OFFICIAL DOCUMENT FOR NECCESITY OF AIR AMBULANCE OR GROUND AMBULANCE EVACUATION OF EMPLOYEE

Date:	Incident Number:	Incident Name:	Unit:
Incident Type:	**Operational Period:**	**Incident Commander:**	**IC Type (1-5)**

Justification:

Name of Individual(s)

Level of medical care on-scene (Circle): **Paramedic AEMT EMT Other_____**

Transport Type (Circle): **Air Ambulance Ground Ambulance Combination**

Nature of illness or injury:

Assessment of Severity of Emergency which triggered Medical Evacuation (Circle):

Red (Life or Limb threatening) Yellow (Serious injury or illness) Green (Minor illness or injury)

Describe the situation(s) that made extraction via ground or air ambulance necessary.

(In the description, consider factors including: Medical condition of the patient, proximity of fire, availability of other evacuation methods, terrain conditions, ground Evacuation time, or other extenuating circumstances such as no resources available for carry out, proximity of nearest ground ambulance, multiple patients or mass casualty, patient was short-hauled to helispot, immediate need for higher level of care).

Incidents are fluid and complex. Decisions to initiate a medical evacuation via ground or air ambulance are based on the best available knowledge, experience and training of staff on-scene and at the incident command post. Based on the information obtained at the time and considering all the above factors, the decision was made that the above patient(s) would have the best chance of a positive outcome only if transported to the appropriate higher level of medical care in a timely manner. After considering all factors mentioned above, the government authorized the medical evacuation to provide timely and adequate patient care in the wildland fire environment. Employees are required to submit worker's compensation claims through their employing agency's prescribed process.

Signature of Medical Caregiver on scene (if available)		
Name:	Title:	Date:
Signature of Medical Unit Leader (if available)		
Name:	Title:	Date:
Signature of Incident Commander		
Name:	Title:	Date:

Copy to be given to Patient for filing with appropriate Worker's Compensation Program.