
Med -6	463.125/468.125 MHZ
Med -7	463.150/468.150 MHZ
Med -8	463.175/468.175 MHZ
Med -9	462.950/467.950 MHZ
Med -10	462.975/467.975 MHZ (Regional Coordination)

TAC -1	453.025/458.025 MHZ (local/regional coordination)
TAC -2	453.075/458.075 MHZ (local/regional coordination)
TAC -3	453.125/458.125 MHZ (special E.M.S. operations)
TAC -4	453.175/458.175 MHZ (special E.M.S. operations)

CT Trauma Centers

Level One (1) Trauma Centers

Baystate Memorial Hospital, MA	Adult & Pediatric
Hartford Hospital	Adult
Yale-New Haven Hospital	Adult & Pediatric

Level Two (2) Trauma Centers

Backus Hospital	Adult
Bridgeport Hospital	Adult
Danbury Hospital	Adult & Pediatric
Norwalk Hospital	Adult
ST Francis Hospital	Adult
ST Mary's Hospital	Adult
Hospital of ST Raphael	Adult
Stamford Hospital	Adult
ST Vincent's Medical Center	Adult
Waterbury Hospital	Adult

DPH rev. 03/07

Connecticut Hospitals

Backus Hospital
326 Washington St., Norwich, CT

From the New Haven area and Southwestern Connecticut: Take I-95 North to Exit 76 for I-395 North. Follow 395 to Exit 81 -East for the Routes 2 and 32 connector in Norwich. Follow the connector until you exit to your right onto Washington Street. The Hospital entrance is on the right.

From the Hartford area: Take Route 2 East to Norwich. Exit right onto Washington Street. The Hospital entrance is on the right.

Hospital of Central CT – Bradley Memorial
81 Meriden Ave, Southington, CT 06489

From Hartford:
I-84 West; exit 32; right at ramp; travel south on route 10 approximately 3 miles to route 120 (Meriden Ave.); hospital is on the left.

From Meriden/New Haven:
Route 691 West to exit 4; right at ramp; right at first light onto route 120 (Meriden Ave.) follow to hospital.

From Waterbury:
I-84 East; exit 30; (Marion Ave.) right at ramp; straight to route 10; follow "H" signs; right at Meriden Ave.; (Route 120).

Bridgeport Hospital
267 Grant Street, Bridgeport, CT 06610

From the Merritt Parkway,
(Route 15)

Traveling North (from New York):
Take Exit 49S to Route 25 South. Take Exit 5 to Boston Avenue. Turn right on Boston Avenue. Continue for 1.8 miles. Turn right on Mill Hill Avenue. Turn right on Grant Street. Visitor parking garage is on left

Traveling South (from New Haven):
Take Exit 52 to Route 8 South. Take Exit 5 to Boston Avenue. Turn right on Boston Avenue. Continue for 1.8 miles. Turn right on Mill Hill Avenue. Turn right on Grant Street. Visitor parking garage is on left.

From the Connecticut Turnpike, I-95

Traveling North (from New York):
Take Exit 29 -Stratford / Seaview Avenue. At the end of the ramp, take a left onto Seaview Avenue. Continue on Seaview Avenue for 1 mile. Turn right on Barnum Avenue. Turn left on Central Avenue. Turn right on Grant Street. Visitor parking garage is on right.

Traveling South (from New Haven):
Take Exit 32. Turn left at the end of the ramp on Linden Avenue. Turn right on West Broad Street. Turn left on Barnum Avenue. Turn right on Boston Avenue. Continue for 1.2 miles. Turn left on Mill Hill Avenue. Turn right on Grant Street. Visitor parking garage is on left.

Bristol Hospital
Brewster Road, Bristol, CT 06011

From Hartford:
Take I-84 West to exit 38 (Route 6). Follow Route 6 to Route 229 South. At Route 229, take a left and follow the blue hospital signs.

From Waterbury:
Take I-84 East to exit 31 (West Street). Take a left off the exit onto Route 229. Follow Route 229 to Route 72 West. Turn left onto Route 72 West and follow the blue hospital signs.

From New Haven:
Take I-91 North to Route 691 West. Take Route 691 West to I-84 East, to exit 31 (West Street) and follow the directions from Waterbury.

From New Britain:
Take I-84 East to Route 72 West to the end of the expressway. Take a right at the traffic light. Go through 2 more traffic lights; take a left onto Broad Street. Follow Broad Street until the end. Take a left at the traffic light. Go under the railroad bridge overpass and take an immediate right. Follow blue hospital signs.

From Torrington/Winsted:
Take Route 8 South to exist 39 (Bristol/Terryville). Take a left at the end of the exit ramp onto Route 6. Follow Route 6 into Bristol. Follow blue hospital signs.

Charlotte Hungerford Hospital
540 Litchfield St, Torrington, CT 06790

From Winsted (North):
Take Route 8 SOUTH to Exit 43. Once you get off the exit, there will be blue and white "H" signs to the hospital. At the end of the ramp, take a right, then a left at the stop sign. At the next stop sign, take right onto East Albert Street. You will continue straight through 2 more stop signs and 2 more traffic lights. At the third light bear left up the hill (Litchfield Street). The hospital will be on the right about 1/4 mile.

From Waterbury (South):
Take Route 8 NORTH to Exit 43 (Harwinton Avenue). Turn left at end of ramp.
At first intersection go straight on to East Albert Street and Albert Street to Litchfield Street**.**
Continue up the hill. The hospital will be on your right.

From Hartford (East):
Take I-84 WEST to exit 39 at Farmington. Take Route 4 WEST to route 118. Follow Route 118 to the intersection of Route 8 NORTH. Go NORTH on Route 8 to Exit 43 (Harwinton Avenue). Turn left at exit. At first intersection go straight on to East Albert Street and Albert Street to Litchfield Street. Continue up the hill. The hospital will be on your right.

Emergency Department
Follow the instructions for the hospital, then:
Continue up Litchfield Street past the Main Hospital Entrance on your right and up the hill.
Pass the Outpatient Services parking area entrance on your right and continue up the hill.
Take the next right into the Emergency Department Parking area.
If this lot is full, take a right up the hill and take the next Right. There is additional parking above the first parking area.

Connecticut Children's Medical Center
282 Washington Street, Hartford, CT 06106

Emergency Entrance: Seymour St., opposite "85 Seymour Street Medical Building"

From North or South of Hartford
Take I-91S or I-91N to Exit 29A, "Capitol Area." Proceed under three overpasses to rotary. Follow rotary three-quarters around and take right onto Hudson Street. Take Hudson Street to the end. Turn right onto Jefferson Street. At the traffic light turn left onto Seymour Street. You will be on the property for Connecticut Children's Medical Center and Hartford Hospital. At the stop sign turn right. The Children's Medical Center will be on your left, "Public Parking" will be on your right.

From Route 2
Take Route 2 West to Exit 5D, "Route 3/Putnam Bridge Exit." Get on 91 North and follow directions above.

From East of Hartford
Take I-84W and follow signs to Exit 54, "Downtown Hartford." Cross Founders Bridge then take first left onto Columbus Boulevard. Proceed through three lights and over a small bridge. After the bridge, turn right at second light, Charter Oak Avenue. Proceed through three lights and cross Main Street. After Main Street, proceed through one light and turn left at end onto Washington Street. Proceed through third light (at Jefferson Street), then take first left into hospital entrance. Connecticut Children's Medical Center is on your right as you enter the garage marked "Public Parking" on your left.

From West of Hartford
Take I-84E to Exit 48B, "Capitol Ave." Follow road as it curves right and under one overpass. Take left at light onto Capitol Avenue and proceed through next traffic light. Turn right at second light (at horse and rider statue), then bear left immediately at fork onto Washington Street. At the fifth light, take a left into hospital entrance. Connecticut Children's Medical Center is on your right as you enter the garage marked "Public Parking" on your left.

Danbury Hospital
24 Hospital Ave, Danbury, CT 06810

Traveling West on I-84
Take Exit 6, Turn right at exit ramp light at North Street, Turn right on Hayestown Avenue, Turn right on Tamarack Avenue. Follow Tamarack Avenue uphill to traffic light, Turn left at this light onto Hospital Avenue, Follow Hospital Avenue to appropriate visitor parking lot on right

Traveling East on I-84
Take Exit 5After stop sign, go straight ahead to intersection of Main Street and North Street. Go straight through onto North Street; Turn right off North Street to Maple Avenue. Go on Maple Avenue to Osborne Street, Turn left on Osborne Street, Turn left onto Hospital Avenue. Follow Hospital Avenue to appropriate visitor parking lot on right

Day Kimball Hospital
320 Pomfret Street (Route 44)
Putnam, CT 06260

From the North
I-395 South to Exit 97 (Route 44) at end of ramp, turn right. Continue on Route 44 West through town, Hospital is on your left, halfway up the hill

From the West
I-84 East to Exit 69 (Route 74). Continue on Route 74 East to Route 44. At blinker light, turn left onto Route 44 East. Follow Route 44 to Day Kimball Hospital, Hospital is on your right

From the South
I-395 North to Exit 95 (Kennedy Drive), at end of ramp, turn right onto Kennedy Drive. Continue to traffic light at intersection with Route 44, Turn left onto Route 44 West. Hospital is on your left, halfway up the hill

From the East
Route 44 East to Putnam, Continue through town on Route 44. Hospital is on your left, halfway up the hill

University of Connecticut Health Center (UCONN)
(John Dempsey)
263 Farmington Ave., Farmington, CT 06030

From Bradley International Airport
Follow Route 20 to I-91 South to I-84 West in Hartford. Follow I-84 West about 7 miles to Exit 39 which is after 39A. Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the Health Center campus.

From Farmington Center
Stay on Route 4 East/Farmington Avenue. As you drive up the hill toward I-84, stay in the right lane and follow the signs as Route 4 East/Farmington Avenue loops to the right and crosses the I-84 access road. At the fourth traffic light, turn right to enter the Health Center campus.

From West Hartford Center
Stay on Farmington Avenue/Route 4 West. The Health Center is about 3.3 miles on the left.

From Route 44 Canton/Avon
Proceed on Route 44 eastbound through Avon. Turn right onto Route 10 South/Waterville Road. Turn left onto Talcott Notch Road and continue to Farmington Avenue/Route 4 West. Turn right; the Health Center is a ¼ mile on the left.

From I-84
Take Exit 39 (if coming from I-84 West, Exit 39 is after 39A). Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the Health Center campus.

From Northbound Route 9
Take Exit 32 (left exit) onto I-84 west and stay in the right lane. Take Exit 39 (first exit). Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the Health Center campus.

To Return to Route 9
From the Farmington Avenue entrance on the Lower Campus, take a left onto Route 4 West/Farmington Avenue. At the second light, take a left onto South Road. At the first stop sign, turn right and follow the signs to Route 9 South (you will enter I-84 East briefly prior to exiting onto Route 9 South).

To Return to I-84 East or West
From the Farmington Avenue entrance on the Lower Campus, take a left onto Route 4 West/Farmington Avenue. At the third light, take a left towards the highway entrance ramps and follow the signs staying right for I-84 West or staying left for I-84 East.

Greenwich Hospital
5 Perryridge Road, Greenwich, CT 06830

From I-95
Southbound, Exit 3
Right onto Arch Street. Turn left onto Soundview Drive. At top of hill, turn right onto Field Point Road. At second traffic light, bear left. Cross Putnam Avenue (Route 1) onto Dearfield Drive. At circle, bear right onto Lake Avenue. Hospital on left and the Sherman and Gloria H. Cohen Pavilion/Bendheim Cancer Center straight ahead.

Northbound, Exit 3
Left onto Arch Street. Same as above.

Merritt Parkway
Southbound
Exit 31--Right onto North Street. Approximately 4 miles to Maple Avenue. Left onto Maple to stop light. Right onto East Putnam Avenue (Route 1) to Lafayette Place. Turn right. Hospital campus is straight ahead on left, with Sherman and Gloria H. Cohen Pavilion on your right.

Northbound
Exit 31--Left onto North Street. Same as above.

Griffin Hospital
130 Division St., Derby, CT 06418

Route 34 from New Haven:
Follow signs to Route 8 North, take Exit 18 and take a right onto Division St. Take right at first light. Griffin Hospital is on left.

Route 8 South:
Take Exit 17 and take a left onto Seymour Ave. Follow road for a 1/4 mile. Griffin Hospital is on right.

Route 8 North:
Take Exit 18 and take a right onto Division St. Take right at first light. Griffin Hospital is on left.

Route15/Wilbur Cross Parkway (from points north of New Haven):
Take exit 58 to Route 34 West, Follow signs to Route 8 North, Take Route 8 North to Exit 18 (Wakelee Ave.) Take a right at end of exit and right at traffic light, Griffin Hospital is on left

Route 15/Merritt Parkway - North & South (from points south of New Haven):
Take Exit 52 (Route 8 North/Waterbury) Take Route 8 North, Exit 18 (Wakelee Ave.) Take a right at end of exit and right at traffic light, Griffin Hospital is on left

Hartford Hospital
80 Seymour Street, Hartford, CT 06102

From WEST (traveling east)
Take I-84 East to Hartford. Take the Capitol Avenue Exit 48-B (a right hand exit). At the end of the ramp between the State Capitol Building and the Legislative Office Building, turn left onto Capitol Avenue and turn right onto Washington St. (at the equestrian statue of Gen. Lafayette) continuing south to the fifth traffic light (Connecticut Children's Medical Center and public garage on left). Turn into the drive at that light. The entrance to the public garage is on the left.

FROM NORTH (traveling south)
Take I-91 South to Hartford. Take the Capitol Area Exit 29A (a right hand exit). Keeping in the right lane, take the first exit (Columbus Boulevard/Convention Center) and turn left crossing the Columbus Boulevard Bridge. Continue through five (5) traffic lights (Columbus Blvd. will curve west and uphill, becoming Wyllis St.). At the fifth traffic light, continue straight, crossing Main St. onto Jefferson Street. At the second traffic light on Jefferson St., turn left onto Seymour St. At the front of Hartford Hospital, turn right; the entrance to the public garage is on the right immediately past the Medical Office Building and across from Connecticut Children's Medical Center.

FROM EAST (traveling west)
Take I-84 West to Hartford. Take the "Downtown Hartford" Exit 54 (a left hand exit) over the Founders Bridge and guide your vehicle to the far left lane. At the bottom of the bridge, turn left

onto Columbus Boulevard; travel past the Convention Center and across the Columbus Boulevard Bridge. Continue through five (5) traffic lights traffic lights (Columbus Blvd. will curve west and uphill, becoming Wyllis St.). At the fifth traffic light, continue straight, crossing Main St. onto Jefferson Street. At the second traffic light on Jefferson St., turn left onto Seymour St. At the front of Hartford Hospital, turn right; the entrance to the public garage is on the right immediately past the Medical Office Building and across from Connecticut Children's Medical Center.

FROM SOUTH (traveling north)
Take 1-91 North to Hartford, follow "Capitol Area" signs to exit 29A (a left-hand exit). Move immediately to the right lane and take the first exit (Columbus Boulevard/Convention Center) and turn left crossing the Columbus Boulevard Bridge. Continue through five (5) traffic lights traffic lights (Columbus Blvd. will curve west and uphill, becoming Wyllis St.). At the fifth traffic light, continue straight, crossing Main St. onto Jefferson Street. At the second traffic light on Jefferson St., turn left onto Seymour St. At the front of Hartford Hospital, turn right; the entrance to the public garage is on the right immediately past the

FROM SOUTH-EAST (ROUTE 2)
Take the "Downtown Hartford" exit onto the Founders Bridge. At the bottom of the bridge, turn left onto Columbus Boulevard, travel past the Convention Center and across the Columbus Boulevard Bridge. Continue through five (5) traffic lights traffic lights (Columbus Blvd. will curve west and uphill, becoming Wyllis St.). At the fifth traffic light, continue straight, crossing Main St. onto Jefferson Street. At the second traffic light on Jefferson St., turn left onto Seymour St. At the front of Hartford Hospital, turn right; the entrance to the public garage is on the right immediately past the Medical Office Building and across from Connecticut Children's Medical Center.

Johnson Memorial Hospital
201 Chestnut Hill Rd., Stafford Springs, CT 06076

From Hartford
Take I-84 East to Exit 67. At the end of the exit ramp, turn left and follow Route 31 to stoplight. Turn right onto Route 30. Continue on Route 30, turning left at stoplight by Leonard's Corner Veterinary Clinic. Follow Route 30 to intersection with Route 190. Turn left (west) and travel approximately 2 miles to Hospital complex. Turn right into the entrance.
OR
Take I-91 North to Exit 47E. Follow Route 190 East approximately 12 miles. Turn left into the Hospital complex.

From Springfield
Take I-91 South to Exit 47E. Follow Route 190 East approximately 12 miles. Turn left into the Hospital complex

Lawrence & Memorial
365 Montauk Ave., New London, CT 06320

From Hartford:
Take Route 2 east to Route 11, follow to the end. At the end of the exit ramp turn left on to Route 82. At the light (Salem Four Corners) turn right onto Route 85. Continue south for approximately 12 miles into New London. Turn right at traffic light onto Colman Street (Route 213).

At the end of Colman, turn right onto Bank Street, then an immediate left onto Lee Avenue. At the end of Lee, turn right onto Ocean Avenue. Go through one stop light, then turn left at the fourth street onto Faire Harbour Place (for Same-Day Surgery, Emergency Room, Community Cancer Center and Physicians Office Suites, patient drop-off area will be on the right). At stop sign turn right on Montauk Avenue. The Ambulatory Care Center and Main Hospital Entrances are on the right.

From Worcester or Norwich:
Take I-395 south to exit 78 to Route 32. Follow Route 32 into downtown New London where it becomes Eugene O'Neill Drive and then Green Street. Turn left at the end onto Tilley Street and a right onto Bank Street at the fire station. Follow Bank Street to the fourth stop light and turn left at Shalett's Cleaners onto Montauk Avenue. The Ambulatory Care Center and Main Hospital Entrances will be on the right, approximately one mile.

From New York and New Haven:
Take I-95 north to exit 82A, Frontage Road. Keep right and follow to Colman Street exit (Route 1 south). Turn left onto Colman Street and follow second paragraph of the directions From Hartford.

From Providence and Boston:
Take I-95 south to exit 83, Frontage Road. Take Colman Street exit and turn left onto Colman Street. Follow second paragraph of the directions From Hartford.

Manchester Memorial Hospital
71 Haynes Street, Manchester, CT 06040

From the Waterbury-Hartford area (heading down I-84 East):
Take I-84 East to I-384 East. Take Exit 3 (Route 83, Downtown Manchester) and take a right at the end of the exit ramp. Follow Main Street through the business district for approximately two (2) miles until you reach the light for Haynes Street. Turn left onto Haynes Street. The hospital is located on the right at 71 Haynes Street. Visitor parking is available on the left (across the street from the hospital). Free valet parking is available at the hospital's front entrance.

From the Boston-Sturbridge area (heading down I-84 West):
Take I-84 West to Exit 63 (Route 30) Take a right off the ramp onto Deming Street. Proceed less than a half mile, then take a right onto Oakland Street (Route 83). Continue about one mile; take a right at the light onto North Main Street (will still be on Route 83). At the next light, take a left onto Main Street (will still be on Route 83). Proceed about one mile. Pass the Middle Turnpike intersection, then take a right onto Haynes Street. The hospital is located on the right at 71 Haynes Street. Visitor parking is available on the left (across the street from the hospital). Free valet parking is available at the hospital's front entrance.

From the Springfield area and points north:
I-91 South to I-84 East, then follow directions above.

From the New Haven area and points south:
I-91 North to I-84 East, then follow directions above.

Middlesex Hospital
28 Crescent Street, Middletown, CT 06457

(i) From North (Hartford)
Take I-91 South to Exit 22S, Route 9 South. Follow Route 9 through Middletown. Take Exit 13, Route 17. Continue straight to the intersection with Route 17, South Main Street. At the light, turn right onto South Main Street. Follow South Main Street to the intersection with Crescent Street. Turn right onto Crescent Street. The entrance to the hospital and the Emergency Department are on Crescent Street.

(ii)

(iii) From South (Meriden)
Take I-91 or Wilbur Cross Parkway to Route 691 East. Follow Route 691 (becomes Route 66) to Main Street, Middletown. Turn right onto Main Street. Continue down Main Street to the intersection with Pleasant Street. Turn right onto Pleasant Street, then bear left at the next light

onto South Main Street. Turn left onto Crescent Street. The entrance to the hospital and the Emergency Department are on Crescent Street.

(iv)

(v) From West

Take I-84 to Route 691 East. Follow Route 691 (becomes Route 66) to Main Street, Middletown. Turn right onto Main Street. Continue down Main Street to the intersection with Pleasant Street. Turn right onto Pleasant Street, then bear left at the next light onto South Main Street. Turn left onto Crescent Street. The entrance to the hospital and the Emergency Department are on Crescent Street.

(vi)

(vii) From New York/New Haven

Take I-95 to I-91 North. Change to Route 9 South toward Cromwell/Middletown. In Middletown, take Exit 13. Continue straight to the intersection with Route 17, South Main Street. At the light, turn right onto South Main Street. Follow South Main Street to the intersection with Crescent Street. Turn right onto Crescent Street. The entrance to the hospital and the Emergency Department are on Crescent Street.

MidState Medical Center
435 Lewis Avenue, Meriden, CT 06451

From New Haven:
I-91N toward Hartford, Take exit 17 for CT-15N/Berlin Tpke/I-691/CT-66 N. Merge onto CT-15N, Take exit 68W to merge onto I-691 W toward Meriden. Take exit 6 to merge onto Lewis Ave. Straight through light.

From Hartford:
I-91 S toward New Haven, Take exit 18 to merge onto I-691 W toward Meriden/Waterbury. Take exit 6. Light at end of exit follow straight through.

From Waterbury:
I-84 E Toward Hartford onto I-691 E (signs for I-691 E/Meriden/Middletown. Take exit 7 to merge onto Columbia Street, Sharp Left at Columbia Pl/Columbia SrN Continue to follow Columbia Pl. Turn Right at Lewis Ave

From Middletown:
Ct-66/Washington St, follow to I-691 W, Take exit 6. Go straight through light at end of exit.

Milford Hospital
300 Seaside Avenue, Milfor, CT 06460

From Hartford Region and Points North:
Take I-91 South to I-95 South to Exit 36 (Plains Road). At the end of the ramp turn left and follow blue Hospital signs.

From Fairfield County and Points South:
Take I-95 North to Exit 36 (Plains Road). At the end of the ramp, turn right and follow blue Hospital signs.

From Merritt/Wilbur Cross Parkways and Points North:
Take Exit 54 to I-95 South. Take I-95 South to Exit 36 (Plains Road). At the end of the ramp turn left and follow blue Hospital signs.

From Merritt/Wilbur Cross Parkways and Points South:
Take Exit 54 to I-95 South. Take I-95 South to Exit 36 (Plains Road). At the end of the ramp turn left and follow blue Hospital signs.

Hospital of Central CT – New Britain General Hospital
100 Grand Street, New Britain, CT 06050

From Route 9
Exit 28 to Route 72 West. Take Corbin Ave. exit (Exit 7) and turn left. Follow the blue hospital signs (left onto Hart St., straight, then left onto Linwood St.) Up the hill, take second right onto Grand St., garage entrance on right.

From I-84
Exit 35 to Route 72 east. Take Corbin Ave. exit (Exit 7) and turn right. Follow the blue hospital signs (left onto Hart St., straight, then left onto Linwood St.) Up the hill, take second right onto Grand St., garage entrance on right.

New Milford Hospital
21 Elm Street, New Milford, CT 06776

From Danbury
Take Route 7 north to New Milford. Bear right onto Route 67/202 East, Bridge St. Cross bridge and after 3 traffic lights, bear left onto Route 202, East St. (distance from bridge about 0.5 mile). Continue on Route 202 about 0.3 mile to traffic light. Turn left at light onto Elm St, then first right into hospital parking lot entrance. Follow signs to main entrance. Distance from Danbury is approximately 15-17 miles from Danbury.

From New York City and Vicinity
Take your choice of highways to reach Interstate 84 East. Continue on Interstate 84 East to Danbury, CT. Take left Exit 7 marked Route 7 North, Brookfield - New Milford and proceed on two-way expressway to end. At the light, turn right and follow Route 7 North. Follow directions from Danbury.

From Bridgeport
Take Route 25 to Brookfield Center. At Congregational Church take Route 133 (right) about 5 or 6 miles to Route 67 (left onto 67). At the intersection of Route 67 and Route 202 in New Milford, bear right onto Route 202 and continue for about 0.3 mile. Turn left at the traffic light onto Elm St., then first right into hospital parking lot entrance. Follow signs to main entrance.

From Hartford/Waterbury
Follow Interstate 84 West and turn off at Exit 15. Bear right at ramp and follow Route 67 north for approximately 17 miles. At the intersection of Route 67 and Route 202 in New Milford, bear right onto Route 202 and continue for about 0.3 mile. Turn left at the traffic light onto Elm Street, then first right into hospital parking lot entrance. Follow signs to main entrance.

From New Haven
From New Haven, follow Whalley Ave. to Route 67W through Seymour, Oxford, Southbury and Roxbury to New Milford. At the intersection of Route 67 and Route 202, bear right onto Route 202 and continue for about 0.3 mile. Turn left at the traffic light onto Elm St., then first right into hospital parking lot entrance. Follow signs to main entrance.

Norwalk Hospital
34 Maple St, Norwalk, CT 06850

I-95 Northbound (from New York)
Take Exit 14. At end of ramp turn left and cross over the turnpike to traffic light. Turn right onto U.S. 1. At the third traffic light (Maple Street.) turn left to hospital area.

I-95 Southbound (from New Haven).
Take Exit 15. Bear right on ramp to traffic light. Turn right, onto West Ave. Pass through the next intersection (and light). At the next traffic light, turn left onto Maple Street and go straight ahead to the next traffic light to reach the hospital area.

Merritt Parkway, Northbound (from NY).
Take Exit 39, going right (South) directly onto the Rte-7 Connector (follow signs saying "to I-95"). Get off at Exit 1; turn left onto Van Buren Avenue (US-1). At the second traffic light turn right onto Maple Street, into the hospital area.

Merritt Parkway Southbound (From New Haven).
Take Exit 38 and turn right onto CT-123 South. At the fourth traffic light, CT-123 goes off to the left, but you do not turn; continue straight ahead to the seventh traffic light (from the Parkway), at Maple Street. Turn right on Maple Street into hospital area.

Rte. 7 Southbound (From Danbury).
Above the Merritt Parkway, just inside the Norwalk line, turn right onto the Route 7 Connector access road (directly opposite the Department of Motor Vehicles building). Follow signs "To I-95" onto Route 7 Connector. Take Exit 1; turn left onto Van Buren Avenue (US-1). At second traffic light turn right onto Maple Street, into hospital area.

Rockville General Hospital
31 Union St., Vernon Rockville, CT 06066

From either the Waterbury-Hartford area or the Sturbridge-Boston area (I-84 East or West):
Take I-84 to Exit 67
Follow Route 31 North toward Rockville
At the intersection of Route 74 (at the traffic light), take a left.
The hospital is approximately a half mile ahead on your left.
Blue hospital signs clearly mark the way from the highway to the hospital.

From the Springfield area and points north:
I-91 South to I-84 East, then follow directions above.

From the New Haven area and points south:
I-91 North to I-84 East, then follow directions above.

Saint Francis Hospital and Medical Center
114 Woodland St., Hartford, CT 06105

From Interstate 91 Northbound And Southbound
Take Exit 32A to Interstate 84 Westbound. From Interstate 84 Westbound, take Exit 48, Asylum Street. From exit ramp, take right onto Garden Street. At second traffic light, take left onto Collins Street for six blocks. At light, take left onto Woodland Street to hospital entrance on left.

From Interstate 84 Westbound
Take Exit 48, Asylum Street. From exit ramp, take right onto Garden Street. At second traffic light, take left onto Collins Street for six blocks. At light, take left onto Woodland Street to hospital entrance on left.

From Interstate 84 Eastbound
Take Exit 46, Sisson Avenue (a left exit). From exit ramp, take right onto Sisson Avenue for four blocks. Take right onto Farmington Avenue for four blocks. Take left onto Woodland Street for three blocks to hospital entrance on right.

Saint Mary's Hospital
55 Franklin St., Waterbury, CT 06706
Section 1.02
Section 1.03 **From the North**
Section 1.04 (Thomaston, Torrington, Winsted, etc.)
Route 8 South to I-84 East to Exit 23/Route 69 - Hamilton Avenue-Wolcott-Prospect. Take right hand exit - Hamilton Avenue/Route 69 North/Wolcott. Take RIGHT at the light onto Washington Street and stay in the left lane. Take a LEFT at the light onto Hamilton Avenue. Go straight and follow signs for Union Street/Downtown. At the 5th light, past the Brass Mill Center Mall and Commons, take a RIGHT onto Mill Street. At the second traffic light Go Straight and take a RIGHT onto Cole Street and LEFT into the visitors' parking garage. Additional parking is available in the visitors' lot across from the hospital's main entrance on Franklin Street.
Section 1.05
Section 1.06 **From the South**
(Naugatuck, Seymour, Bridgeport, etc.)
Route 8 North to I-84 East to Exit 22 (Downtown Waterbury/Baldwin Street). At second traffic light turn LEFT onto South Main Street. At second light take a RIGHT on to Scovill Street. At first light continue straight on Scovill Street. Then turn LEFT on to Cole Street and LEFT into the visitors' parking garage. Additional parking is available in the visitors' lot across from the hospital's main entrance on Franklin Street. To use the Franklin Street lot, turn RIGHT at the intersection of Cole Street, Scovill Street and Franklin Street.

Section 1.07 **From the East**
(Cheshire, Southington, Hartford, etc.)
I-84 West to Exit 22 (Union Street/Downtown area). LEFT at the traffic light onto Union Street. At the third traffic light, turn RIGHT onto South Elm. At the first traffic light turn RIGHT onto Scovill Street. Turn LEFT onto Cole Street and LEFT into the visitors' parking garage. Additional parking is available in the visitors' lot across from the hospital's main entrance on Franklin Street. To use the Franklin Street lot, turn RIGHT at the intersection of Cole Street, Scovill Street and Franklin Street.

Section 1.08 **From the West**
(Middlebury, Southbury, Danbury, etc.)
I-84 East to Exit 22 (Downtown Waterbury, Baldwin Street).). At second traffic light turn LEFT onto South Main Street. At second light take a RIGHT on to Scovill Street. At the first light go continue on Scovill Street. Turn LEFT on to Cole and turn LEFT into the visitors' parking garage. Additional parking is available in the visitors' lot across from the hospital's main entrance on Franklin Street. To use the Franklin Street lot, turn RIGHT at the intersection of Cole Street, Scovill Street and Franklin Street.

Hospital of Saint Raphael
1450 Chapel Street, New Haven, CT 06511

Emergency Department
Orchard Street Entrance

From Hartford (North)
Leave I-91 at Exit 1 (Downtown New Haven) CONTINUE straight on the exit expressway, where it merges with North Frontage Rd. CONTINUE through four lights and then turn right at the fifth light onto Orchard St. After the first light, the Emergency Department is halfway up the block on your left.

From Shore Towns (East)
Leave I-95 at Exit 47 (Downtown New Haven) CONTINUE straight on the exit expressway, where it merges with North Frontage Rd. CONTINUE through four lights and then turn right at the fifth light onto Orchard St. After the first light, the Emergency Department is halfway up the block on your left.

From Waterbury and Upstate New York (Northwest)
Follow Route 69 South to Route 63 South (Whalley Ave.) CONTINUE down Whalley Ave. for about 2¼ miles and take a right on Orchard St. Follow Orchard St. pass Chapel St. The Emergency Department is halfway up the block on your right.

From Bridgeport and New York City Areas (West)
Leave the Wilbur Cross Parkway at Exit 57 (Route 34 east) CONTINUE on Route 34 until you cross Ella Grasso Boulevard. CONTINUE straight ahead onto Derby Ave. Derby Ave. changes into George St. Once past Sherman Ave. take the next left onto Orchard St. The Emergency Department is halfway up the block on your left.

Or, leave I-95 north at Exit 47(Downtown New Haven) CONTINUE straight on the exit expressway, where it merges with North Frontage Rd. CONTINUE through four lights and then turn right at the fifth light onto Orchard St. After the first light, the Emergency Department is halfway up the block on your left.

St. Vincent's Medical Center
2800 Main Street, Bridgeport, CT 06606

From the Merritt Parkway:
Take Exit 48 (Main Street); proceed two miles south to St. Vincent's campus, on the left.

From I-95:
Take Exit 27A onto the Route 8 & 25 Connector; take Exit 4 (Lindley St.); turn left onto Lindley and proceed three blocks to Hawley Ave.; turn left onto Hawley and to the Medical Center on the right.

From the Route 8 & 25 Connector (southbound):
Take Exit 5 (Boston Ave.); turn left at end of ramp and proceed to Summit St.; follow Summit to Main and turn left; Medical Center will be on the left.

Stamford Hospital
30 Shelburne Road, Stamford, CT 06904

From New Haven
Via Merritt Parkway
Exit 34. Turn left onto Route 104 (Long Ridge Road) and travel 0.9 miles to light at rotary island. Bear right onto Stillwater Road (follow hospital sign) and continue 2.3 miles to light at island intersection. Municipal golf course is on your left. Proceed past golf course, bearing left onto W. Broad Street at wide intersection. Continue three short blocks and turn right onto Shelburne Road. Hospital entrance is on the left.

Via Connecticut Turnpike
Exit 6. Turn right at light onto West Avenue. Continue 0.7 miles to traffic island and stop sign. Turn left on Stillwater Avenue. Turn right at next island intersection onto W. Broad Street. Continue three short blocks and turn right onto Shelburne Road. Hospital entrance is on the left.

Waterbury Hospital
54 Robbins Street, Waterbury, CT 06721

Route 84 - Eastbound from New York or Danbury area
Exit 18 (Chase Parkway). Turn right and go to the first traffic light. Then turn right and go to the next light. Turn right (this is West Main Street). At fork in road, bear left on Robbins Street for 1/2 mile. Hospital is on the left.

Route 84 - Westbound from Hartford area
Exit 18 (Highland Avenue/West Main Street). Take fork to West Main Street. Turn right (this is West Main Street). At fork in road, bear left on Robbins Street for 1/2 mile. Hospital is on the left.

Route 8 - Northbound from Naugatuck or Bridgeport area
Exit 32 (Downtown Waterbury). Turn left at the second light, underneath underpass and up hill (West Main Street). Take the first right (Colley Street). Hospital is straight ahead, on Robbins Street.

Route 8 - Southbound from Watertown, Thomaston or Torrington
Exit 34 (West Main Street/Downtown Waterbury exit). Take a right at the end of the exit onto West Main Street. Take the first right onto Colley Street (this is a one-way street). Hospital is straight ahead, on Robbins Street.

Windham Community Memorial Hospital
112 Mansfield Ave., Willimantic, CT 06226

From Bradley International Airport
Follow signs out of Bradley towards Route 91 South
Get off exit 35A - Route 291 East, follow it to the end and bear right at the split.
Follow the signs for Route 384 East and follow it to the end.
At the split, bear right and follow Route 6 East towards Willimantic / Providence
(about 15 to 20 minutes later) you'll see Columbia Ford on your right.
At the next light, turn left onto the Route 6 expressway.
Take the first exit (Route 32).
Turn right off the ramp.
At the fourth light (by McDonald's) turn left onto West Avenue, bearing right onto Valley Street at the next intersection.
At the first stop sign, turn left onto Mansfield Avenue. The entrance to Windham Hospital is on the left.

From Hartford, Connecticut
Take Route 84 East to exit 59 (Route 384 East) and follow to end
At the split, bear right and follow Route 6 East towards Willimantic / Providence
(about 15 to 20 minutes later) you'll see Columbia Ford on your right.
At the next light, turn left onto the Route 6 expressway.
Take the first exit (Route 32).
Turn right off the ramp.
At the fourth light (by McDonald's) turn left onto West Avenue, bearing right onto Valley Street at the next intersection.
At the first stop sign, turn left onto Mansfield Avenue. The entrance to Windham Hospital is on the left.

From Norwich, Connecticut
Take Route 32 North towards Willimantic.
When you hit Main Street, Willimantic (Dunkin Donuts in front of you at the light) turn left
(still following Route 32 N).
At the fork in front of Stop & Shop, bear right (still following Route 32 N)
Take your first right onto West Avenue, bearing right onto Valley Street at the next intersection.
At the first stop sign, turn left onto Mansfield Avenue. The entrance to Windham Hospital is on the left.

Yale-New Haven Hospital
20 York Street, New Haven, CT 06510

YNHH Emergency (enter from York Street)

I-95 traveling north or south
Exit 47 to Route 34 west to Exit 2. Turn left on College Street. Follow College until it merges with Congress Avenue. At the second light, turn right onto Howard Avenue. At the next intersection, turn right onto York Street. The Emergency driveway is on your left.

I-91 traveling south
Exit 1 to Route 34 west to Exit 2. Turn left on College Street. Follow College until it merges with Congress Avenue. At the second light, turn right onto Howard Avenue. At the next intersection, turn right onto York Street. The Emergency driveway is on your left.

Wilbur Cross Parkway (Rte. 15) traveling south
Exit 59 immediately after tunnel. Right at end of ramp. Merge left onto Whalley Avenue at light. Stay on Whalley until you see signs for Yale-New Haven at Park Street. Turn right onto Park and follow it until it merges with Howard Avenue. At the next light, turn left onto York and the Emergency driveway is on your left.

Merritt Parkway (Rte. 15) traveling north
Exit 57 to Route 34 east into New Haven. Right onto Ella T. Grasso Boulevard (Rte. 10) and left onto South Frontage Road (Legion Ave.). Follow hospital and Rte. 34 signs. At Howard Avenue, turn right. At the third light, turn left onto York Street. The Emergency driveway is on your left.

Route 1 (Boston Post Road) traveling east
After crossing Ella T. Grasso Boulevard (Rte. 10), turn left onto Davenport Avenue. Cross Howard Avenue and the Emergency driveway is on your left.

Children's Emergency (enter from Howard Avenue)

I-95 traveling north or south
Exit 47 to Route 34 west to Exit 3. Follow N. Frontage Road to Park Street. Turn left onto Park Street and proceed through two lights, veering left onto Howard Avenue. The Children's Emergency driveway will be immediately on your left.

I-91 traveling south
Exit 1 to Route 34 west to Exit 3. Follow N. Frontage Road to Park Street. Turn left onto Park Street and proceed through two lights, veering left onto Howard Avenue. The Children's Emergency driveway will be immediately on your left.

Wilbur Cross Parkway (Rte. 15) traveling south
Exit 59 immediately after tunnel. Right at end of ramp. Merge left onto Whalley Avenue at light. Stay on Whalley into downtown until you see signs for Yale-New Haven at Park Street. Turn right onto Park and follow it until it merges with Howard Avenue. Children's Emergency will be immediately on your left.

Merritt Parkway (Rte. 15) traveling north
Exit 57 to Route 34 east into New Haven. Right onto Ella T. Grasso Boulevard (Rte. 10) and left onto South Frontage Road. Follow hospital and Rte. 34 signs. At Howard Avenue, turn right. The Children's Emergency driveway is after the second light on your left.

Route 1 (Boston Post Road) traveling east
After crossing Ella T. Grasso Boulevard (Rte. 10), turn left onto Davenport Avenue. At Howard Avenue turn left and the Children's Emergency driveway will be on your right before the next light.

Out of State Hospitals Bordering CT

Directions from Hartford, CT

Massachusetts

Baystate Medical Center
759 Chest Nut Street, Sprinfield, MA 01199
(413) 794-0000

Merge onto I-91 N via the ramp to Springfield 27.2 entering Masssachusetts. Take exit 10 for Main St. toward Chicopee 0.02 turn right at Dover St. 0.2. Turn right at Chestnut St 118ft

Cooley Dickinsont Hospital Inc. The
30 Locust Street, Northampton, MA 01060
(413) 582-2000

Merge onto I-91 N via the ramp Springfield 42 mi. entering Massachusetts. Take exit 18 for US-5 N 0.2 mi. Turn left at Mount Tome Rs/US-5 continue to follow US-5 1.1, turn left at Maint St./RT-10/RT-9, continue to follow RT-9 1.8 mi.

Fairview Hospital
29 Lewis Avenue, Great Barrington, MA 01230
(413) 528-0790

Continue on Albany Ave/US-44, continue to follow US-44 14.1 mi., slight right at Albany Turnpike/US-44, continue to follow US-44 27.9 mi, turn right at Railroad St./US-7, continue to follow US-7 12.1 mi entering Massachusetts, turn left at South St. 0.2, turn right at West Ave 404 ft, turn left at Lewis Ave. 0.2 mi.

Harrington Memorial Hospital
100 South Street, Southbridge, MA 01550
(508) 765-9771

I-84 toward Boston 38.2 mi, entering Massachusetts. Take exit 1 toward Southbridge/Mashapaug Rd 0.1 Rd 0.1 mi. Merge onto Haynes St/Route 15 0.1 mi. Turn left at Mashapaug Rd 0.1 mi. Turn left to stay on Mashapaug Rd 1.8 mi, continue on South St. 1.7 mi.

Holyoke Medical Center
575 Beech Street, Holyoke, MA 01040
(413) 534-2500

Merge onto I-91 N via the ramp to Springfield- 33.9 mi, entering Massachusetts, take exit 16 for US-202N-0.3 mi, merge onto Cherry St/US-202N -0.4 mi, turn left at Hospital Dr -318 ft. Destination on right.

Hubbard Regional Hospital
340 Thopson Road, Webster, MA 01570
(508) 943-2600

I-84 E toward Boston 3.8 mi, slight left at I-384 E signs for I-384E 8.2 mi, Slight Right at Boston Way/Boston Turnpike/Route6/US-6 27.5, continue to follow us-44 27.5 mi, turn left at Averil Rd/US-44, continue to follow US44 7.9, turn left to merge onto I-395N Worcester entering MA 8.2 mi, take exit 1 for State Hwy 193 toward Webster 0.3mi, turn right at RT-193/Thompson Rd 0.6 mi, destination on right.

Mercy Medical Center
271 Carew Street, Sprinfield, MA 01104
(413) 748-8900

Merge onto I-91 N via the ramp to Sprinfield 26.1 mi, entering Massachusetts, take exit 8 for I-291E/US 20 E toward I-90/Mass. Pike 0.2mi, take exit 2B for Dwight St. 0.2 mi, turn left at Dwight St. 0.2 mi, turn right at Carew St/RT-20A 0.3mi.

Noble Hospital
115 West Silver Street, Westfield, MA 01085
(413) 568-2811

Merge onto I-91 N via the ramp to Springfield 9.8 mi. Take exit 40 for State Hwy 20 0.7 mi. Merge onto CT-20W 2.7 mi. Take the State Hwy 20 W exit toward E Graby/Granby 0.8 mi. Merge onto CT-20/Rainbow Rd. Continue to follow CT – 20 5.3 mi. Turn right at CT-10/Salmon Brook St N/US-202 11.7 mi. Turn left at Mill St. 0.5, turn right at W Silver St 420ft. Destination on left.

St. Vincent Hospital
123 Summer Street, Worcester, MA 01608
(508) 363-5000

I-84 toward Boston Partial Toll Road entering Massachusetts 42.5 mi. Take the exit onto I-90 toward Boston Toll Rd 11.5. Take exit 10 to merge onto I-290E toward Worcester, partial Toll Road 7.2 mi. Take exit 16 toward Central St. 0.1 mi, slight left at Mulberry St. 138 ft. Turn left at E. Central St. 0.2 mi. Turn L at Summer St. 184 ft.

Umass Memorial Medical Center, Inc.
55 Lke Avenue North, Worcester, MA 01655
(508) 334-1000

I-84 E towrd boston Partial Toll Road entering Massachusetts 42.5 mi. Take the exit onto I-90E toward Boston Toll Road 11.5 mi. Take exit 10 to merge onto I-290E toward Worcester Partial Toll Road 7.7 mi. Take exit 17 for State hwy 9 toward Ware/Framingham 0.2 mi. Turn right at Belmont St/RT-09 (signs for Framingham Belmont St/RT9E 1.8 mi. Turn left at Lake Ave N 0.3 mi, make u-turn 190 ft.

Wing Memorial Hospital and Medical Center
40 Wright Street, Palmer, MA 01069
(413) 283-7651

Merge onto I-91 N via the ramp to Springfield entering Massachusetts 26.1 mi. Take exit 8 for I-291 E/US 20E toward I-90 Mass Pike 0.2 mi. Keep left at the fork to continue toward I-291E/US-

20E and merge onto I-29E/US20E. Continue to follow 5.0 mi. Take I-90E exit toward Boston Toll road 11.8 mi. Take exit 8 State Hwy 32 toward Ware/US-20/Palmer 0.5 mi, turn right at RT-32/Thorndike St. 223 ft. Turn right at Lawrence St 0.3 mi, turn left at Shearer St. 0.2 mi, turn left 0.2 mi.

Rhode Island

Kent County memorial Hospital
455 Toll Gate RD, Warwick, Ri 02886
(401) 737-7000

I-84 E toward Boston, I-384 E, 8.2 mi, Slight right at Boston Way/Boston turnpike/Rte6/US-44/US-6 0.2 mi. Slight right at Hopriver Rd/Route 6/US-6/Willimantic Rd, continue to follow Us-6 15/7 mi. take the exit toward Boston Post Rd/CT-66/US-6 0.5mi. Keep right at the fork, follow signs for US-6/Danielson/Providence and merge onto Boston Post Rd/CT-66./US-6. Continue to follow US-6 entering Rhode Island 38.1. Take the ramp to I-295 S 0.4 mi. Keep left at the fork, follow signs for Warwick/I-295 S and merge onto I-295 S 7.6 mi. Take exit 2 for State hwy 2 S toward Warwick 0.4 mi. Merge onto Bald Hill Rd/RI-2 0.9 mi. Turn left at RI-115/Toll Gate Rd 0.6 mi.

Memorial Hospital of Rhode Island
111 Brewster Stret, Pawtucket, Ri 02860
(401) 729-2000

I-84 toward Boston slight left at I-384E (signs for I-384E) 8.2 mi, slight right at Boston Way/Boston Turnpike/Route 6/US-44/US-6 0.2 mi. Slight right at Hopriver Rd/Route 6/US-6/Willimantic Rd. Continue to follow US-6 15.7 mi. Take the exit toward Boston Post Rd/CT-66/US-6 0.5 mi. Keep right at the fork, follow signs for US-6/Danielson/Providence and merge onto Boston Post Rd/CT-66/US-6 continue to follow US-6 entering Rhode Island 38.1 mi. Take the ramp to US-6 E 0.4 mi. Take exit 5 to merge onto US-6 E toward Providence 5.9 mi. Take the exit onto I-95 N 4.6 mi. Take exit 28 for School St/State Hwy 114 0.1 mi. Turn right at School Street 0.5 mi. Turn left at Beechwood Ave. 0.2 mi. Destination will be on the left.

Rhode Island Hospital
593 Eddy Street, Providence, RI 02902
(401) 444-4000

I-84 E toward Boston slight left at I-384 E (signs for I-384 E) slight right at Boston Way/Boston Turnpike/Route 6/US-44/US-6, slight right at Hopriver Rd/Route 6/US-6/Willimantic Rd. Continue to follow US-6, take the exit toward Boston Post Rd/CT-66/US-6 keep right at the fork, follow signs for US-6/Danielson/Providence and merge onto Boston Post Rd/CT-66/US-6 38.1, continue to follow US-6 entering Rhode island, take the ramp to US-6 E, take exit 5 to merge onto US-6 toward Providence 5.9 mi, take the exit onto I-95 toward I-195 S 1.3 mi. Take exit 19 for Eddy St 0.4 mi Sharp right at Eddy St 299 ft, turn left 407 ft, turn left 131 ft. Destination will be on the right.

Roger Williams Hospital
825 Chalkstone Avenue, Providence, RI 02908
(401) 456-2000

I-84 toward Boston, slight left at I-384 E (signs for I-384 E) 8.2 mi, slight right at Boston Way/Boston Turnpike/Route 6/US-44/US-6 0.2 mi., slight right at Hopriver Rd/Route 6/US-6/Willimantic Rd, continue to follow US-6 15.7 mi. Take the exit toward Boston Post Rd/CT-66/US-6 0.5 mi. Keep right at the fork, follow signs for US-6/Danielson/Providence and merge onto Boston Post R/CT-66/US-6. Continue to follow US-6 entering Rhode Island 38.1 mi.

Take the ramp to US-6 E 0.4 mi. Take exit 5. Take exit 2 to merge onto US-6 E toward Providence. Take the Dean St exit 0.3 mi. Turn left at Dean St. 220 ft. Continue on DE Pasquale Ave 0.3. Continue on Pleasant Valle Pkwy 0.2. Continue on Raymond St 0.2. Turn left at Chalkstone Ave 0.2. Turn right 157 ft. Turn left, destination will be on the right.

Westerly Hospital
25 Wells Street, Westerly, RI 02891
(401) 596-6000

CT-2 E 36.8 mi. Take exit 28S for State Hwy 2A S/I-395 toward New Haven 0.3 mi. Merge onto I-395 S 8.1 mi. Take exit 78 on the left toward New London/State hwy 32 0.4 mi. Merge onto Montville Connector 0.9 mi. Slight right at CT-32/Mohegan Ave/Mohegan Ave Ext/Mohegan Ave Pkwy 3.2 mi

Continue to follow CT-32. Merge onto I-95 N/US-1 N via the ramp to Groton/Providence. Continue to follow I-95 N 11.1 mi, take exit 91 toward Borough/No. Main St/Stonington/State Hwy 234 0.2 mi. Merge onto CT-234/Pequot Trail/Route 234 (signs for Pequot Trail) 3.5, slight left at W Broad St/Route 1/US-1, continue to follow W Broad St 0.6 mi entering Rhode Island. Slight right at main St/RI-1A 1.1 mi. Continue to follow RI-1A. Turn left at Wells St 0.1 mi. Turn righ 217ft. Destination will be on left.

New York – NYC Vicinity

Bellevue Hospital Center
First Avenue at 27th Street, New York, NY 10016
(212) 561-4132

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3, entering New York. Continue on I-278W (signs for Bruckner Exp/I-278 W) Partial Toll Road 7.5 mi. Take the exit toward 25th Ave. S/Hoyt Ave 0.1 mi. Slight left at 25th Ave S/Hoyte Ave 47ft. Turn left at 32nd St 200 ft. Turn left at Astoria Blvdd N 236ft. Turn left at 31st St 358ft. Turn right at Astoria Blvd 0.4 mi. Turn right at Astoria Blvd 0.6 mi.

Beth Israel Medical Center
First Avenue at 16th Street, New York, NY 10003
(212) 420-2000

Take the exit onto I-91 S 38.2. Merge onto I-95 S 64.3, entering New York. Continue I-278W (signs for Bruckner Exp/I-278 W). Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge toll Road 0.4 mi. Take the ramp to FDR Dr Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 5.0 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 98 ft. Merge onto FDR Dr 0.1 mi. Continue on Avenue C 0.5 mi. Turn right at E 14th St. 0.4 mi. Turn right at 1st Ave 0.1 mi.

Bronk-Lebanon Hospital Center
1276 Fulton Avenue
Bronk, NY 10456
(212) 588-7000

Take the exit onto I-91 S 38.2. Merge onto I-95 S 64.3mi. Entering New York 67.8mi. Take exit 3 toward Third Ave 456ft. Merge onto E 175th St 190 ft. Turn left at 3rd Ave 1.0 mi. Turn left at E 168th St 400ft. Turn left at Fulton Ave 495 ft.

Caritas Health Care, Inc

90-02 Queens Boulevard
Elmhurst, NY 11373

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 8.2 mi. Take exit 4 to merge onto I-278 W toward Brooklyn 1.4 mi. Take exit 40 for Roosevelt Ave. 0.2 mi. Merge onto 69th St 0.6mi. Turn left at Queens Blvd 0.3mi.

Community Hospital at Dobbs Ferry
128 Ashford Avenue, Dobbs Ferry, NY 10522
(914) 693-0700

Turn left to merge onto I-84 W 65.0 mi entering New York. Take exit 20 to merge onto I-684 S toward White Plains 11.0 mi. Take exit 5 for Saw Mill Pkwy/State Hwy 117 1.0 mi. Merge onto Saw Mill Rivera Pkwy S 21.4 mi. Take exit 17 toward Ardsley/Dobbs Ferry 374 ft. Turn right at Ashford Ave 0.7 mi.

Elmhurst Hospital Center
79-01 Broadway, Elmhurst, NY 11373
(718) 334-1141

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 59.5 entering New York. Entering New York take exit 14 for Hutchinson Pkway toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkwy S 7.0 mi Partial Toll Road. Continue on I-678 S Partial Toll Road 3.6 mi. Take exit 12B for L I Expy/I-495 W 0.5 mi. Merge onto I-495 W 1.0 mi. Take exit 19 for Queens Blvd 0.5 mi. Take exit 19 for Queens Blvd 0.6 mi. Turn right at Reeder St 459 ft. Turn right at 51st Ave 92 ft. Destination will be on the right.

Flushing Hospital Medical Center
45th Avenue and Parsons Boulevard, Flushing, NY 11355
(718) 670-5000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 59.5 mi. entering New York. Entering New York take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkway S 7.0 mi Partial Toll Road. Continue on I-678 S Partial Toll Road 1.2 mi. Take exit 14 toward Linden PI 0.2 mi. Merge onto Whitestone Expressway Service/Whitestone Expy 0.2 mi. Turn left at Linden PI 0.5 mi. Turn left at 35th Ave 0.4 mi. Turn right at Parsons Blvd 0.9 mi.

Franklin Hospital
900 Franklin Avenue, Valley Stream, NY 11580
(516) 256-6000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 63.7 mi. Entering New York. Slight left at I-695 S 1.4 mi. Merge onto I-295 S Partial Toll Road 2.5 mi. Take exit 8 for Cross Is Pkwy 0.5 mi. Take exit 25A to merge onto Southern State Pkwy E 8.5 mi. Take exit 15 for Corona Ave toward Franklin Ave 0.2 mi. Slight left at Park Dr 0.1 mi. Turn right at Franklin Ave 0.1. Destination will be on the right.

Good Samaritan Hospital of Suffern
255 Lafayette Avenue, Suffern, NY 10901
(914) 368-5000

Take the exit onto I-91. Merge onto I-95 S 48.1 mi. Entering New York take exit 21 toward White Plains 0.2 mi. Merge onto I-287 W 26.9 mi Partial Toll Road. Take exit 14B for Airmont Rd toward Montebello/Airmont 0.3 mi. Turn left at N Airmont Rd/County Rte 89 0.4 mi. Turn right at Route 59/RT-59 1.0 mi. Continue to follow RT-59 1.0 mi. Destination will be on the left.

Harlem Hospital Center

506 Lenox Avenue, New York, NY 10037
(212) 491-8400

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3. Entering New York continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 4.7 mi. Take exit 47 for Maj Deegan Expy/I-87 N toward Albany 0.4, Merge onto I-87 N 0.8 mi. Take exit 3 toward E 138 St. 0.2 mi. Merge onto Gerard Ave 46 ft. Turn left at E 138th St 108 ft. Continue on Madison Ave Bridge 0.3 mi. Turn right at E 135th St. 0.3 mi. Turn right at Esplanade Gardens Plaza/Lenox Ave/ Malcolm X Blvd 161 ft. Destinatino will be on the right.

Helen Hayes Hospital
51 North Rout 9W, West Haverstraw, NY 10993
(845) 786-4000

Take the exit onto I-91 S. Merge onto I-95 S 48.1 mi. Entering New York merge onto I-95 S 0.2 mi entering New York onto I-287 W 17.1 Partial Toll Road. Take exit 11 toward US 9W/Nyack 0.2 mi. Merge onto High Ave 0.1 mi. Turn left at N Highland Ave/US-9W. Continue to follow US-9W 10.1 mi. Turn left 0.1 mi. Turn left 0.2 mi.

Hospital for Special Surgery
535 East 70th Street, New York, NY 10021
(212) 606-1000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York continue on I-278 W (signs for Bruckner Exp/I-278 W) 5.4 mi. Partial Toll Road. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge 0.4 mi. Toll Road. Take the ramp to FDR Dr 0.4 mi. Partial Toll Road. Merge onto FDR Dr S/ Franklin Delano Roosevelt Dr S 2.6 mi. Take exit 13 toward E 71 St 167ft. Merge onto FDR Drive et S 0.1 mi. Turn right at E 71st St 0.1 mi. Turn left at York Ave 259 ft. Turn left at E 70th St/Hospital Access Rd 197 ft. Destination will be on the right.

Hudson Valley Hospital Center
1980 Crompond Road, Cortlandt Manor, NY 10567

Turn left to merge onto I-84 W 65.0 mi. Entering New York take exit 20 to merge onto I-684 S toward White Planis 10.8 mi. Take exit 6 for State Hwy 35 0.2 mi. Turn right at Cross River Rd/RT-35/US-202 135 ft. Turn right at Crompound Rd/RT-35/US-202 6.6 mi. Turn right 348ft. Turn right 161ft.

Interfaith Medical Center
1545 Atlantic Avenue, Brooklyn, NY 11213
(718) 918-5000

Take the exit onto I-91 S 38.3 mi. Merge onto I-95 59.5 mi. Entering New York take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. merge onto Hutchinson River Pkwy S 7.0 Partial Toll Road. Continue on I-678 S 5.7 mi. Partial Toll Road. Take exit 7 for I-678 S/Van Wyck Expy/J Robinson Pkwy 0.2 mi. Merge onto Interborough Pkwy S/Jackie Robinson Pkwy S 4.8 mi. Continue on Granville Payne Ave/Penssylvania Ave 0.2 mi. Turn right at Atlantic Ave. 2.1 mi.

Jacobi Medical Center
1400 Pelham Parkway South, Bronx, NY 10461
(718) 918-5000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 62.1 mi. Entering New York. Take exit 8C for Pelham Pkwy 0.3 mi. Merge onto Bronx and Pelhma Pkwy 1.4 mi. Make a u-turn at 217th Rd/Williamsbridge Rd 0.4 mi. Slight right toward Pkwy S 240 ft. Slight left at Pelham Pkwys S 0.1 mi.

Jamaica Hospital Medical Center
89th Avenue and Van Wyck Expressway, Jamaica, NY 11418
(718) 262-6000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 59.5 mi Entering New York. Take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson Rivera Pkwy S 7.0 mi. Partial Toll Road. Continue on I-678 S 6.4 mi. Partial Toll Road. Take exit 6 toward Hillside Ave/Jamaica Ave 0.4. Merge onto Van Wyck Expy 0.2 mi.

Kings County Hospital Center
451 Clarkson Avenue, Brooklyn, NY 11203
(718) 245-3901

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 59.5 mi entering New York. Take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkwy 7.0 mi. Partial Toll Road. Continue on I-678 S 5.7 mi. Partial Toll Road. Take exit 7 for I-678 S/Van Wyck Expy/J Robinson Pkwy 0.2 mi. Merge onto Interborough Pkwy S/Jacke Robinson Pkwy S 4.8 mi. Turn right at Jamaica Ave 0.2 mi. Continue on E new York Ave 0.3 mi. E New York Ave turns slightly right and becomes Pacific St 0.2 mi. Turn left at Eastern Pkwy 1.8 mi. Turn left at Albany Ave 0.9 mi. Turn right at Clarson Ave 0.3 mi.

Lawrence Hospital Center
55 Palmer Avenue, Bronxville, NY 10708
(914) 787-1000

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 2.4 mi. Take exit 6 for Bronx Pkwy toward Sprain Pkwy 0.5 mi. Merge onto Bronx River Pkwy N/Sprain Brook Pkwy N 0.3 mi. Take the Bronx Pkwy exit toward White Plains 400ft. merge onto Bronx Rivera Pkwy N 0.3 mi. Take exit 2 toward Yonkers/Bronxville 0.1. Turn right at Pondfield Rd W 257 ft. At the traffic circle, take the 1st exit onto Palmer Ave 157 ft.

Lenox Hill Hospital
100 East 77th Street, New York, NY 10021
(212) 439-2345

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278W). Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Partial Toll Road 0.6 mi. Slight left toward E 125th St/Martin Luther King Blvd (signs for 2 Ave/125 St) 253ft. Slight right at E 125th St.Martine Luther King Blvd 0.3. Turn left at Park Ave 2.4 mi. Turn left at E 78th St 0.1 mi. Turn right at Lexington Ave 262 ft. Turn right at E 77th St 466 ft.

Lincoln Medical & Mental Health Center
234 East 149th Street, Bronx, NY 10451
(718) 579-5302

Take the exit onto I-91 S 38.2 Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) 4.7 mi. Take exit 47 for Maj Deegan Expy/I-87 N toward

Albany 0.4 mi. Merge onto I-87 N 0.8 mi. Take exit 3 to merge onto Grand Concourse 0.6 mi. Turn right at e 149th St 0.2 mi. Turn left at Hicks St 0.1 mi.

Long Island Jewish Medical Center
270 -05 76th Avenue, New Hyde Park, NY 11040
(718) 470-7000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 63.7 mi. Entering New York. Slight left at I-695 S 1.4 mi. Merge onto I-295 S Partial Toll Road 2.5 mi. Take exit 8 for Cross Is Pkwy 0.5 mi. Merge onto Cross Island Pkwy S 3.4 mi. Take exit 30E for I-495 E/Long Is Expy 0.5 mi. Merge onto I-495 E 1.5 mi. Take exit 33 toward Community Dr. Lakeville Rd 0.3 mi. Merge onto Long Island Expressway Service Rd/N Service Rd 0.1 mi. Turn right at Lakeville Rd 1.1 mi. Turn right at 77th Ave 115 ft. Turn right at Hewlett St 0.1 mi Turn left at 76th Ave 246ft.

Memorial Hospital for Cancer and Allied Diseases
1275 York Avenue, New York, NY 10021
(212) 639-2000

Take the exit onto I-91 S 38.3 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. Take the ramp to FDR Dr Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 2.6 mi. Take exit 13 toward E 71 St 167 ft. Merge onto FDR Drive et S 0.1 mi. Turn right at E 71st St 0.1 mi. Turn left at York Ave 0.1 mi.

Mercy Medical Center
1000 North Village Avenue, RockVille Centre, NY 11570
(516) 705-2525

Take the exit onto I-91 S 38.2 mi. Merge onto I095 S 63.7 mi. Entering New York. Slight left at I-695 S 1.4 mi. Merge onto I-295 S Partial Toll Road 2.5 mi. Take exit 8 for Cross Is Pkwy 0.5 mi. Merge onto Cross island Pkwy S 8.5. Take exit 25 A to merge onto Southern State Pkwy E 5.7mi. Take exit 19S to merge onto Peninsula Blvd 0.3 mi. Sharp left to stay on Peninsula Blvd 0.1 mi. Turn right 0.1 mi. Destination will be on the right.

Metropolitan Hospital Center
1901 First Avenue, New York, NY 10029
(212) 423-7554

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. Take the ramp to FDR Dr Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt DR S 1.2 mi. Take exit 14 toward E 96 St 33 ft. Merge onto FDR DR/FDR Dr W Ln 256 ft. Turn right at E 97th St 217ft. Turn right at 1st Ave 259 ft.

Montefiore Medical Center
111 East 210th Street, Bronx, NY 10467
(718) 920-4321

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E MainSt/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 2.4 mi. Take exit 6 for Bronx Pkwy 0.4 mi. Merge onto

Bronx River Pkwy S 2.1 mi. Take exit 10 toward E 233 St 0.3 mi. Turn right toward Webster Ave 66 ft. Turn left at Webster Ave 1.3 mi. Turn right at E Gun Hill Rd 0.4 mi. Turn left at Bainbridge Ave 0.1 mi. Turn right at E-210th St 433 ft.

Mount Sinai Hospital
One Gustave levy Place, New York, NY 10029
(212) 241-7981

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 s 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. Slight left toward E 125th St/Martin Luther King Blvd 0.3 mi. Turn left at Park Ave. 1.0 mi. Turn right at E 106th St 0.2 mi. Turn left at 5th Ave/Museum Mile 0.3 mi.

Mount Vernon Hospital
12 North 7th Avenue, Mount Vernon, NY 10550
(914) 664-8000

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 1.5 mi. Take exit 8 for N Columbus Ave toward NY 22/mount Vernon 0.4 mi. Keep right at the fork, follow signs for Mt. Vernon E 135ft. Turn right at N Columbus Ave/RT-22 0.4 mi. Turn right at E Lincoln Ave 0.6 mi. Turn left at Gramatan Ave 0.3 mi. Turn right at W Prospect Ave/Roosevelt Square N 0.1 mi. Turn right at N 7th Ave 69ft.

New York Downtown Hospital
170 William Street, New York, NY 10038
(212) 312-5133

Take the exit onto I-91 S 38.2mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. Take the ramp to FDR Dr Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 8.0 mi. Take exit 2 toward Robert F. Wagner Sr Pl 0.2 mi. Slight right at Robert F Wagner Sr Pl 197ft. Turn left at Pearl St 322ft. Turn right at Frankfort St. 0.1 mi. Turn left at Gold St/Madison St. 0.1 mi. Continue to follow Gold St. Turn right at Beekman St 328ft.

New York Hospital Medical Center of Queens
56-45 Main Street, Flushing, NY 11355
(718) 670-1231

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 59.5 mi. Entering new York. Take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkwy S 7.0 mi. Partial Toll Road. Continue on I-678 S Partial Toll Road 3.2 mi. Take exit 12A for College Point Blvd toward I-495 E/LI Expy 0.3 mi. Merge onto 57th Rd 0.5 mi. Turn left at main St. 0.1 mi.

New York Presbyterian Hospital
525 East 68th Street, New York, NY 10021
(212) 746-4189

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. take the ramp to FDR Dr. Partial Toll Road 0.4 mi. Merge onto FDR Dr S/ Franklin Delano Roosevelt Dr S 3.0 mi. Take

exit 12 for E 63 St toward State Hwy 25 0.1 mi. Turn right at York Ave 0.2 mi. Turn right at E 68th St 89ft. Destination will be on right.

North Central Bronx Hospital
3424 Kossuth Avenue & 210th Street, Bronx, NY 10467
(212) 519-5000

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 107 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 2.4 mi. Take exit 6 for Bronx Pkwy 0.4 mi. take exit 6 for Bronx Pkwy 2.1 mi. Take exit 10 toward E 233 St. 0.3 mi. Turn right toward Webster Ave 66ft. Turn left at Webster Ave 1.3 mi. Turn right at E Gun Hill Rd 0.4 mi. Turn left at Bainbridge Ave 0.1 mi. Turn left at Bainbridge Ave 0.1 mi. Turn right at E 210th St 0.1 mi.

North General Hospital
1879 Madison Avenue, New York, NY 10035
(212) 650-4000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll road 0.6 mi. Slight left toward E 125th St/Martin Luther King Blvd (signs for 2 Ave/125 St) 253ft. Slight right at E 125th St/Martin Luther King Blvd 0.3 mi. Turn left at Park Ave 0.2 mi. Turn right at E 121st St 479 ft. Turn right at Madison Ave 223 ft.

NY Eye and Ear Infirmary
310 East 14th Street, New York, NY 10003
(212) 979-4000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr. Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. Take the ramp to FDR Dr Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 5.0 mi. take exit 7 toward E 23 St 98 ft. Merge onto FDR Dr 0.1 mi. Continue on Avenue C 0.5 mi. Turn right at E 14th St 0.5 mi.

NYU Hospitals Center
550 First Avenue, New York, NY 10016
(212) 263-7300

Take the exit onto I-91 S 38.2 mi. Merge onto I-95S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278) Partial Toll Road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge Toll Road 0.4 mi. take the ramp to FDR Dr. Partial Toll Road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 5.0. Take exit 7 toward E 23 St 98 ft. Turn right at E 25th St 0.2 mi. Turn right at 1st Ave 0.2 mi. Destination will be on the right.

Our Lady of Mercy Medical Center
600 East 233rd Street, Bronx, NY 10466
(718) 920-9000

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi.

Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 2.4 mi. Take exit 6 for Bronx Pkwy 0.4 mi. Merge onto Bronx Rivera Pkwy S 2.1 mi. Take exit 10 toward E 233 St 0.3 mi. Turn righ toward Webster Ave 6ft Turn left at Webster Ave 400 ft. Turn left at E 233rd St 0.1 mi.

Parkway Hospital
70-35 113th Street, Forest Hills, NY 11375
(718) 990-4131

Take the exit onto I-91 S 38.2 mi. Merge onto Hutchinson River Pkwy S Partial toll road 7.0 mi. Continue on I-678 S partial toll road 4.1 mi. Take exit 11 toward Harry Van Arsdale Jr Ave 0.8 mi. Turn right at 69th Rd/Jewel Ave (Signs for Grand Central Pkwy) 0.5 mi. Continue to follow 69th Rd turn left at 110th St 0.2mi. Turn left at 71st Ave/Continental Ave 0.2 mi. Continue to follow 71st Ave. Turn left at 113th St 167ft.

Phelps Memorial Hospital ASSN
701 North Broadway, Sleep Hollow, NY 10591
(914) 366-3000

I-84 W 65.0 mi. Entering New York take exit 20 to merge onto I-684 toward White Plains 11.0 mi. Take exit 5 for Saw Mill Pkwy/State hwy 117 1.0 mi. Merge onto Saw Mill River Pkwy S 10.9 mi. Take exit 29 for State Hwy 117/Manville Rd toward Pleasantville 384ft. Turn left at Manville Rd/RT-117. Continue to follow RT-117. Take the ramp to Albany Post Rd/US-9 0.3 mi. Turn left at Albany Post Rd/US-9 0.3 mi. Continue to follow US-9.

Queens Hospital Center
82-68 164th Street, Jamaica, NY 11432
(718) 883-3000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 63.7 mi. Entering New York. Slight left at I695 S 1.4 mi. Merge onto I-295 S Partial toll road 7.2 mi. Take exit 1 to merge onto Grand Central/Pkwy W 2.1 mi. Take exit 17 toward 168 St 0.1 mi. Merge onto Grand Central Pkwy/Grand Central Pkwy Service Rd N/Grand CTROL Pklwy S Rd 0.4 mi. Turn right at 164th PI 0.1 mi. Turn left at 82nd Rd 404 ft. Turn left at 164th ST 190ft.

ST. Barnabas Hospital
4422 Third Avenue, Bronx, NY 10457
(212) 960-9000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 62.1 mi. Entering New York. Take exit 8C for Pelham Pkwy 0.3 mi. Merge onto Bronx and Pelham Pkwy 2.1 mi. Continue on E Fordham Rd/US-1 (signs for US-1 S) 1.2 mi. Turn left at 3rd Ave 0.5 mi.

St. Francis Hospital, Roslyn
100 Port Washington Boulevard, Rosly, NY 11576
(516) 562-6000

Take exit onto I-91 S 38.2 mi. Merge onto I-95 S 63.7 mi. Entering New York. Slight left at I-695 S 1.4 mi. Merge onto I-295 S 2.5 mi. Partial toll road. Take exit 8 for Cross Is Pkwy 0.5 mi. Merge onto Cross Island Pkwy S 3.4 mi. Take exit 30E for I-495 E/Long Is Expy 0.5 mi. Merge onto I-495 E 5.2 mi. Take exit 37 toward Mineaola/Willis Ave/Roslyn 0.2 mi. Merge onto Long Island Expressway Service Rd/Powerhouse Rd/S Service Rd 194ft. Turn left at Mineola Ave/Willis Ave 0.5 mi. Turn right at warner Ave 0.3 mi. Turn left at Edwards St 0.2 mi. Destination will be on the right.

St. Johns' Riverside Hospital

976 North Broadway, Yonkers, NY 10701
(914) 964-4444

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 4.7 mi. Take exit 2 for Saw Mill Pkwy toward Albany 0.2 mi. Merge onto Saw mill River Pkwy N 2.4 mi. Take exit 9 to merge onto Executive Blvd toward yonkers 1.1 mi. Turn left at N Broadway/US-9 0.4 mi.

St. Josephs's Hospital Yonkers
127 South Broadway, Yonkers, NY 10701
(914) 378-7000

Take exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State Hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT -15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 10.7 mi. Continue on Cross County Pkwy W (signs for Cross County Pkwy) 4.7 mi. Take exit 2 for Saw Mill Pkwy toward Albany 0.2 mi. Merge onto Saw Mill River Pkwy N 85 ft. Take exit 5 for Yonkers Ave toward Yonkers 0.2 mi. Turn right at Yonkers Ave. Slight left at Nepperhan Ave 0.5 mi. Turn left at S Broadway/RT-9A/US-9 0.2 mi.

St. Luke's Cornwall Hospital
70 Dubois Street, Newburgh, NY 12550
(845) 561-4400

I-84 W 94.5 mi. Entering New York take exit 10S toward Newburgh 0.3 mi. Merge onto N Plank Rd/RT-32 0.1 mi. Merge onto N Plank Rd/RT-32 0.9 mi. Turn left at South St 0.3 mi. Turn right at Dubois St. 0.3 mi. Destination will be on the left.

St. Luke's Roosevelt Hospital
1111 Amsterdam Avenue, New York, NY 10025
(212) 523-4000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W (signs for Bruckner Exp/I-278 W) Partial toll road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge toll road 0.6 mi. Slight left toward E 125th St/Martin Luther King Blvd (signs for 2 Ave/125 St) 253ft. Slight right at E 125th St/Martin Luther King Blvd. 1.4 mi. Turn left at Amsterdam Ave 0.6 mi.

SVCMC-ST Vicent's CTRS NY & West Branches
170 West 12th Street, New York, NY 10011
(212) 604-7000

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 64.3 mi. Entering New York. Continue on I-278 W 9signs for Bruckner Exp/I-278 W) Partial toll road 5.4 mi. Take the exit toward FDR Dr/Manhattan 0.2 mi. Merge onto Triborough Bridge toll road 0.4 mi. Take the ramp to F D R Dr partial toll road 0.4 mi. Merge onto FDR Dr S/Franklin Delano Roosevelt Dr S 5.0 mi. Take exit 7 toward E 23 St 98ft. Turn right at E 25th St 0.6 mi. Turn lerft at Park Ave S 0.4. Continue on Union Square E 0.2 mi. Turn right at E 14th St 0.5 mi. Turn left at 7th Ave 0.1 mi. Turn left at W 12th St 226ft.

Westchester Medical Center
Grasslands Reservation, Valhalla, NY 10595
(914) 285-70017

I-84 W 65.0 mi. Entering New York. Take exit 20 to merge onto I-684 S toward White Plains 11.0 mi. Take exit 5 for Saw Mill Pkwy/State Hwy 117 1.0 mi. Merge onto Saw Mill river Pkwy S

12.9 mi. Take exit 26 toward Bronx Pkwy/New York City/Sprain Pkwy 0.8 mi. Merge onto Taconic State Pkwy S 203 ft. Take the exit toward White Plains/Bronx Pkwy 0.5 mi. Merge onto Taconic State Pkwy 0.2 mi. Turn left at E Stevens Ave 427ft. Turn right at Commerce St 0.4 mi. Turn left at Mount Eden Cemeteray 0.4 mi.

White Plains Hospital Center
41 East Post Road, White Plains, NY 10601
(914) 681-0600

Take the exit onto i-91 S 38.2 mi. Merge onto I-95 S 48.1 mi. Entering New York. Take exit 21 toward white Plains 0.2 mi. Merge onto I-287 W 5.0 mi. Take exit 8 to merge onto RT-119/N Westchester Ave toward White Plains/Westchester Mall Pl 0.5 mi. Turn left at White Plains Ave 495ft.

Winfred Masterson Burke Rehabilitation Hospital
785 Mamaroneck Avenue, White Plains, NY 10605
(914) 597-2232

Take the exit onto I-91 S 18.4 mi. Take exit 17 for E Main St/State hwy 15 S toward W Cross Pkwy 0.4 mi. Keep left at the fork to continue toward CT-15 S and merge onto CT-15 S 64.5 mi. Entering New York. Continue on Hutchinson River Pkwy S 5.4 mi. Take exit 23N toward White Plains 0.3 mi. Merge onto Mamaroneck Ave 2.1 mi. Turn right at Heatherbloom Rd 121ft. Turn left at Mamaroneck Ave 0.5 mi. Turn right 0.1 mi.

Woodhull Medical and Mental Health Center
760 Broadway, Brooklyn, NY 11206
(718) 963-8100

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 59.5 mi. Entering New York. Take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkwy S partial toll road 7.0 mi. Continue on I-678 partial toll road 3.6 mi. Take exit 12B for L I Expy/I-495 W 0.5 mi. Merge onto I-495 W 1.0 mi. Take exit 19 for Woodhaven Blvd/Queens Blvd toward State hwy 25 0.3 mi. Keep left at the fork, follow signs for I-495 W 1.1 mi. Follow signs for 69 St/Grand Ave and merge onto Queens Midtown Expy 0.6 mi. Slight left at Grand Ave 0.3 mi. Slight left at Flushing Ave 2.7 mi. Turn left at Broadway 112ft.

Wyckoff Heights Medical Center
374 Stockholm Street, Brooklyn, NY 11237
(718) 963-7272

Take the exit onto I-91 S 38.2 mi. Merge onto I-95 S 59.5 mi. Entering New York. Take exit 14 for Hutchinson Pkwy toward Whitestone Bridge 0.3 mi. Merge onto Hutchinson River Pkwy S partial toll road 7.0 mi. Continue on I-678 partial toll road 3.6 mi. Take exit 12B for L I Expy/I-495 W 0.5 mi. Merge onto I-495 W 1.0 mi. Take exit 19 for Woodhaven Blvd/Queens Blvd toward State Hwy 25 0.3 mi. Keep left at the fork, follow signs for I-485 W 1.1 mi. Follow signs for 69 St/Grand Ave and merge onto Queens Midtown Expy 0.6 mi. Slight left at Grand Ave 0.3 mi. Slight left at Flushing Ave 1.5 mi. Turn left at Cypress Ave 0.3 mi. Turn right at Dekalb Ave 0.2 mi. Turn left at Wyckoff Ave 259ft. Turn left at Stockholm St 394ft.

New York - Upstate

Catskill Regional Medical Center
68 Harris Bushville Road, Harris, NY 12742
(845) 794-3300

Turn left to merge onto I-84 W 114 mi. Entering New York. Take exit 4W for State Hwy 17 W toward Binghamton 0.5 mi. Merge onto RT-17 W 30.2 mi. Take exit 102 toward Harris 0.4 mi. Turn left at County Rte 174/Old Route 17 (signs for Harris) 0.4 mi. Slight right at County Rte 174/Old Route 17/Sacks Rd 0.1 mi. Turn right at Harris Rd 0.1 mi. Turn left at Big Woods Rd. Destination will be on the right.

Columbia Memorial Hospital
71 Prospect Avenue, Hudson, NY 12534
(518) 828-7601

Main St/US-44 14.3 mi. Continue to follow US-44. Slight right at Albany Turnpike/US-44 27.9 mi. Continue to follow US-44. Turn right at Railroad St/US-7 7.6 mi. Continue to follow US-7, entering Massachusetts. Turn left at Egremont Rd/Sheffield Egremont Rd 3.6 mi. Continue to follow Sheffield Egremont Rd. Continue on Buttonball Ln 0.1 mi. Sharp left at Main St/Ox Bow Rd/RT-23/RT-41 19.3 mi. Continue to follow RT-23 entering New York. Continue on Route 23B/RT-23B 2.7 mi. Continue to follow RT-23B. Turn left at Columbia St/RT-66 0.2 mi. Continue to follow Columbia St. Slight left at Prospect Ave 351ft.

Kingston Hospital
396 Broadway, Kingston, NY 12401
(914) 331-3131

Turn right to merge onto I-91 S toward New Haven 15.8 mi. Take exit 18 to merge onto I-691 W toward Waterbury/Meriden 9.1 mi. Merge onto I-84 W 74.7 mi. Entering New York. Take exit 7S for State Hwy 300 S toward Union Ave/II-87/Thruway 0.3 mi. Merge onto Route 300/RT-300 0.1 mi. Slight right to stay on Route 300/RT-300 0.1 mi. Take the ramp to Albany/I-87/New York Thruway. Toll road 0.2 mi. Merge onto Auto Park Pi toll road 0.1 mi. Merge onto I-87 via the ramp to Albany toll road 31.1 mi. Take exit 19 for State hwy 28 toward Kingston toll road 0.5 mi. At the traffic circle, take the 3rd exit onto RT-28 2.1 mi. Turn left at E Oreilly St 259ft. Turn right at Jansen Ave 0.1 mi. Destination will be on the right.

Northern Dutchess Hospital
6511 Springbrook Avenue, Rhinebeck, NY 12572
(845) 871-3391

Main St/US-44 14.3 mi. Continue to follow US-44. Slight right at Albany Turnpike/US-44 27.9 mi. Turn left at Church St. S-44 12.1 mi. Continue to follow US-44. Entering New York. Turn left at N Elm Ave/RT-22/US-44 1.6 mi. Continue to follow RT-22/US-44. Slight right at route 199/RT-199 164ft. Turn right to stay on Route 199/RT-199 18.8 mi. Continue straight onto Route 308/RT-308 4.4 mi. Turn right to merge onto Route 9G/RT-9G 1.0 mi. Turn left 0.2 mi.

Putnam Hospital Center
670 Stoneleigh Avenue, Carmel, NY 10512
(914) 279-5711

Turn right to merge onto I-91 S toward New Haven 15.8 mi. Take exit 18 to merge onto I-691 W toward Waterbury/Meriden 9.1. Merge onto I-84 W 41.8 mi. Entering New York. Take exit 21 for State Hwy 121 toward Brewster/US-6-202 0.3 mi. Turn right at Peach Lake Rd/RT-121 (signs for Brewster) 0.1 mi. Turn left at Danbury Rd/Route 6/US-202/US-6 1.7 mi. Continue to follow route

6/U-202/US-6. Turn right at Peach Lake Rd/RT-121 (signs for Brewster) 0.1 mi. Turn left at Danbury Rd/Route 6/US-202/US-6 1.7 mi. Continue to follow route 6/US-202/US-6. Turn right at Main St/US-6 1.7 mi. Continue to follow US-6. Turn left at County Rte 35/Stoneleigh Ave 0.2 mi. Turn left 0.2 mi. Turn left 328ft. Destination will be on the left.

St. Francis Hospital
241 North Road, Poughkeepsie, NY

Turn right to merge onto I-91 S toward new haven 15.8 mi. Take exit 18 to merge onto I-691 W toward Waterbury/Meriden 9.1 mi. Merge onto I-84 W 58.3 mi. Entering New York. Take exit 16N to merge onto Taconic State Pkwy toward Albany 10.4 mi. Take the RT-55 W exit toward Poughkeepsie 0.2 mi. Merge onto Freedom Plains Rd/Route 55/RT-55 8.1. Continue to follow RT-55. Slight right at Mill St 367ft. Turn right at Columbus Dr 404ft. Continue on Washington St 0.7 mi.

Vassar Brothers Medical Center
45 Reade Place, Poughkeepsie, NY 12601
(845) 454-8500

Turn right to merge onto I-91 toward New Haven 15.8 mi. Take exit 18 to merge onto I-691 W toward Waterbury/Meriden 9.1 mi. Merge onto I-84 64.7 mi. Entering New York. Take exit 13N for US-9 toward Poughkeepsie 0.3 mi. Merge onto Route 9?US-9 12.4 mi. Continue to follow US-9 take the Columbia St. Exit toward Rinaldi Blvd 0.1 mi. Turn right at Columbia St (sings for Columbia St) 430ft. Turn right at young St 0.1 mi. Turn right at Reade Pl 102ft.

Verified U.S. Burn Centers

Verification of burn centers is a joint program of the American Burn Association (ABA) and the American College of Surgeons (ACS)

The American Burn Association Retrieved 11/14.07

ARIZONA
Phoenix
Arizona Burn Center at Maricopa Medical Center

ARKANSAS
Little Rock
Arkansas Children's Hospital

CALIFORNIA
Los Angeles
LAC+USC Burn Center

Orange
UCI Regional Burn Center

Sacramento
Shriners Hospital for Children- Northern California

UC Davis Regional Burn Center

San Francisco
Saint Francis Memorial Hospital
Bothin Burn Center

Torrance
Torrance Memorial Burn Center

COLORADO

St. Paul
Regions Hospital Burn Center

NEBRASKA
Lincoln
St. Elizabeth Regional Burn Center

Omaha
Nebraska Medical Center Burn Center

NEW JERSEY
Livingston
St. Barnabas Burn Center

NEW YORK
New York
William Randolph Hearst Burn Center

Rochester
Strong Memorial Hospital

Valhalla
Westchester Medical Center Burn Center

NORTH CAROLINA
Chapel Hill
North Carolina Jaycee Medical Center

OHIO
Akron

Denver
University of Colorado Hospital Burn Center

CONNECTICUT
Bridgeport
Bridgeport Hospital Burn Center

DISTRICT OF COLUMBIA
Washington
The Burn Center at Washington Hospital Center

FLORIDA
Gainesville
University of Florida
Shands Burn Center

Tampa
Tampa Bay Regional Burn Center

ILLINOIS
Chicago
University of Chicago Burn Center

Maywood
Loyola University Medical Center

INDIANA
Mass Casualty Incident Communications

Fort Wayne
St. Joseph Hospital

Indianapolis
Indiana University
Riley Burn Unit

Wishard Health Services

IOWA
Iowa City
University of Iowa Burn Center

KANSAS
Wichita
Via Christi Regional Medical Center
St. Francis Campus

MARYLAND
Baltimore
Johns Hopkins Regional Burn Center
Adult Burn Center Verified

MASSACHUSETTS
Boston

Children's Hospital Medical Center of Akron
CR Boeckman Regional Burn Center

Cincinnati
Shriners Hospital for Children
Shriners Burns Hospital – Cincinnati

The University Hospital Burn Center

Cleveland
MetroHealth Medical Center

Columbus
Nationwide Children's Hospital

OREGON
Portland
Oregon Burn Center

PENNSYLVANIA
Allentown
Lehigh Valley Hospital Burn Center

Philadelphia
Temple University Hospital

Pittsburgh
Western Pennsylvania Hospital Burn-Trauma Center

Upland
The Nathan Speare Regional Burn Treatment Center
Crozer Chester Medical Center

TEXAS
Dallas
Parkland Memorial Hospital
Regional Burn Center

Fort Sam Houston
US Army Institute of Surgical Research
Adult Burn Center Verified

Galveston
Shriners Hospitals for Children
Shriners Burns Hospital

University of Texas Medical Branch
Blocker Burn Center
Lubbock
University Medical Center

UTAH
Salt Lake City

Brigham and Women's Hospital Burn Center

Shriner's Burn Hospital – Boston

Sumner Redstone Burn Center
Massachusetts General Hospital

MICHIGAN
Ann Arbor
University of Michigan Health Systems

Detroit
Detroit Receiving Hospital

MINNESOTA
Minneapolis
Hennepin County Medical Center

University of Utah Hospital Burn Center

WASHINGTON
Seattle
University of Washington Burn Center
Harborview Medical Center

WISCONSIN
Madison
University of Wisconsin Hospitals and Clinics

Connecticut CMED Centers

CMED New Haven (South Central)
PO Box 475
New Haven, CT 06502
Telephone: (203) 499-5600

Colchester Emergency Communications (KX)
PO Box 911
Colchester, CT 06415
Telephone: (860) 537-3412

Groton Communications
68 Groton Long Point Rd
Groton, CT 06340
Telephone: (860) 448-1562

Litchfield County Dispatch (LCD)
Po Box 1349
Litchfield, CT 06759
Telephone: (860) 567-3877

North Central CMED
Po Box 1833
Hartford, CT 06144-1833
Telephone: (860) 769-6051

Northwest CT Public Safety
28 Cheshire Rd
Prospect, CT 06712
Telephone: (203) 758-0050

Norwich CMED
One American Way
Norwich, CT 06360

Tolland County Mutual Aid Fire Assn
Po Box 6 **(TN)**
Tolland, CT 06084
Telephone: (860 875-2543

Valley Shore Emergency Comm.
Po Box 497
Westbrook, CT 06498
Telephone: (860) 399-7921

Waterford Dispatch
204 Boston Post Road
Waterford, CT 06385
Telephone: (860) 442-5331

Willimantic Dispatch
Po Box 138
Willimantic, CT 06226
Telephone: (860) 465-3128

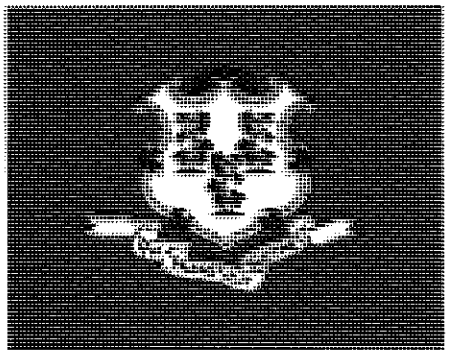
Massachusetts CMED Centers

Boston CMED	1-617-343-1400
Springfield CMED	1-800-544-1170
Worcester CMD	1-508-854-0100

Mass Casualty Incident Communications
Telephone: (860) 886-1461

Quinebaug Valley Dispatch
55 Westcott Rd
Danielson, CT 06239
Telephone: (860) 774-7555

Southwest Regional Comm. Center
267 Grant Street, Marsh 4
Bridgeport, CT 06610
Telephone: (203) 338-0762



STATEWIDE FIRE SERVICE DISASTER RESPONSE PLAN

The Connecticut Fire Chiefs Association in cooperation with the Commission on Fire Prevention and Control

December 2010

Version 2.1

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This document is the culmination of a desire to succeed and to improve in our mission to serve and protect the citizens of the state of Connecticut. Through the efforts and leadership of the Connecticut Fire Service and the Fire Rescue Disaster Response Committee, this document was possible. A special thanks goes to the members of the Disaster Response Task Force who brought the original concept forward from an idea to a reality.

ORIGINAL TASK FORCE MEMBERS

Chief Edward Richards, Enfield FD, Past President
Chief John Brady, North Madison FD, CFCA President
Chief Thomas G. Weber, Manchester FRE, CFCA 1st Vice-President
Chief Michael Varney, Ellington FD, CFCA 2nd Vice-President
Chief William Dunn, Meriden FD
Chief William Austin, West Hartford FD
Chief Tim Wall, North Farms FD
Chief Robert Ross, Middletown FD
Fire Marshal Philip Visintainer, East Hampton
Lieutenant Richard Warriner, Meriden FD
Jeffrey Morrissette, State Fire Administrator
Chief Kerry Flaherty, Naugatuck FD

SIGNATORY SECTION

In accordance with my authority under Conn. Gen. Stat. §7-323o, I have reviewed and approve this Plan.

Jeffrey Morrissette
State Fire Administrator

3/22/11
Date

In accordance with my authority under Conn Gen. Stat. §28-1a, to ensure a coordinated and integrated program for state-wide emergency management and homeland security, I have reviewed and approve this Plan.

Peter J. Boynton
Commissioner
Department of Emergency Management
and Homeland Security

3/21/11
Date

In its continuing effort to guide and support the Chief Fire Officers and Fire Service in the State of Connecticut through continuing education, unity in the fire service, safety, and organized response, I have reviewed and approve this Plan.

Chief Kenneth Richards, Jr., President
Connecticut Fire Chiefs' Association

3/22/11

CONCEPT AND DESIGN

Purpose:

In 1999 and 2001 the fire service was devastated by two large catastrophic events. Both extended the capabilities of the departments affected. Numerous Fire agencies from across affected states and the nation assisted in valiant efforts to control the events and maintain coverage response. It became abundantly clear from these disasters, and the ensuing relief effort, which followed, that greater coordination for inter-agency disaster management was required.

The purpose of this plan is to provide such coordination. It is based on a series of observed occurrences resulting from the shared experiences during these events. It is also an evolution of our past experiences in dealing with the day-to-day incidents that continually challenge our resources and competencies. Most importantly, it is a practical approach in providing a useful guide to assist the fire service in managing the types of devastation that our region is susceptible to.

The Connecticut Fire Chiefs Association in cooperation with the Commission on Fire Prevention and Control created the Statewide Fire Service Disaster Response Plan to provide for the systematic mobilization, deployment, organization, and management of Fire resources throughout the State, the Region and the Nation, in *assisting* local agencies in remediation of the effects of a disaster (see Connecticut General Statutes §7-323o(7)). The local Fire agency is the initial response to everything up to and including catastrophic, major disasters. The primary functions of Fire personnel in the wake of any disaster are Life Safety, Incident Stabilization and Property Conservation.

No community has the resources sufficient to cope with all emergencies. The effective management of emergency response personnel during the incipient stage of any major disaster and throughout its extended operations, will, by far, have the most significant impact on life loss and the severity of injuries to the affected population. The Statewide Fire Service Disaster Response Plan lends itself to the rapid activation and response of aid to a community in the event of a disaster. These events include train derailments, hazardous materials incidents, wildland fires, domestic terrorism and other events that may overwhelm the Fire department serving the community and its normal mutual aid resources.

Key Concepts of the Plan:

The Plan is directed towards enhancing disaster management at the local, County, Regional and State level by:

1. Utilizing the National Incident Management System (NIMS) as a model to assist the Authority Having Jurisdiction (AHJ) to manage actions during a disaster.

2. Providing central coordination for Fire resource response through County and Regional Fire Coordinators via Emergency Support Functions (ESF) and Regional Emergency Support Functions (RESF) for firefighting (ESF and RESF 4), and through Regional Incident Management Teams (IMTs), as needed. See IMT Bylaws in Appendix. See DEMHS Coordinating Council IMT Committee Bylaws, Appendix A

3. Providing resources for pre hospital Emergency Medical Services (EMS) in coordination with ESF and RESF 8.

4. Pre-designating responsibilities for leadership and resources at the local, County, Regional and State levels.

5. Integrating the Fire Service into the planning and response phases of Emergency Management systems at the regional and state level.

6. Encouraging each Fire agency to participate in the Statewide Mutual Aid Agreement and the Intrastate Mutual Aid System (Connecticut General Statutes §28-22a) which can be used in certain circumstances by all Fire agencies responding in support of this Plan.

7. Assist the local fire chief or AHJ, if requested, in incident management duties until the arrival of an Incident Management Team (IMT). IMT Activation Forms can be found in the Forms section of this document.

The coordination of the Statewide Fire Service Disaster Response Plan (SFSDRP or Plan), including its development, revision, distribution, training and implementation is the responsibility of the State Fire Administrator, in cooperation with the Connecticut Fire Chiefs Association. The Statewide Fire Service Disaster Response Plan Committee will oversee this process, on behalf of the State Fire Administrator. The Committee will be composed of the following members:

- State Fire Service Disaster Coordinator (Chair);
- State Fire Service Disaster Coordinator Alternate (Vice-Chair);
- Regional Fire Coordinators-- each Regional ESF 4 (RESF) chairs totaling five;
- County Fire Coordinators-- totaling eight;
- Commission on Fire Prevention and Control-- one representative;
- Office of Emergency Medical Services, Department of Public Health--one representative;
- Department of Emergency Management and Homeland Security--one representative;
- Department of Environmental Protection (DEP) Division of Forestry, one representative;
  Office of State Fire Marshal-- one representative;

The State Fire Administrator or Committee Chair can add to this membership as deemed necessary for the success of the Plan.

Guide for Bi-Annual Revision Process (or as deemed necessary by the SFSDRP Committee):

September: The SFSDRP Committee members are requested by the Fire Service Disaster Coordinator to solicit their respective areas, for recommended revisions to the Plan. These individuals will provide written comments to the Chair by the September meeting.

October: The SFSDRP Committee summarizes the recommended revisions to the Plan. The Full Committee provides preliminary direction as to the scope of the proposed changes and sends it back to the Statewide Fire Service Disaster Response Plan Committee for final draft.

January-February: The SFSDRP Committee provides a final draft of the Revised SFSDRP to State Fire Administrator for review and approval. The State Fire Administrator reviews the Plan under the authority granted in Connecticut General Statute §7-323o, particularly 7-323o(3), which requires the State Fire Administrator to provide technical assistance and guidance to firefighting

forces of any state or municipal agency and 7-323o(7) which requires the Administrator to assist in mutual aid coordination . The final draft shall also be provided to the DEMHS Commissioner for review and approval. The DEMHS Commissioner reviews the Plan under the authority granted in Connecticut General. Statute §28-1a(a), which requires the Commissioner to be responsible for a coordinated and integrated program for state-wide emergency management and homeland security. The State Fire Administrator shall then arrange for the reproduction and distribution of the Plan.

April: The Revised Plan will be distributed to all of the County and Regional Fire Coordinators and revisions will be included in the annual plan training. The updated plan will be posted on the Plan's Web page - **http://www.ct.gov/cfpc/.**

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITIES

The organizational structure of the fire service utilizes the designated roles of the National Incident Management System (NIMS) at both the county and regional level. As described in more detail below, the SFSDRP Committee in conjunction with DEMHS divided the state five regional response areas, DEMHS Regions 1-5. The Fire Service also uses its existing County system to serve a vital organized response role.

When requested by the AHJ, members of a Regional IMT may be appointed to fill functional responsibilities, outlined below. These may include Operations, Planning, Logistics, Finance/Administration, and EMS Liaison. The 8 Counties and 5 Regions comprise the SFSDRP resource network, which ultimately will receive its direction during a disaster from the State Fire Service Disaster Coordinator. The State Fire Service Disaster Coordinator or his designee will staff ESF 4 in the State Emergency Operations Center (SEOC), with the State Fire Administrator, coordinating resource response into the affected Region.

The State Fire Administrator, representing the Commission on Fire Prevention and Control, manages the ESF 4 function, at the State level. A list of pre-designated positions, will be established in the SEOC in Hartford. Support staff will consist of members of the Commission on Fire Prevention & Control office and designated members of the Connecticut Fire Service. The Support Staff personnel may coordinate resource requests, supporting the Logistics function for Statewide Fire resources. These personnel may also serve as an advisor to DEMHS and the Commission on Fire Prevention & Control on general emergency management issues.

Key Positions in the Organizational Structure:

State Fire Service Disaster Coordinator: Responsible for staffing ESF 4 in the State EOC and responsible for the oversight and implementation of the Plan and direction of the SFSDRP Committee. The State Fire Service Disaster Coordinator shall appoint a Vice Chair of the Disaster Committee and alternate(s) as needed. He shall be appointed by the State Fire Administrator in consultation with the Connecticut Fire Chiefs Association.

State Fire Service Disaster Plan Administrator: Provide support and assistance to the SFSDRP Committee, County and Regional Fire Coordinators through meetings, training programs, maintaining current Coordinator contact database for the Statewide emergency

activation/notification system, as well as the Task Force and Strike Team database. The SFSDRP Administrator may also seek financial support for equipment to support the SFSDRP and Fire Coordinators. This position works under the direct supervision of the State Fire Administrator.

Regional Fire Coordinators: Coordinates disaster assistance operations at the Regional level and provide resources into the affected area(s). Supports County Fire Coordinators for each County within their region. Serves as the RESF 4 chair for the DEMHS Regional Emergency Planning Team (REPT). There are a total of 5 coordinators, one per region, with at least one alternate per region, appointed.

County Fire Coordinator: One per County. County Fire Chief Associations, or like groups, may be contacted for a name to be submitted to the Regional Fire Coordinator for appointment. This position is the liaison between the County Fire Emergency Plans, within each County, and the Regional and State Fire Coordinators for the Plan. This person shall coordinate assistance among Fire agencies in that County and will be the primary contact for the regional logistics officer for resources. At least one alternate should be chosen for this position.

Operations, Planning, Logistics, Finance/Administration, PIO, and Liaison: These positions should be filled from within the Region to support the activation and implementation of the Plan. It is stressed that these positions are to support the requests of the Incident Commander for Fire Resources from the County and Region, and not to assume Command and Control of the Incident. However, upon the request of the AHJ for the incident, the Regional IMT may be activated to assist with Command and Control operations.

Regional EMS Liaison: Regional Fire Coordinator shall appoint One (1) for each Region. This position shall represent fire and non-fire based EMS resources. This position will assist in coordinating the efforts with ESF 8.
A checklist for each key position with their role and responsibilities are identified in Appendix A.

Regional Haz Mat Liaison: Regional Fire Coordinator shall appoint One (1) for each Region. This position shall represent fire and non-fire based HAZ MAT Teams and resources. This position will assist in coordinating the efforts with ESF 10.
A checklist for each key position with their role and responsibilities are identified in Appendix A.

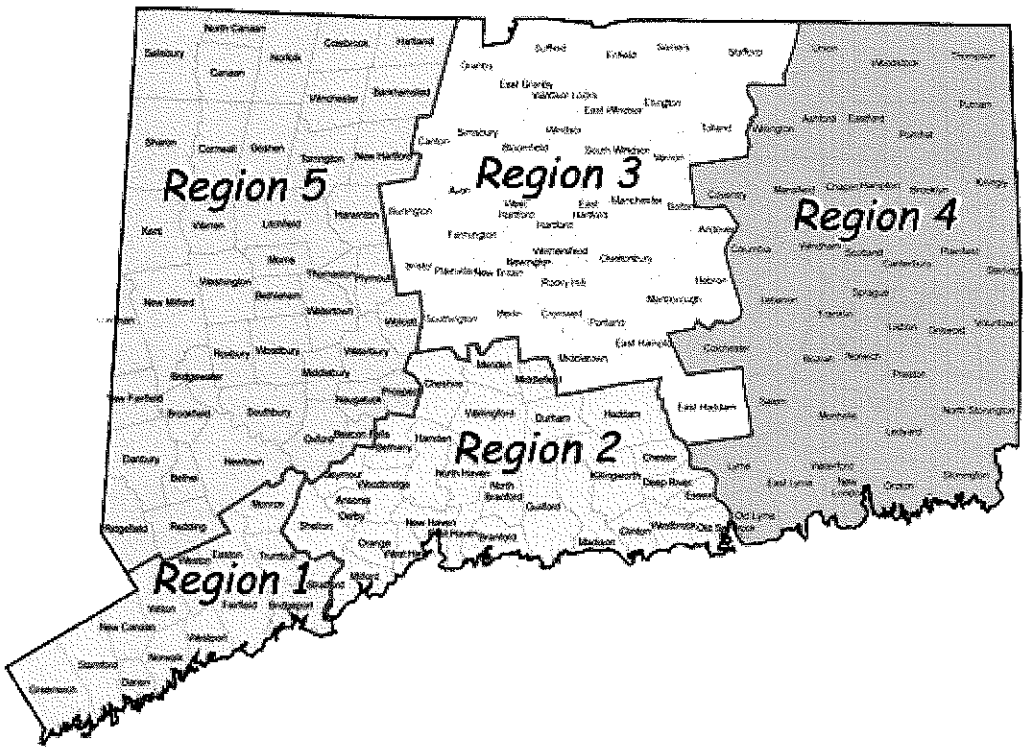
Fire Service Coordination Center ESF 4 : The FSCC shall be developed in the future, by the State Fire Administrator or his designee, to provide space for ESF 4 staff to support to the State Fire Administrator and/or State Fire Coordinator at the SEOC. It is the recommendation that the CFA be equipped with the necessary communications equipment and other support equipment to provide proper staff support.

Regional Representation :

The SFSDRP Committee in conjunction with DEMHS, divided the state into five regional response areas. The Regions are designated Region 1 through 5; (see DEMHS map for clarification of municipalities within the 5 regions). Within each region, The Regional Fire Coordinator (RESF 4 Chair) will appoint at least one alternate for the RESF 4 position. Representatives should be geographically separate in the region when possible, minimizing the possibility of both persons being directly affected in the event of a disaster striking that region.

The SFSDRP has incorporated standardized forms for ordering resources into the affected areas. Activity logs and chronological logs that are in compliance with State and Federal guidelines are available to participating agencies. Current standardized fee schedules for the use of apparatus and equipment, allowable replacement costs will be provided to the participating agency when reimbursements are requested in accordance with Connecticut General Statute, Title §28-22a on declared disasters. It will be the responsibility of the participating agency to submit reimbursement forms to the appropriate Local, State or Federal agency.

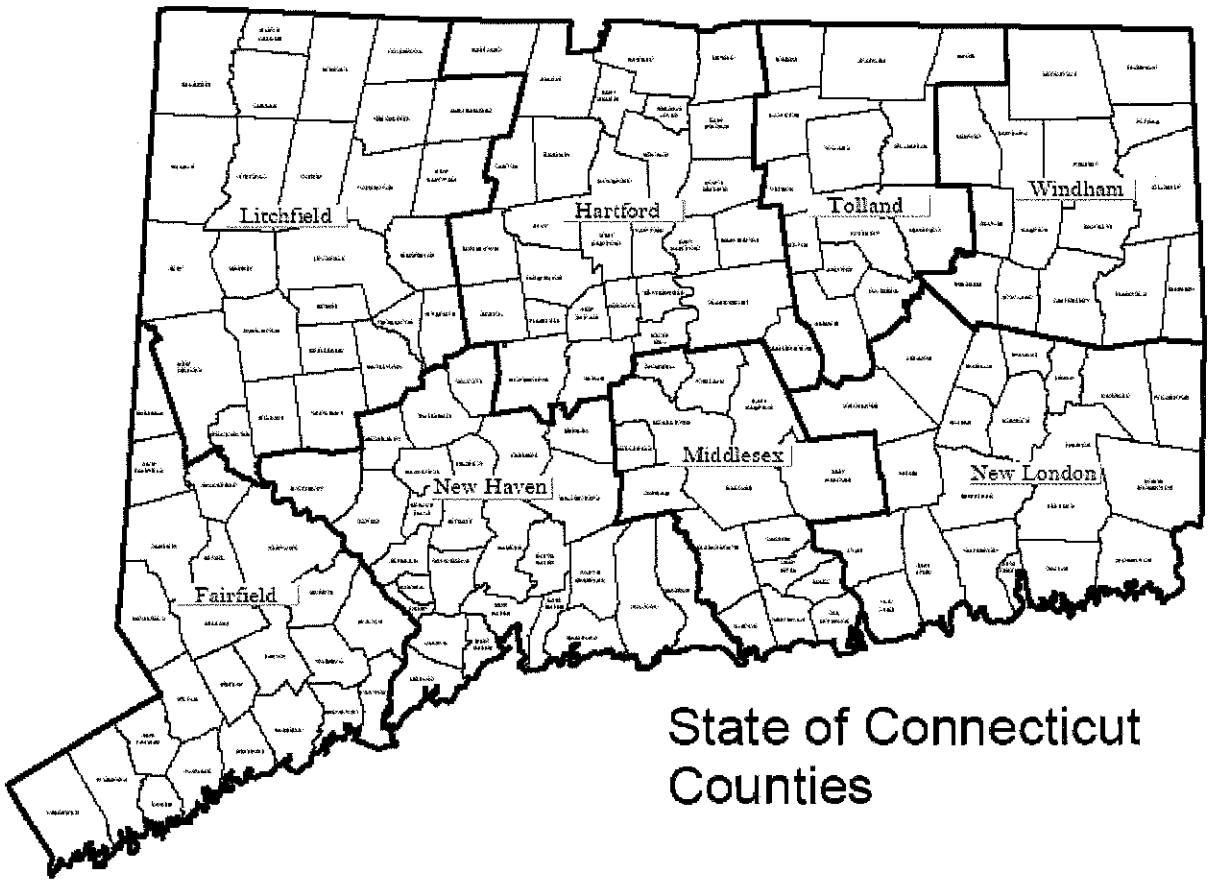
The 5 DEMHS Regions are designated on the following map



County Representation :

County Fire Coordinators must be appointed for each County as a vital logistical link from the area. Alternates for each position should be appointed in the event that the primary person is not available during a disaster and should be geographically separate in the County when possible. Each County Fire Coordinator is responsible for tracking all available resources within the County (supported by resource typing work performed by DEMHS). The above appointments should be geographically separate from each other in the Region when possible. The individual departments shall then muster resources for the County and /or Region in support of the Plan.

The 8 Counties are designated on the following map.



Training Competencies :

Each of the personnel appointed to a designated role within this Plan should be encouraged to complete the following phases of training, when available. These include:

Incident Management System training through Connecticut Fire Academy (CFA), National Fire Academy (NFA), Emergency Management Institute (EMI), DEMHS or I-200 offered through the Division of Forestry.

State Fire Service Disaster Response Plan Training offered through CFA or coordinated by the State Fire Disaster Plan Administrator at the County , Regional and State levels.

Positional Training and Certification coordinated through the DEP Division of Forestry within each Region (I-200, basic IMS, is a pre-requisite)

Integrated Emergency Management System available through DEMHS, FEMA EMI and IAFC, offered on a rotating basis, nationwide.

ACTIVATION OF THE SFSDRP

When a Fire Department is affected by a disaster situation locally, the Fire Chief will request additional assistance from area mutual aid agencies. When the department is no longer able to obtain additional assistance from area departments using normal mutual aid, requests for County Fire Coordinators to assist with additional resources should be made. When the requests for resources expand outside of the County, the County Fire Coordinator will notify the Regional Fire Coordinator/s for additional assistance. The Regional Fire Coordinator will advise the Department of Emergency Management and Homeland Security (DEMHS) Regional Coordinator. If the Incident Commander determines a need for further resources, the municipality will request additional resources through the DEMHS Regional Coordinator. The request to DEMHS will be forwarded to ESF 4, working with other ESF's, including 9 or 10, depending on the situation. The DEMHS Regional or State EOC may be activated as needed. The SFSDRP will be activated when a request for additional assistance has been made to ESF 4 at the SEOC. See Appendix – for Flowchart.

Request for Assistance (RFA):

Any municipality that has not opted out of the Intrastate Mutual Aid Compact (see §28-22a) and/or that has signed the Statewide Mutual Aid Agreement has authorized three (3) individuals to sign on behalf of that agency when requesting or deploying resources. All requests for assistance will be processed through the State EOC (SEOC) utilizing the "Request for Assistance Form" (CFS Form 1a) or subsequent plans. The requesting agency will complete the top portion of the form, assuring that a detailed explanation of the mission to which those resources will be assigned is included. The requestor then utilizes the remainder of the form to identify exactly what and how many of each resource type will be needed. The form utilizes the accepted resource typing methodology included within this plan. That request will then be forwarded to the SEOC for processing, through the appropriate ESF who will fill the request utilizing this plan. Once a Region has committed to

filling a request, the responding agency is to complete the "Response to Request for Assistance Form" (CFS Form 1b). Care should be taken to assure the proper type of resource and number being committed is completed, for each resource being deployed by the assisting agency. In addition, an hourly estimate of costs for the committed resources and estimated transportation costs to and from home base must be included on this form. That form, along with the Crew Deployment Form for that mission is to be returned to the SEOC, ESF 4 desk.

Resource Inventory:

Each Regional Fire Coordinator will maintain an updated inventory of its equipment, vehicles and personnel which are available for response within the scope of this Plan. The participating agencies will review the resource inventory section for completion and submit to their County Fire Coordinator, who will gather the resource information to pass on to the Regional Fire Coordinator. County Fire Coordinators may utilize any resources from any agency, municipality, political subdivision or department that has agreed to participate in this Plan, these include Task Forces, Strike Teams, Fire Brigades or Haz-Mat Teams as examples. It is clearly understood, as is the standard practice with all mutual aid agreements that all equipment, vehicles, and personnel listed, will respond as described within this Plan only if available at the time of the request. When a request for assistance is received, the County Fire Coordinator will properly notify each participating department to request their available resources for deployment. The County Fire Coordinator will utilize the resource inventory as a guide to track and request available resources. The Connecticut Fire Service developed a method of typing resources which is consistent with resource typing used by FEMA and (supported by resource typing work performed by DEMHS) is indicated in Appendix B along with completed examples.

The available resources are to be updated when necessary in accordance with the following guidelines utilizing the "Resource Inventory Forms" (CFS Form 2).

The following options should be considered when using the Resource Inventory Form:

1. Only include resources that are available for response to a disaster elsewhere, without reducing your own capabilities to an unacceptable level.

2. The Types refer to minimum requirements. If all requirements are not met for a Type 1, but are for a Type 2, then list it accurately as a Type 2
3. Use the special information area on the inventory list for resources that need clarification for unusual attributes (Example: personnel that are bi-lingual or sign for the deaf).
4. Use a separate list, if necessary, for additional resources not typed on these resource lists. Be specific in describing features or qualifications.

DEPLOYMENT OF RESOURCES

Critical Concepts

Critical to the success of this deployment plan are the three (3) concepts of: (1) efficient timeframe for deployment; (2) the ability to pre-stage resources in advance of a pending disaster and (3) pre-identified Strike Teams and Task Forces within each County and Region. In concert with these concepts, it is critical that all resources deployed are adequately documented and tracked from within each sponsoring County and Region. In addition, it is imperative that our personnel arrive on scene of a disaster with complete,

appropriate Personal Protective Equipment (PPE). The minimum PPE for all out of jurisdiction assignments through the SFSDRP shall be full structural PPE, as specified in NFPA Standards. In addition, it is highly recommended that for deployments including wildfire assignments, wildland PPE as specified in NFPA standards be carried as well.

- Time Frame for Deployment: Unless specified otherwise at the time of request, the standard for deployment of Fire Service resources shall be within three (3) hours of the mission assignment from the State EOC. Under certain circumstances a more rapid deployment may be deemed necessary by the SEOC and authorized as a "Rapid Activation". Time frame for deployment of these missions shall be within one (1) hour of the mission assignment from SEOC. It is anticipated that the pre-identified Task Forces and Strike Teams will fill these resource requests.

- Pre-identified Task Forces and Strike Teams: each Region is encouraged to pre-identify Strike Teams, made up of five (5) like resources, and/or Task Forces, made up of five (5) mixed resources. Each Strike Team and/or Task Force is to have a designated, trained Team Leader and common radio communications. The primary mission of the Strike Teams and/or Task Forces will be response into areas affected by a disaster, to work within the Command Structure within that affected area. The most common use of these pre-identified teams will be for incidents requiring a rapid response, particularly those designated "Rapid Activation". It is anticipated that "Rapid Activations" will peak quickly and terminate within a shorter time frame, thereby allowing for a shorter preparation time. To accomplish the rapid deployment all of the required deployment documentation should be compiled and maintained by the Regional Fire Coordinator in advance.

- Pre-Staged Resources: Based on the forecast of an imminent disaster, it may be advisable to stage resources in advance, to better position them geographically for a timely response into an affected area. That decision will be made by the AHJ with the knowledge of the SEOC, the ESF 4 representative and the sponsoring Regional Fire Coordinator. Once that mission has been assigned, the resources shall be prepared for deployment and sent to the identified staging area. The staging area designated must be under the direct supervision of a Staging Area Manager, provide the necessary logistical support to accommodate the deployed resources for a prolonged time period and provide a high degree of safety and security for all deployed resources. Once deployed to a staging area, all resources shall be considered in "active mission" status. Staged resources will only be released into an affected area, after confirming mission orders have been confirmed from the SEOC, ESF 4 representative.

Resource Definitions:

To provide standardization in deployment, specific terminology has been chosen:

Strike Team: Five (5) like units, e.g. Type 1 Engines, with common communications, predefined amount of personnel, and an assigned Strike Team Leader. The Leader should be in a separate vehicle for mobility and will meet with the Team at a staging area or other designated location and coordinate their response to, and efforts during, the incident.

Task Force: Five (5) units, which need not be identical, e.g. three (3) Type 1 Engines and two (2) Aerials, with common communications, predefined amount of personnel and an assigned Task Force Leader. The leader may be in a separate vehicle for mobility and will meet with the team at a staging area or other designated location and coordinate their response to, and efforts during, the incident.

Single Resource: Individual engines, equipment, personnel that may be requested to support the incident. A single resource will be the equipment, plus the individuals required to properly utilize it.

Company Staffing: Individual personnel that make up a company for staffing purposes are designated in Appendix B (Personnel & Miscellaneous Equipment).

The advantage of the regional configuration in the SFSDRP is to provide effective mobilization and deployment of Fire Service resources in order to provide rapid assistance to areas affected by a disaster. Regions have been configured to mirror the DEMHS regional areas which provides for closer coordination with DEMHS and enables travel by Fire Service resources within any Region to be accomplished in an efficient manner.

Specialty Positions:

1. During a disaster there are often requests for specialty positions to fill specific needs. For the most part these will be activated and deployed as a typical single resource based on their availability as determined by the County Fire Coordinator working with the Incident Commander. Several key positions have their own disaster response deployment plans and organizational structure. The SFSDRP is designed to utilize their system while still maintaining the integrity of the plan concept. Examples of these types of positions include public information officers, Foam Trailers and specialized Search and Rescue resources (DEMHS CT Task Force-1, USAR Team).

2. The State Fire Service Coordinator will then notify the appropriate Regional Fire Coordinator that they have responsibility for coordinating requests for the specialty position.

3. When a request is received at the State Emergency Operations Center and a mission has been authorized, the State Fire Service Coordinator will contact the Regional Fire Coordinator for the specialty position and initiate the request.

4. The State Fire Service Coordinator will identify the resource and working with the Regional or County Fire Coordinator, will then task the request through the local agency that will be providing the resource.

5. The State Fire Service Coordinator for the specialty position will track the deployment and keep the Regional Fire Coordinator up to date on the status of the mission and any future needs related to the assignment.

The purpose of this system is to keep the primary tasking through the system to the County Fire Coordinators and the local agencies. This provides a common issuer of tasking numbers at the local level and will minimize confusion by agencies being tasked.

Documentation

Once a Request For Assistance has been received by the State Emergency Operations Center, and a Region has agreed to fill that request, the Regional Fire Coordinator must complete a "Disaster Team Deployment Form" (CFS Form 3) and an "Emergency Contact Form" (CFS Form 4) and fax them to ESF 4 at the SEOC.

The Crew Deployment Form shall contain the following information on each individual being prepared for deployment:

1. **Mission #** - to be issued by State E.O.C. Place next to the mission number the type of mission being filled. (Ex: ALS Strike Team)

2. **Date/Time Deployed** - to be updated as replacement crews are deployed.

3. **Message #** - original message number issued by the State E.O.C.

4. **Date/Time Demobilized** - to be updated as the mission is completed.

5. **Full Name** - as it would appear on payroll, social security, etc.

6. **Agency** - sponsoring department.

7. **Social Security Number** - as it appears on the individual's payroll records.

8. **Hourly Wage** - must indicate whether rate includes fringe. If it does not include fringe benefits, then the fringe benefit amount must be indicated in a percentage basis.

9. **Position** - to indicate position within strike team, task force or position filled resource request. (May also indicate fire service rank)

10. **Unit Designation** - apparatus number/designation individual is assigned to.

11. **Comments** - to provide additional information such as; fringe amount, special skills or when providing replacement personnel.

The Emergency Contact Form shall contain the name of a family member/friend and 24-hour contact number for each team member deployed.

Uniform Mission Tasking Numbers

Each Regional Fire Coordinator will assure that all personnel and all equipment deployed under this plan are accounted for prior to, during and upon returning from each mission. To assist in the accountability process, the State Emergency Operations Center ESF 4 may issue uniform mission tasking numbers to all equipment, apparatus and personnel that are sent into an affected area or sent into staging areas. These numbers will be formatted as follows:

(Year) (Incident #) (Assignment #)

CFS / 01 / 001 / TF001

Mission Book

When resources are deployed to an affected area, the Regional **Fire** Coordinator shall assure that the Strike Team Leader, or individual if single resource, receives a Mission Book which includes the following items prior to leaving home base:

1. Copy of all ICS forms (multiple copies of ICS 214,Unit Log).
2. Emergency Contact Form.
3. Copy of all vehicle/apparatus registrations.
4. Copy of basic vehicle/apparatus inventory.

Mission Orders

In addition, the Strike Team Leader, or individual if single resource, will receive mission orders. The Mission Orders will clearly identify:

1. The mission tasking number.
2. Contact name and telephone number of the staging location in affected area.
3. Directions to staging area (maps are always helpful).
4. Primary mission objective and any special instructions.
5. 24-hour contact numbers for regional coordinator/staff (to allow team leader the ability to submit daily situation reports and any necessary emergency communications).

Two copies of the Crew Deployment Form; one will remain in the possession of the Strike Team Leader, the other will be submitted to the affected area's representative upon reporting to the staging area.

LOGISTICAL SUPPORT

Self Contained

The logistical support of mutual aid resources is critical in the management of a disaster effort. It is believed a tiered resource response will be necessary. Initial units sent to a disaster should be self-contained for a period of 72 hours or able to return home each day, unless otherwise advised by the affected jurisdiction that logistical support has been established for the mutual aid forces. It is a fundamental assumption that this logistical support will be established as soon as possible and will be maintained by the agency requesting the resources. This shall include full structural fire PPE and wildland fire PPE, as appropriate.

The size of the response sent to the area, the severity of the disaster, the extent of the area involved, and the infrastructure that is still functional within the affected area, will ultimately determine the extent to which logistical support is required.

1. Transportation to and from the area:
    - Staging areas, within and outside, the disaster area
    - Overnight storage for vehicles
    - Maps and directions for responding personnel
    - Emergency towing and repairs

- Designating fuel, oil, and water depots

2. Food supplies and preparation:
   - Self contained mobile food preparation units
   - Personnel to prepare/distribute meals
   - Sanitation and clean up
   - Food supplies/utensils

3. Overnight shelter and rehabilitation areas:
   - Provide suitable (secure) overnight shelter
   - Environmental considerations (rain, sun/heat, insects)
   - Bedding
   - Transportation to and from shelter
   - Parking and security of apparatus
   - Electricity/generator power
   - Water and sanitary facilities
   - Communications links (in and out of the disaster area)

4. Critical Incident Stress Debriefing (CISD) considerations – provided by DMHAS

5. Affected worker support/assistance

Communications

The key to the successful operation of the various resources into a region will depend heavily upon the ability of these agencies to communicate effectively among them. It is realistic to assume that in the wake of a major disaster, such as a hurricane, the existing communication system in the affected area will be inoperable or severely compromised. Therefore, responding mutual aid forces must be able to communicate with each other, independent of the local communications network. In addition, common terminology for all voice transmissions must be utilized.

It is essential that a statewide disaster communications network be established. This is perhaps the highest priority in the effort to design an effective statewide disaster response plan. A Frequency Plan has been established and is listed in Appendix C. The Communication Network should include the following:

1. The designation of a Statewide Communications Network (within the Statewide Emergency Management Radio Network) using non-proprietary hardware.

2. The non-proprietary hardware must have a cost that most small fire agencies can afford to purchase.

3. The Network must meet the eligibility requirements of FCC part 90.

4. The Network must be consistent with the State of Connecticut EMS Communications Plan.

5. The Network should be consistent with the use of transportable communications caches available through State Emergency Management, Regional, and local government agencies.

6. The CFS will maintain a current list of emergency contact telephone numbers and pager numbers of the Officers, Board of Directors, Disaster committee, State, Regional, and County Coordinators.

7. Computer access, regionally, with Internet connection.

8. Use of clear text during disaster for radio communication with all Fire Service resources.

9. Designate a Statewide Communications frequency within the Statewide Emergency Management Radio Network.

Mutual Aid Communications Units

821 MHz. Common Channel Operation and Implementation:
As adopted by FCC Region 8 (New Haven, Middlesex, Litchfield and Fairfield) and FCC Region 19 (Hartford, New London, Tolland and Windham) Counties have established rules for the use of these National Calling and Tactical channels. These are to be used for response under the guidelines of this Plan and for coordination between different levels and types of services. The following assignments are designated by CFCA Technical Advisory Fire Frequency Plan:

Region 1	Fairfield:	Group 4 - 1
Region 1	Litchfield:	Group 2 - 3
Region 2	Hartford:	Group 4 - 1
Region 2	New Haven:	Group 3 - 2
Region 2	Middlesex:	Group 1 - 4
Region 3	New London:	Group 2 – 3
Region 3	Tolland:	Group 3 – 2
Region 3	Windham:	Group 1 - 4

Regional Communications Personnel:

Each region shall assure that it maintains communications personnel, which are capable of maintaining, operating and troubleshooting their assigned communication responsibilities. At a minimum, each region shall assure the availability of a communications technician and/or a communications unit leader. Detailed position descriptions can be found in the Appendix section of this plan.

- Communications Technician: Personnel serving in this capacity shall be responsible for the effective operations, troubleshooting and programming of radio equipment. This position shall provide technical advice to the requesting agency and/or the Communications Unit Leader.

- Communications Unit Leader: Personnel serving in this capacity shall be responsible for developing plans for the effective and efficient use of any statewide radio system or equipment, distribution of the radio equipment, inventory of communications equipment and the maintenance of same. When deployed, this position will report to the incident Command structure in place within the requesting agency.

REIMBURSEMENT PROCEDURES

Financial Assistance

When a major or catastrophic emergency exceeds local resources and area departments are unable to fulfill the needs of the citizens, then aid and assistance may be requested from the state of Connecticut. Such financial assistance is made available on a supplemental basis through a process of application and review. If community resources are insufficient, the local government may apply to the state for state assistance. The governor reviews the application, studies the damage estimates and, if appropriate, declares the area a state disaster. This official declaration makes state funds, personnel, and resources available.

However, if damages are so extensive that the combined local and state resources are not sufficient, the governor applies to the President for federal disaster assistance. A similar assessment of the application and damage estimates is completed. If the need for federal assistance is justified, the President issues a major declaration and resources are made available. This official declaration makes federal funds, personnel, and resources available. Federal funding is usually on a shared cost basis with 75% federal funds and 25% state funds.

FEMA Reimbursement

This section serves as a reference for information on disaster cost recovery to assist individuals in documenting disaster-related expenditures following a Presidential and/or State Declaration to facilitate reimbursement from the federal government, the state of Connecticut and the County's private insurance carriers. This section may appear tedious and burdensome, but it reflects FEMA's requirements and emphasizes the need for close compliance. If the department fails to be comprehensive, detailed, and accurate in the type and extent of documentation, portions of the claim and possibly the entire claim will be disallowed, and the department will be required to absorb these costs.

Reimbursement Eligibility

To meet eligibility requirements for FEMA reimbursement, an item of work must:

- Be required as the result of the major disaster event
- Be located within a designated disaster area
- Be the legal responsibility of the eligible applicant

FEMA Categories of Work

FEMA provides reimbursement of funds based on the type of disaster-related work that was performed. Each activity for disaster-related work is eligible for a specific amount of reimbursement. Therefore it is imperative that all disaster-related work activities must be identified and documented as one of the following FEMA categories. Under the Statewide Emergency Response Plan, the work most often performed under this Plan is Emergency Work: Work performed immediately to save lives and protect improved property and public health and safety, or to avert or lessen the threat of a major disaster. Emergency Work contains two categories: Debris Clearance and/or Protective Measures.

Disaster-Related Expenditures

FEMA will provide reimbursement of expenditures to perform emergency protective measures in disaster-related work. Reimbursements must be in accordance with Federal Financial Management Annex and 44 CFR, Part 206. Examples of eligible reimbursement activities include, but are not limited to:

1. Payroll expense for personnel operating at the incident
2. Hourly cost to operate capital equipment (fire engines, rescues, etc)
3. Expendable materials used at the incident
4. Equipment leased/purchased specifically for the incident
5. Contracted services made necessary by the disaster

Expenses for Personnel

According to the federal regulations only actual hours worked, either overtime hours or regular time hours, can be claimed for FEMA category A & B (emergency work). If time and one-half or double time is paid to regular hourly employees for overtime or holiday work, these payments must be in accordance with rates established prior to the disaster (i.e. Collective Bargaining Agreement).

On occasion, FEMA approves reimbursement for an option known as "backfilling". If approved, this option would allow the department to be reimbursed when personnel are called back to work to replace an existing employee already approved to perform disaster related activities elsewhere. Accurate payroll records must be maintained to clearly identify the employee's overtime hours versus regular time hours. In addition, records must identify each employee by location and purpose of the work in order to designate the proper FEMA category and organize the claim. The records must also include the CFS Mission Tracking Number. It is imperative that each member of a deployed CFS resource is accounted for daily on an ICS 214, "Unit Log". In cooperation with the Commission on Fire Prevention & Control, resources deployed under the CFS Disaster plan will be reimbursed only for actual hours worked while assisting the requesting agency, plus travel time to and from home base. The practice known as "portal-to-portal" pay is not endorsed by the Fire Chiefs' Association and will not be reimbursed as a routine part of CFS deployments.

Expenses for Equipment

Each department may be eligible for reimbursement of equipment owned by the department used in disaster work. To assist in the reimbursement process, FEMA has developed an equipment rate schedule. The Finance Section Chief should obtain the most recent version of the FEMA equipment rate schedule prior to submitting for reimbursement. The current approved FEMA rate schedule, for use in cooperation with this plan is included within this section.

Each request for reimbursement of department owned equipment must contain the following information:

1. Mission Tracking Number as issued by CFS
2. Type and description of equipment
3. Location equipment was used
4. Number of hours used each day (show dates)
5. Total hours actually used (no standby time allowed)
6. Category of work performed

Approved FEMA Equipment Rates for CFS

FEMA maintains the base rates most often used for resources deployed under the SFSDRP. A complete listing may be obtained at www.fema.gov under Schedule of Equipment Rates.

Damage/Loss of Equipment

Equipment that is damaged and/or lost during disaster incidents may be eligible for reimbursement. The damage and/or lost must be documented along with sufficient supportive documentation such as video and/or photographs. If the documentation is not comprehensive, detailed, and accurate, portions of the claim and possibly the entire claim may be disallowed, and the department will be required to absorb these costs.

Reimbursement Processing

Each department is responsible for preparing the necessary documentation and submitting a reimbursement claim for resources deployed under this Plan. The County Fire Coordinator is responsible for collecting all documentation relative to the disaster incident from each department deployed. The County Fire Coordinator will compile the documentation and identify eligible reimbursement in accordance with current FEMA guidelines.

The County Fire Coordinator must coordinate the collection and documentation of all disaster-related forms and supportive documents for final review and possible submission to the Regional Fire Coordinator. The FEMA reimbursement process is unique to each disaster and has led to processing reimbursement funds in a different manner, creating some degree of confusion and problems in reconciliation. Therefore coordination between the County and Regional Fire Coordinators is paramount to ensure full and timely reimbursement.

CONNECTICUT FIRE SERVICE TRAVEL REIMBURSEMENT

This section is intended to be a guide for the processing and submission of reimbursement requests for travel associated with the operation, support, or training for the SFSDRP. It is not intended to serve as a reimbursement procedure for expenses associated with the deployment of Fire-Rescue resources under this plan.

Travel Purpose

The reimbursement process varies according to the purpose of the travel. Each purpose is subject to limitations, financial restrictions, and method of processing. The two purposes of allowable reimbursement are:

Section I Travel in support of the State EOC and SFSDRP.

Section II Non-emergency travel associated with the SFSDRP.

Processing

The need for proper and accurate documentation cannot be overemphasized. The processing of travel requests will vary dependent upon the purpose of the travel. Any questions that may arise in the processing of these forms should be directed to the CFCA Executive Director.

Section I and Section II travel is processed through the State Fire Administrator to DEMHS in accordance with the CFS's Memorandum of Understanding with the State of Connecticut.

Section I: Reimbursement Process for State EOC

Travel expenses, including per diem are eligible for reimbursement when an individual is operating at the State EOC or filling an assignment in a support role for ESF 4, such as liaison officer. Individuals will only be eligible for reimbursement if their activities are authorized, in response to a request for assistance through the State Disaster Response Network, and the necessary tasking number has been received. Individuals will only be reimbursed for actual travel expenses and will receive a per diem rate for meals as established by the State of Connecticut. Individuals operating under these guidelines will be considered as part of the state mutual aid program and will not be eligible for wages or overtime. Individuals traveling will be considered in the employment of their own respective agency. Any medical coverage or workers compensation claims will be processed through the individual's place of employment.

A. Travel Reimbursement Form

All requests for reimbursement must be submitted on the four-part, "State Voucher for Reimbursement of Travel Expenses Form". This form is available through the Division of State Fire Marshal. All completed forms will be processed through the State Fire Administrator's Support Staff to DEMHS for reimbursement. Completed travel request vouchers should be submitted as soon as possible after the completion of your travel.

B. Per Diem

Individuals will be paid in accordance with the standard State of Connecticut per-diem rate. Receipts are not required for this reimbursement.

C. Lodging

Lodging costs are reimbursed on the basis of the actual costs for accommodations. Individuals are expected to stay in standard rooms and to request a government rate if available. An original receipt indicating payment in full and a zero balance must be submitted with your travel voucher to insure reimbursement.

D. Transportation Costs Transportation Costs

Individuals are expected to travel in personal or an agency-owned vehicle when operating in the disaster response plan. Airline transportation or automobile rental requires approval from the State Fire Administrator or through the Commission on Fire Prevention & Control. Personal vehicle reimbursement is on a per mile basis. Individuals using a personal vehicle will be reimbursed at the current IRS mileage rate for business mileage. Individuals using an agency owned vehicle will be reimbursed for the actual cost of the fuel. Original receipts for fuel purchases must be submitted with your travel voucher.

E. Other Expenses

Other expenses including tolls, parking fees, laundry charges, etc. are reimbursable if they are a direct result of your travel. Personal telephone calls, movie rentals or entertainment costs are not eligible for reimbursement. Original receipts must be submitted with your voucher for reimbursement.

Section II: Non-emergency travel associated with the SFSDRP

Travel expenses, including per diem, are eligible for reimbursement when an individual is required travel in conjunction with the SFSDRP. The State Fire Service Coordinator will coordinate travel requests through the State Fire Administrator. Members of the Disaster Response Committee will coordinate their travel through the Chair of the Disaster Committee. Individuals will only be eligible for reimbursement if their activities

are authorized and involve activities associated with the Plan. Individuals will only be reimbursed for actual travel expenses and
will receive a per diem rate for meals as established by the State Fire Administrator. The Plan will NOT be responsible for any wages or the replacement of personal leave time from the employing agency of the individual. Individuals traveling will be considered in the employment of their own respective agency. Any medical or worker compensation claims will be processed through the individual's employing agency.

A. Travel Reimbursement Form:

All requests for reimbursement must be submitted on the "CFS Expense Report Form" (CFS Form 5). All completed forms are to be sent to the State Fire Administrator. Completed travel forms should be submitted as soon as possible after the completion of your travel.

B. Per Diem:

Individuals will be paid in accordance with the standard State of Connecticut per-diem rate. Receipts are not required for this reimbursement.

C. Lodging

Lodging costs are reimbursed on the basis of the actual costs for accommodations. Individuals are expected to stay in standard rooms and to request a government rate if available. An original receipt indicating payment in full and a zero balance must be submitted with your travel voucher to insure reimbursement.

D. Transportation Costs

Individuals are expected to travel in personal or agency owned vehicles when traveling in conjunction with the disaster response plan. Airline transportation or automobile rental requires prior approval from the State Fire Administrator. Personal vehicle reimbursement is done on a per mile basis. Individuals using a personal vehicle will be reimbursed at the standard State of Connecticut rate per mile. Individuals using an agency owned vehicle will be reimbursed for the actual cost of fuel. Original receipts for fuel purchases must be submitted with your travel voucher.

Other expenses, including, tolls, parking fees, laundry charges, etc. are reimbursable if they are a direct result of your travel. Personal telephone calls, movie rentals, or entertainment costs are not eligible for reimbursement. Original receipts must be submitted with your travel expense form for reimbursement.

PLAN IMPLEMENTATION

Responsibility: The implementation of this plan shall remain with the person or persons with incident management authority in the event of a disaster within that jurisdictional area.

Actions:

_____ Adopt Statewide Fire Service Disaster Response Plan and blend into current Incident Management System.

_____ In the event of an emergency/disaster when mutual aid assistance has been exhausted, the local jurisdiction shall conduct a needs assessment for determining the type and amount of additional resources required.

_____ The locally affected jurisdiction establishes contact with County Fire Coordinator through the office of the Regional Emergency Manager.

_____ Transmit to the County Fire Coordinator what logistical support, equipment, and personnel are needed for the affected local jurisdiction.

_____ The County Fire Coordinator contacts the State Fire Coordinator through the Regional Fire Coordinator and Emergency Manager with the needs assessment for the affected jurisdictions within the County.

_____ The State Fire Coordinator contacts the Regional Fire Coordinator to verify the resources available within the Region to respond to the affected County.

_____ Regional Fire Coordinator gathers resources within the Region, verifies their response through the County Fire Coordinator into the affected jurisdictions and advises State Fire Coordinator which resources (committed or sent) from within the region.

_____ Regional Fire Coordinator contacts the State Fire Coordinator when resource requests can not be filled from within the Region.

_____ The State Fire Coordinator gathers resources from the unaffected Regions and outside State assistance for response to the affected Counties/jurisdictions through the Regional Fire Coordinator.

_____ Regional Fire Coordinators contact their County Fire Coordinators to notify them of State activation and that resources may be requested.

_____ The State Fire Coordinator will establish an appropriate Fire Command/IMS structure (ESF 4, working with ESF's 9 and 10) in close proximity to or at the State EOC.

STATE FIRE ADMINISTRATOR

Position Responsibilities: Overall coordination and implementation of the Disaster Response Plan through the Disaster Coordinator.

Actions:

_____ Annually appoints the Chair of the SFSDRP Disaster Committee who also serves as the Statewide Fire Disaster Coordinator.

_____ Notifies the State EOC Coordinator through the Commission on Fire Prevention & Control annually with the identity of the Statewide Disaster Coordinator.

_____ Appoints other members to assist the Disaster Committee as deemed necessary.

_____ Communicates with Statewide Fire Disaster Coordinator on all matters affecting Statewide Disaster Planning.

_____ Assists Statewide Fire Disaster Coordinator with Plan implementation and management as necessary.

_____ Contacts adjacent State Chiefs' Associations, as necessary, to coordinate planning activities.

_____ Liaison with IAFC for situation updates and assistance needs.

_____ Attends critiques of the Plan.

STATEWIDE DISASTER COORDINATOR

Position Responsibility: Overall direction, coordination, implementation and management of the Statewide Disaster Response Plan.

Actions:

_____ Appointed annually by the State Fire Administrator upon recommendation from the Statewide Disaster Response Committee of the Connecticut Fire Chiefs Association.

_____ Serves as Chairman of the Disaster committee for the SFSDRP.

_____ Appoints a Vice Chair of the Disaster Committee.

_____ Appoints Regional Fire Coordinators for each of the three (5) DEMHS response regions

_____ Maintains contact with all Regional Fire Coordinators upon appointment.

_____ Holds regular Disaster committee meetings. These meetings shall be conducted at least quarterly.

_____ Represents the Disaster Committee to the Boards of Directors of CFCA.

_____ Makes reports to the full CFS on the Plan and the activities of the Disaster Committee, as needed.

_____ Assists Regional Fire Coordinators with assigning key staff members for the Plan, as well as County Fire Coordinators. Personnel may be drawn from law enforcement, EMS, or other fields as deemed appropriate for the success of the Response Plan.

_____ Insures Plan updating, training, funding and other administrative functions are on-going.

_____ Coordinates Plan activation.

_____ Serves as the Incident Commander for the Statewide Fire Service Disaster Response Plan during Plan activation.

_____ Serves as Fire Service representative/liaison in the State Emergency Operations Center to ESF 4.

STATEWIDE DISASTER COORDINATOR (Continued)

_____ Assigns qualified personnel to work as Logistics Officers at ESF 4 in the State EOC in the event of activation.

_____ Develops appropriate IMS support structure to implement the Plan. Such a support structure may be activated in cooperation with the Commission on Fire Prevention & Control's Office.

_____ Serves as the liaison, during the disaster, to the affected Regional Fire Coordinator in providing needed resources from other regions in the state.

_____ Notifies Regional Fire Coordinators of Plan activation and that resources may be required.

_____ Coordinates and manages the Plan while implemented.

_____ Assigns or is assigned a liaison in the affected area.

_____ Coordinates response requests from outside the disaster area or.

_____ Coordinates demobilization of resources and deactivation of the Plan.

_____ Critiques response with Disaster Committee and makes appropriate recommendations to the SFSDRP for changes in the Plan.

VICE-CHAIR DISASTER RESPONSE COMMITTEE

Position Responsibilities: Assists the Disaster Coordinator in the overall direction, coordination, implementation and management of the Statewide Disaster response plan.

_____ Appointed annually by the Chairman of the Disaster Committee.

_____ Serves as chairman and disaster coordinator in the absence of the Statewide Disaster Coordinator.

_____ Responsible for coordinating all grants and training programs offered by the Disaster Committee.

_____ Serves as the Logistics Officer at the SEOC as necessary.

_____ Provides recommendations on revisions necessary to update the Plan.

_____Liaisons with external associations and agencies on training opportunities.

REGIONAL FIRE DISASTER COORDINATOR

Position Responsibility: Command disaster assistance operations at the regional level.

Actions:

_____ Appointed annually by the Chair of the Disaster Committee.

_____ Identifies at least one (1) alternate for the Region.

_____ Appoints Fire-Rescue personnel and/or activates a Regional IMT to assist in filling the roles of Operations, Planning, Logistics, Administration, EMS Liaison, Liaison, Public Information and their alternates as well as other positions deemed necessary to fill the Incident Management positions prior to or immediately after the disaster.

_____ Serves as Incident Commander for the SFSDRP in the affected Region. Uses the Statewide Fire Coordinator as liaison for assistance outside of the Region.

_____ Serves as member of the State Disaster Planning Committee.

_____ Identifies County Fire Coordinators.

_____ Interacts with various Area Emergency Operations Centers in the Region.

_____ Identifies mobilization staging areas for disaster assistance. Updates this information as needed.

_____ Coordinates mutual aid assistance into the disaster area.

_____ Pre-determines equipment, personnel, etc. that are available for response from within the region.

_____ Communicates with the State Fire Disaster Coordinator.

_____ Responsible for training of staff, functional leaders, and alternates.

_____ Maintains access to inventories of equipment, personnel, etc. in region.

_____ Utilizes NIMS as the management structure and establishes the components of it, as needed in support of the Region's activities.

REGIONAL FIRE DISASTER COORDINATOR (Cont)

_____ Prepares Task Forces or Resources available for rapid mobilization within 2 hours of a request.

_____ May serve as a liaison between Unified Command agencies within their region during an activation.

COUNTY FIRE COORDINATOR

Position Responsibility: Serves as the liaison for the Regional Fire Disaster Coordinator to the local emergency management authority.

Actions:

_____ Appointed annually by the Regional Fire Disaster Coordinator.

_____ Serves as a liaison for the Plan within the local EOC.

_____ Identifies a contact for each department in the County.

_____ Identifies each department's ability to provide assistance and what form that assistance will take; personnel, apparatus, etc.

_____ Identifies resources for response; reports and updates this information to the Regional Fire Coordinator.

_____ Keeps records for rapid activation of personnel, equipment, etc. in the County.

_____ Updates the Regional Fire Coordinator and reports changes of equipment, personnel, etc.

_____ Shall receive and/or assist the affected jurisdiction with their response needs assessment and transmits this through the Local Emergency Manager to the State Fire Coordinator through the Regional Fire Coordinator.

_____ If the County Fire Coordinator is in the affected area, the Coordinator becomes the requestor for assistance through the Regional Fire Coordinator.

_____ If the County Fire Coordinator is in an unaffected area, resources are gathered as requested by the Regional Fire Coordinator.

_____ Utilize NIMS as the recognized management system and activate the components of it as needed.

INFORMATION OFFICER

Position Responsibility: This is a specialty position deployed through the Plan using an established system developed by the Connecticut Fire Service. Their responsibility is to deploy as requested and work for the requesting agency as tasked to formulate and release information about the incident to news media, the Public, and other appropriate agencies in a timely and accurate manner as approved by the State EOC, Public Information. Represent the CFS in a professional manner.

Actions:

_____ Appropriate Regional Fire Coordinator shall contact the PIO Section Deployment Team Committee Chairperson to identify requested resources.

_____ A roster of members for the PIO Deployment Team will be kept by the Deployment Team Chairperson.

_____ The PIO Deployment Chairperson shall check in and establish communications with the State EOC, ESF 14, Public Information.

_____ All Fire Service PIO resources will be coordinated through ESF 4 at the State EOC. Tasking numbers will be received from the Regional Fire Coordinator and be confirmed to the local agency through the County Fire Coordinator.

_____ When deployed to an incident the PIO will serve at the direction of the local agency and assigned local incident commander.

REGIONAL EMS LIAISON

Position Responsibility: Contact, communicate, and coordinate with the EMS private providers and those not directly under the immediate authority of the local fire department within the Region in accordance with the Disaster Response Plan. The emergency medical services function is the responsibility of ESF 8 "Health and Medical." The SFSDRP is used as the method to mobilize and deploy pre-hospital EMS resources. The Regional EMS Liaison provides a link between the Regional Fire Coordinators and the field for EMS resources, especially those that may not be associated with local fire departments.

Actions:

_____ Appointed by the Regional Fire Coordinator annually.

_____ Check in and establish communications with the Regional Fire Coordinator, and receive briefing and assignment.

_____ Identify assisting EMS agencies/jurisdictional representatives and establish communications and link them into the resource availability process.

_____ Provide a point of contact for assisting EMS agencies/jurisdictional representatives, in coordination with the Regional Coordinator and appropriate County Coordinator.

_____ Identify available ALS and BLS units, the number and types of transport units, and personnel that are State certified paramedics or EMT's, and report these numbers to the Regional Logistics Officer.

_____ Respond to requests for EMS organizational contacts.

_____ Monitor emergency situation and involvement of each EMS agency/jurisdiction.

_____ Monitor incident operations to identify and resolve EMS related inter-organizational coordination problems.

_____ Demobilize at the request of the Regional Fire Coordinator and forward pertinent incident documentation.

REGIONAL OPERATIONS SECTION OFFICER

Position Responsibilities: Management and coordination of all resource deployment from the Region consistent with the Plan. This position is staffed at the determination of the Regional Fire Coordinator.

Actions:

_____ Activate and brief Operations Section branches, groups, and/or divisions, as necessary, to support the mission request.

_____ Participate in the preparation of an incident action plan for resource deployment, after consultation with Operations staff.

_____ Execute the incident action plan.

_____ Contact, assemble and brief all branch, group, and division supervisors.

_____ Implement pre-staging areas as necessary.

_____ Determine on going needs, request additional resources as necessary, and resolve problems reported by subordinates.

_____ Update Regional Fire Coordinator, as needed.

_____ Maintain log, including operational times, significant events, names of section personnel, etc.

_____ Brief personnel as to current status of emergency operations and incident action plan objectives prior to deployment and relief.

_____ Implement demobilization of Regional Operations Section, forward all logs and pertinent data for incident documentation.

REGIONAL PLANNING SECTION OFFICER

Position Responsibility: Collect, evaluate and disseminate information about the incident situation and status of resources, prepare strategies for the regional incident action plan, and manage the planning section unit(s). This position is activated at the determination of the Regional Fire Coordinator.

Emergency Actions:

_____ Check in and obtain briefing from the Regional Fire Coordinator.

_____ Organize, activate, brief, and manage planning section units (Situation, Resource, Documentation, Demobilization) as necessary.

_____ Screen incoming damage and casualty information and see that pertinent data is posted to status boards, maps or similar records.

_____ Utilize ICS forms 202-206, 221 as necessary.

_____ Gather complete intelligence regarding the incident situation and status of resources.

_____ Evaluate preliminary disaster information. Determine the extent of damage and estimate the extent of records required to support the emergency operations.

_____ Schedule and facilitate planning meetings with Regional Fire-Rescue Coordinator and staff.

_____ Maintain status of all emergency response resources.

_____ Compile and display incident and resource status summary information.

_____ Assist in preparation of the regional incident action plan for operational periods.

_____ Assemble information on alternative strategies and make recommendations for the plan to the Regional Fire Coordinator.

_____ Prepare and distribute regional incident action plan.

_____ Prepare demobilization plan and distribute as necessary.

_____ Brief relief personnel as to plan section/incident status.

_____ Maintain a unit log, including operational times, significant events, names of personnel, etc.

_____ Insure documentation is complete for this section and entire incident.

REGIONAL LOGISTICS SECTION OFFICER

Position Responsibility: Manage resources, which provide for personnel, equipment, facilities, Services, transportation and material in support of the disaster activities. This position is activated at the determination of the Regional Fire-Rescue Coordinator.

Emergency Actions:

_____ Organize, activate, brief and manage Logistic Section branches/personnel (County Coordinator, Support Branch, Services Branch, Other), as necessary.

_____ Participate in the preparation of the regional incident action plan.
- Advise on current service and support capabilities.
- Prepare service and support elements of the incident action plan.

_____ Identify current and future services and support requirements for planned and expected operations.

_____ Coordinate and process all requests for additional resources from the Section Chiefs (in conformity with priorities established within the incident action plan).

_____ Utilize resources as established within the Statewide Fire Service Disaster Response Plan through the Regional Fire Coordinator or liaison.

_____ Maintain a section log including operational times, significant events, contracts, names of personnel, etc.

_____ Notify relief personnel of current emergency/logistics status.

_____ Demobilize section in conformity with demobilization plan.

_____ Forward all pertinent data, logs, reports, paperwork to Plans for incident documentation.

REGIONAL FINANCE/ADMINISTRATIVE SECTION OFFICER

Position Responsibility: Manages and coordinates the financial and administrative aspects of the incident. Supplies documentation for reimbursements. This position is activated at the determination of the Regional Fire Coordinator.

Emergency Actions:

_____ Organize, activate and brief administrative units (Time Recording, Legal, Cost Analysis, Compensation and Claims), as necessary.

_____ Attend planning meetings to gather information and provide financial, cost, and administrative analysis.

_____ Provide information to the County Fire Coordinators on reimbursement issues associated with the event.

_____ Obtain and record all financial data and prepare incident cost summaries, as necessary.

_____ Maintain a unit log to include times, significant events, names of personnel, etc. that are assigned to administrative section.

_____ Demobilize Administrative Section in accordance with plan approved by the Regional Fire Coordinator.

LIAISON OFFICER

Position Responsibilities: Serves as a Liaison for the Statewide Fire Disaster Coordinator to the Incident Command structure within an affected area.

_____ Appointed by the Statewide Fire Disaster Coordinator or Logistics Section Chief at the State EOC to respond to an impacted area.

_____ Assesses the situation at the local emergency operations center and from input gathered from the Incident Commander, Emergency Manager, and Fire Chief.

_____ Act as an intelligence source for ESF 4 and the DEMHS, reporting back to them on the status from ground zero.

_____ Serve as a resource for the local jurisdiction, guiding them on the process to obtain resources through the Disaster Plan.

_____ Function as a liaison in the re-deployment of units by advising the local jurisdiction of requests coming from other jurisdictions for resources and by advising the State EOC of the status/need for resources within the jurisdiction where they are currently deployed.

_____ Verify that requested resources have, in fact, made it to the requesting jurisdiction and report to ESF 4/9/10 on their status as well as keeping the local jurisdiction advised as to the status of requested but not yet received resources.

_____ Evaluate local support of mutual aid resources and determine if needs are being met. Work with requesting agency(s) to address resource support needs.

_____ Assist in the demobilization process.

_____ Log Plan weaknesses so revisions can be made and identify future training needs.

_____ Assist with any questions that come up about the Plan or the reimbursement process.

_____ Liaison between the local jurisdiction, State Division of Forestry, and other agencies for Plan implementation.

COMMUNICATIONS UNIT LEADER

Position Responsibilities: Personnel serving in this capacity shall be responsible for developing plans for the effective and efficient use of deployed communication equipment, distribution of communications equipment, inventory of equipment and maintenance of the same.

_____ When deployed, this position shall report to the Incident Management structure in place within the requesting agency/jurisdiction.

_____ Prepare a regional communications plan to serve the communications needs of the requesting agency/jurisdiction.
- Assess and advise on current communication service and support capabilities.
- Prepare service and support elements of the communications plan.

_____ Ensure the communication equipment is deployed, set-up, tested and functioning properly.

_____ Coordinate and assure the distribution of portable/mobile radio equipment in conformity with priorities established within the Incident Communications Plan.

_____ Assure an appropriate communications equipment accountability system is established and that all equipment is tested and inventoried upon return.

_____ Assure repair, testing and programming communications equipment, as required.

_____ Maintain a section log including operational times, significant events, contracts, unit actions and personnel names.

_____ Demobilize in conformity with the Incident Demobilization Plan.

_____ Forward all pertinent data, logs, reports and paperwork to Plans Section for proper incident documentation.

COMMUNICATIONS TECHNICIAN

Position Responsibilities: Personnel serving in this capacity shall be responsible for the effective operations, troubleshooting and programming of radio equipment. In addition, this position may provide technical advice to the requesting agency and/or the Communications Unit Leader.

_____ Assure communications equipment is deployed, set-up, tested and functioning properly.

_____ Assure communications equipment is utilized to fulfill the critical elements of the established Incident Communications Plan.

_____ Coordinate and assure the distribution of portable/mobile radio equipment in conformity with priorities established within the Incident Communications Plan.

_____ Assure an appropriate communications equipment accountability system is established and that all equipment is tested and inventoried upon return.

_____ Assure repair, testing and programming of communications equipment, as required.

_____ Maintain a log of all repairs/service performed on equipment while deployed.

_____ Provide for the transportation and security of equipment while deployed to, and returning from an affected agency/jurisdiction.

_____ Demobilize in conformity with the Incident Demobilization Plan.

_____ Forward all pertinent data, logs, reports and paperwork to Plans Section for proper incident documentation.

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCES
(MOBILE)

RESOURCE	RADIO CALL	COMPONENTS (MINIMUM)	MINIMUM COMPONENTS			
			TYPE I	TYPE 2	TYPE 3	TYPE 4
ENGINE COMPANY	ENGINE	PUMP WATER TANK HOSE – 2 ½" (supply) HOSE – 1 ½" (attack) HOSE – ¾" PERSONNEL	1000 GPM 500 GALLONS 1200 FEET 200 FEET 4	500 GPM 500 GALLONS 1000 FEET 200 FEET 300 FEET 3	50 GPM 200 GALLONS 100 FEET 2	 N/A
WATER TANKER	TANKER	PUMP WATER TANK	300 GPM 5000 GALLONS	300 GPM 2500 GALLONS	100 GPM 1000 GALLONS	 1000 GALLONS
BRUSH/WOODS TRUCK	BRUSH TRUCK	PUMP HOSE – ¾" WATER TANK PERSONNEL WHEELS X DRIVE	50 GPM 100 FEET 1000 GALLONS 2 6 X 6	10 GPM 100 FEET 150 GALLONS 1 4 X 4	5 GPM 100 FEET 75 GALLONS 1 4 X 4	5 GPM 100 FEET 75 GALLONS 1 4 X 2
AERIAL EQUIPMENT	AERIAL	LADDER PLATFORM TELESQUIRT	100 FEET	50 FEET	N/A	N/A
RESCUE/ AMBULANCE TRANSPORT CAPABLE	RESCUE	PARAMEDIC EMT ALS EQUIPMENT BLS EQUIPMENT STATE CERT. FF'S	1 1 YES YES	 2 YES YES	1 1 YES NO	 2 YES NO
TECHNICAL RESCUE	TECH. RESCUE	AIR BAGS, SHORING, RAPELLING, ETC.	HEAVY	LIGHT	N/A	N/A
HAZARDOUS MATERIALS UNIT	HAZ-MAT	TECHNICAL LEVEL OR HIGHER	4	3	2	N/A
CFD (AIRPORT)	CFR	WATER FOAM TURRET GUN BUMPER TURRET PURPLE K PREMIXED FOAM	3000 GALLONS 400 GALLONS 1200 GPM 300 GPM	1500 GALLONS 200 GALLONS 300 GPM 500 LBS	 500 LB. EXT. 100 GAL. EXT.	 N/A

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCES
(MOBILE) - CONTINUED

RESOURCE	RADIO CALL	COMPONENTS	MINIMUM COMPONENTS			
			TYPE I	TYPE 2	TYPE 3	TYPE 4
ALL TERRAIN VEHICLE	ATV	PUMP WATER TANK HOSE – 1' PERSONNEL	50 GPM 500 GALLONS 100 FEET 1	50 GPM 300 GALLONS 100 FEET 1	 6 SEATS	 2 SEATS
BULLDOZER (WITH OR W/O PLOW)	DOZER	SIZE PERSONNEL	HEAVY (D-7, D-8) 1	MED. HEAVY (D-5, D-6) 1	MEDIUM (D-4) 1	LIGHT (JD-350) 1
TRACTOR TENDER	TRACTOR TENDER	FUEL COMPRESSED AIR	100 GALLONS OPTIONAL	N/A	N/A	N/A
TRACTOR PLOW	TRACTOR	SIZE PERSONNEL	HEAVY (D-7) 1	MED. HEAVY (D-6) 1	MEDIUM (D-4) 1	LIGHT (JD-350) 1
CREW TRANSPORT	CREW TRANSPORT	PASSENGER SEATS	40	30	20	10
FIELD MOBILE MECH. W/ VEHICLE	MECHANIC	REPAIR OF MOBILE EQUIPMENT	HEAVY EQUIPMENT	LIGHT EQUIPMENT	N/A	N/A
FIELD KITCHEN	FIELD KITCHEN	MEALS	150	50	N/A	N/A
FUEL TRUCK	FUEL TRUCK	FUEL, SPECIFY TYPE (AV, DIESEL, GAS, JET)	1000 GALLONS	100 GALLONS	N/A	N/A
HEAVY EQUIPMENT TRANSPORT	TRANSPORT	CAPACITY	HEAVY (D-7, D-8)	MED. HEAVY (D-6)	MEDIUM (D-4)	N/A
ILLUMIN-ATION	LIGHT	PORTABLE LIGHTS	TRUCK	TRAILER	N/A	N/A
PORTABLE PUMP	N/A	PUMPING CAPACITY	500 GPM	250 GPM	100 GPM	50 GPM
UTILITY TRANSPORT	UTILITY TRANSPORT	PAYLOAD WHEELS X DRIVE	1 TON + 4 X 4	UNDER 1 TON + 4 X 4	1 TON + 4 X 2	UNDER 1 TON + 4 X 2
MOBILE COMMAND VEHICLE	COMMAND POST	COMMUNICATION PERSONNEL (WORK AREA)	10	5	NA/	N/A
COMMUNI-CATIONS VEHICLE	COMMUNI-CATIONS	FREQUENCY RANGE	PROGRAM-MABLE	LOW BAND-VHF, UHF, 800 MHZ	VHF, UHF	N/A
AIR SUPPLY TRUCK	AIR TRUCK	COMPRESSOR STORAGE TANKS	25 CMF @ 5000 PSI 2000 CU FT	20 CMF @ 3000 PSI 1000 CU FT	15 CFM 2200 PSI 1000 CU FT	N/A

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCES
(AIRCRAFT)

RESOURCE	RADIO CALL	COMPONENTS	MINIMUM COMPONENTS			
			TYPE 1	TYPE 2	TYPE 3	TYPE 4
AEROMEDICAL/RESCUE HELICOPTORS	AIR RESCUE	CREW MAXIMUM PATIENTS	4 6	3 3	2 2	2 1
AIR TANKER	AIR TANKER	CAPACITY	2000 GALLONS	1000 GALLONS	100 GALLONS	N/A
SUPPRESSION HELICOPTORS	CHOPPER	SEATS (INCLUDING PILOT) CARD WEIGHT CAPACITY (POUNDS) TANK: GALLONS OF RETARDENT EXAMPLE	16 5000 700 BELL 214 HEAVY	9 2500 300 BELL 204, 205, 212 MEDIUM	5 1200 100 BELL 206 LIGHT	3 600 75 BELL 47 LIGHT
HELICOPTOR TENDER	HELI-TENDER	FUEL AND SUPPORT EQUIPMENT	ALL	N/A	N/A	N/A
HELITACK CREW	HEITACK	3-CREW PERSONNEL	ALL	N/A	N/A	N/A
FIXED WING	AIR	SEATS	7	6	4	2

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCES
(PERSONNEL & MISCELLANEOUS EQUIPMENT)

RESOURCE	COMPONENTS	MINIMUM COMPONENTS			
		TYPE I	TYPE 2	TYPE 3	TYPE 4
ADMIN./COMMAND PERSONNEL	INCIDENT COMMAND	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
	OPERATIONS SECTION CHIEF	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
	PLANNING SECTION CHIEF	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
	MEDICAL SECTION CHIEF	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
	LOGISTICS SECTION CHIEF	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
	ADMIN. SECTION CHIEF	*STATE CERT.	EXPERIENCED	FAMILIAR	N/A
SUPPRESION	FIREFIGHTERS/OFFICER	STATE CERT.	VOL. W/TRAIN.	FAMILIAR	N/A
PARAMEDIC	STATE CERTIFIED PARAMEDIC STATE CERTIFIED FIREFIGHTER	YES YES	YES NO	N/A N/A	N/A N/A
EMERGENCY MED. TECHNICIAN	STATE CERTIFIED EMT STATE CERTIFIED FIREFIGHTER	YES YES	YES NO	N/A N/A	N/A N/A
HAZARDOUS MATERIALS	CERTIFICATION	COMMAND	TECHNICIAN	N/A	N/A
URBAN SAR	URBAN SEARCH & RESCUE	EXPERIENCED	N/A	N/A	N/A
URBAN SAR CANINE	URBAN SEARCH & RESCUE	EXPERIENCED W/HANDLER	N/A	N/A	N/A
WILDERNESS SAR	WILDERNESS SEARCH & RESCUE	EXPERIENCED	N/A	N/A	N/A
WILDERNESS SAR CANINE	WILDERNESS SEARCH & RESCUE	EXPERIENCED W/HANDLER	N/A	N/A	N/A
WATER RESCUE	SCUBA – OPENWATER RESCUE SKIN DIVER	YES YES	YES NO	NO YES	N/A N/A
FIRE INSPECTOR	STATE CERTIFIED	YES	COMPANY LEVEL	N/A	N/A
FIRE INVESTIGATOR	EXPERIENCED	ALL	N/A	N/A	N/A
COMM. OPERATORS	EMERGENCY MEDICAL DISPATCHER	YES	NO	N/A	N/A
MOBILE MECHANIC	EXPERIENCED	HEAVY EQUIPMENT	LIGHT EQUIPMENT	N/A	N/A
RADIO TECHNICIAN	LIST QUALIFICATIONS	ALL	N/A	N/A	N/A
MISCELLANEOUS EQUIPMENT					
RADIOS	LIST FREQ. & PL (CHANNEL GUARD)	TABLE TOP	MOBILE	HANDHELD	N/A
CELLULAR PHONE		ALL	N/A	N/A	N/A
FAX MACHINE		ANY	N/A	N/A	N/A
DUPLICATION MACHINE	DESCRIBE	FULL SIZE	DESK TOP	N/A	N/A

***PENDING CERTIFICATION PROCESS**

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCE INVENTORY FORM

EXAMPLE

Region:	II	**County:**	Hartford
Department Name:	Manchester Fire-Rescue-EMS		
Department Address:	75 Center Street		
City:	Manchester	**Zip Code:**	06040
Fire Chief:	T. Weber	**Daytime Phone:**	(860) 647-3266
24-Hour Phone:	(860) 643-7373	**Fax Number:**	(860) 647-3268
Contact Person:	A/C Bob Bycholski		

RESOURCE	TYPE 1	TYPE 2	TYPE 3	TYPE 4	SPECIAL INFORMATION
MOBILE EQUIPMENT					
ENGINE COMPANY	1	1	1		
WATER TANKER					
BRUSH TRUCK					
AERIAL	1				
RESCUE/AMBULANCE					
TECHNICAL RESCUE					
HAZ-MAT UNIT					
CFR (AIRPORT)					
ALL TERRAIN VEHICLE					
BULLDOZER					
TRACTOR TENDER					
TRACTOR-PLOW					
CREW TRANSPORT					
MOBILE MECHANIC		1			
FIELD KITCHEN					
FUEL TRUCK					
HEAVY EQ. TRANSPORT					
ILLUMINATION		1			
PORTABLE PUMP			1		
POWER GENERATOR					
UTILITY TRANSPORT					
MOBILE COMMAND VEH.					
COMMUNICATIONS VEH.					
AIR SUPPLY TRUCK		1			With Personnel

CONNECTICUT FIRE SERVICE
STATE FIRE RESCUE RESOURCE INVENTORY

EXAMPLE

Region:	II	**County:**	Hartford
Department Name:	Manchester Fire-Rescue-EMS		
Department Address:	75 Center Street		
City:	Manchester	**Zip Code:**	06040
Fire Chief:	T. Weber	**Daytime Phone:**	(860) 647-3266
24-Hour Phone:	(860) 643-7373	**Fax Number:**	(860) 647-3268
Pager:	(860) 596-8800		
Contact Person:	A/C Bob Bycholski		

RESOURCE	TYPE 1	TYPE 2	TYPE 3	TYPE 4	SPECIAL INFORMATION
AIRCRAFT					
RESCUE HELICOPTER					
AIR TANKER					
SUPPRESS. HELICOTERS					
HELICOPTER TENDER					
HELITACK CREW					
FIXED WING					
PERSONNEL ONLY					
INCIDENT COMMANDER		1			
OPERATIONS SEC. CHIEF		1			
PLANNING SEC. CHIEF		1			
MEDICAL SEC. CHIEF		1			
LOGISTICS SEC. CHIEF		1			
ADMIN. SEC. CHIEF		1			
SUPPRESSION		10			
PARAMEDIC		5			
EMT		10			
HAZ-MAT					
URBAN SAR					
URBAN SAR-CANINE					
WILDERNESS SAR					
WILDERNESS SAR CANINE					
WATER RESCUE					
FIRE INSPECTOR	1				
FIRE INVESTIGATOR	1				
COMM. OPERATORS					
MOBILE MECHANIC	1				
RADIO TECHICIAN					
OTHER EQUIPMENT					
RADIOS			5		List Attached
CELLULAR PHONE	2				
FAX MACHINE	1				
DUPLICATING MACHINE					

LIST ADDITIONAL PERSONNEL (W/QUALIFICATIONS) AND ADDITIONAL EQUIPMENT ON SEPARATE PAGE

FREQUENCY PLAN

Base, Mobile, Portable

Frequency	CTCSS	Primary Use
CONNECTICUT FIRE MUTUAL AID (Statewide)		
46.16 MHz	141.3 Hz	Statewide Base to Base
33.78	179.9 Hz	Mobile for Fire Ground
CONNECTICUT FIRE MUTUAL AID (Counties)		
33.70 MHz	None	Litchfield & New Haven
33.86 MHz	None	Fairfield
33.88 MHz	None	Tolland & Windham
33.90 MHz	None	Tolland, Windham, New London
33.94 MHz	None	Hartford
46.18 MHz	Different per Town	Middlesex
33.80	Different per Town	Tolland & Windham Mutual Aid
VHF INTERCITY NETWORK		
154.265 MHz	107.2 Hz	Hartford
154.265 MHz	82.5 Hz	Fairfield
154.295 MHz	107.2 Hz	South Central
154.295 MHz	118.8 Hz	Waterbury
154.280 MHz	82.5 Hz	Springfield
154.280 MHz	203.5 Hz	Winsted
NATIONAL PUBLIC SAFETY		
821.0125/866.0125	156.7	National Public Safety Calling Repeater
821.5125/866.5125	156.7	National TAC 1 Repeater
822.0125/867.0125	156.7	National TAC 2 Repeater
822.5125/867.5125	156.7	National TAC 3 Repeater
823.0125/868.0125	156.7	National TAC 4 Repeater

STATE OF CONNECTICUT EMERGENCY MANAGEMENT

Sec. 28-7. Local and joint organizations: Organization; powers; temporary aid. (a) Each town or city of the state shall establish a local organization for civil preparedness in accordance with the state civil preparedness plan and program, provided any two or more towns or cities may, with the approval of the commissioner, establish a joint organization for civil preparedness. The authority of such local or joint organization for civil preparedness shall not supersede that of any regularly organized police or fire department. **In order to be eligible for any state or federal benefits under this chapter, not later than January 1, 2008, and annually thereafter, each town or city of the state shall have a current emergency plan of operations that has been approved by the commissioner. The plan shall be submitted to the commissioner after it has been approved by the local director of civil preparedness and the local chief executive. Such plan may be submitted with a notice stating that the plan remains unchanged from the previous year's version. The emergency plan of operations of every town or city situated on the shoreline of the state shall contain provisions addressing an emergency caused by any existing liquefied natural gas terminal located on the Long Island Sound and every town or city situated on the shoreline of the state shall submit such plan to the joint standing committee of the General Assembly having cognizance of matters relating to public safety, in accordance with the provisions of section 11-4a, and the commissioner to obtain approval. The committee shall hold a public hearing regarding such plan not later than thirty days after receiving the plan. Not later than five days after the hearing, the committee shall (1) hold a roll-call vote to approve or reject the plan, and (2) forward the plan and a record of the committee's vote to the General Assembly. Such emergency plan of operations shall not be approved by the commissioner unless the commissioner determines that the plan proposes strategies that address all the activities and measures of civil preparedness identified in subdivision (4) of section 28-1. Each town or city of the state shall consider whether to provide for the nonmilitary evacuation of livestock and horses in such plan.**

(b) Each local organization for civil preparedness shall consist of an advisory council and a director appointed by the chief executive officer. The advisory council shall contain representatives of city or town agencies concerned with civil preparedness and representatives of interests, including business, labor, agriculture, veterans, women's groups and others, which are important to the civil preparedness program in the particular community. The director shall be responsible for the organization, administration and operation of such local organization, subject to the direction and control of the state director. The chief executive officer may remove any local director for cause.

(c) Each local or joint organization shall perform such civil preparedness functions in the territorial limits within which it is organized as the state director prescribes. In addition, such local or joint organization shall conduct such functions outside such territorial limits as are prescribed by the state civil preparedness plan and program or by the terms of any mutual aid agreements to which the town is a party.

(d) The director of each local or joint organization may, with the approval of the state director, collaborate with other public and private agencies within the state and develop or cause to be developed mutual aid agreements for civil preparedness aid and assistance in case of disaster too great to be dealt with unassisted. The director of such joint or local organization may, with the approval of the state director, enter into such mutual aid

agreements with civil preparedness agencies or organizations in other states. Such agreements shall be consistent with the state civil preparedness plan and program and, in time of emergency, each local or joint organization shall render assistance in accordance with the provisions of such agreements to which it is a party unless otherwise ordered by the state director.

(e) Each town or city shall have the power to make appropriations for the payment of salaries and expenses of its local or joint organization or any other civil preparedness agencies or instrumentalities.

(f) In the event of a serious disaster or of a sudden emergency, when such action is deemed necessary for the protection of the health and safety of the people, and upon request of the local chief executive authority, the Governor or the state director, without regard to the provisions of section 22a-148, may authorize the temporary use of such civil preparedness forces, including civil preparedness auxiliary police and firemen, as he deems necessary. Personnel of such civil preparedness forces shall be so employed only with their consent. The provisions of section 28-14 shall apply to personnel so employed.

(g) The state shall reimburse any town or city rendering aid under this section for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of employees of such town or city while rendering such aid, and for all payments for death, disability or injury of such employees in the course of rendering such aid and for all losses of or damage to supplies or equipment of such town or city incurred in the course of rendering such aid.

(h) Whenever, in the judgment of a local civil preparedness director, with prior approval of the state director of emergency management, it is deemed essential to authorize the temporary assignment, with their consent, of any members of civil preparedness forces who are not paid employees of the state or any political subdivision thereof, for a temporary civil preparedness mission, the provisions of section 28-14 shall apply. A complete written record of the conditions and dates of such assignment shall be maintained by the local director concerned and such record shall be available for examination by the state director of emergency management and the Attorney General. The state director shall establish the necessary procedures to administer this section.

Sec. 28-6. Mutual aid or mobile support units. (a) All civil preparedness units, forces, facilities, supplies and equipment in the state are deemed to be available for employment as mutual aid or mobile support. They may be ordered to duty by the Governor or the commissioner only under the conditions defined in subsection (f) of section 28-7 or section 28-9, except that such civil preparedness units, forces, facilities, supplies and equipment may be employed in another state under the conditions specified in subsection (e) of this section.

(b) Personnel of such civil preparedness units or forces, while engaged in officially authorized civil preparedness duty, shall: (1) If they are employees of the state, have the powers, duties, rights, privileges and immunities and receive the compensation incident to their employment; (2) if they are employees of a political subdivision of the state, and whether serving within or without such political subdivision, have the powers, duties, rights, privileges and immunities and receive the compensation incident to their employment; and (3) if they are not employees of the state or a political

subdivision thereof, be entitled to such compensation from the state as is determined by the Commissioner of Administrative Services under the provisions of section 4-40 and to the same rights and immunities as are provided by law for the employees of this state, provided in no instance shall such compensation be determined at a rate less than the minimum wage as determined by the Labor Commissioner. All personnel of mobile support units shall, while on duty, be subject to the operational control of the authority in charge of civil preparedness activities in the area in which they are serving.

(c) The state shall reimburse a political subdivision for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of employees of the political subdivision while in training or on call by the Governor for emergency duty as members of a mobile support unit, and for all payments for death, disability or injury of such employees incurred in the course of such training or duty, and for all losses of or damage to supplies and equipment of such political subdivisions used by such mobile support units.

(d) Whenever the mobile support unit of another state renders aid pursuant to the orders of the Governor of its home state and upon the request of the Governor of this state, this state shall reimburse such other state for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of the personnel of such mobile support units incurred in rendering such aid, and for all payments for death, disability or injury of such personnel incurred in rendering such aid, and for all losses of or damage to supplies and equipment of such other state or a political subdivision thereof resulting from rendering such aid, provided the laws of such other state shall contain provisions substantially similar to those of this section.

(e) No personnel of mobile support units of this state shall be ordered by the Governor to operate in any other state unless the laws of such other state contain provisions substantially similar to those of this section or unless such state is a signatory to the Emergency Management Assistance Compact established in section 28-23a.

Sec. 4-58a. Mutual aid fire pacts between state institutions and municipalities. (a) The superintendent of any state institution shall have the power to enter into agreements with any town, city, borough, fire district or other governmental subdivision having the duty to extinguish fires within its limits or any volunteer fire department respecting mutual fire protection, including, but not limited to, arrangements respecting use of fire fighting equipment and the services of such personnel of such institution who are members of an institutional fire brigade.

(b) Any employee of a state institution who is a member of its regular or volunteer fire department or institutional fire brigade who is injured or dies as a result of responding to, working at or returning from a fire outside of such institution, in accordance with an agreement entered into under subsection (a) with the municipality in which the fire occurred, shall be deemed to have been injured in the course of his employment and he and his estate shall be entitled to all the benefits of title 5 and chapter 568, provided the superintendent of such institution shall have authorized his service at such fire.

(c) The superintendent of any such institution may withhold the services of any member of the regular, volunteer or institutional fire brigade for fire fighting duty outside of such institution by reason of his assignment to regular or special duties at such institution.

Sec. 28-22a. Intrastate Mutual Aid Compact
Article I. Purposes

This compact shall be known as the Intrastate Mutual Aid Compact and is made and entered into by and between the participating political subdivisions of this state. The purpose of this compact is to create a system of intrastate mutual aid between participating political subdivisions in the state. Each participant of this system recognizes that emergencies transcend political jurisdictional boundaries and that intergovernmental coordination is essential for the protection of lives and property and for best use of available assets. The system shall provide for mutual assistance among the participating political subdivisions in the prevention of, response to, and recovery from, any disaster that results in a declaration of a local civil preparedness emergency in a participating political subdivision, subject to that participating political subdivision's criteria for declaration. The system shall provide for mutual cooperation among the participating subdivisions in conducting disaster-related exercises, testing or training activities.

Article II. General Provisions (1) For purposes of this compact: (A) "Participating political subdivision" means each political subdivision of the state whose legislative body has not adopted a resolution withdrawing from this compact in accordance with the provisions of this article; and (B) "chief executive officer" means the elected or appointed officer granted the authority to declare a local civil preparedness emergency by the charter or ordinance of his or her political subdivision.

(2) On and after October 1, 2007, each political subdivision within the state shall automatically be a participating member of this compact. A participating political subdivision may withdraw from this compact by adopting a resolution indicating its intent to do so. The political subdivision shall automatically be deemed to have withdrawn from this compact upon adoption of such a resolution. The chief executive officer of such political subdivision shall submit a copy of such resolution to the Commissioner of Emergency Management and Homeland Security not later than ten days after the adoption of the resolution. Nothing in this article shall preclude a participating political subdivision from entering into a supplementary mutual aid agreement with another political subdivision or affect any other inter-local municipal agreement, including any other mutual aid agreement, to which a political subdivision may be a party or become a party.

(3) In the event of a serious disaster affecting any political subdivision of the state, the chief executive officer of that political subdivision may declare a local civil preparedness emergency. The chief executive officer of such political subdivision shall notify the Commissioner of Emergency Management and Homeland Security of such declaration not later than twenty-four hours after such declaration. Such a declaration shall activate the emergency plan of operations of that political subdivision, as established under subsection (a) of section 28-7, and authorize the request or furnishing of aid and assistance, including any aid and assistance provided under the intrastate mutual aid system described in this section. No immunity, rights or privileges shall be provided for any individual who self-dispatches in response to a declaration, without authorization by such individual's participating political subdivision.

Article III. Responsibilitiesof the Local and Joint Organizationsof Participating Political Subdivisions

The participating political subdivisions shall ensure that the duties of their local or joint organizations, as described in subsection (a) of section 28-7, include the following:

(1) Identifying potential hazards that could affect the participating political subdivisions using an identification system common to all participating jurisdictions;

(2) Conducting of joint planning, intelligence sharing and threat assessment development with contiguous participating political subdivisions, and conducting joint training at least biennially;

(3) Identifying and inventorying the current services, equipment, supplies, personnel and other resources related to planning, prevention, mitigation, response and recovery activities of the participating political subdivisions; and

(4) Adopting and implementing the standardized incident management system approved by the Department of Emergency Management and Homeland Security.

Article IV. Implementation **Any request for assistance made by the chief executive officer of a participating political subdivision who has declared a local civil preparedness emergency shall be made to the chief executive officers of other participating political subdivisions or their designees. Requests may be oral or in writing, and shall be reported to the Commissioner of Emergency Management and Homeland Security not later than twenty-four hours after the request. Oral requests shall be reduced to writing not later than forty-eight hours after the request.**

Article V. Conditions **A participating political subdivision's obligation to provide assistance in the case of a declared local civil preparedness emergency is subject to the following conditions:**

(1) A participating political subdivision shall have declared a local civil preparedness emergency;

(2) A responding participating political subdivision may withhold or recall resources to the extent it deems necessary to provide reasonable protection and services for its own jurisdiction;

(3) Personnel of a responding participating political subdivision shall continue under the command and control of their responding jurisdiction, including emergency medical treatment protocols, standard operating procedures and other protocols, but shall be under the operational control of the appropriate officials within the incident management system of the participating political subdivision receiving assistance; and

(4) Assets and equipment of a responding participating political subdivision shall continue under the control of the responding jurisdiction, but shall be under the operational control of the appropriate officials within the incident management system of the participating political subdivision receiving assistance.

Article VI. Licenses, Certificates and Permits **(1) If a person or entity holds a license, certificate or other permit issued by a participating political subdivision or the state evidencing qualification in a profession, mechanical skill or other skill, and the assistance of that person or entity is requested by a participating political subdivision, such person or entity shall be deemed to be licensed, certified or permitted in the political subdivision requesting assistance for the duration of the declared local civil preparedness emergency, subject to any limitations and conditions as may be prescribed by the chief executive officer of the participating political subdivisions, by executive order or otherwise; or by the person or entity's sponsor hospital.**

(2) The officers, members and employees of the responding political subdivision, including, but not limited to, public works personnel, firefighters, police or other

assigned personnel rendering aid or assistance pursuant to the compact and this section shall have the same duties, rights, privileges and immunities as if they were performing their duties in the responding political subdivision.

Article VII. Reimbursement (1) Participating political subdivisions shall maintain documentation of all assets provided. In the event of federal reimbursement to a requesting political subdivision, any political subdivision providing assistance under the compact and this section shall receive its appropriate share of said reimbursement.

(2) A participating political subdivision may donate assets of any kind to a requesting participating political subdivision. Unless requested in writing, no reimbursement shall be sought by a responding political subdivision from a requesting political subdivision that has declared a local civil preparedness emergency. Any written request for reimbursement must be made not later than thirty calendar days after the response, except that notice of intent to seek reimbursement shall be given at the time the aid is rendered, or as soon as possible thereafter.

(3) Any dispute between political subdivisions regarding reimbursement shall be resolved by the parties not later than thirty days after written notice of the dispute by the party asserting noncompliance. If the dispute is not resolved within ninety days of the notice of the claim, either party may request that the dispute be resolved through arbitration. Any such arbitration shall be conducted under the commercial arbitration rules of the American Arbitration Association.

Article VIII. Liability For the purposes of liability, all persons from a responding political subdivision under the operational control of the requesting political subdivision are deemed to be employees of the responding political subdivision. Neither the participating political subdivisions nor their employees, except in cases of wilful misconduct, gross negligence or bad faith, shall be liable for the death of or injury to persons or for damage to property when complying or attempting to comply with the intrastate mutual aid system

Sec. 7-323o. State Fire Administrator, appointment and duties. There is established the position of State Fire Administrator who shall be appointed by the commission and who shall: (1) Carry out the requirements of section 7-323n; (2) administer federal funds and grants allocated to the fire services of the state; (3) provide technical assistance and guidance to fire fighting forces of any state or municipal agency; (4) develop a centralized information and audiovisual library regarding fire prevention and control; (5) accumulate, disseminate and analyze fire prevention data; (6) recommend specifications of fire service materials and equipment and assist in the purchasing thereof; (7) assist in mutual aid coordination; (8) coordinate fire programs with those of the other states; (9) assist in communications coordination; (10) establish and maintain a fire service information program, and (11) review the purchase of fire apparatus or equipment at state institutions, facilities and properties and, on and after July 1, 1985, coordinate the training and education of fire service personnel at such institutions, facilities and properties. The provisions of this section shall not be construed to apply to forest fire prevention and control programs administered by the Commissioner of Environmental Protection pursuant to sections 23-33 to 23-57, inclusive.

Sec. 7-310. Operation of fire equipment in and provision of personnel and assistance to other municipality. Any city, town, borough, fire district, independent fire department or independent fire company may locate, use, man and operate fire stations, fire apparatus, ambulances, rescue trucks, radio and fire-alarm systems and other fire equipment and provide personnel and other assistance for the investigation of the cause and origin of fires, in any other city, town, borough or fire district, upon such terms respecting the location, use,

management and operation as may be mutually agreed upon between the boards of fire commissioners or other persons having the management and control of the fire departments or fire companies. Any officer or member of a fire department or fire company while operating outside the jurisdictional limits of his fire department or fire company in accord with such an agreement shall have the same rights, privileges and immunities that are granted him when operating within the jurisdictional limits of his fire department or fire company.

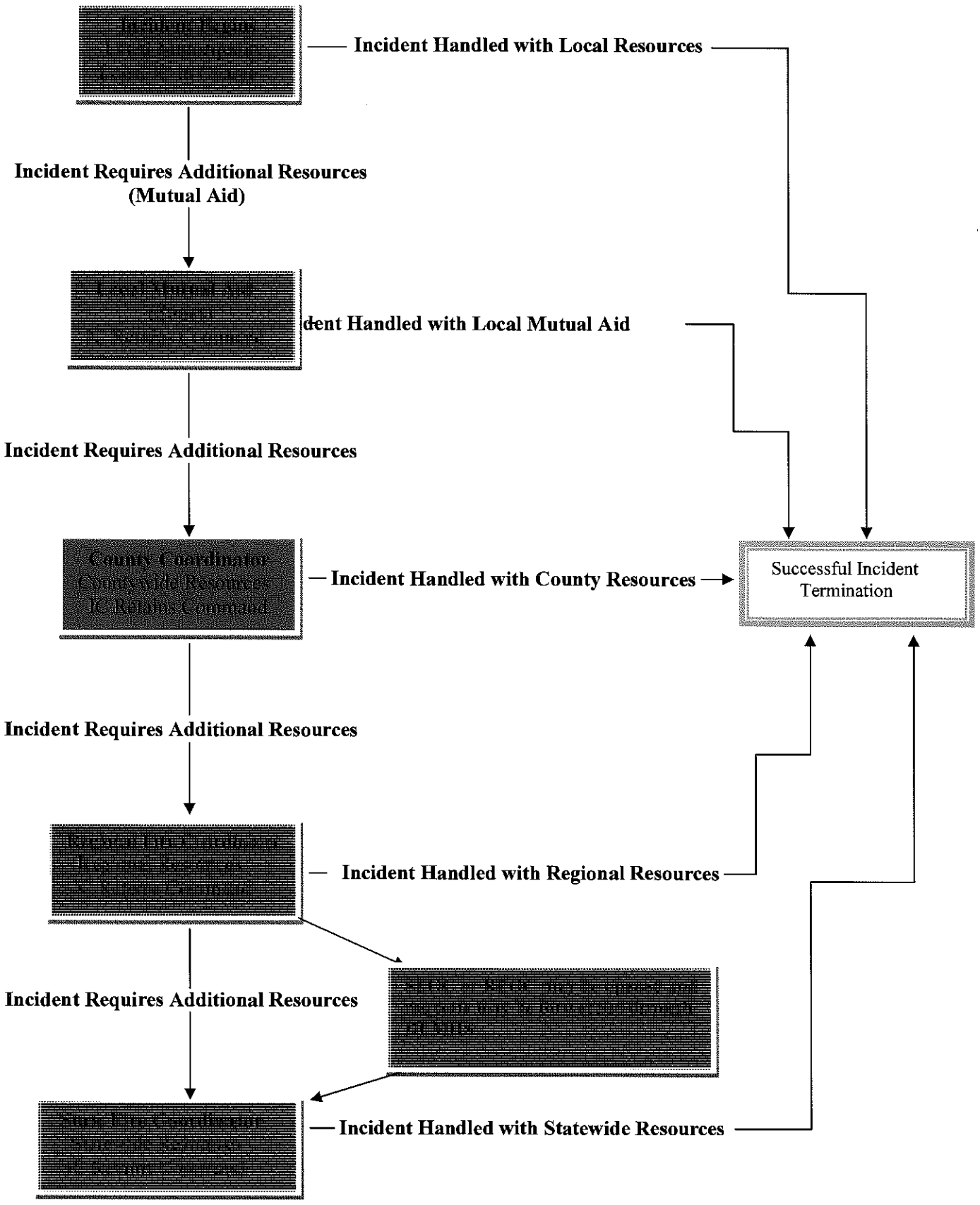
Sec. 28-8. Outside aid by local police, fire or other preparedness forces. (a) At the request of the chief executive authority of any town or city, the appropriate authority of any other town or city may, with the approval of the state director, or, if so ordered by the state director, shall, assign and make available for duty and use outside his own town or city, under the direction and command of an officer designated for the purpose, any part of the police, fire fighting or other civil preparedness forces under his control.

(b) The officer and members of police, fire fighting or other civil preparedness forces rendering outside aid pursuant to this section shall have the same powers, duties, rights, privileges and immunities as if they were performing their duties in their home town or city.

(c) The state shall reimburse any town or city rendering aid under this section for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of employees of such town or city while rendering such aid, and for all payments for death, disability or injury of such employees in the course of rendering such aid and for all losses of or damage to supplies or equipment of such town or city incurred in the course of rendering such aid.

APPENDIX E

Connecticut Fire Response Plan
Requests for Assistance Flow Chart



CFS Form 1a **REQUEST FOR ASSISTANCE – ESF 4 & 9**

Message #:		Date:		Time:			County:		Agency:		
Requestor:	Name:			Tel #:			Fax #:		Net:		
Brief Description of Mission Requested :											
Resources Report:	Date:		Time:			Estimated Resource Release:		Date:		Time:	
On Scene Contact:			Tel #:			Fax #:		Net:			
Resources Report Location:								Staging Tel #:			
Equipment Estimated Daily Work Hrs:			Personnel Estimated Daily Work Hrs:					Mission #:			
Comments/Information/Notes:											

RESOURCES REQUESTED

Category - Equipment	Type	CCode	Quantity	Comment/Info	Category – Personnel	Type 1	Type 2
Strike Team – Engine					Incident Commander/Manager		
Strike Team – Brush Truck					Chief/Officer – Administration		
Strike Team – WaterTanker					Chief/Officer – Finance		
Strike Team – Other -					Chief/Officer – HazMat		
Aerial – Ladder Truck					Chief/Officer – Liaison		
Aircraft, Fixed Wing					Chief/Officer – Logistics		
Aircraft, Rotary					Chief/Officer – Medical		
Ambulance – ALS					Chief/Officer – Operations		
Ambulance – BLS					Chief/Officer – Planning		
Arson Van – SFM					Chief/Officer – Public Information Officer		
All Terrain Vehicle, Bombardier					Chief/Officer – Safety		
All Terrain Vehicle, Personnel Carrier					Diver – Skin/Scuba – Open Water		
All Terrain Vehicle, Honda type 4 wheel					Diver – Skin/Scuba – Fast Water		
Automobile					Dispatcher – Emergency Medical		
Automobile, Fire/Police					Dispatcher – Fire Service		
Bus					Dispatcher – Public Safety		
Command Trailer					Driver – Engine		
Command Vehicle					Driver Operator		
Fire Engine (structural)					EMT – State Certified		
Foam Truck					EMT/Firefighter		
Kitchen Trailer					EOC Staffing – FFCA,DOF,CAP,FASAR		
Pumper, Fire					EOC Staffing – SFM		
Radio – Cache					Fire Fighter – Structural		
Radio – Mobile					Fire Fighter – Volunteer		
Radio – Portable					Fire Fighter – Forestry		
Radio – Tower					Fire Inspector – State Certified		
Tanker, Water					Fire Inspector – Company Level		
Tender/Trailer, Water					Fire Investigator		
Trailer, Equipment					Fire Officer – Structural		
Trailer, Office					Fire Officer – Volunteer		
Truck, Brush					Fire Officer – Forestry		
Truck, Fire					Mechanic – Mobile – Heavy Equip		
Truck, Pick Up					Mechanic – Mobile – Light Equip		
Truck, Water					Paramedic – State Certified		
Other:					Paramedic/Firefighter		
Other:					SAR Leader		
Other:					SAR Leader - Assistant		
Other:					SAR Member – SFM		
Other:					SAR Member – Urban		
Other:					SAR Member – Urban – w/canine		
Other:					SAR Member – Wilderness		
Other:					SAR Member – Wilderness – w/canine		
Other:					Strike Team / Task Force Leader		
Other:					Strike Team / Task Force – Asst Leader		
Other:					Technician – HazMat		
Other:					Technician – Radio		
Other:					Other:		
Other:					Other:		

CFS Form 2

STATE FIRE RESCUE RESOURCE INVENTORY FORM

Region:		**County:**	
Department Name:			
Department Address:			
City:		**Zip Code:**	
Fire Chief:		**Daytime Phone:**	
24-Hour Phone:		**Fax Number:**	
Pager:			
Contact Person:			

MOBILE EQUIPMENT

RESOURCE	TYPE 1	TYPE 2	TYPE 3	TYPE 4	SPECIAL INFORMATION
ENGINE COMPANY					
WATER TANKER					
BRUSH TRUCK					
AERIAL					
RESCUE/AMBULANCE					
TECHNICAL RESCUE					
HAZ-MAT UNIT					
CFR (AIRPORT)					
ALL TERRAIN VEHICLE					
BULLDOZER					
TRACTOR TENDER					
TRACTOR-PLOW					
CREW TRANSPORT					
MOBILE MECHANIC					
FIELD KITCHEN					
FUEL TRUCK					
HEAVY EQ. TRANSPORT					
ILLUMINATION					
PORTABLE PUMP					
POWER GENERATOR					
UTILITY TRANSPORT					
MOBILE COMMAND VEH.					
COMMUNICATIONS VEH.					
AIR SUPPLY TRUCK					

CFS Form 2

STATE FIRE RESCUE RESOURCE INVENTORY FORM

Region:		**County:**	
Department Name:			
Department Address:			
City:		**Zip Code:**	
Fire Chief:		**Daytime Phone:**	
24-Hour Phone:		**Fax Number:**	
Pager:			
Contact Person:			

RESOURCE	TYPE 1	TYPE 2	TYPE 3	TYPE 4	SPECIAL INFORMATION
AIRCRAFT					
RESCUE HELICOPTER					
AIR TANKER					
SUPPRESS. HELICOTERS					
HELICOPTER TENDER					
HELITACK CREW					
FIXED WING					
PERSONNEL ONLY					
INCIDENT COMMANDER					
OPERATIONS SEC. CHIEF					
PLANNING SEC. CHIEF					
MEDICAL SEC. CHIEF					
LOGISTICS SEC. CHIEF					
ADMIN. SEC. CHIEF					
SUPPRESSION					
PARAMEDIC					
EMT					
HAZ-MAT					
URBAN SAR					
URBAN SAR-CANINE					
WILDERNESS SAR					
WILDERNESS SAR CANINE					
WATER RESCUE					
FIRE INSPECTOR					
FIRE INVESTIGATOR					
COMM. OPERATORS					
MOBILE MECHANIC					
RADIO TECHICIAN					
OTHER EQUIPMENT					
RADIOS					
CELLULAR PHONE					
FAX MACHINE					
DUPLICATING MACHINE					

LIST ADDITIONAL PERSONNEL (W/QUALIFICATIONS) AND ADDITIONAL EQUIPMENT ON SEPARATE PAGE

CFS Form 3

CFS - DISASTER TEAM DEPLOYMENT FORM

MISSION:
Date/Time Deployed:
Message #:
Date/Time Demobilized:

Personnel	Agency	Social Security #	Hourly Wage	Position	Unit Designation	Comments

*Fringe:

CFS Form 4

PERSONNEL EMERGENCY CONTACT NUMBERS

MISSION # _____

EMPLOYEE NAME	CONTACT PERSON	PHONE NUMBER

CFS Form 5

CFS EXPENSE REPORT

Payment is requested for expenses, which were incurred while on official Association business. Please submit separate expense report for each meeting.

Name:				**Date:**	
Address:					
City:		**State:**		**Zip:**	

Reason for Travel:	

Total Miles Traveled:		**@ $0.21 per mile**	**$**

Lodging & Meals:			
	Days Lodging	**@ per day**	**$**
	Breakfast	**@ $ per day**	**$**
	Lunch	**@ $ per day**	**$**
	Dinner	**@ $ per day**	**$**

All other items such as tips, parking, cabs, etc. should be itemized:	
	$
	$
	$
	$
TOTAL DUE	**$**

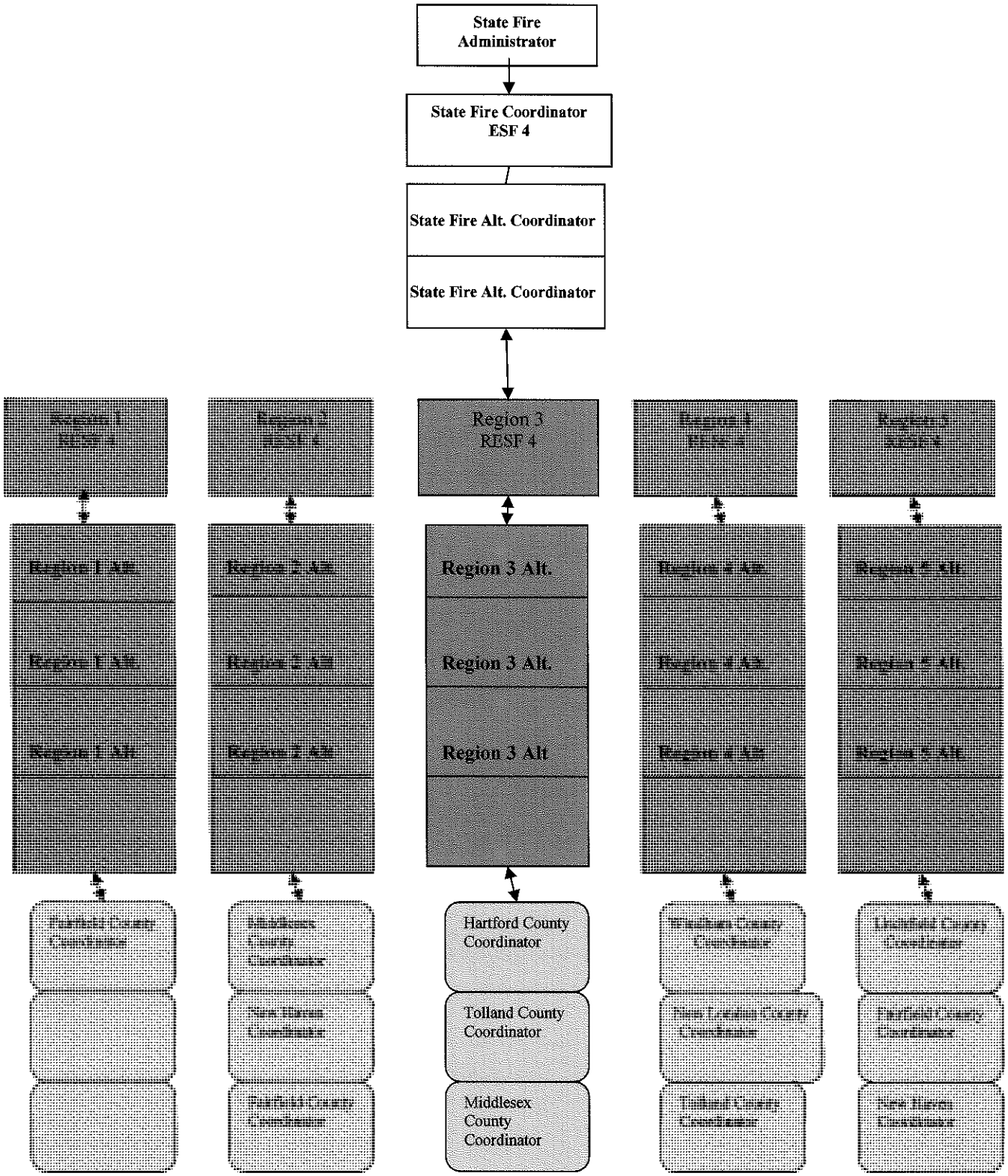
Signature:	

Approved:		**Date:**	

Receipts, with the exception of mileage, tips, and meals not exceeding the amounts indicated above must accompany all listed expenses.

APPENDIX F

Statewide Fire Service Disaster Response Guide Organization



Annexes :

Annex A. ESF 4 Firefighting

Firefighting

Regional Emergency Support Function (RESF) #4

Coordinating or Support Organizations:

Federal Government Organizations

Department of Homeland Security, Federal Emergency Management Agency
Department of Homeland Security, Office of Domestic Preparedness
Department of Defense
US Department of Agriculture

Connecticut State Government Organizations

Connecticut Department of Emergency Management and Homeland Security
Commission on Fire Prevention and Control
Connecticut Department of Public Safety
Connecticut Military Department (CT National Guard)
Connecticut DEP

Local Organizations

Municipal and tribal governments and agencies with resources capable of supporting Firefighting Activities

Municipal, tribal, and district Fire Departments

Municipal and tribal Police Departments
PSAPs
CMEDs

Private Organizations

State Fire Chief's Associations
County Fire Chief's Associations

I. Introduction

a. Purpose

The purpose of this document is to summarize how firefighting resources within DEMHS Regions will be mobilized and coordinated during a regional emergency or disaster requiring firefighting resources. A more detailed description of firefighting resource mobilization and coordination with the state of Connecticut can be found in the Connecticut Fire Service Disaster ResponsePlan. The concepts described in this document are based on the concept of operations detailed in that plan.

b. Scope

FIREFIGHTING, RESF 4 identifies, requests mobilization of, and coordinates the response of specific firefighting resources within DEMHS Regions. FIREFIGHTING, RESF 4 provides for the strategic collaboration of firefighting efforts, and does not exert any direct operational control over FIREFIGHTING resources. Whereas catastrophic events may require the use of FIREFIGHTING resources from the local, state, and federal level, coordination of efforts at the regional level during catastrophes is essential. Therefore, the role of the RCC and FIREFIGHTING, RESF 4 cannot be overemphasized.

II. Policies

a. FIREFIGHTING, RESF 4 will not usurp or override the policies of any federal agency, state government, or local government or jurisdiction.
b. The National Incident Management System (NIMS) and the Incident Command System (ICS) as taught by the National Fire Academy will be used by the RCC and FIREFIGHTING, RESF 4 during response activities.
c. DEMHS Region 5 staff will facilitate coordination among member organizations to ensure that FIREFIGHTING, RESF 4 procedures are appropriately followed and are in concert with stated missions and objectives of the REOP.
d. Essential information will be conveyed through the DEMHS Regional Coordination Center (RCC) as required by the incident and in accordance with existing ICS protocols.
e. At the request of the DEMHS Regional office or Emergency Management, RESF 5, FIREFIGHTING, RESF 4 will staff the RCC and participate in regional emergency decisions concerning FIREFIGHTING. This action will provide technical expertise and the information necessary to develop an accurate assessment of an ongoing situation.
f. FIREFIGHTING, RESF 4 will share information with the appropriate private, local, state, and federal agencies involved in FIREFIGHTING, RESF 4 related activities.

III. Situation

a. Regional Emergency Condition

A variety of situations may occur that require the coordination of FIREFIGHTING activities on a regional level. Large structure fires, wild land fires, urban interface fires, air disasters, large scale flooding events, major storms, or coordinated terrorist events are some examples of situations that may rapidly exceed local firefighting abilities. Additionally, events of this type may significantly disrupt transportation, energy, and communication networks within DEMHS Regions, further complicating the process of searching for and rescuing victims.

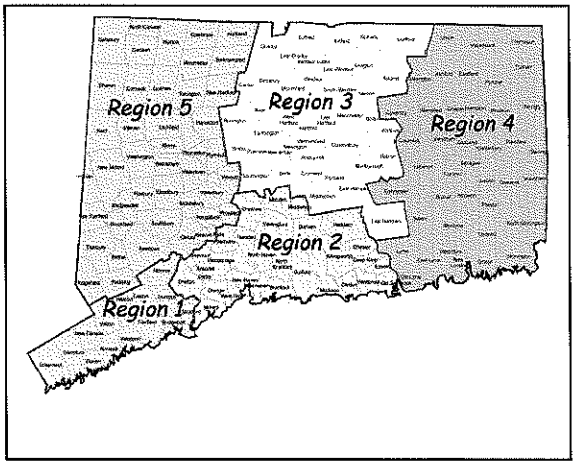
b. Planning Assumptions

- A request has been made, based on events that have occurred or are anticipated to occur in the near future, for regional coordination of emergency management efforts, including but not necessarily limited to FIREFIGHTING. This request may come from:
  - Local jurisdictions within DEMHS Regions, or
  - The SEOC, at the direction of the Governor during a declared State of Emergency
- FIREFIGHTING, RESF 4 will not assume direct command and control over any FIREFIGHTING activities or organizations.
- Sharing information during a regional emergency will benefit all communities. There are immediate and continuous information needs unique to the jurisdictional decision makers.
- FIREFIGHTING activities are life-saving and time critical activities, and coordination and prioritization of FIREFIGHTING tasks during regional emergencies is essential.
- Due to the nature of FIREFIGHTING activities, FIREFIGHTING, RESF 4 may play a key role during the initial hours or days following a major event and may require the support of other regional emergency support functions within the RCC.
- The RCC will be the point-of-contact for local municipalities within DEMHS Regions for information and requests concerning FIREFIGHTING.

IV. Concept of Operations

a. General

According to the Connecticut Fire Service, Fire-Rescue Disaster Plan, the state is divided into five large regions for the purposes of fire service coordination (see figure). Each of the five regions has a designated a Regional Fire Coordinator, tasked with facilitating responses within the region. Further, the plan designates a County Fire Coordinator for each Connecticut county, who works on the sub-regional level in support of the Regional Fire Coordinator. Disaster response, on the state-wide level, is overseen by the State Fire



Coordinator, who is responsible for leading Emergency Support Functions for Firefighting at the State EOC.

DEMHS Regions include parts of the state fire plan's regions 1 and 2 (Western and Central Connecticut, respectively). Additionally, DEMHS Region 5 includes municipalities from Litchfield, Hartford, Fairfield, and New Haven Counties. Therefore, coordination of resources within Region 5 may require the coordination of multiple regional and county fire coordinators.

If the Region 5 RCC staff determines that Firefighting, RESF 4 representation is required at the RCC, the Region 5 RCC will request that the State Fire Coordinator designate a Firefighting, RESF 4 lead for Region 5 who will represent Firefighting, RESF 4 in the RCC.

A current list of State, Regional, and County Fire Coordinators (and alternates), including contact information, is maintained by the State Fire Service

b. Notification

The DEMHS Regional staff has established an emergency notification matrix for FIREFIGHTING, RESF 4 based on the Connecticut Fire Service, Fire-Rescue Disaster Plan. This matrix is included as an attachment to this document, for ease of updating. This matrix identifies the State Fire Coordinator as the lead for Firefighting, RESF 4 in DEMHS Regions. Once contacted, the State Fire Coordinator will designate a DEMHS Regional lead appropriate for the situation, based on the geographic area involved. Options for the DEMHS Regional lead could include the Regional Fire Coordinator for Region 1 or 2, or a County Coordinator from New Haven, Litchfield, or Fairfield County.

Emergency notification for FIREFIGHTING, RESF 4 will follow this format:

i. Request(s) for regional coordination of FIREFIGHTING efforts is (are) made by a local authority(ies) to the DEMHS Regional office; or
ii. During a declared State of Emergency, the SEOC directs the DEMHS Regional offices to establish FIREFIGHTING, RESF 4 within the regional RCC.
iii. The DEMHS Regional staff (or Emergency Management, RESF 5) will contact the Regional FIREFIGHTING, RESF 4 lead, as identified on the FIREFIGHTING, RESF 4 emergency notification matrix.
iv. The Lead for FIREFIGHTING, RESF 4 will be responsible for selection of and notification of other FIREFIGHTING, RESF 4 personnel required to staff the RCC, based on the circumstances and nature of the mission(s).

c. Coordination

i. Initial Actions

Upon establishment of FIREFIGHTING, RESF 4 at the RCC, FIREFIGHTING, RESF 4 will conduct an assessment of FIREFIGHTING related needs and capabilities within Region 5, including but necessarily limited to:

- Current requests from local municipalities with Region 5

- Ability to coordinate intra-regional FIREFIGHTING assets based on:
    - Scope of the incident
    - Municipalities directly affected or already involved in the response effort
    - Available resources within the region, based on the FIREFIGHTING, RESF 4 inventory list (based on the County Fire Coordinators' inventory, as outlined in the Connecticut Fire Service, Fire-Rescue Disaster Plan)
- Based on the assessment of intra-regional resources, FIREFIGHTING, RESF 4 will determine the need for resources from outside of the affected Region. Such resources may include municipal or private agencies from towns outside of the DEMHS Region, State resources including CT-TF-1, the National Guard, CSP, or Federal resources including FIREFIGHTING strike teams or task forces.
    - Requests for any resources (local, state, or federal) from outside of a DEMHS Region will be made by FIREFIGHTING, RESF 4 to the SEOC through DEMHS communication protocols.

ii. Continuing Actions

Throughout the event, or as long as FIREFIGHTING, RESF 4 is a functional element of the RCC, FIREFIGHTING, RESF 4 will coordinate the flow of FIREFIGHTING related information through the RCC to appropriate local, state, federal, and private agencies. FIREFIGHTING, RESF 4 will collaborate with other regional support functions and the regional planning and operations staff in developing Incident Action Plans for each operational period during the incident.

iii. Stand Down

FIREFIGHTING, RESF 4 will perform its function in collaboration with the command staff of the RCC and at the request or direction of the local and state authorities. When the decision to de-activate FIREFIGHTING, RESF 4 is agreed upon, FIREFIGHTING, RESF 4 will stand down in a manner consistent with ICS and NIMS protocols.

V. Execution for FIREFIGHTING, Emergency Support Function 4

a. Responsibilities for FIREFIGHTING, RESF 4

FIREFIGHTING, RESF 4 is responsible for assessment of and coordination of search and rescue related activities within Region 5 during catastrophic events. As part of the RCC, FIREFIGHTING, RESF 4 participates in planning, operational, and logistics activities as needed. FIREFIGHTING, RESF 4 is responsible for providing discipline-specific information during the development of Incident Action Plans throughout the course of the event.

b. Essential Elements of Information

The primary role of the RCC is to convey information about the event and response to the state and local governments, as well as all agencies involved in

the response. Information specific to FIREFIGHTING, RESF 4 may include, but is not necessarily limited to:

- Jurisdictions involved
- Agencies participating in the response
- Injuries and medical emergencies
- Detailed damage reports
- Intra-regional response capabilities
- Extra-regional response capabilities and availability
- Response needs and priorities
- Weather or other conditions that may affect the response

c. Functions Before and During a Regional Emergency

i. Mitigation/Prevention Phase

During the mitigation phase, FIREFIGHTING, RESF 4 will:

- Monitor the development of FIREFIGHTING capabilities within DEMHS Regions
- Keep the FIREFIGHTING, RESF 4 resource inventory for DEMHS Regions up to date
- Keep the FIREFIGHTING, RESF 4 emergency notification matrix for DEMHS Regions up to date
- Assist DEMHS Regional (RCC) agencies in the development of FIREFIGHTING capabilities as opportunities present

ii. Preparation Phase

During the preparation phase, all regional emergency support function personnel will accomplish the following:

- Train on the DEMHS Regional Emergency Operations Plan activation and implementation.
- Train on NIMS / ICS protocols
- Participate, as determined, in regional exercises
- Train on the regional coordination center (RCC) setup and coordination of FIREFIGHTING, RESF 4

iii. Emergency Response Phase

When activated during the emergency phase, FIREFIGHTING, RESF 4 will assemble at the RCC and perform the information, planning, and coordination role described in this plan.

iv. Recovery Phase

During this phase, FIREFIGHTING, RESF 4 will continue to provide any associated coordination and information relevant to FIREFIGHTING, RESF 4.

VI. Administrative Information for FIREFIGHTING, RESF 4

Administrative information and supplemental data for FIREFIGHTING, RESF 4 operations is contained in the following policies and/or documents:

- The National Response Plan
- State of Connecticut, Statewide Fire and Rescue Disaster Plan
- State of Connecticut, Regional Emergency Operations Plan

APPENDIX G

STATE EMERGENCY OPERATIONS CENTER (S.E.O.C)

- **ACTIVATION of STATE E.O.C.**
- **E.O.C. EQUIPMENT NEEDED**
- **FIRE DEPARTMENT RESPONSIBILITIES IN E.O.C.**
- **EOC IMS STAFF AND LAYOUT CHART**
- **AGENCY LOG**
- **ORGANIZATIONAL CHARTCT EOC SOP**

The State Emergency Operations Center (S.E.O.C.) is the State's coordination center for emergency services during any major emergency affecting the State of Connecticut. The S.E.O.C. is activated when ordered by the Governor, Commissioner of the Department of Emergency Management and Homeland Security (DEMHS), or one of their designated representatives.

The S. E.O.C. is located on the ground floor of the State Armory, 360 Broad Street, Hartford, Connecticut. Phone number 860-566-3180

Day-to-day operations are conducted from regional offices that are widely dispersed throughout the State. When a major emergency or disaster strikes, centralized emergency management is needed. This facilitates a coordinated response by the Governor, DEMHS representatives from State and Federal organizations who are assigned specific emergency management responsibilities.

The SEOC operates under the nationally-recognized National Incident Management System (NIMS).

An EOC provides a central location of authority and information and allows for face-to-face coordination among personnel who must make emergency decisions. The following functions are among those performed in the State of Connecticut EOC:

- Receiving and disseminating warnings.
- Developing policies.
- Collecting intelligence from and disseminating information to the various SEOC representatives and, as appropriate, to municipal, military and federal agencies.
- Preparing intelligence/information summaries, situation reports, operation reports and other reports as required.
- Maintaining general and specific maps, information display boards and other data pertaining to emergency operations.
- Continuing analysis and evaluation of all data pertaining to emergency operations.

- Controlling and coordinating, within established policy, the operations and logistical support of the fire service resources committed to the emergency operations.
- Maintaining contact with support EOC's, be it regional or local, other jurisdictions and levels of government.
- Providing emergency information and instructions to the public utilizing the Governor's Press Desk. Making official releases to the media and the scheduling of press conferences as necessary in coordination with the Governor's Press Desk.

All requests for special assistance from the field and significant status information should be directed to S.E.O.C. Operations Chief. Frequent progress and status reports should be provided to the Operations Chief every hour or more frequently as requested.

ACTIVATION OF S.E.O.C.

The S.E.O.C. is activated only on orders of the Governor or Commissioner of DEMHS. Notification of the activation of S.E.O.C. will be made to the State Fire Administrator (SFA) or designee.

Upon notification that the S.E.O.C. has been activated the SFA will immediately notify all senior staff and designated Fire Academy personnel (FAP). Unless otherwise instructed by the SFA, the notification will advise all notified personnel to report to the SEOC to staff the fire service workstation. Selected FAP will be assigned to the S.E.O.C. and a shift schedule established when needed. Typically, the schedule is to work a 12-hour shift commencing at midnight and ending at noontime. The on coming shift should arrive at 1100 hours to be briefed by the SFA or a designated lead FAP. Parking is available at the Legislative Office Building parking garage located along side the east side of the State Armory.

The SFA or his designee will need to report to the S.E.O.C. A minimum of two additional personnel are required to operate the fire department position at the S.E.O.C. on a 24-hour basis during an active incident. Additional and relief personnel will be assigned as needed.

E.O.C EQUIPMENT NEEDED

Fire Academy Personnel assigned to the S.E.O.C. should take the following items:

- Cellular telephones
- Statewide Fire – Rescue Disaster Response Plan

- Fire Service Disaster Operations Manual
- Note pads
- Pencils, pens

Once in the SEOC FAP shall retrieve the Tupperware container stored in the SEOC. This container has support equipment needed during the activation

Additional items to consider:

- Personal toiletries
- Earplugs for Cellular
- Flip charts, felt tip pens, duct tape

FIRE SERVICE RESPONSIBILITIES IN E.O.C.

The fire service personnel assigned to the S.E.O.C. are responsible for:

- Obtaining and prioritizing resource needs for field incident commanders.
- Providing the Operations Chief information on field conditions.
- Interpreting directives from the Operations Chief (OPS Chief) or Operations Desk (OPS Desk) staff.
- Requesting policy direction from the OPS Chief when necessary.
- Communicating policy directives to field forces.
- Providing liaison with other involved agencies.
- Maintaining constant awareness of field conditions and deployment.
- Obtaining authorization for expenditures for requested resources needed to complete assigned functions.

All field deployed Fire/Rescue Plan Coordinators (FRPC) will keep the S.E.O.C. FRPC's informed of conditions, progress, level of commitment, resource requirements and situation urgency during a major emergency. The FAP S.E.O.C. staff will ensure that field command(s) (Incident Command Post) will establish an S.E.O.C. liaison with the FRPC deployed to the incident (s). All significant changes in conditions will be directed to the S.E.O.C. by telephone, radio, fax, or email. All requests for policy direction or additional resources (beyond normal levels) should be directed to the FAP in the S.E.O.C. (particularly state and federal resources).

The FAP staff assigned to the S.E.O.C. will maintain a log of all major decisions by the FAP staff, the SFA, Governor or Commissioner of DEMHS.

The log will indicate the time, the decision, and who made the decision. The S.E.O.C. staff should utilize the S.E.O.C. *Agency Log form* for this purpose.

FIRE SERVICE STAFF

The SFA, or his designee, is a member of the Governor's policy advisory staff in the S.E.O.C., responsible for emergency management of statewide fire rescue operations. The Governor's Command Staff (State Agency Commissioners) interprets incoming information, makes management decisions, issues policy statements and directives and coordinates the efforts of all state agencies.

EAST HAMPTON
PUBLIC SCHOOLS
COMMITTED TO EXCELLENCE

East Hampton Public Schools
East Hampton, Connecticut

Emergency Operations Manual

2020-21

September 2020
Version 8.0

This document is based on:

State of Connecticut All-Hazards School Security and Safety Plan Template
Emergency Response and Crisis Management Manual – CABE
Emergency Operations Plan – Connecticut State Police
Emergency Responses – CABE
Emergency Response Software
Threat Assessment in Schools – U.S. Department of Education

This plan has been updated to meet the requirements of P.A. 13-3 An Act Concerning Gun Violence Prevention and Children's Safety

Advisors:

Dennis Woessner – Chief, East Hampton Police Department
Greg Voelker – Chief, East Hampton Fire Department
Richard Klotzbier – East Hampton Fire Marshal
Joey Guest – East Hampton Deputy Fire Marshal
Donald Scranton – Chief, East Hampton Ambulance Association
David Whitty – Safety Officer, East Hampton Ambulance Association
Russell Melmed – Director, Chatham Health District
Paul K. Smith – Superintendent of Schools, EHPS
Don Harwood – Director of Operations, EHPS

Table of Contents

EAST HAMPTON
PUBLIC SCHOOLS
COMMITTED TO EXCELLENCE

East Hampton Public Schools
East Hampton, Connecticut

East Hampton Public Schools
Emergency Operations Manual

Emergency Response & Crisis Management Plans

The purpose of the *Emergency Response & Crisis Management Plans* document is to provide a clear and rapid response guide to school officials, teachers, staff, and the school's Crisis Team in the handling of emergency situations.

The East Hampton Public Schools have an obligation to ensure the safety and well-being of both students and staff. The plans in the Emergency Operations Manual were developed for the sole purpose of providing guidance in implementing a safe, timely, and prudent response to a crisis or potential crisis situation.

The safety of the students and staff is an ongoing expectation in the East Hampton Public Schools and is treated with paramount importance. In any crisis, the first concern of school personnel will be the safety of students and staff. All decisions will be made with safety concerns in mind. In developing this plan, it is recognized that not every contingency could possibly be foreseen, but an effort has been made to codify basic procedures that should be followed in several types of emergencies.

Crises and emergencies happen suddenly and most often without warning. The best preparation for them is to be ready to make the decisions necessary to ensure that students and staff are safe and properly protected. Awareness and planning help to promote the best and safest possible school environment for everyone.

This manual provides the action steps and procedures that will be a part of the response to any emergency. The specific actions for particular emergencies are provided, but frequently, time is not available to review detailed plans and steps. Emergency and school security plans must be easily understood, sufficiently detailed to be quickly implemented, and periodically reviewed by the school's Crisis Team, emergency officials, and the entire staff. In a crisis, the staff should be prepared for:

- Confusion and ambiguity – information will not always be available.
- Flexible responses, depending on the circumstances
- Pressure

This East Hampton Public Schools Emergency Operations Manual establishes the expected protocol when responding to the following:

- Emergency Medical/Other Health Situations
- Weather or Natural Disasters
- [redacted]

East Hampton Public Schools Emergency Operations
Purpose

The purpose of the Emergency Operations Manual is to provide a guide to the school Principal, designee, staff, Crisis Team, and any responder in the handling of emergency situations in the East Hampton Public Schools.

The DISTRICT Chain of Command is:

Superintendent of Schools
District Emergency Management Coordinator / School Facilities Director
Director of Curriculum and Instruction
Director of Special Education
Business Manager
Designated Principals (for district emergency)

The SCHOOL Chain of Command is:

Principals – Memorial, Center, Middle, and High Schools
Assistant Principals – Memorial, Middle, and High School *(Most often will be the designated as the School Incident Commander)*
Director of Guidance or Lead Teacher
Nurse - Memorial, Center, Middle, and High School - *if medical emergency*
Designated Teacher or Staff Member 1 at Memorial, Center, Middle, and High School
Designated Teacher or Staff Member 2 at Memorial, Center, Middle, and High School

Note: At least two to three people will be assigned as being emergency responders at each school. At least one designated "in charge" person should be in the building at all times when school is in session.

At all times, the judgment of the ranking staff member in the building, as set forth in the Chain of Command will prevail. Consideration will be given to the following in the order shown:

- Safety of the students
- Safety of the staff and other building occupants
- Protection of the building, its contents and grounds
- Minimizing the disruption to the education process

When an emergency occurs the steps to be taken are:

- Size up – quickly learn all you can about the situation
- Protect students and staff during evacuation or in appropriate shelter or relocation area
- Attempt to minimize the situation and damages
- Make the needed modifications

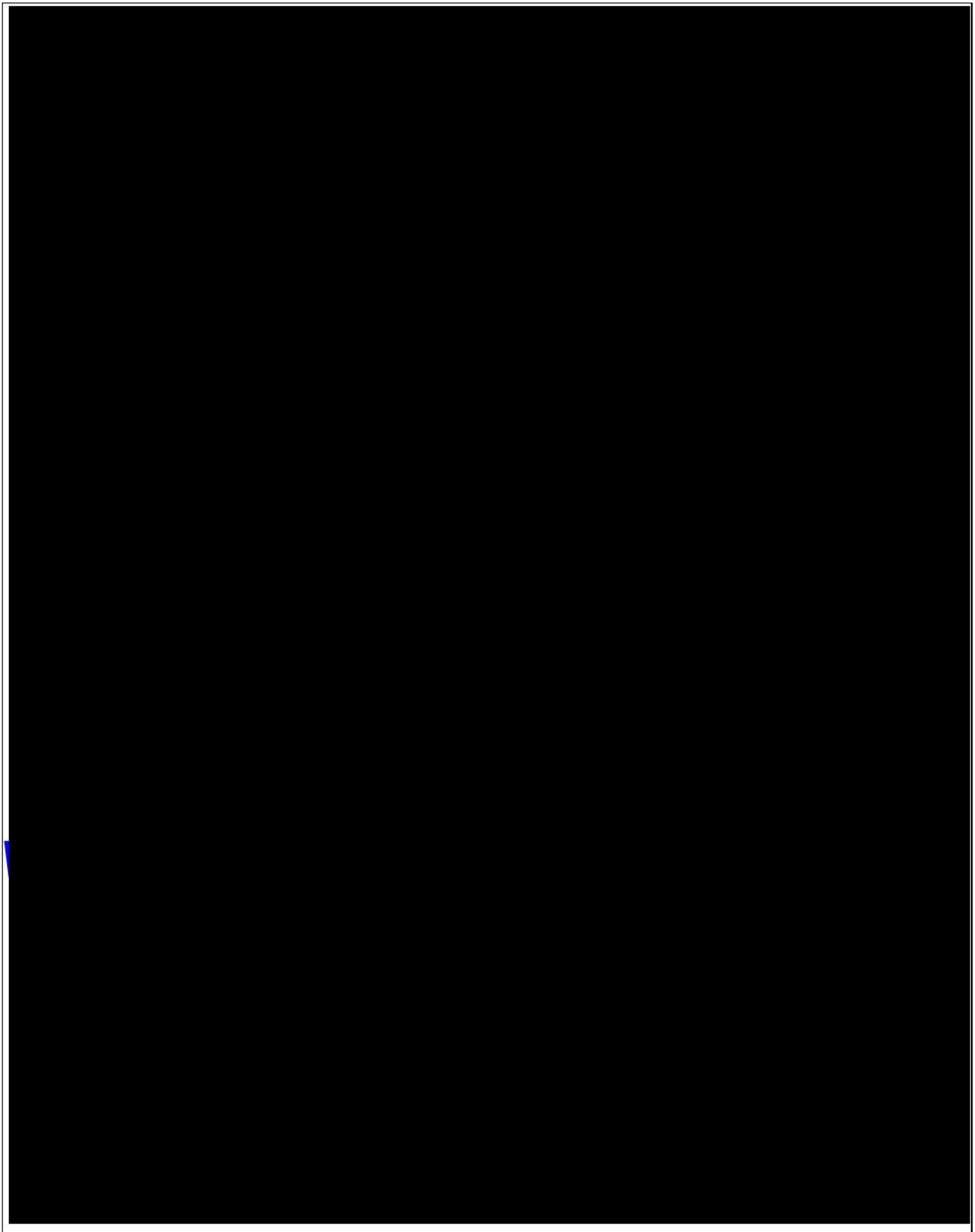
After the emergency, the situation should be reviewed by the Crisis Team of each building to:

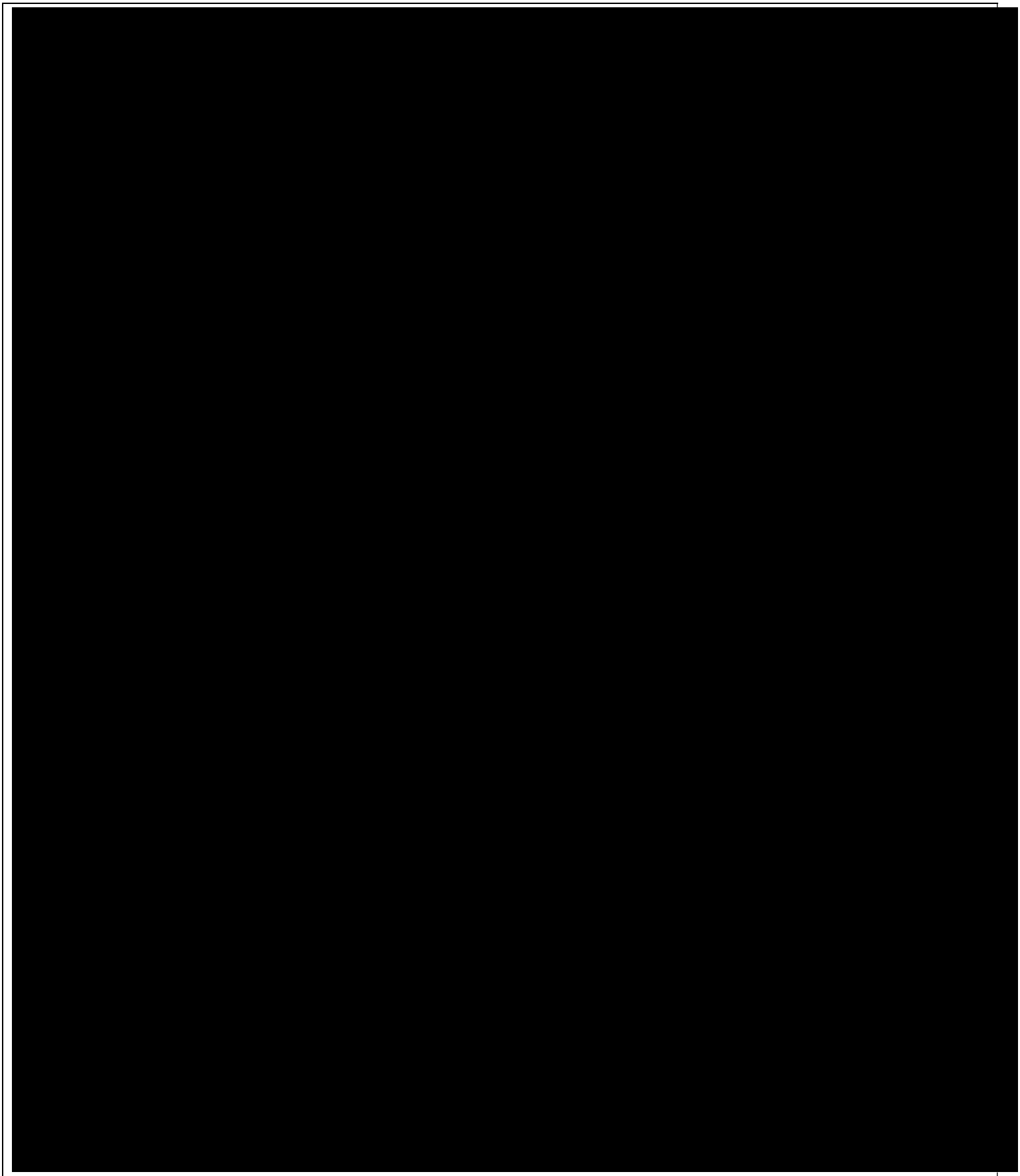
- Prevent its recurrence
- Improve the operation should it recur
- Provide a report from which others can learn

East Hampton Public Schools Emergency Operations
Awareness of Emergency Response Plan

In order to have an effective emergency response plan, it is vital that all the members of the school community know it exists. In addition, they must know of the protocol to be followed in specific situations to maintain school safety. The following procedures are recommended to ensure that staff, students, and community agencies are familiar with this safety plan.

- Review and revision of plan by Community Emergency Officials and District Administrative Team
- Review of plan and revision suggestions by each School's Crisis Team
- Presentation of plan to Board of Education members
- Presentation of plan to state police, fire department, and emergency agencies
- Training for all school staff members
- Periodic review of plan with staff members
- Information sessions for students
- Periodic review of school safety plan with students
- Promoting parent awareness
- Providing specialized training as needed for administrators and support personnel





East Hampton Public Schools Emergency Operations

List of Administrators & Contact Numbers

East Hampton Office of the Superintendent
94 Main Street, East Hampton, CT 06424

Paul K. Smith, Superintendent of Schools
Office Phone # 860-365-4000
[redacted]

Mary Clark, Director of Curriculum
Office Phone # 860-365-4000
[redacted]

Donald Harwood, Facilities Director
Office Phone # 860-365-4000
[redacted]

Karen Asetta, Business Manager
Office Phone # 860-365-4000
[redacted]

Rodney Mosier II, Director Special Ed
Office Phone # 860-365-4000
[redacted]

East Hampton High School
15 North Maple Street, East Hampton, CT 06424

Eric Verner, Principal
Office Phone # 860-365-4030
[redacted]

Matthew Warner, Assistant Principal
Office Phone # 860-365-4030
[redacted]

East Hampton Middle School
19 Childs Road, East Hampton, CT 06424

Eric Kissinger, Principal
Office Phone # 860-365-4060
[redacted]

Christina Amaral, Assistant Principal
Office Phone # 860-365-4060
[redacted]

Center School
7 Summit Street, East Hampton, CT 06424

Christopher Sullivan
Office Phone # 860-365-4050
[redacted]

Memorial Elementary School
20 Smith Street, East Hampton, CT 06424

Andrew Gonzalez, Principal
Office Phone # 860-365-4020
[redacted]

Brandy Gadoury, Assistant Principal
Office Phone # 860-365-4020
[redacted]

The Learning Center
Main Street, East Hampton, CT 06424

Paula Bosco
Office Phone # 860-365-4071
[redacted]

Dawn Walsh
Office Phone # 860-365-4071
[redacted]

IN ANY EMERGENCY CRISIS SITUATION, THE SUPERINTENDENT OR HIS/HER DESIGNEE IS THE SOLE SPOKESPERSON FOR THE EAST HAMPTON PUBLIC SCHOOLS.

1	Unless otherwise notified, all media relations are to be conducted though the Superintendent's office. The Superintendent will serve as the district spokesperson unless other arrangements or notification has been made.
2	Should someone be contacted relative to an issue, refer the media source to the Superintendent's Office.
3	Take measures to limit media access on school grounds to a designated area. (Determined by situation.)
4	Do not allow media access to students either on school buses or school grounds.
5	Confer with Crisis Team and agree on precisely what will be communicated and how it will be done. Wait until the most accurate information is complete and available. Determine what may or may not be shared with the members of the press or public.
6	Designate individuals to answer telephone. Provide such individuals with fact sheets.
7	Prepare fact sheets for distribution to staff and others, including the media.
8	Make sure parents are well informed of any incidents. Prepare information to be sent home.

Public Act No: 02-133
AN ACT CONCERNING THE DISCLOSURE OF SECURITY INFORMATION UNDER THE FREEDOM OF INFORMATION ACT.
Summary: *This act exempts certain records from disclosure under the Freedom of Information Act if reasonable grounds exist to believe their release could pose a safety risk.*

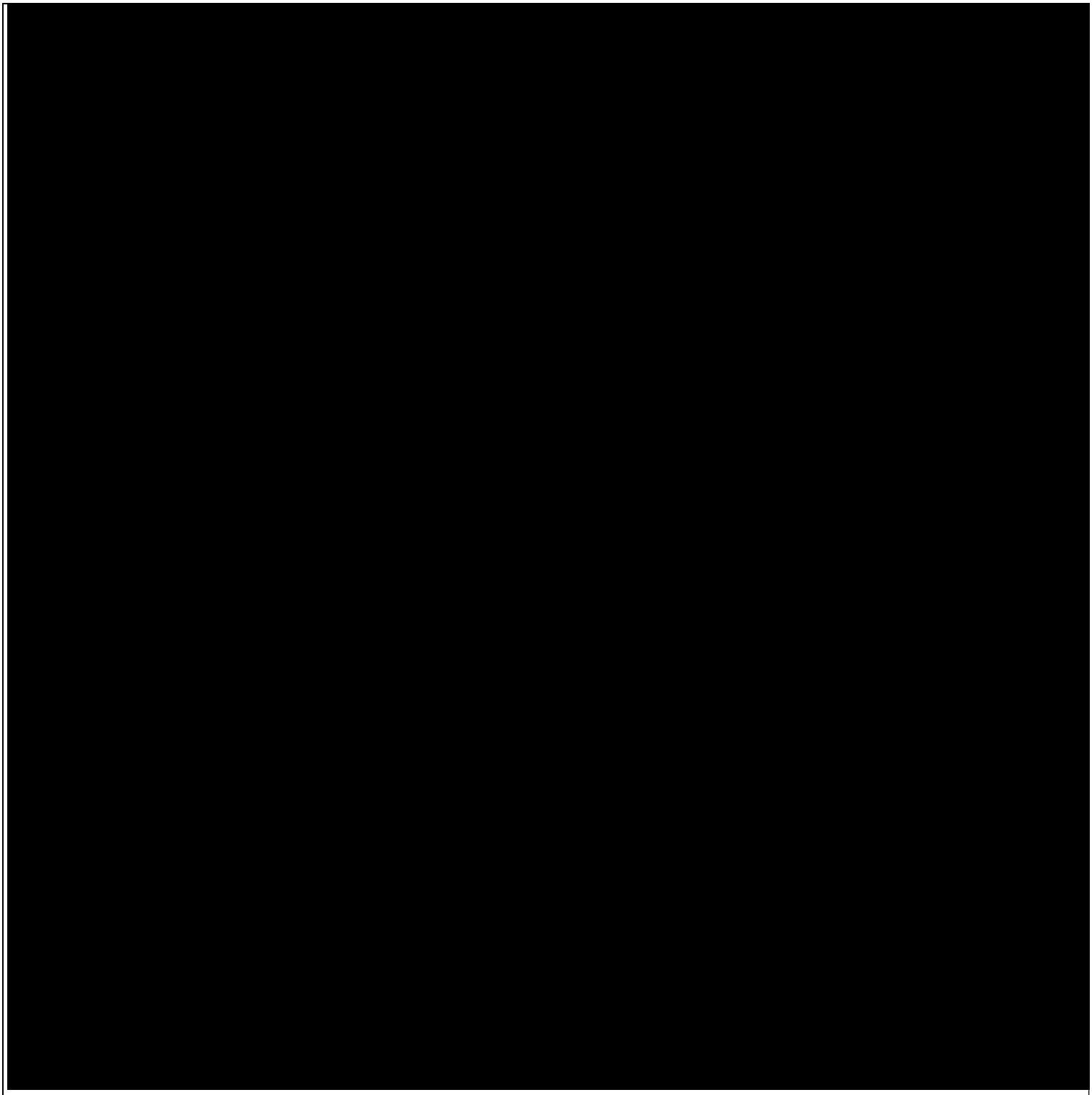
Effective Date: October 2, 2002

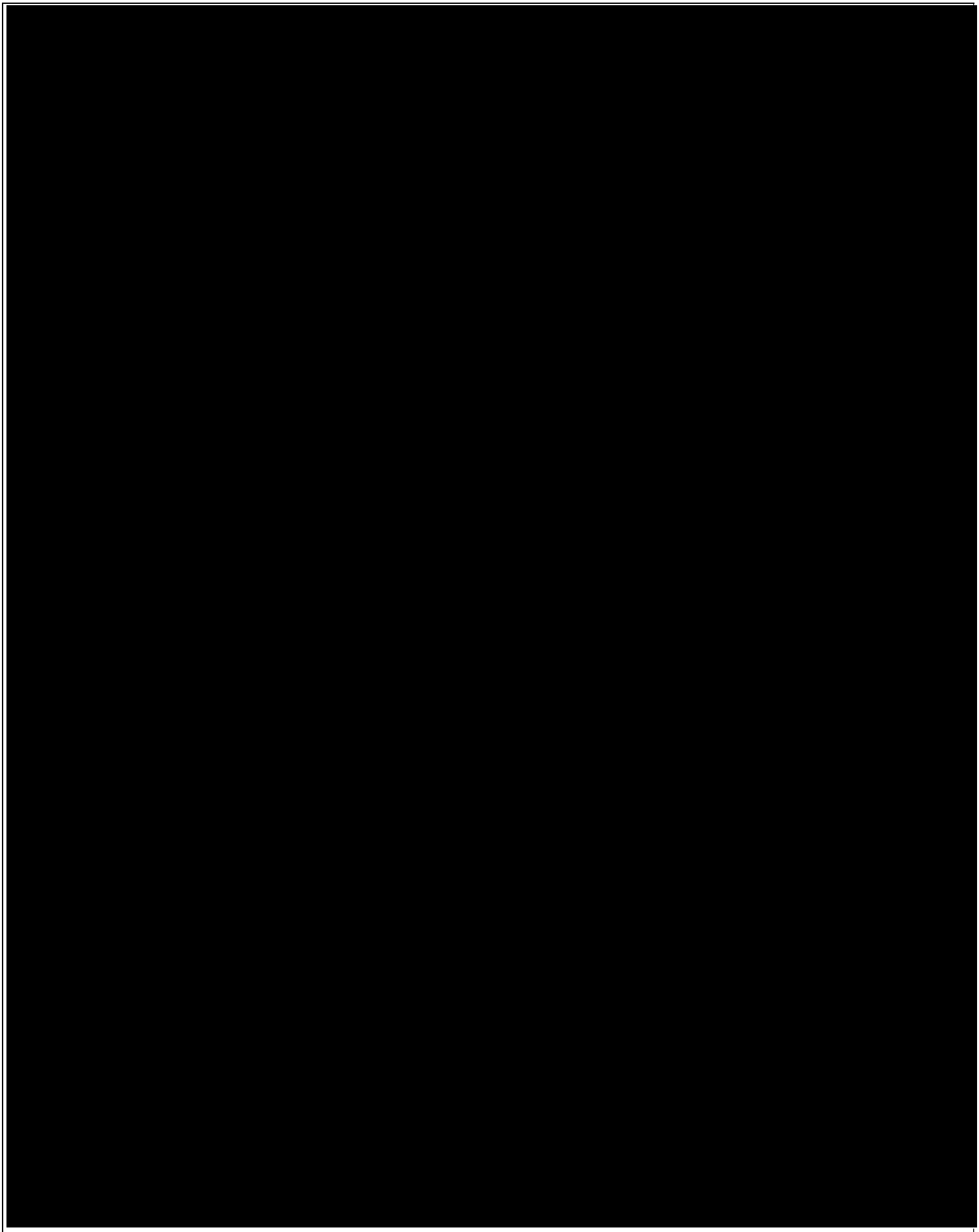
School Crisis Team should determine components of response plan to any situation including:

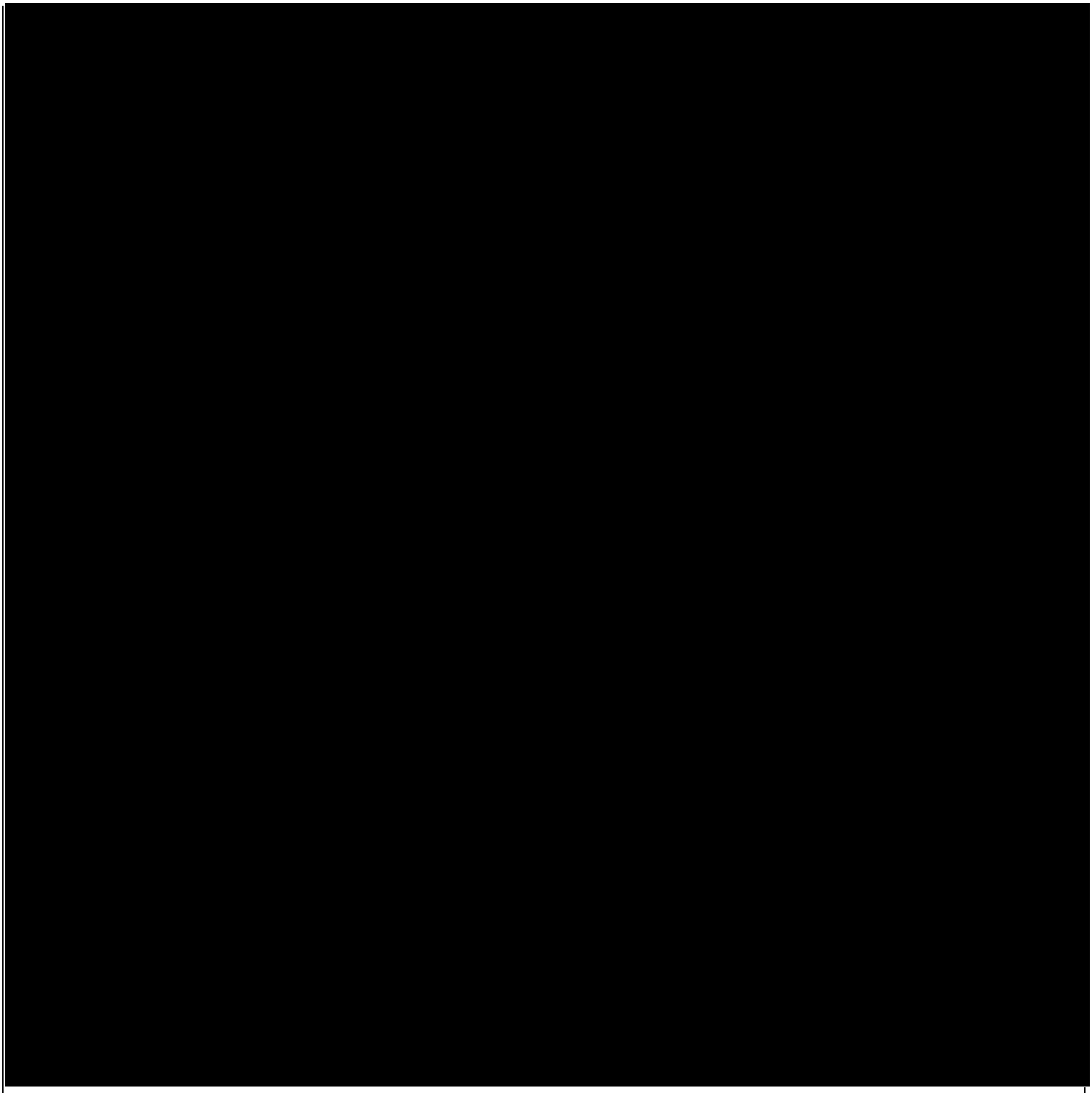
- ❑ Support to students and families involved
- ❑ Staff involvement and notification procedures
- ❑ Student notification
- ❑ Building management issues
- ❑ Media information / facts for Superintendent's Office
- ❑ Involvement of community services and agencies
- ❑ Level of parent involvement and notification to parents
- ❑ Assignment of crisis response duties to individual team members
- ❑ Necessary coverage for team members to carry out crisis response duties

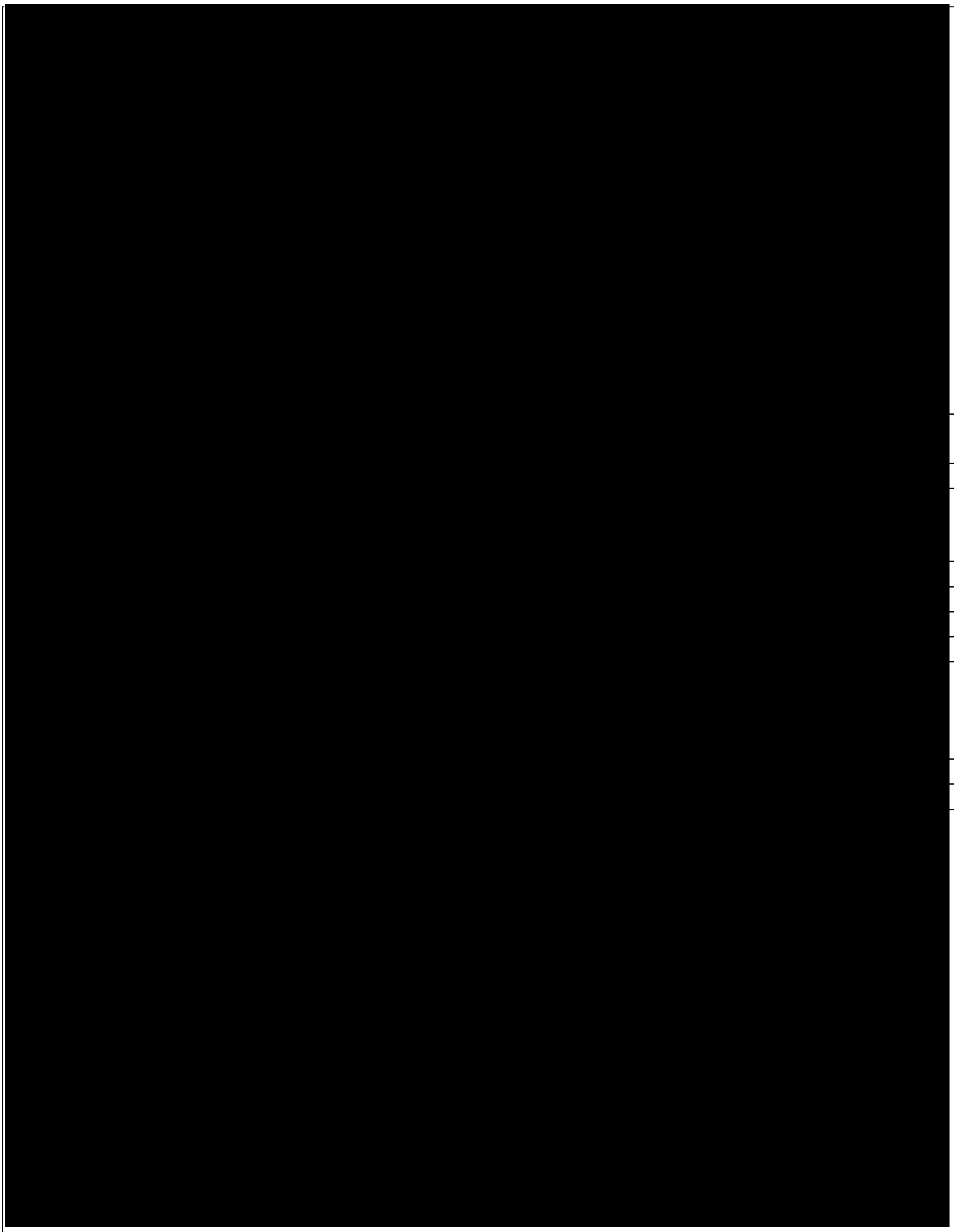
Notes:

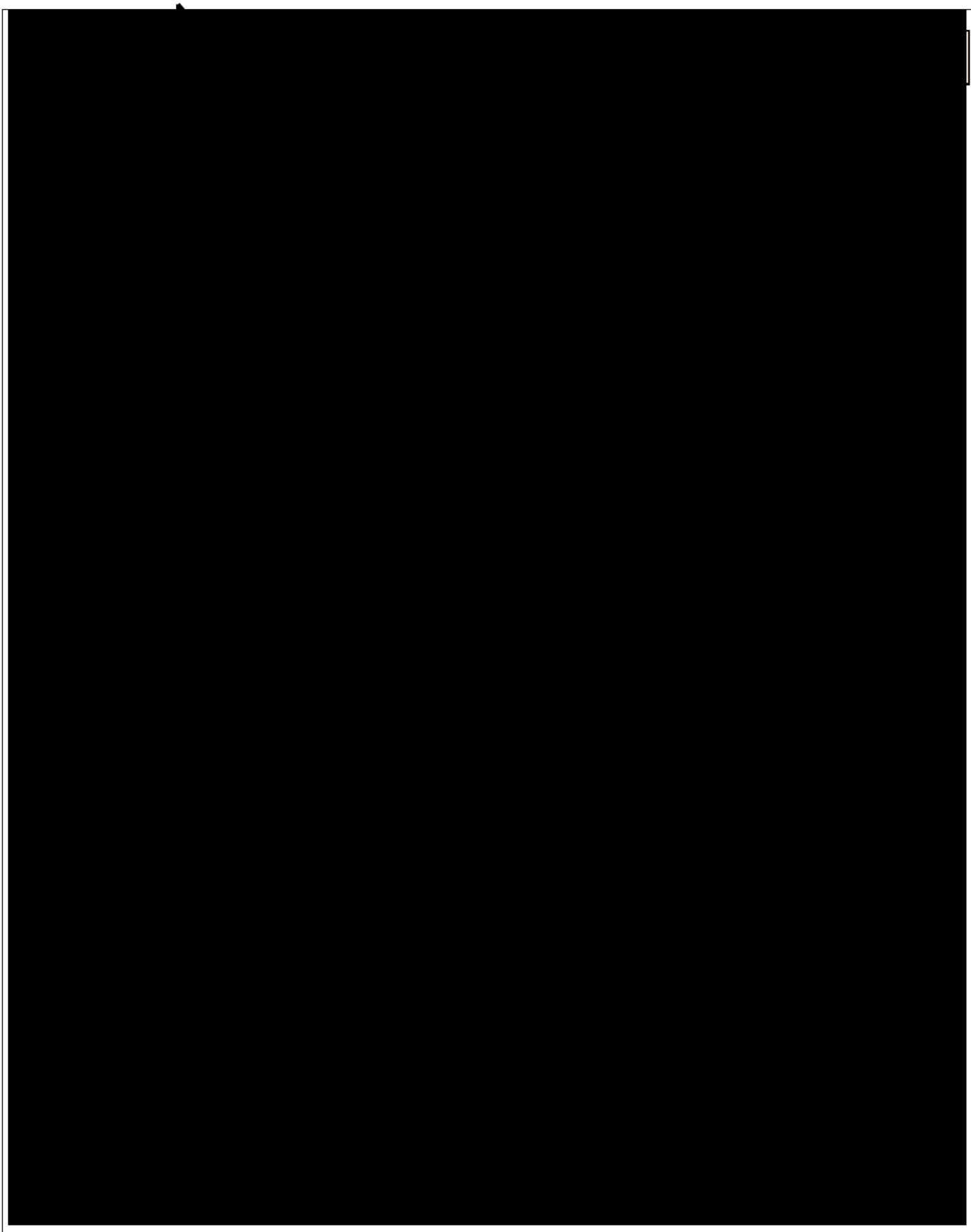
[redacted]











East Hampton Public Schools Emergency Operations
BUS ACCIDENT Emergency Response

In the case of accident, the bus driver will implement and adhere to bus company policy and procedures regarding the safety of the bus and its occupants.

The main priority shall be the safety of the students on the bus.

1	• The bus driver immediately contacts the bus company dispatcher and informs the bus company of the accident by radio or by phone. • The bus driver takes attendance and notes the location of each student on the bus. • The bus driver keeps all students on the bus unless they must be moved for safety reasons.
2	• The bus company dispatcher notifies the public safety agencies (Police, Fire, and EMS), calling 911. • If the driver cannot reach the dispatcher, the driver makes the 911 call.
3	• The bus company dispatcher notifies the school office and the Superintendent's Office of the accident and all known facts pertaining to the accident.
4	• The school Principal or school office notifies the school nurse of the accident and severity. • The school's Crisis Team should be alerted as necessary. • The administration and the Superintendent designate a school representative to report to the site.
5	• The senior officer of the responding emergency personnel is in charge of the accident scene and will work with the driver, Police, and rescue personnel in order to handle the emergency. • **All students are carefully examined for injuries on site by the rescue squad / EMTs**. • Injured student(s) will receive first aid treatment by the responding medical team / EMTs.
6	• The bus driver and the school designee make note of where students were seated at the time of the accident. • Any student injuries recorded by the rescue squad are shared with the school representative. • If first aid treatment is necessary at site, parents of injured students will be notified/contacted – and/or advised of transport to hospital. • Parents of non-injured students will be notified at soonest convenience.
7	• The bus company supervisor will provide a back-up vehicle to transfer the non-injured students to school (Morning Run) or to home (Afternoon Run) unless it is determined that students will return to school. • For an afternoon bus run, decision is made by the school representative with assistance from medical personnel at the site whether to return all students to school to be seen immediately by school nurse. • **When given permission by emergency officials to move students,** attendance should be taken before disembarking to back-up vehicle, indicating which students are on bus and which students have been transported to hospital.
8	• **For safety and protection of the students, at no time should students be released to anyone at the accident site without permission of the senior officer of the fire or rescue squad, the Police, medical personnel, as well as the school designee at the site.** • The school designee at the site will refer any members of the press to the Superintendent's Office.
9	• The nurse will assess each student upon arrival to the school and notify any parents of concern/injury.
11	• In the case of a return to school on an Afternoon Run, parents will be called and if reached given the option of picking the students up at school or having them transported home by the back-up vehicle after being seen by nurse.
12	• The school office will call parents with an explanation of the details regarding the accident.
13	• The bus company will cooperate with the proper authorities. The bus company will provide a written report to the Superintendent of Schools.
14	• The Superintendent of Schools will notify the board chairman and board members of the accident details.
15	• The nurse shall inform the Principal as to the names of students who receive follow-up medical treatment as a result of the accident. • The Principal shall give these names to the Superintendent.

*NOTES: Name of Driver*_____ *Bus #*_____ *Date/Time*_____

Bus Diagram

FRONT OF BUS

Row				Aisle			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

East Hampton Public Schools Emergency Operations
FIRE DRILL Procedure Emergency Response

NOTE: Fire "DRILL" Procedures are different from FIRE/[redacted] Procedures.
A "DRILL" is considered a planned event by the school and should be monitored for speed and efficiency.

1	**ALL PERSONS** in the building are expected to respond to the first sounding of the alarm by evacuating to the predetermined area. This includes students, teachers, office staff, visitors, contractors, cafeteria personnel and custodians.
2	All students in the cafeteria and hallways are to leave quickly and quietly proceed away from the building. Principals will plan for reunification with appropriate staff for attendance when outdoors.
3	Students who are not in a classroom (for example: in the bathroom, at the media center, etc.) should leave the building by the nearest available doorway and report to the area where their class musters outside.
4	The students who are leaving from a particular room are to remain with that group, under the teacher's supervision, during the entire drill.
5	Classroom doors and windows should be closed during a fire drill. Teachers should outline to each of their group's proper procedures and exit routes when the fire alarm goes off. Directions for exiting should be posted prominently in all rooms.
6	Teachers are expected to remind the students to remain with their groups during a fire drill and to file out of the building quietly. Teachers are responsible for checking attendance outside the building.
7	Attendance should be taken by all teachers. The attendance collectors should be at a centralized location. **List of missing students/staff provided to Fire officials & EMS.** **List of students/staff at area of refuge provided to Fire officials & EMS.** **List of students/staff with disabilities preventing exit shared with Fire officials & EMS.**
8	As this is the most common drill practiced, there should be high expectations of effective results.

NOTE: Even though "DRILLS" are common, drills should be conducted as an actual event:

1	Check the corridor for heat; if the door is hot, **do not open the door**. Exit room by secondary exit if available. If there is no other means of egress, block the door and await evacuation by fire personnel.
2	Check the corridor for smoke; use the exit route that is away from the fire and smoke.
3	Assemble the students, take attendance book/class roster, and lead an orderly and quick evacuation to the nearest accessible exit.
4	Assemble the students away from the building and take student attendance. Report students who are not accounted for to the designated collector.
5	Maintain order during the evacuation.

Fire drill Schedule for East Hampton Public Schools:

- **2 fire drills within first 30 days of school**
- **One drill for each month of school**
- **During January, February, and March – emergency drill may be substituted for fire drill**

East Hampton Public Schools Emergency Operations
FIRE / [redacted] Emergency Response

1	Pull fire alarm at smell of smoke [redacted] to signal evacuation to pre-designated route – **OR** – Use PA announcement for **Fire "Drill" procedure** or [redacted] if alternative site or area is to be used. ❑ **Close classroom windows and doors.** ❑ **Leave lights and computers as they are.** ❑ **Turn off gas if in use.**
2	**Call 911** for police and/or fire department.
3	If necessary, alert school nurse for first aid procedures and activate Crisis Team to assist.
4	Ensure that building has been cleared of students and staff. **Do not use elevators.**
5	Ensure custodian and cafeteria staff members have turned off all power equipment.
6	Advise whether ambulances are needed.
7	Rescue anyone in immediate danger, if possible without endangering yourself. Feel doors – a "too hot to touch" door means the fire is outside the door. NEVER enter an unknown area, especially if smoke is visible.
8	You are not required to extinguish a fire with a fire extinguisher and should use an extinguisher only if you have been trained and the situation does not present a personal safety hazard.
9	Do not re-enter the building once you have left until you have been instructed to do so.
*	[redacted]
*	Collect attendance roster. Pre-appointed staff members search building for any missing students *only if situation warrants*. No member of the staff should enter the building if there is any risk of injury.
*	Wait for "all clear" signal to return to building – if deemed safe.
*	Plan for additional move to alternative site if situation is deemed high risk. Organize transportation by grade level / bus assignment if dismissal is warranted.
*	Organize dismissal "check out" with faculty if students to be released from site.

Notes:

Special considerations:

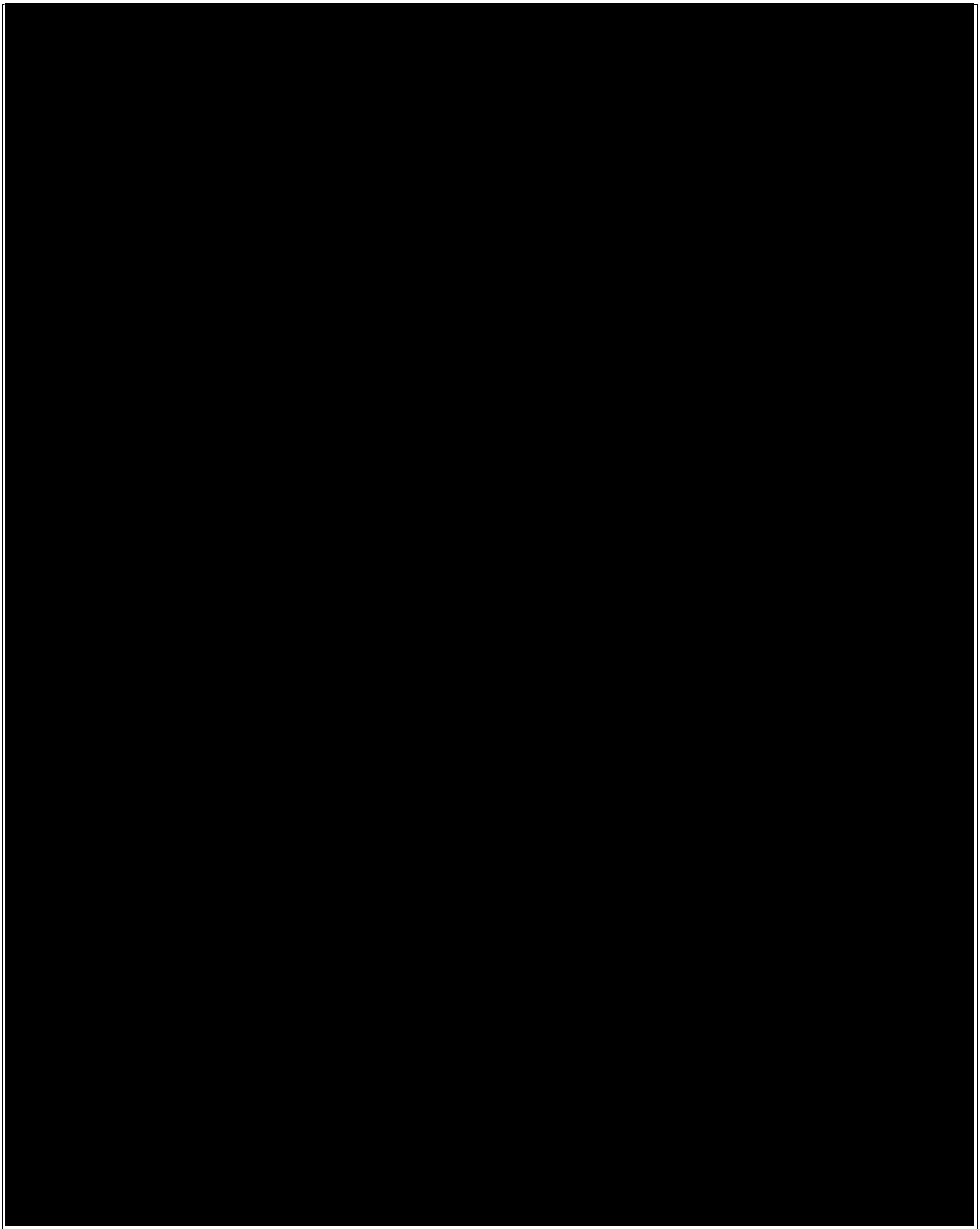
East Hampton Public Schools Emergency Operations

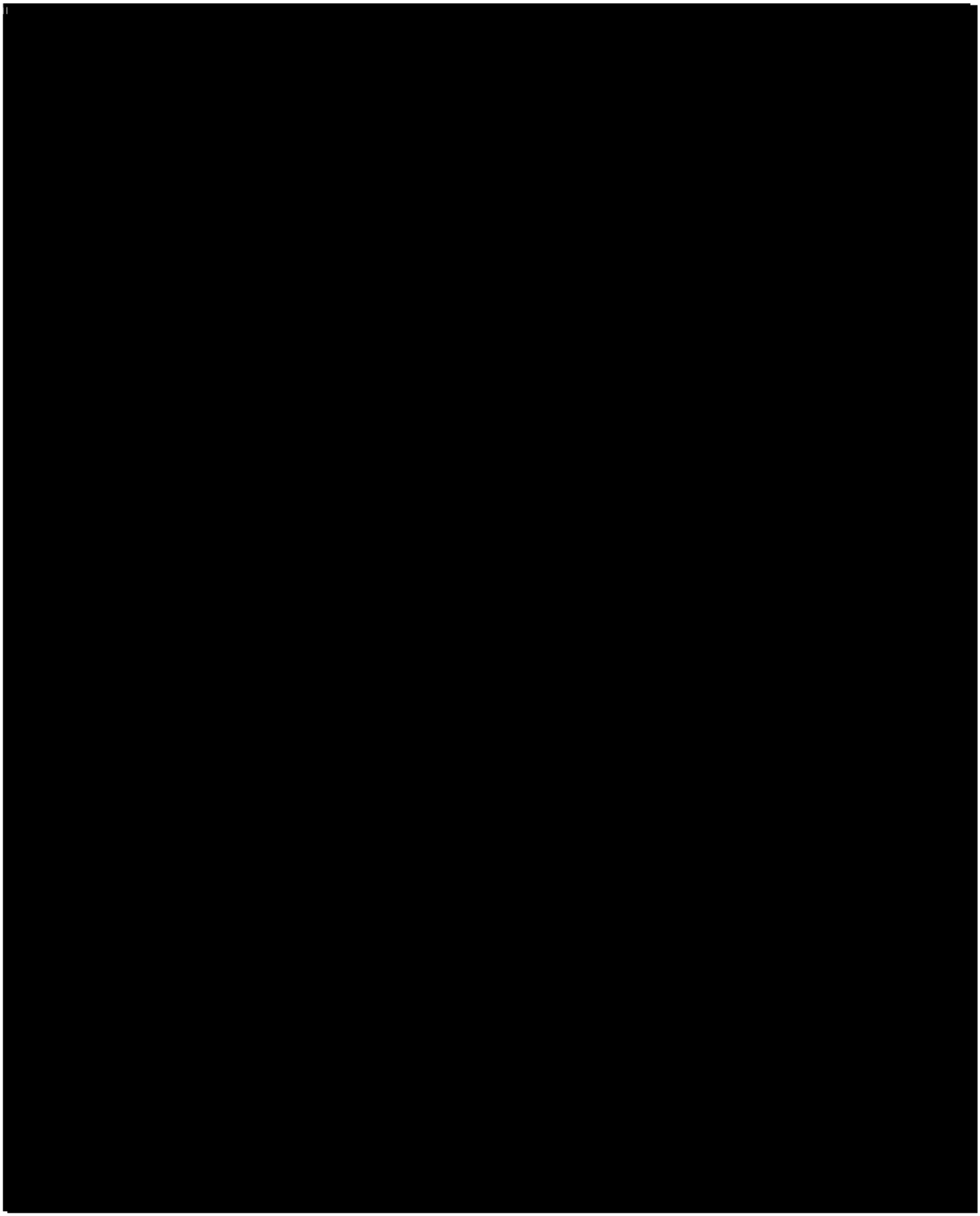
GAS LEAK / HAZARDOUS MATERIAL Emergency Response

1	Pull fire alarm at smell of gas or release of serious chemical spill in building or on/near campus – **OR** – Use PA announcement for **Fire "Drill" procedure** or [redacted] if alternative site or area is to be used. ❑ **Close classroom windows and doors.** ❑ **DO NOT OPERATE ELECTRICAL SWITCHES OR ELECTRONIC EQUIPMENT: Leave lights and computers as they are.**
2	**Call 911** for police and/or fire department.
3	If necessary, alert school nurse for first aid procedures and activate Crisis Team to assist.
4	Evacuate and make sure that building has been cleared of students and staff.
5	Ensure custodian and cafeteria staff members have turned off all power equipment.
6	Advise whether ambulances are needed.
7	[redacted]
*	Collect attendance roster. Pre-appointed staff members search building for any missing students *only if situation warrants*. No member of the staff should enter the building if there is any risk of injury.
*	Wait for "all clear" signal to return to building – if deemed safe.
*	Plan for additional move to alternative site if situation is deemed high risk. Organize transportation by grade level / bus assignment if dismissal is warranted.
*	Organize dismissal "check out" with faculty if students to be released from site.

Notes:

Special considerations:





East Hampton Public Schools Emergency Operations

CHEMICAL SPILL / MERCURY SPILL Emergency Response

1	**CALL 911.**
2	Contain Area – Remove all students from area – **except for those who have come in contact with spill.** Block off access to area. Seclude all from contaminated areas. **No one should enter a contaminated area under any circumstances.**
3	Place and keep all contaminated items in contained area.
4	Close ALL interior doors.
5	If necessary, alert school nurse for first aid procedures and activate Crisis Team to assist.
6	**Designate an isolation area if instructed to move those who have had contact. Isolate any person in contact with any unknown chemical.**
7	Lower temperature in spill area (if possible).
8	Turn off or isolate HVAC system in spill area from rest of building.
9	Designate communications person to: **CALL CT DEEP – Emergency Response and Spill Prevention Division (24/7) 860-424-3338, 1-800-DEP-SPIL**
10	**Notify Chatham Health District**
*	[redacted]
	NOTE: Those in contact with substance or in contaminated area stay in place and do not evacuate until instructed to do so. Maintain isolation of any person in contact with unknown substance.
*	Collect attendance roster. Pre-appointed staff members search building for any missing students *only if situation warrants*. No member of the staff should enter the building if there is any risk of injury.
*	Wait for "all clear" signal to return to building – if deemed safe.
*	Plan for additional move to alternative site if situation is deemed high risk. Organize transportation by grade level / bus assignment if dismissal is warranted
*	Organize dismissal "check out" with faculty if students to be released from site.

Notes for Officials

Spill Date & Time:
Spill Location:
Names of Students/Staff Potentially Exposed:

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Connecticut Department of Public Health
Environmental & Occupational Health Assessment Program
Environmental Health Section
410 Capitol Avenue, MS # 11EOH, PO Box 340308
Hartford, CT 06134-0308
Telephone: (860) 509-7740 Fax: (860)

[redacted]

Maintain isolation of those who have had contact with any unknown substance.

The silver beads of metallic mercury vaporize and contaminate the air. The longer the spill is left unaddressed, the greater the potential is for exposure and more widespread contamination.

If a mercury spill is not contained and cleaned up, mercury can be tracked into hallways, further spreading contamination. You can minimize exposure by following the recommendations below.

Things to do:

• **Report the spill immediately**.

• **Contain the area. Block access to area.** Keep people out of area until clean-up is completed. Someone may walk through it and spread the contamination further.

• **Bring potentially exposed Individuals to a cool, ventilated, staging area** for evaluation by Connecticut Department of Energy and Environmental Protection (CT DEEP) or emergency response personnel.

• **Leave contaminated items** (i.e., shoes, brooms, mops, clothing) in the contained area to reduce the potential for contamination spread.

• **Close interior doors** to reduce the amount of air that could circulate from the spill area into other parts of the building.

• **Turn off or isolate heating, ventilating and air conditioning (HVAC) Systems** to reduce the amount of air that could circulate from the spill area into other parts of the building.

• **Turn the thermostat down (if possible)** in the affected area to slow the release of mercury vapor into the air.

Things NOT to do:

• **Do not vacuum.** Vacuuming is especially dangerous because heat from the motor turns solid/liquid mercury beads into dangerous vapor that gets blown out with the vacuum cleaners exhaust.

• **Do not sweep.** Sweeping stirs up the air, dust, and mercury beads. This can spread the vapor. It also contaminates the broom.

• **Do not use a metal dust pan**. Mercury can bind to the metal.

• **Do not walk through an area where there was a spill** – your shoes can become contaminated, and spread the contamination further.

The East Hampton Public Schools will maintain a booklet of all SDS sheets in the Main Office of each school.

East Hampton Public Schools Emergency Operations

SEVERE WEATHER (Thunderstorm) Watch/Warning Procedures

Severe Weather Watch

This term is used whenever conditions indicate that severe weather is **possible**.

Severe Weather Warning

This term is used whenever conditions indicate that severe weather is **imminent**.

1	Superintendent's Office and School Offices will monitor weather during a storm watch, warning, or alert situation.
2	Superintendent will notify Principals to initiate weather alert procedures.
3	If **"Watch"** is issued curtail plans for outdoor activities.
4	If **"Warning"** is issued cancel plans for outdoor activities and after school programs / athletics or in an emergency situation. Relocate outdoor activities to indoors.
5	Ensure that students and staff not in regular classrooms are in safe locations.
6	Close all windows and blinds. Move students from windows.
7	Advise Crisis Team of weather predicted.
8	If necessary, alert school nurse for first aid procedures and activate Crisis Team to assist.
9	Designate staff to monitor radio and TV warnings and advisories.
10	Secure emergency assistance if necessary.
11	Shutdown/unplug computers and other electrical equipment.
12	Continue to monitor weather situation.

Notes:

Special Considerations:

East Hampton Public Schools Emergency Operations
TORNADO
Watch/Warning Procedures

Tornado Watch

This term is used when the possibility of tornadoes exists.

Tornado Warning

This term is used when a tornado is spotted or indicated in radar.

There may not be time for a Tornado Warning before a tornado strikes.

1	During a "Watch" assign specific teachers or other staff members to monitor commercial radio or TV for Tornado "Warnings".
2	Danger signs: • **Severe Thunderstorms** with thunder, lightning, heavy rains, and strong winds. • **Hail** usually comes from dark-clouded skies as pellets of ice. • **Roaring noise** which sounds like trains or a crashing, thunderous sound. • **Funnel** with a dark, spinning "rope" or column stretching from the sky to the ground or a sudden increase in wind.
3	If a "Warning" is issued, be aware school may be isolated from rescue officials and that staff may need to be self-sufficient.
4	Alert school nurse for first aid procedures and activate Crisis Team to assist.
5	**All students and staff will take shelter in designated Ares,** which are NOT parallel to the tornado's path, which is usually from the southwest. Do not take shelter in gymnasium, auditorium, cafeteria or other rooms with wide, free span roofs. The most dangerous locations in a building are usually along the south and west sides and at all corners.
6	Review instructions to students and staff in designated areas: Stay inside. • Move away from any boxes, shelves, heavy objects, and furniture. There should be no loose items in area. • Close windows, blinds/shades, doors and corridor fire doors. Avoid all windows and other glassed areas. • Assume a protective posture facing an interior wall. • **"Drop and Tuck" – face wall – hands interlocked overhead.**
7	Secure emergency assistance if necessary – if available.
8	Have custodians SHUT OFF boilers and all gas and electricity at main switches. SHUT OFF all gas appliances and motors.
	If there is a tornado strike in immediate area:
*	Determine condition and status of building/facility.
*	As situation dictates, keep students in hallways if safe or other area if no further danger. If students and staff are outside the building, immediately have them return inside to shelter in place locations – **OR** -
*	[redacted].
*	Have school nurse complete inventory of first aid supplies available if school will be designated as a "public shelter."
*	Await instructions of emergency personnel and Superintendent's Office.
*	Do not permit students to walk home or drive home.

East Hampton Public Schools Emergency Operations
HURRICANE
Watch/Warning Procedures

Tropical Storm Watch
This term is used whenever tropical storm conditions are possible within **36 hours.**
Tropical Storm Warning
This term is used whenever tropical storm conditions are possible within **24 hours.**
Hurricane Watch
This term is used whenever hurricane conditions are possible within **36 hours.**
Hurricane Watch
This term is used whenever hurricane conditions are possible within **24 hours.**
Category 1 Sustained winds of 74-95 MPH – Minimal damage expected
Category 2 Sustained winds of 96-110 MPH – Moderate damage expected
Category 3 Sustained winds of 111-130 MPH – Extensive damage expected
Category 4 Sustained winds of 131-155 MPH – Extreme damage expected
Category 5 Sustained winds over 155 MPH – Catastrophic damage expected

1	Track hurricane position and predicted path whenever storm enters Gulf of Mexico or threatens Atlantic Coast and review hurricane shutdown plans and school closing with staff. If school is in session, designate staff to monitor radio and TV warnings and advisories.
2	If school is in session and an official **Hurricane Watch** is issued, make preparations to close down school building if alerted.
3	**If school must evacuate and/or dismiss** advise transportation and secure needs of all students prior to school closing and dismissal of students.
4	Dismiss students and close schools when directed by Superintendent or designee's office.
5	Ensure safe storage of all vital and expensive equipment. Protect computers and audio-visual equipment.
6	Have school nurse complete inventory of first aid supplies is available if school will be designated as a "public shelter."
7	Direct staff and other employees to close down their areas and leave school facility after students have left school.
8	Have custodial staff secure all windows and glass as appropriate.

Notes:

East Hampton Public Schools Emergency Operations
EARTHQUAKE
Response Procedures

1	**Due to sudden nature of earthquakes be aware school may be isolated from rescue officials and that staff may need to be self-sufficient.**
2	Give instructions as much as possible: • Stay inside. • Move away from windows, shelves and heavy objects or furniture that may fall. • Take cover under a table or desk, not in a doorway. • Move to the interior wall. Move to hallways if possible. • Turn away from windows. • "Drop and Tuck." • If the table or desk moves, hold the legs and move with it.
3	Alert school nurse for first aid procedures and activate Crisis Team to assist.
4	Designate staff to monitor radio and TV warnings and advisories.
5	Secure emergency assistance if necessary.
6	Have custodians SHUT OFF all gas and electricity at main switches. SHUT OFF all gas appliances and motors.
	After area is stable:
*	Determine condition and status of building/facility. Do not turn light switches on or off if gas leak is suspected.
*	As situation dictates, keep students in hallways if safe or other area if no further danger **– OR -**
*	[redacted].
*	Have school nurse complete inventory of first aid supplies is available if school will be designated as a "public shelter."
*	Await instructions of emergency personnel and Superintendent's Office.
*	Do not permit students to walk home or drive home.
*	Determine condition and status of building/facility.

Potential Hazards:

- **Windows:** Non-tempered glass will shatter and gouge whatever it hits.
- **Lighting Fixtures:** Fixtures may fall and break; fluorescent bulbs will fall and break.
- **Ceilings:** Improperly installed ceilings may come down. Glued tiles may fall. Ducts may fall.
- **Chemical Spills:** In chemistry labs, cafeterias and custodial supply closets, chemical bottles can fall and break creating toxic fumes, combustible mixtures, and exposed corrosives.
- **Furnishings and Miscellaneous Items:** File cabinets may fall over or fly across the room. Freestanding bookcases, lockers, shelves and contents will fall over. Heavy objects such as TV's, typewriters and computers may fly through the air. Screens and maps may become projectiles. Pianos will roll.
- **Compressed Gas Cylinders, Gas Appliances and Water Heaters:** All of these may pull away from the wall, become projectiles and create other gas hazards.
- **Gas Lines:** Lines will rupture. If gas lines are near a sparking wire or arcing motor, an explosion could result.
- **Basements and Electrical Supply:** Water pipes may rupture. Basements may flood deeply. Electrical switching mechanisms may become inaccessible.
- **Wall-Mounted and Hanging Objects:** Clocks, maps, fire extinguishers, hanging plants will all pull free and become projectiles.

East Hampton Public Schools Emergency Operations

FLOODING

Watch/Warning Procedures

Flash Flood or Flood Watch

This term is used whenever flooding is **possible** in the designated "watch" area.

Flash Flood or Flood Warning

This term is used whenever flooding is **has been reported** or is **imminent**.

Urban and Small Stream Advisor

This term is used whenever flooding of small streams, streets, and low lying areas is occurring

1	Superintendent's Office and School Offices will monitor weather during a flood watch, warning, or alert situation.
2	Designate staff to monitor radio and TV warnings and advisories.
3	Superintendent will notify Principals to initiate weather alert procedures.
4	Check all building areas and classrooms for water leaks.
5	Monitor low areas of school property.
6	Assign staff member to keep eye on entry roads, parking lots, sidewalks, etc. for accessibility.
7	Secure emergency assistance if necessary - especially in determining road conditions.
8	**If school must evacuate and/or dismiss** advise transportation and secure needs of all students prior to school closing and dismissal of students.
9	Protect contents of building by moving books, files and other items from floors and bottom shelves.
10	Ensure safe storage of all vital and expensive equipment. Protect computers and audio-visual equipment.
11	Alert teachers and students to locate high ground areas along regular route.
12	Remind all drivers: **DO NOT ATTEMPT to drive through dips of unknown depths or water in roads.** • Even six inches of fast-moving floodwater can knock you off your feet, and a depth of two feet is enough to displace the weight of most automobiles, causing them to float away. • Never try to walk, swim, or drive through swift-moving water.

Notes:

East Hampton Public Schools Emergency Operations

MEDICAL ACCIDENT Emergency Response

TEACHER		PRINCIPAL'S OFFICE	
1	**Do not move child** – keep stable. Apply first aid if possible.	1	Call School Nurse.
2	Call office with name of injured student and nature of problem or injury.	2	Review incident report.
3	Keep students away from the scene.	3	Call Superintendent.
4	Complete incident report with nurse ASAP.		

SCHOOL NURSE	
1	Check student's emergency health information.
2	Bring necessary medical supplies to site.
3	Assess severity of injury or illness.
4	Call parent/guardian.

ADMINISTRATIVE GUIDELINES: Serious Problem	
1	**Call 911** for ambulance.
2	[redacted]
3	Call Superintendent's Office.
4	Contact parent.
5	Stabilize student and administer first aid until medical personnel arrive.
6	Have student's emergency health information available to accompany student to hospital.
7	Convene Crisis Team.
8	Obtain diagnosis and details of incident.
9	File report.

ADMINISTRATIVE GUIDELINES: Minor Problem	
1	Move student to Nurse's office and assess.
2	Administer first aid.
3	Contact parent.
4	File report.

East Hampton Public Schools Emergency Operations

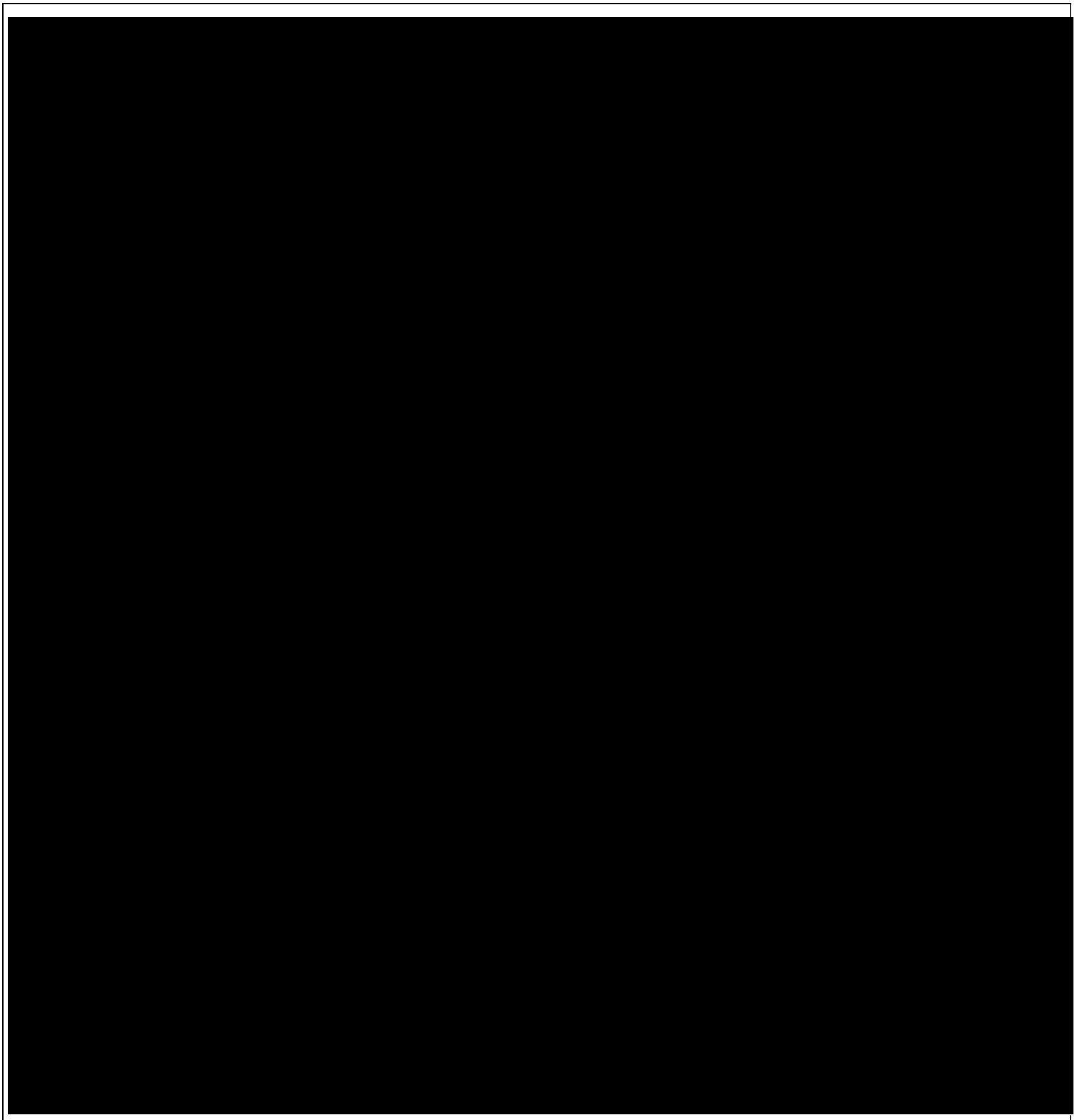
STUDENT IN CRISIS Emergency Response

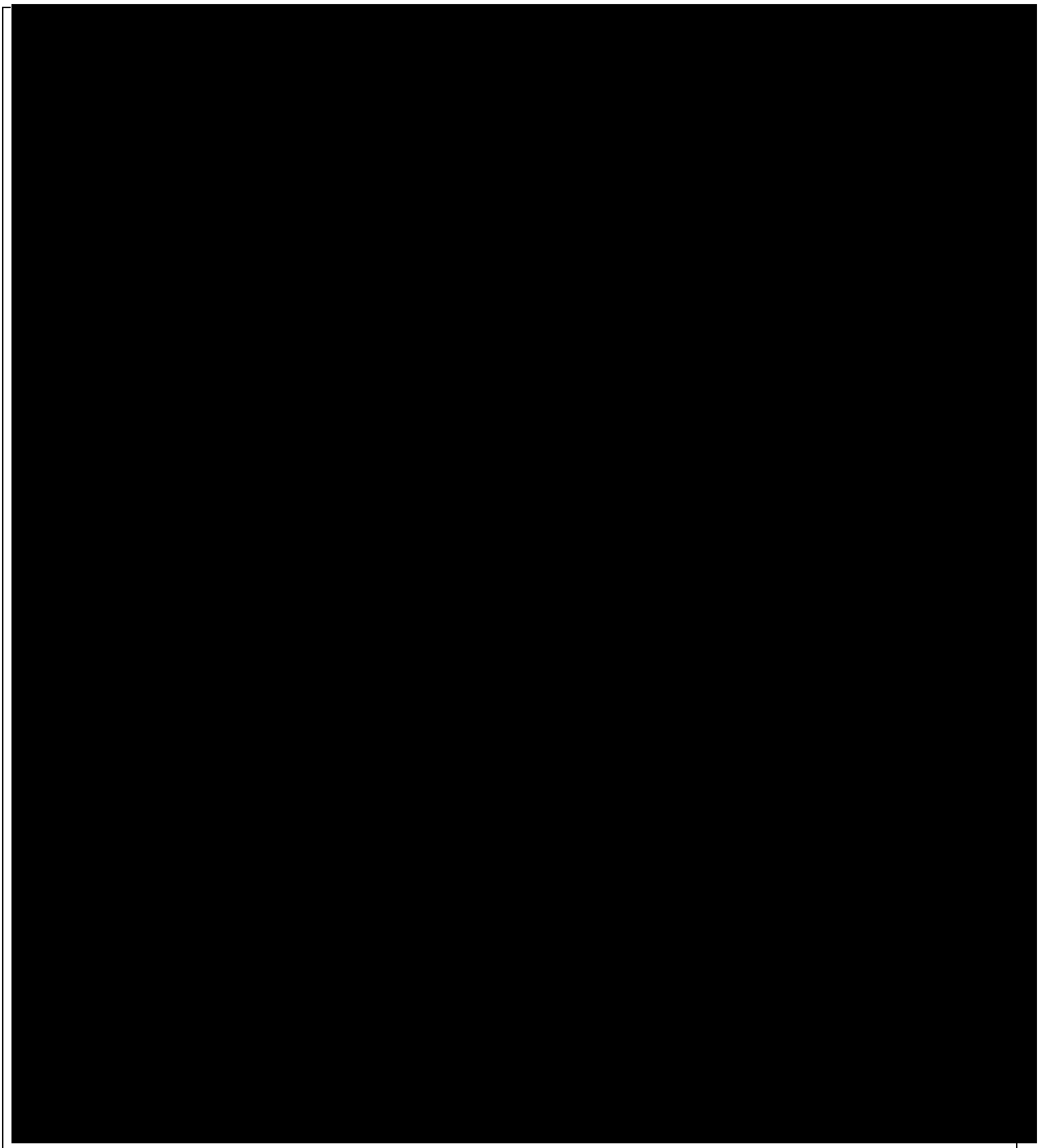
Identifiers: These behaviors *may* help teachers identify mental health needs in students.

Do not ignore RED FLAGS in students.

•	disassociated behavior	•	"dark" writings or drawings
•	exaggerated reactions	•	deterioration in hygiene
•	physical and verbal aggression	•	giddy
•	detaching from peers	•	impulsive
•	tearful/despondent	•	refusal to work/non-
•	disruptive	•	chronic lateness
•	withdrawn	•	missing classes/poor
•	obsessive/perfectionism/ compulsive	•	excessive daydreaming
•	sensory issues/easily over-stimulated	•	falling asleep in class
•	change in grades	•	change in physical appearance
•	change in personality		

Notes:





East Hampton Public Schools Emergency Operations

DRUG OVERDOSE Emergency Response

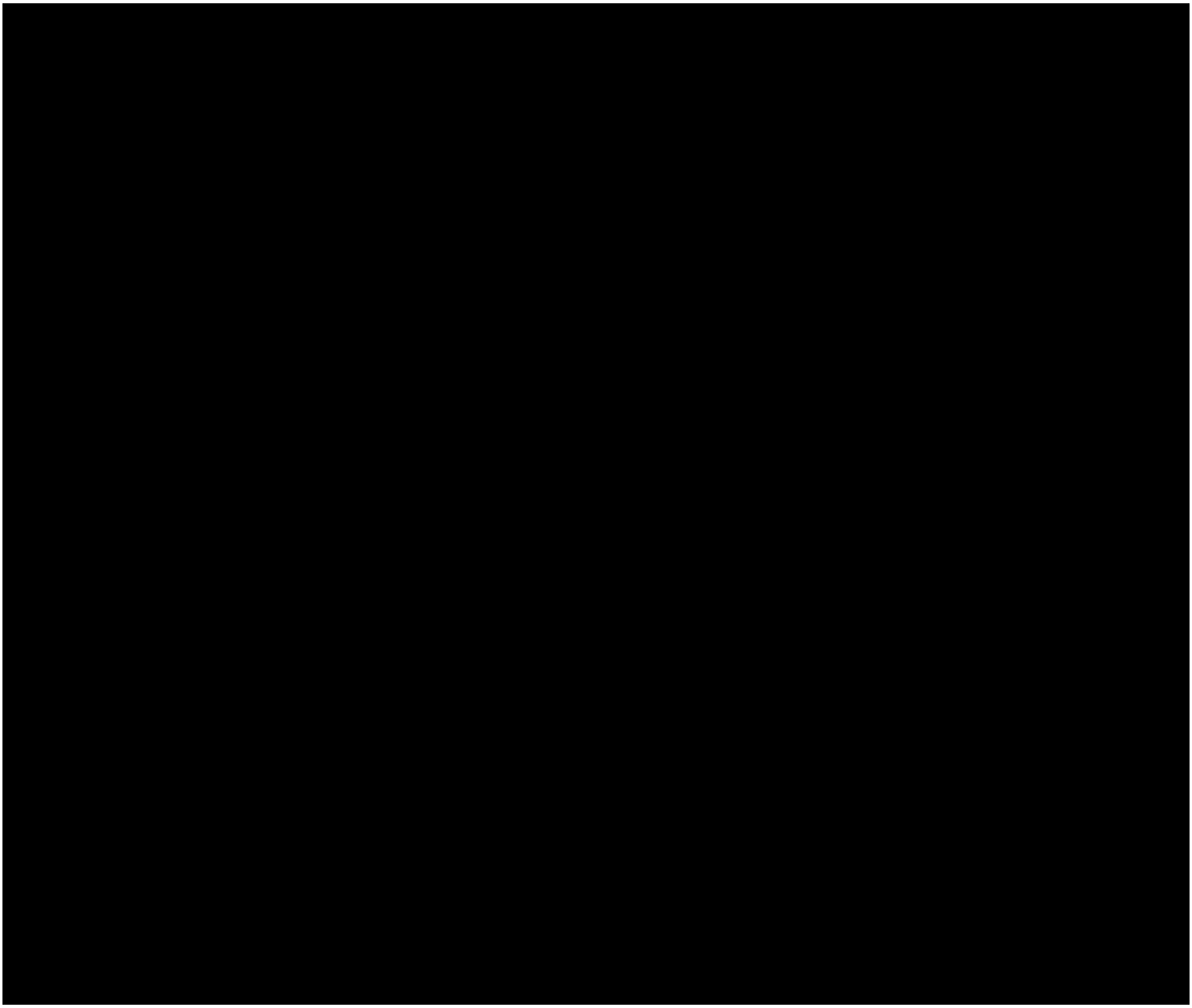
[redacted]

ADMINISTRATIVE GUIDELINES	
1	**Call 911** for ambulance.
2	[redacted]
3	Call Superintendent's Office.
4	Contact parent.
5	Stabilize student and administer first aid until medical personnel arrive.
6	Have student's emergency health information available to accompany student to hospital.
7	Notify police as per policy.
8	Convene Crisis Team.
9	Obtain diagnosis and details of incident.
10	File report.

How does Narcan™ (naloxone) work?

If a person has taken opioids and is then given Narcan™ (naloxone), the opioids will be knocked out of the opiate receptors in the brain. Narcan™ (naloxone) can help even if opioids are taken with alcohol or other drugs. After a dose of Narcan™ (naloxone), the person should begin to breathe more normally and it will become easier to wake them. It is very important to give help to an overdosing person right away. Brain damage can occur within only a few minutes of an opioid overdose as the result of a lack of oxygen to the brain. Narcan™ (naloxone) gives concerned helpers a window of opportunity to save a life by providing extra time to call 911 and carry out rescue breathing and first aid until emergency medical help arrives.

FOOD POISONING or VOMITING Emergency Response



	If NOT Severe Problem
1	Administer first aid until parents arrive.
2	Hand out to parents suggested treatment for mild food poisoning.
3	File incident.

SEASONAL FLU Emergency Response

Seasonal Flu: School Coordination

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• **Monthly Planning Meeting:** Superintendent, Principals, Administrators, School Nurses – as need. • Updates to Board of Education as necessary. • Updates to school district's medical advisor as necessary. • Communications to Parents via East Hampton Public Schools website weekly/monthly. • Monitoring of flu through CDC, state, and Chatham Health District.	• **Weekly to Daily Meeting:** Superintendent, Principals, Administrators, School Nurses - Include School Psychologists, Guidance Counselors, Food Service Director, and Board of Education / town government representatives as available. • Daily updates to Board of Education. • Daily updates to school district's medical advisor. • Daily communications to Parents via East Hampton Public Schools website, Connect Ed, and letters. • Weekly/Daily instructions to/from CDC, state, and Chatham Health District. • Communications with local schools for attendance update.	• **Daily Meeting:** Superintendent, Principals, Administrators, School Nurses - Include School Psychologists, Guidance Counselors, Food Service Director, and Board of Education / town government representatives as possible. • If several of the above are not available, Superintendent identifies additional stakeholders who are available to make appropriate decisions. • Daily updates to Board of Education. • District medical advisor plays major role in determining protocol for district procedure. • State guidelines and protocol from Chatham Health district. • Daily communications to Parents via East Hampton Public Schools website, Blackboard Connect Ed, and letters (if possible). • Coordinate school and town efforts. • Coordinate school/town and state efforts. • Additional meetings/decisions as often as information and updates become available.

Seasonal Flu: Prevention and Education Efforts

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• Promote hand washing and cough hygiene via school-wide campaigns and modeling by school staff. • Encourage staff and students to practice "respiratory etiquette" when they have mild respiratory symptoms. • Encourage vaccination of staff and students for whom the flu vaccine is recommended. • Publicize guidelines for treatment of persons developing symptoms. • Publicize instructions / guidelines for staying home during illness and return of students and staff after illness. • Prevention information available at: www.ed.gov www.cdc.gov www.pandemicflu.gov www.ct.gov/ctfluwatch	• Possible school closure for a short amount of time – depending on student and staff absenteeism. • Encourage the use of social distancing as appropriate in classrooms at school and in the community. • Work with Chatham Health District and school district's medical advisors to assess whether any additional measures should be taken. • Ensure that all food service staff follow established school district infection control policies and procedures.	• Possible extended school closure – depending on students and staff absenteeism as well as instructions from the state. • Promote social distancing of children outside the school setting by reducing their social circulation and contacts. • Prepare to work with local health officials and emergency preparedness officials – who may want to use the schools as a way to disseminate information to families or use facilities for other shelter/medical purposes, as well as distribution site. • Re-entry screening plan for sick students and staff is organized.

Selective dismissal: used when some students in the school are at higher risk for complications once infected with flu. For example, a school with medically fragile children may decide to close based on the local situation while other schools in the community may remain open.

Reactive dismissal: used when many students and staff are sick and are not attending school, or many students and staff are arriving at school sick and are being sent home.

Preemptive dismissal: used early during a flu response in a community to decrease the spread of the flu before many students and staff get sick. This is based on information about the spread of severe flu in the region. This dismissal is most effective at decreasing flu spread and burden on the healthcare system when done early in relation to the amount of flu activity in the area.

Seasonal Flu: Surveillance System

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• Nurses and Principals monitor daily attendance rates. • Weekly attendance reports are forwarded to Superintendent of Schools. • Attendance reports are forwarded to Chatham Health District and school district's medical advisor through the Superintendent as requested by officials and/or if flu like illness increases. • The East Hampton Public Schools will be prepared to participate in any program established by the state to make available antiviral agents and vaccinations to the most severely affected persons and groups.	• The East Hampton Schools will keep track of daily absenteeism among students as a percentage of enrolled students and daily absenteeism among staff as a percentage of all staff. This information will be used to guide school closings and reopening as well as to monitor the changing impact of the influenza problem. • Daily absenteeism reports are forwarded to Chatham Health District and school district's medical advisor. • The East Hampton Public Schools will use a surveillance system to assist school nurses in monitoring reasons for student absenteeism. (For absent students it will be determined whether they are ill with symptoms, recovering from flu, or home to avoid flu.) • In order to minimize introduction of influenza into the school, the East Hampton Public Schools will be prepared to do universal symptom and (if possible) selected temperature screening of students and staff before they enter the building. Depending on the severity of the pandemic influenza strain, it may become necessary to actively find and exclude students and staff who may be infected with influenza and who are potentially highly contagious. • The East Hampton Public Schools will be prepared to participate in any program established by the state to make available antiviral agents and vaccinations to the most severely affected persons and groups.	• Officials of the State of Connecticut will play a role in decision making and provide guidance and/or directions. • The Governor may declare a civil emergency, or the Commissioner of Public Health may declare a public health emergency. In an emergency, the East Hampton Public Schools could be given an order to close for a period of time to reduce the rate of spread of influenza. • The East Hampton Public Schools will follow guidelines form the state government, which will be very closely monitoring the influenza situation and providing information to schools regarding the severity of the influenza strain, what can be expected, the course of the pandemic, and what additional steps can be taken to minimize chances of developing illness. • The East Hampton Public Schools will be prepared to participate in any program established by the state to make available antiviral agents and vaccinations to the most severely affected persons and groups. • The East Hampton Public Schools will set up a "command center" of individuals who are able to access the latest information from the national Centers for Disease Control and Prevention and the Connecticut Department of Public Health on the pandemic, vaccine, antivirals, and protective measures, and to be knowledgeable enough to convey it to staff, students, parents, and the community.

Seasonal Flu: Communication

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• The East Hampton Public Schools website, newsletters, and letters home will address prevention efforts, information from state and national authorities, as well as Chatham Health District as materials become available. • Information will be made available to parents and community members if school participates as vaccination site. • Encourage staff and students to practice "respiratory etiquette" when they have mild respiratory symptoms.	• Daily information on the East Hampton Public Schools website, Connect Ed, as well as newsletters and letters home will address prevention efforts, information from state and national authorities, as well as Chatham Health District. • Update information to send home to parents and present in class to students • Students who are absent from school are called to confirm flu-like symptoms or to confirm if staying home for prevention or family care. • Close communication is maintained with absent staff members to confirm flu-like symptoms or to confirm if staying home for prevention or family care. • Develop and implement protocols for managing students who develop influenza-like illness in school (e.g., put mask on student, isolate until parent pick up). • Consider any special concerns/procedures needed for the special needs population within the schools. • Educate student and staff to ensure prevention policies are followed. • Provide information and education to staff, students and families regarding pandemic flu, individual prevention measures, and various community/school plans and updates. • News media will be contacted for school closing / opening information.	• Daily information on school website, newsletters, and letters home will address containment efforts, information from state and national authorities, as well as Chatham Health District. • Update information to send home to parents and present in class to students. • Students who are absent from school are called to confirm flu-like symptoms or to confirm if staying home for prevention or family care. • Close communication is maintained with absent staff members to confirm flu-like symptoms or to confirm if staying home for prevention or family care. • Returning students notified about screening procedures upon re-entry. • News media will be contacted for school closing / opening information.

Seasonal Flu: Continuity of Instruction

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• The East Hampton Public Schools remain open but will monitor communications from the state and the Chatham Health District. • Substitutes cover ill staff members. • Student work sent home as appropriate. • The East Hampton Public Schools website utilized for communication of assignments, homework, and website lessons.	• The East Hampton Public Schools will consider recommendations by the State and the Chatham Health District when making school closure decisions. • Decisions will be made concerning the extent to which students and staff will be encouraged or required to stay home when they are mildly ill or have family members who are ill. • All extra-curricular, after school activities, and social gatherings (dances, clubs) and athletic contests may be cancelled to minimalize contact and spread of flu. • Create plans for continuation of students' education if schools are closed. Website utilized for assignments, homework, and website lessons. • Identify students who are most vulnerable to serious illness (immune compromised, chronic illness, etc.) and prepare school work in advance. For students who may have a greater risk of infections, encourage those families to talk to their health care provider. Some parents may need to be more cautious about keeping their children out of school. • Short term school closings may be necessary and require advance communication to teachers, parents, and students during exam periods, upcoming vacations, standardized testing, etc.	• The East Hampton Public Schools will consider recommendations by the State and the Chatham Health District when making school closure decisions. • Determine and communicate to staff the sick leave policies for absences unique to a pandemic. • Public gatherings, extra-curricular, after school activities, and social gatherings, as well as athletic contests cancelled. • Make specific plans for continuation of students' education if schools are closed for extended time using website and/or mailed lessons. The ability to provide lessons may depend on the health of teachers and staff. • The East Hampton Public Schools could be closed for either of two reasons: *First, there could be levels of absenteeism among staff and/or students that make it difficult to achieve the educational mission. The decision to close on this basis will be the decision of the Superintendent and the Board of Education in conjunction with guidance from school district's medical advisors and local health agencies. *Second, the schools could close specifically to slow the spread of influenza. Close contact among many persons in schools make them a center for respiratory disease transmission, including influenza. A decision to close for this reason will be made by the Governor or local health officials. • The town may need access to schools for distribution of food, supplies, or other reasons.

Seasonal Flu: School System Review

Level 1 - Seasonal Flu / Mild Outbreak *0% - 5% student illness*	Level 2 – Mild to Moderate Pandemic *10% - 20% student illness*	Level 3 – Severe Pandemic *30 - 40 % student illness*
• At end of flu season review practices and incidents with Superintendent, Principals, Administrators, Board of Education, teachers, staff, school nurses, etc. • East Hampton Public Schools Pandemic Flu procedures will be reviewed and revised on a yearly basis. • Coordinate school plan with any local or state plans and/or updates and determine who should be involved in future planning. • Review procedures for communicating with the parents, the community, and the public. • Develop inclusion and exclusion policies in conjunction with the school nurses and school district's medical advisor. • Continue to inform and educate families and staff regarding wellness policies, and encourage students and staff to remain at home when ill. • Encourage staff and students to practice "respiratory etiquette" when they have mild respiratory symptoms.	• Establish and implement steps school can take to minimize outbreak in schools: cleaning precautions, personal protection supplies, i.e. masks, (high-quality surgical and respirator N95), gloves, alcohol, hygienic soap, etc., personal contact/hygiene. • Review and roles and responsibilities of Superintendent, Principals, Administrators, Board of Education, teachers, staff, school nurses, etc. and plan for absenteeism in any and all of the above.	• Upon reopening, closely monitor students for flu-like symptoms. • Review screening and re-entry plans for students and staff members who have been absent. • The East Hampton Public Schools remains on high alert for family, security, and medical issues in the wake of any pandemic flu experience.

PANDEMIC FLU Emergency Response

Pandemic Response planning for East Hampton Public Schools

 LITTLE OR NO COMMUNITY TRANSMISSION	 MINIMAL or MODERATE COMMUNITY TRANSMISSION	 SUBSTANITAL COMMUNITY TRANSMISSION
Instruction is 100% in-person	Instruction is 100% in-person or 50/50% Hybrid	Instruction is 100% Distance Learning
Daily attendance rates monitored	Daily attendance rates monitored and shared with local health officials	Attendance for Distance Learning is monitored based on participation from home
Teaching and reinforcing of healthy hygiene	Concentrated reinforcement of healthy hygiene	Communication to home on healthy hygiene practices
Prevention measures in place	Heightened prevention meausres in place	Quarantine measures in place for essential personnel
Social distancing in place	Heightened social distancing in place with limitations in activities/events	Quarantine measures in place
Group gatherings/events limited; all require approval	Group gatherings/events postponed	All group gatherings/events canceled
Remain prepared for Distance Learning while learning is In-Person at school or hybrid learning takes place	Active Preparation for Distance Learning and/or short-term school dismissals resulting in possible Distance Learning for two-week periods	Continued engagement in Distance Learning during extended school dismissals for long periods
Cleaning and disinfecting in place	Intensified cleaning and sanitizing in place	Classroom and buildings sanitized and shut down
Regular communication with local health officials	Coordination of closure with local health officials	Order of closure from local health officials and/or Executive Order for closure from Governor's Office

A confirmed case in the school building:
Assess risk with local health officials.
Plan for short (2-5 days) or longer (10 days) closure to clean, disinfect, and contact trace in consultation with the Chatham Health District.

	Pandemic Response expectations for reopening East Hampton Public Schools
1	**The East Hampton Pandemic Response includes a tiered response for school attendance based on transmission in the community and/or in the school.**

Community transmission of COVID 19 will impact the schools' planning, operations, and instruction as indicated in the chart above. (Detailed schedules included earlier in this reopening packet).

2	**The East Hampton Pandemic Response includes for an immediate response for a confirmed diagnosis in the school.**

If a student, staff member, volunteer, or visitor has been present in school has a **confirmed diagnosis** of COVID-19, the School Nurse and the building Principal contact the Central Office and the Superintendent of Schools. In addition, the Superintendent will be notified by school personnel that a student is suspected of being sick, maintaining confidentiality in accordance with FERPA, privacy expectations, and the Americans with Disabilities Act (ADA).

The Superintendent of Schools notifies the local health officials (Chatham Health District) immediately.

The Chatham Health District will assess risk of further transmission in the school.

Decisions are made concerning:

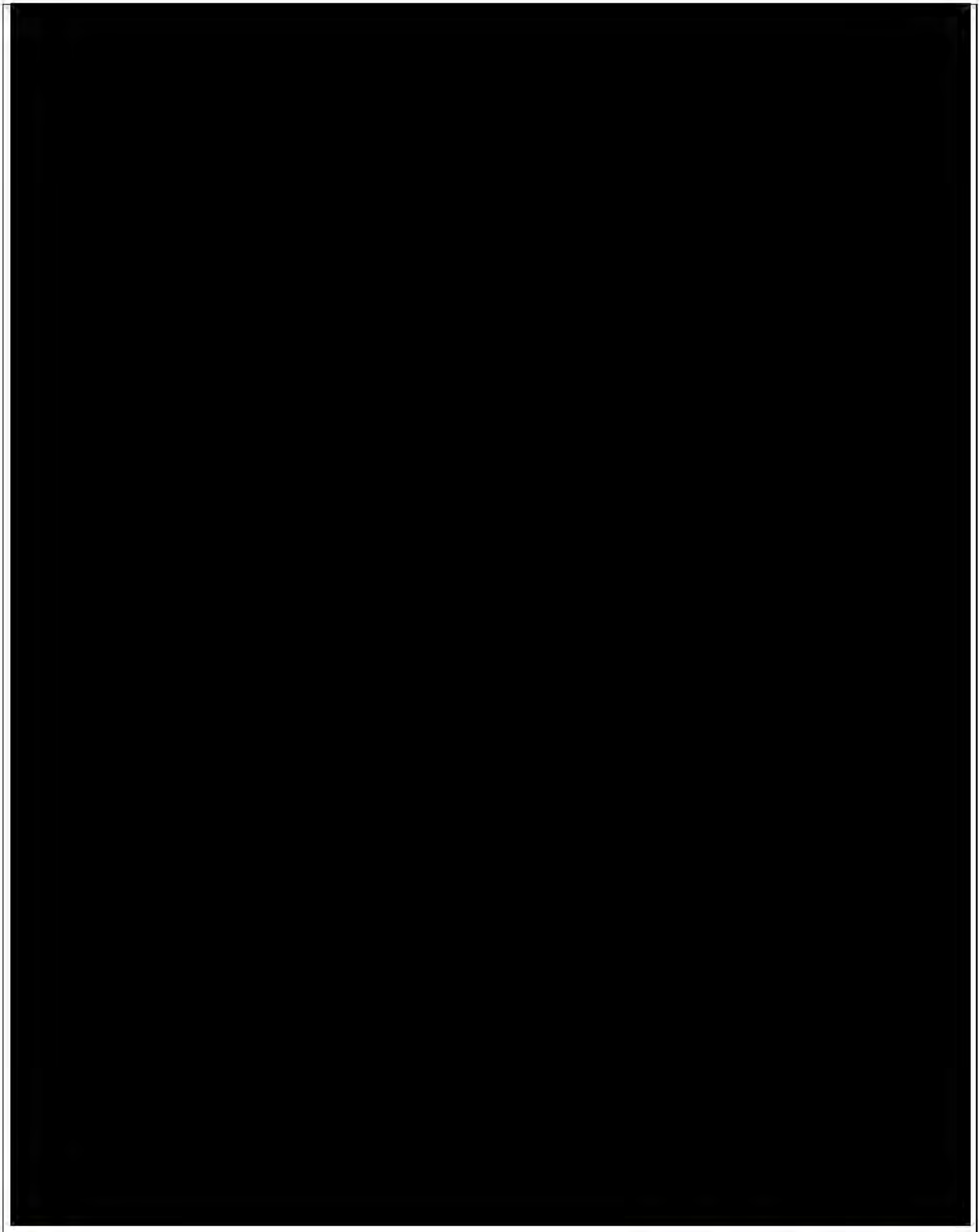
- CONTACT TRACING
- CLOSURE
- CLEANING
- CONTINUITY OF EDUCATION
- REOPENING OF SCHOOL

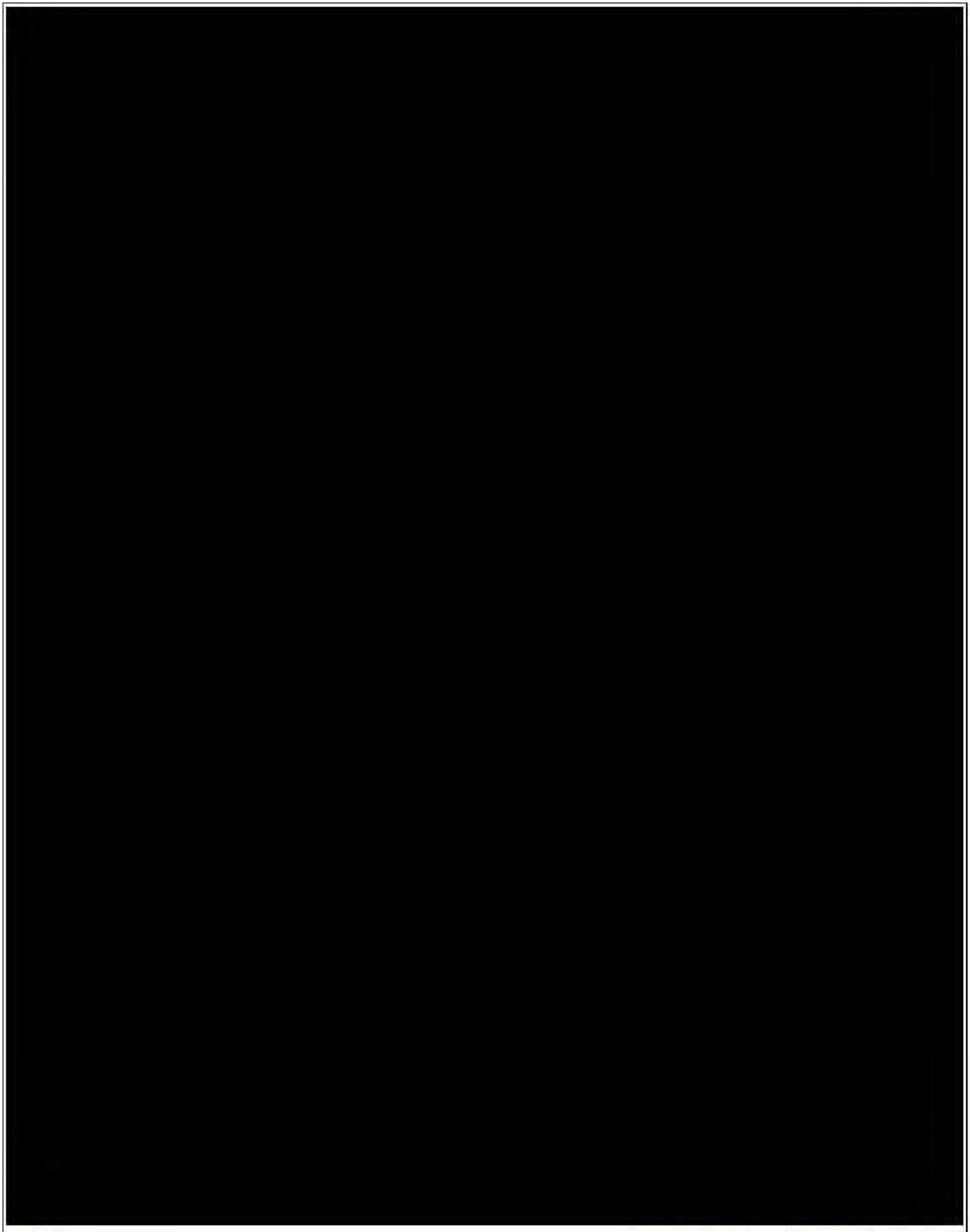
The decision to suspend or close a school (or the entire school district) will be made by the Superintendent or designee based on information and recommendation from local health officials (Chatham Health District). Board of Education members and town officials are notified of closure as well as the State Department of Education.

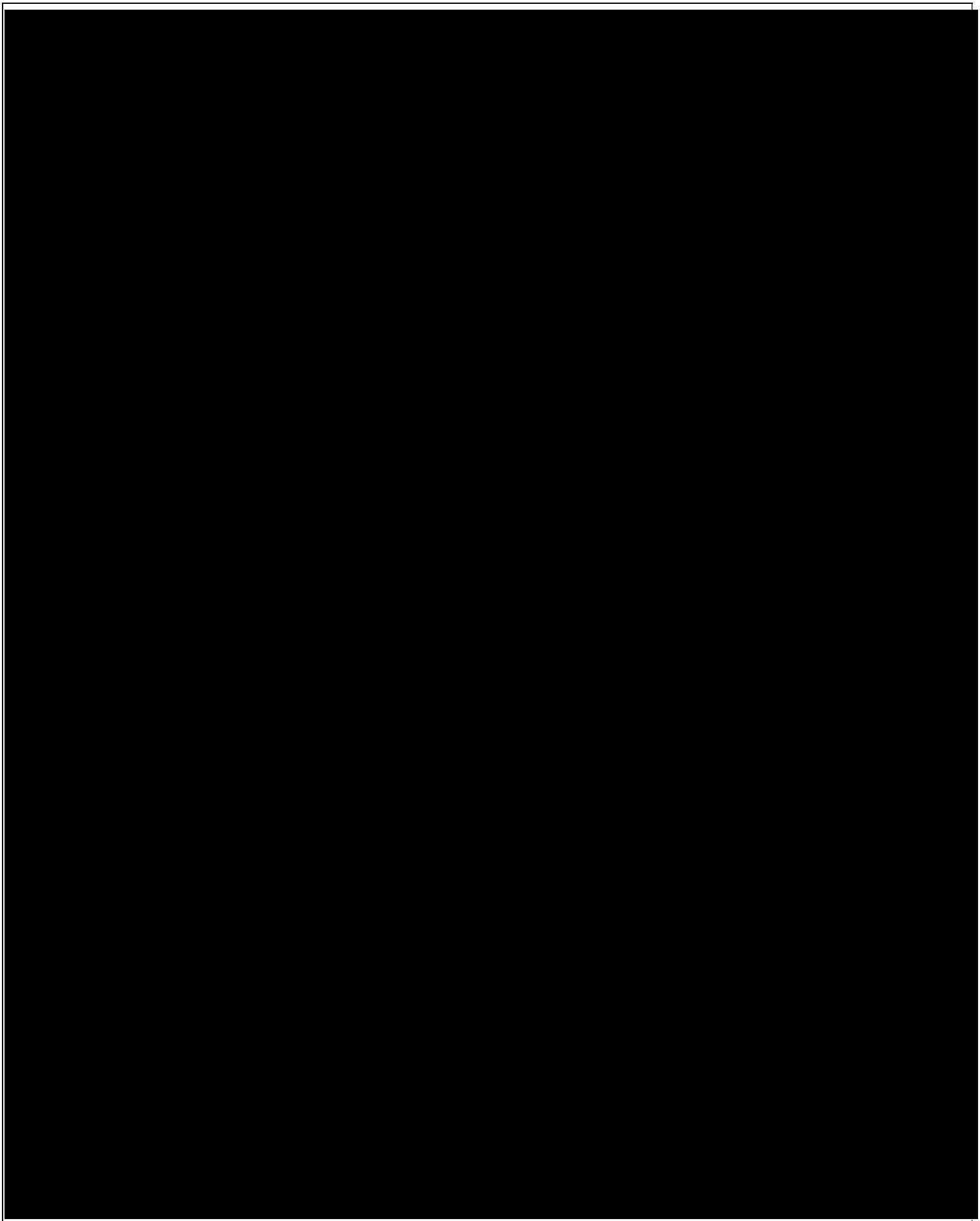
Schools will likely implement a short-term closure (2-5 days) or longer regardless of community spread if an infected person has been in a school building. The CDC recommends dismissal of students and most staff for 2-5 days. This initial short-term dismissal allows time for the local health officials to gain a better

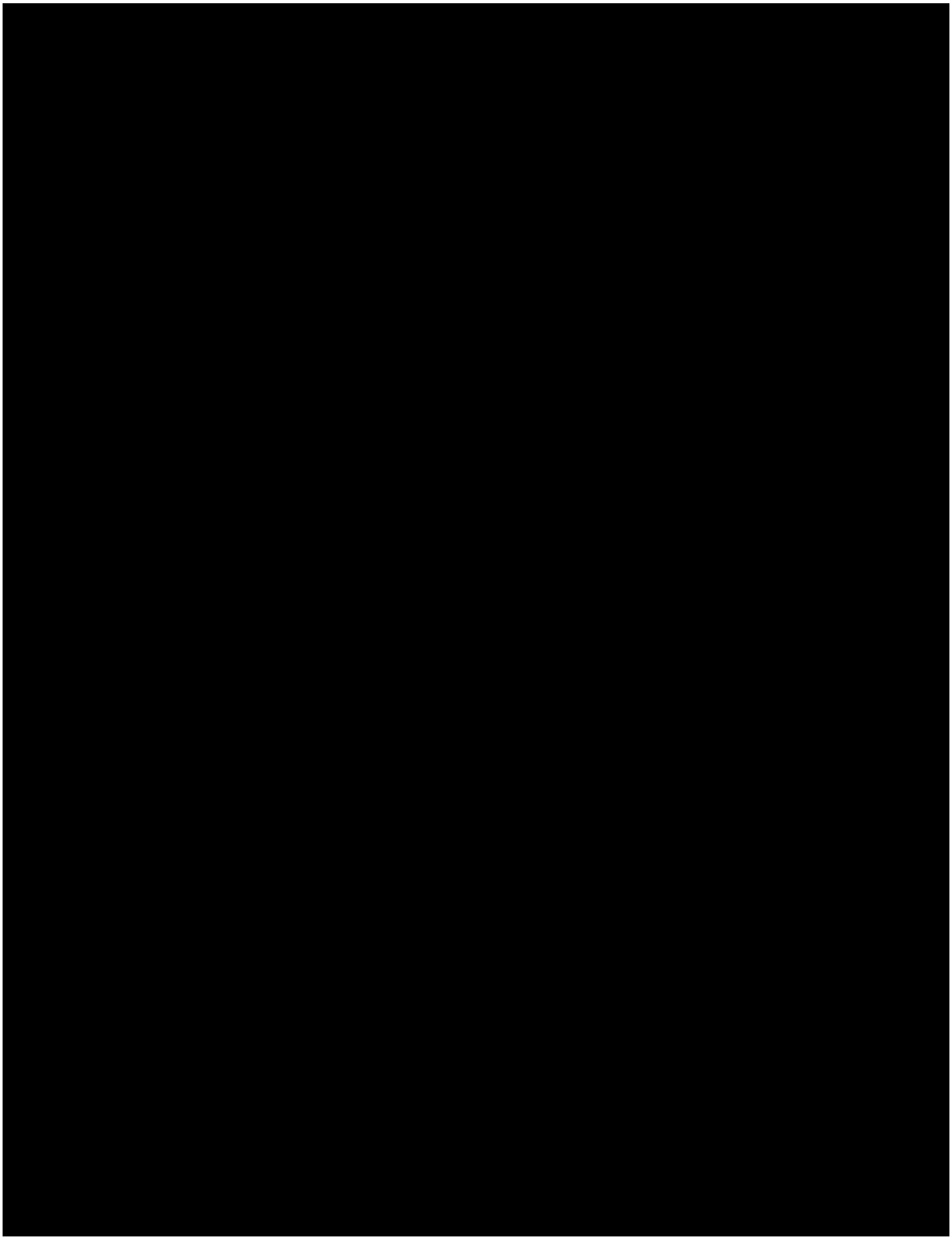
	understanding of the COVID-19 situation impacting the school. This allows the Superintendent, in consultation with the local health officials, to determine appropriate next steps, including whether an extended dismissal duration is needed to stop or slow further spread of COVID-19. All communications to the school community including staff and families are made through the Central Office. During school dismissals, all extracurricular activities, athletics, and school-based afterschool programs are canceled.
3	**As part of the East Hampton Pandemic Response, the Superintendent of Schools is authorized to make immediate decisions for the safety of the students and staff.**
	The Superintendent of Schools may exclude staff and/or students who have signs or symptoms of COVID-19 until a documented negative COIVD-19 test result of note from a healthcare provider clearing them to return to schools is provided. **The Superintendent of Schools may exclude staff and/or students who have recently had close contact with a person with COVID-19 for a duration that is appropriate given the situation.** **The Superintendent of Schools may suspend any activity or program at any time due to health and safety risks.** **The Superintendent of Schools may suspend in-person classes at any time due to health and safety risks.**
4	**There will be a coordinated effort among all schools to ensure that students and staff take everyday preventive actions to prevent the spread of respiratory illnesses.**
	The Superintendent and Principals will develop a strong communication program, **"Keeping our Schools Open"** encouraging all parties to stay home when sick or feeling sick; appropriately covering coughs and sneezes; practicing social distancing; cleaning and disinfecting frequently touched surfaces; and washing hands often with soap and water or using hand sanitizer. 
4	**Communication guidelines are established in each school according to the appropriate transmission tiers or an in-school case.**
	• Daily to weekly communication will be shared with staff and families concerning the status of school's reopening efforts and continuing safety efforts. • The East Hampton Public Schools website, newsletters, ParentSquare, Facebook pages, and letters home will address prevention efforts, updated information from local, state, and national authorities, and publications from the Chatham Health District as materials become available. • Information will be made available to parents and community members if one of the school buildings is designated or participates as vaccination site.

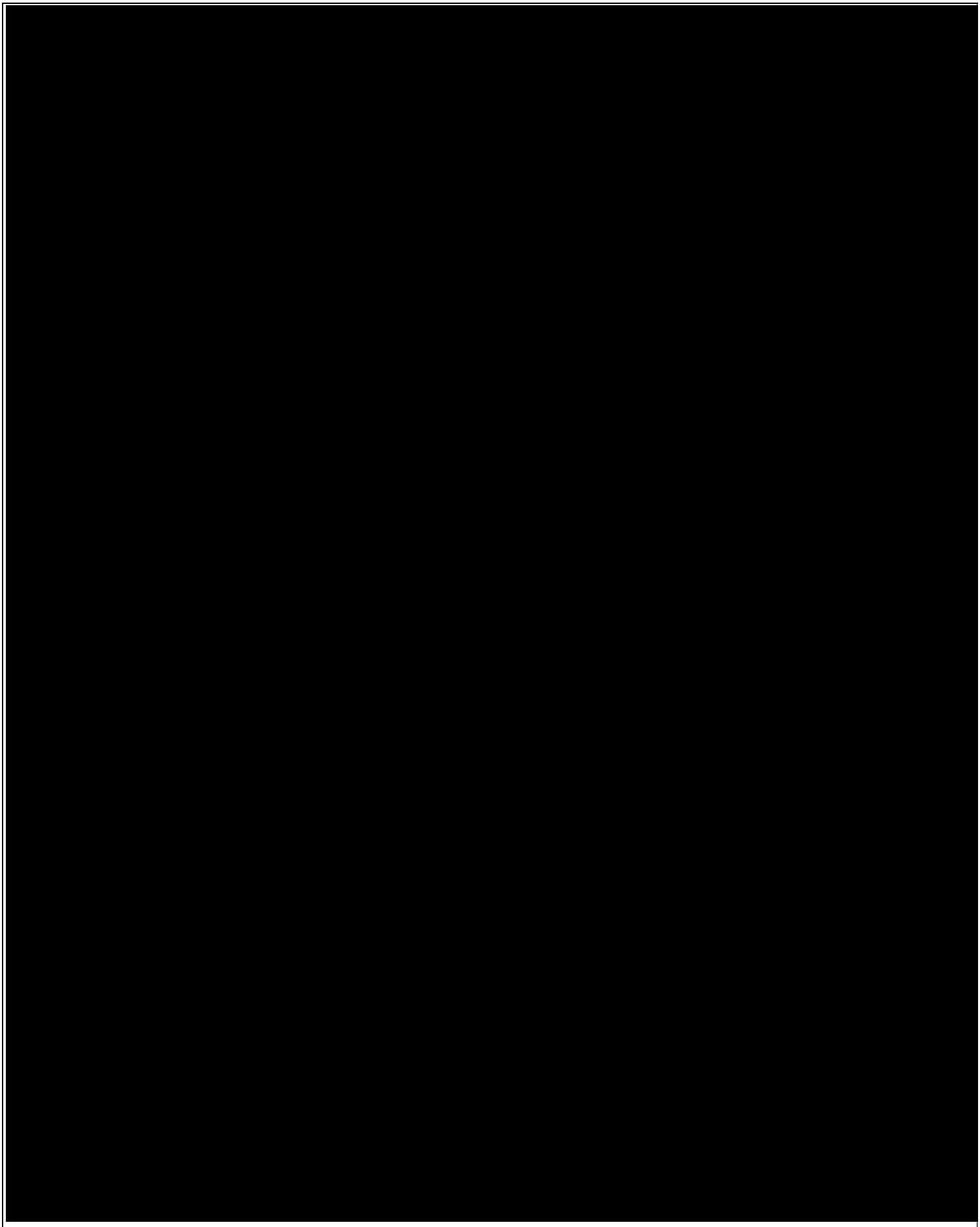
	• Daily to weekly communication will be shared with staff and families concerning the status of school. • The East Hampton Public Schools website, newsletters, ParentSquare, Facebook pages, and letters home will address prevention efforts, updated information from local, state, and national authorities, and publications from the Chatham Health District as materials become available. • As needed, update and share information on Distance Learning plan and procedures for school closure and moving to learning at home. • If necessary, update and share information on moving to hybrid scheduling (50% of students) and procedures for any adjusted schedule. • Students who are absent from school are called to confirm COVID 19 symptoms or to confirm if staying home for prevention or family care. • Close communication is maintained with absent staff members to confirm COVID 19 symptoms or to confirm if staying home for prevention or family care. • Provide information and education to staff, students and families regarding pandemic flu, individual prevention measures, and various community/school plans and updates.
	• The East Hampton Public Schools website, newsletters, ParentSquare, Facebook pages, and letters home will address prevention efforts, updated information from local, state, and national authorities, and publications from the Chatham Health District as materials become available. • As needed, update and share information on length of Distance Learning and procedures for school reopening. • If necessary, share information on possible return to school and outline procedures for moving to a hybrid scheduling (50% of students) and procedures for any adjusted schedule. • Students who are absent from online instruction are called to confirm COVID 19 symptoms or to confirm if staying home for prevention or family care. • Close communication is maintained with absent staff members to confirm COVID 19 symptoms or to confirm if staying home for prevention or family care. • Provide information and education to staff, students and families regarding pandemic flu, individual prevention measures, and various community/school plans and updates.
	• A confirmed case in the school building results in immediate communication with local health officials (Chatham Health District) resulting in a determination of length of closure. • Communication is immediate to all staff and families, as well as to local and state officials that a school or the school district is shutting down for a time period (to be determined). • The East Hampton Public Schools website, newsletters, ParentSquare Facebook pages, and letters home will address prevention efforts, updated information from local, state, and national authorities, and publications from the Chatham Health District as materials become available. • Procedures for closure and reopening are shared with the staff and parents.











East Hampton Public Schools Emergency Operations

EMERGENCY DRILL RECORD

School _____

Type of Drill	Date Held	Time		Remarks	Recorded by
		Start	End		

East Hampton Public Schools Emergency Operations

BUILDING OPERABILITY CHECKLIST

This checklist is to be used when assessing a building's ability to be operational following a major storm such as a hurricane, blizzard, etc. It should be completed with emergency officials present.

ITEM	OPERATIONAL	DAMAGED
Water availability	☐ Y ☐ N	☐ Y ☐ N
Gas availability	☐ Y ☐ N	☐ Y ☐ N
Electricity availability	☐ Y ☐ N	☐ Y ☐ N
Sanitation system functioning	☐ Y ☐ N	☐ Y ☐ N
HVAC functioning	☐ Y ☐ N	☐ Y ☐ N
Boilers functioning	☐ Y ☐ N	☐ Y ☐ N
Roof leaks	☐ Y ☐ N	☐ Y ☐ N
Fallen trees	☐ Y ☐ N	☐ Y ☐ N
Fallen electrical wires **DO NOT TOUCH!**	☐ Y ☐ N	☐ Y ☐ N
Windows, doors damaged	☐ Y ☐ N	☐ Y ☐ N
Water lines, plumbing damaged	☐ Y ☐ N	☐ Y ☐ N
Flooding	☐ Y ☐ N	☐ Y ☐ N
Access to building	☐ Y ☐ N	☐ Y ☐ N
Parking availability	☐ Y ☐ N	☐ Y ☐ N
Debris removed from walkways	☐ Y ☐ N	☐ Y ☐ N
Debris removed from roads leading to school	☐ Y ☐ N	☐ Y ☐ N
Debris / Snow removal from roof area	☐ Y ☐ N	☐ Y ☐ N
Broken Glass removed from all areas	☐ Y ☐ N	☐ Y ☐ N
Building Phones	☐ Y ☐ N	☐ Y ☐ N
Other:	☐ Y ☐ N	☐ Y ☐ N

Facility inspection completed by:_____

Date and time:_____

CLASSROOM	DAMAGE	SAFE FOR RE-ENTRY
Test of Fire Alarm System		☐ Y ☐ N
Egress Doors Functioning		☐ Y ☐ N
Main Office		☐ Y ☐ N
Guidance Suite		☐ Y ☐ N
Library		☐ Y ☐ N
Gym		☐ Y ☐ N
Cafeteria		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N
Classroom #		☐ Y ☐ N

☐ **Building or rooms safe for re-occupancy**

☐ **Building or rooms indicated above closed due to hazardous condition. The following corrective measures need to be completed prior to re-occupancy:**_____

_____

_____

Classroom inspection completed by:_____

Date and time:_____

East Hampton Public Schools Emergency Operations
(Sample) EMERGENCY DRILL REPORT FORM

Staff Member _____ Room _____ Building _____

Name of students <u>not</u> with class at time of drill	Location of these students at time of drill or indicate "Absent from school"	Comments

Name of students <u>with</u> your class but <u>from</u> another room	Name of Teacher/Room #	Comments

OTHER – Adults, guests, teachers, etc. with your class		

East Hampton Public Schools Emergency Operations

(Sample) EMERGENCY DISMISSAL EVACUATION FORM

Staff Member _____ **Room** _____ **Building** _____

Student	Departed by School Bus	Parent/Family Pick-Up	Drove self-home (GHS)	Left with non-family member *Departed with:*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
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34				
35				

East Hampton Public Schools Emergency Operations

(Sample) EMERGENCY STUDENT RELEASE LOG

Staff Member _____ **Room** _____ **Building** _____

Student	Release Time	Name of Person Released To	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
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32			
33			
34			
35			

East Hampton Public Schools Emergency Operations

(Sample) INJURY AND MISSING PERSONS REPORT

Staff Member	Room	Building

INJURED

Name	Type of Injury	Location
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

MISSING

Name	Last Seen Location
1	
2	
3	
4	
5	
6	
7	
8	
9	
10