The CA-6 Chronicles

The latest news and information from the San Francisco Bay Area Disaster Medical Assistance Team, DMAT CA-6

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Vol. 6, No. 8 **August, 2006**

Caregivers to the Nation…Building a bridge between hope and despair

Founded in 1997

Mark Your Calendars

- **17 Aug** – Plans Section conf call, 1900 – 2100 hrs. Contact Kathy Burgardt at plans@dmatca6.org.
- **19 Aug** – Clinician's mtg, 0800 hrs breakfast followed by 0900 meeting. Contact Annie Bustin for more information.
- **20 Aug** – Work day, Menlo Park op center, 1000 – 1500 hrs. Logs and Admin will be working and/or training.
- **26 Aug** – Forklift operator training, Menlo Park op center, 1000 – 1500 hrs. Contact Bill Bush at logistics@dmatca6.org to sign up. Space limited.
- **12 Sep –** Stanford / UCSF Journal Club for ER residents meets at our Menlo Park operations center to review medical journal articles and learn a bit about DMAT. Limited team member participation is available. Contact David Lipin at command@dmatca6.org.
- **16 Sep** – Team meeting and training, Menlo Park operations center, 1000 – 1500 hrs. Clinician's meeting at 0830 hrs. Team orientation at 0900, for those possibly interested in joining a DMAT.

Commander's Corner

By David Lipin, Commander

As you can see from our calendar, we're into our Q3 and Q4 dry spell of nothing but the occasional training and meeting, to accommodate the active summer and fall response season.

Lots of interesting material in this month's newsletter, so let's get right to it!

Haiti 2007

Next year's missions to Haiti have been scheduled. Information and the application form are at the end of this newsletter.

To attend as a CA-6 member, you must be an active member in good standing and have permission from the commander.

ESAR-VHP

Just a reminder to sign up for ESAR-VHP through San Mateo County. We've got until the end of August. Details are in last month's newsletter, available on our website. Or just go to their website: www.smhealth.org/ems/esarvhp.

San Jose Grand Prix

Thanks to everyone who joined us at the San Jose Grand Prix. We "earned our keep" over the three-day event:

- 35 total patients (excluding the "Band-aids and Tylenol dispensary patients). Mostly heat/fluid challenges, a couple of wound closures, and a few odds n' ends.
- 2 transports: 1 heat, 1 burn.
- 13 ED/MD visits prevented (e.g., treat and release, to seek follow-up care if needed.)
- 7 ED/MD visits postponed (e.g., see your doctor or go to the ED tomorrow).

No critical patients, so not much "drama". However, without our presence there would have been 20 additional transports (or AMAs). That means we conservatively provided about \$30K in cost-savings to the system (ambulance transport cost plus ED visit cost), at a cost to us of about \$400 in supplies. That's not bad!

Golden Guardian

The statewide Golden Guardian '06 exercise will be conducted November 15th. The Bay Area will play a significant role in this year's exercise. We are looking for team members willing to serve as evaluators, advisors or in other roles at local hospitals and other locations throughout the Bay Area. If you are willing to participate in this capacity, please contact our team administration office at administration@dmatca6.org.

We will have much more specific information as the date approaches.

NDMS News

Information from NDMS HQ

NDMS Conference 2007

The 2007 NDMS Conference will be held at the Gaylord Opryland Hotel in Nashville, TN from March 19-21 (pre-conference on March 17-18). So save the dates!

EMR Technicians Wanted

NDMS is looking to certify 2 Electronic Medical Record field support technicians (FSTs) from each team at a soon-to-be-announced training.

We're looking for two individuals with sufficient interest, drive and experience in computer hardware,

software, and communications to take on this role for the team.

As an FST, you might deploy with our team, another team, or to a local MST to assist in the field.

If you are interested, contact me by 24 Aug at command@dmatca6.org.

Administrivia

By Bonnie Atencio, Administration Section Chief

National Finance Center

Again, I'd like to encourage you all to sign into the National Finance Center website. www.nfc.usda.gov. This is how you get paid. If we are deployed, and the chances are good that we will be deployed some time during this hurricane season, you won't get paid if this information is not correct.

This site can give you copies of your check stubs and your W-2 at the end of the year. It's a valuable site, and it's yours. You are the only one who can change information on your site. Please take the time to do it today.

It takes two weeks for you to get your password in order to enter the site, so now is the time to review your site. In the future the expectation is that all employees will have this access. Do it now, and avoid the rush.

Address changes

If you do have changes in your address, phone number, banking, etc., you MUST advise me of the changes. Contact me at administration@dmatca6.org. I will then submit them to our Team Specialist in order to complete the payroll loop.

Admin Help!

The Admin section is still looking for someone who will be responsible for arranging for mentoring of new members (I can help) and to work with our various contracts. If you feel you can help in these areas, please let me know ASAP.

We're also looking for someone to come down to the warehouse for a few hours on a weekday to help separate medical information (immunizations, respiratory surveys, deployment screening forms) from the personnel files into separate medical files. This would be paid work. If you're interested, contact command@dmatca6.org.

The Admin Section will be meeting at the ops center during the upcoming workday on Sunday, August 20. If you need a Unit to join (and each member is responsible for being on at least one Unit, remember?) you are invited to join us. We'll be going over the things we do during our "down" time, and will review the responsibilities of the Admin Officer (AO) during deployments.

License & Immunization Updates

Don't forget to get all of your license and certification renewals in to us as soon as possible after you receive them. You are not available for Federal deployment if these are not up to date. We also need immunization records as those are updated. New yellow cards are always available at the ops center, or you can let me know if you need one.

Operations Update

By Terry Holbrook, Operations Section Chief

Another month gone… I'm not sure where it went, but I think it was a pretty good one… at least really busy for all of us.

Ops section is, as usual, busy, but feeling somehow tardy in all we are doing. We are thrilled to have several new folks "volunteering" for jobs, and every single person makes a huge difference, so "Thank You" from all of us.

There are several groups in our section who are doing just fine….Respiratory, under our very own Leanne Andrews, is trying hard to get 100% compliance from our members in the (on-line) respiratory questionnaire (up to 62% as of newsletter publication time). Those received have been forwarded to our Medical Director, Brian Blaisch, for review and follow-up as needed. Fit-testing will be done at the September meeting, so it is really important that you try to make it so one more requirement can be checked off.

Immunizations are going well, beautifully handled by Bobbie Johnson, and have been offered at every single significant team get-together since the program was started. This is another mandated program, and there is not much point in not getting compliant immediately. So please remember to bring your yellow immunization form with you to the next meeting. You can get so many things taken care of at once!!

The Ops Policies and Procedures are coming along nicely, but very, very slowly. It is a big job, but not insurmountable, if enough hands are there to knock them out. We are going to solicit information from other teams in the near future to see what all they have done, and how it was handled by them, in hopes of finding some shortcuts in this cumbersome task.

The Clinician's Group has several tasks being discussed at the Clinician's Meetings, the next one of which is on the 19th of this month at the home of Annie Bush. We will be welcome to come and eat (yes, it's a pot luck again)

between 8-9 am, and will start work promptly at 9 am. There are many things to discuss, among them quality assurance review, p and p's, nursing field guidelines, and training issues. Please feel free to join us. This is truly a "the more the better" kind of get together, and your input would be so appreciated.

The pharmacy caches issues are being handled most aptly by Iris Tam, and she is in the process of meeting with the Kaiser folks about updating the cache, how to do outdates, quarterly reviews, and many, many more things. She is also looking into and buffing up our local response caches, so they are ready and suitable for our Wildland responses.

LeNai Dohr and her team are still working on our fitness standards, and our essential functions for each job description, and our ongoing team development for pre-deployment screenings. And, and, and.

And so it goes. Same report, different month, and a lot of person-hours in between. You are all so very welcome to join us in doing what is truly important work for the team. It sometimes seems never-ending, but it is also very nice to see the difference your hours make in the overall efficiency of our crew, and the preparedness we all need.

Speaking Engagements?

By Mary Clare Bennett, Public Information Officer

[Editor's note: The following article is a reprint of a 2004 article, as a reminder to those of us who present material about DMAT or NDMS in a public forum.]

"Remember not only to say the right thing in the right place, but far more difficult still, to leave unsaid the wrong thing at the tempting moment." – Benjamin Franklin

FEMA guidelines require pre-approval before DMAT CA-6 members may speak on behalf of the team or NDMS. This means that each and every opportunity that presents itself is now subject to review and pre-approval by the team commander.

Going forward, all team members need to be aware that there are many FEMA ethics rules and federal governances that apply when speaking to outside groups or the media. The goal of maintaining consistent messaging in support of FEMA's mission is driving this approach, and cuts across the entire FEMA organization. In addition to the multitude of federal regulations, there is a "truckload" of federal forms and guidelines that go hand in hand with every communication opportunity. The team maintains copies of these.

Please always contact our team commander via e-mail at commander@dmatca6.org, **before** you consider either speaking as a member of the team, or speaking for NDMS. This requirement also applies to accepting any non-federal source payment for travel, lodging or meals. The team commander is required to preview and approve **all** communications and presentations, and must provide courtesy copies to Public Affairs at FEMA.

Plans Briefing

By Kathy Burgardt, Plans Section Chief

Plans Section needs you! Aileen Hayes is doing a terrific job updating the manual notification procedures, but she needs personnel to assist should we actually have to implement it. If you are willing to make a few phone calls, please email Aileen at macahayes@yahoo.com. The manual notification will only be used in the event that we are activated and the automated system does not work.

Annie Bustin is working on the overall Policies and Procedure manual, so please be sure to respond to her request for information.

Cheryl Tomlinson and Dan Guerra have done great work on the Mobilization Plan. Please join us at the September meeting for an entire training module on the new and improved Mob Plan.

As we enter the peak of hurricane season and begin to think about deployment, please think about actively working with the Home Team when you're not deployed. The responsibilities include staying in contact with family of deployed members, but assisting with the return home. The exact responsibilities differ with every event and with each member, but Home Team is a great way to be involved when you can't actually be activated. To volunteer, please email Dan Guerra at hometeam@dmatca6.org.

ANOTHER KIND OF DEPLOYMENT

By Terry Holbrook, FNP

USNS MERCY

You just can't imagine how excited I was when in April of this year I was notified of a deployment to

Indonesia, specifically to the island of Nias and then Banda Aceh. The purpose of this trip was to provide medical care to the people we served after the tsunami in Aceh province and the huge earthquake which flattened the island of Nias. We were chosen by virtue of having served there previously, and the deployment was for two weeks, though we could have joined earlier and stayed later if we had so desired.

We were a group of ten, mainly from the San Diego area, but also No. California and Oregon. Most of us didn't know the others in the group, but it was truly a stellar compilation of folks….we all got along just fabulously. We met in Taiwan on our way, already 14 hours into what became a 28 hour trip, not counting the unexpected overnight. We were two MDs, one PA, 3 NPs, two OR nurses, and two other nurses.

The Mercy is an old tanker, manned by Seabees and a wide variety of US armed force personnel….Navy, Air Force, Army. She is painted white, and has huge red crosses on every flat surface, it seems. She is truly pretty inspiring when seen from afar, and even more so when it is your home away from home. Must admit to chills up my back every time we boated out to her at the end of a day.

There are 15 surgical suites, 3 of which are used. This is due to the shortage of anesthesiologists, though all types of medical professionals were in short supply. Not enough nurses to care for more than the 60 patients aboard at one time, with rare exception. Not enough space or time to helicopter or boat more groups, and on and on. But the care and services provided to those who did join us was exceptional. The staff of civilian volunteers and military folks were so eager to make the patients at home in this unusual environment, and get them well enough to return home the next day full of satisfaction and a sense of the caring from across the world.

Each patient is screened ashore, sometimes by our teams, and sometimes by local medical personnel. They each come with an escort, usually preferred to be someone of the same sex for billeting reasons. They begin to arrive on the ship about 10am, and are taken to Casualty Receiving for all of their admit work, blood work, special x-rays. In addition to this, all patients and escorts are given a face mask before boarding and are taken immediately to have a chest film. They must wear their face masks until the radiologist clears them as being free of TB. Their stay in CasRec is between 2-4 hours. They are then escorted to their ward, and their stay is like any other in a day surgery kind of setting.

Not all of the patients are in and out. We had a lot of cataracts and cleft lips and palates, but also a ton of thyroid masses, many post-tsunami injury repairs (i.e., old fractures with plates/screws not in place anymore, or badly set fractures (or more likely those not set at all). We had several fulminant cancers, one at the site of a leg fracture during the tsunami which was now a huge osteosarcoma, the size of a melon, which had spread to both lungs. We removed his leg, not for cure, but because it was so infected and painful, it would make his last months more comfortable. By the way, did you know that Muslims want to take any removed body parts to bury in a small grave, which is where they will choose to be buried when the time comes?

The outreach teams were so large that we traveled in two busses to the sites. The best sites were usually the IDP camps, for Internally Displaced Persons. They are crowded sites, with people waiting for housing of a more permanent nature, and all wanted medical care. The complaints were what we see in our homeless population, more or less. Few had access to regular care, and chronic conditions were expensive to treat over the counter. Additionally, we saw many, many people with post traumatic stress disorders, and many of those exhibited themselves as vague medical complaints – headaches, insomnia, nausea, etc.

The chance to serve aboard the ship was such a gift….I can't tell you how great it was to see the places you had last seen in such a traumatic time, and know that with time many unfixable things do, indeed, improve. And the shipboard experience was fabulous. The staff was always so much more than helpful, and friendly. They made you feel right at home immediately, and tried never to roll their eyes the third time you asked where something was aboard the ship. I wish you all could have been there with me.

What Would MacGyver Do?

Recipe: "Alternative" EKG Pads

Submitted by Ron Lopez, RN

Purpose

An alternative means of establishing an electrical connection with an EKG monitor when the customary sticky-pad EKG electrodes have run out - like what happens in disasters.

Ingredients

- 3 or 4 alcohol prep pads per patient, depending on what type of EKG monitor used. One pad is used for each connection needed, typically 3 per patient, but [our DMAT] monitors will require a minimum of 4.
- 1 roll, plastic medical tape, ½" to 1" wide; most any kind will do, but I like Dermicell for its controlled tearing characteristics.

Steps

Step 1: Open the alcohol packet, preserving as much moisture as possible.

Step 2: Place the pad on the patient's skin where the EKG contact point is needed. (Works for 12-leads too!)

Step 3: Place the metal contact of the EKG wire so that it is in direct contact with the alcohol prep pad sitting on the patient's skin.

Step 4: Using a piece of tape 3 to 4 inches long, tape down the EKG wire over the pad so that it compresses the pad between the metal contact and the skin.

Step 5: Add a piece of tape to the end of the wire in a longitudinal fashion, proximal to the patient, to tape the wire to the patient's skin. This secures the wire better than using only the tape mentioned in the previous step.

Caveats

A) In situations involving limited electrical sources for recharging monitor batteries, use the monitors only for direct observation during the short time necessary to check a cardiac rhythm, then shut down the monitor to conserve the batteries.

B) Don't use this method to deliver therapeutic electricity!

C) Large amounts of artifact usually indicate dry alcohol pads. Ultrasound or EKG gel can be used as a wetting medium to increase conductivity to the EKG wire.

D) EKG gel will not dry out as fast as alcohol and is therefore good for long patient transports involving this method of EKG monitoring.

Blisters in the Backcountry

By Fred Mayers, MD; August 9, 2006; reprinted from the Big Medicine Website (www.bigmedicine.ca/wildernessmed.htm#Blisters_in_the_Backcountry); submitted by Brandon Bond, as a particularly relevant subject to DMATs

I call it the blister boogie. It's that awkward, shuffling, "if only I could walk without flexing my ankles" kind of walk that you can see in countless hikers at the end of the day. Sit at a trailhead some afternoon with your video camera and you'd catch some clips that would clearly be worthy of Monty Python's "The Ministry of Silly Walks."

The ironic thing is that most hikers knew they were getting blisters with miles to go! It starts with a tickle, an itch, or perhaps a little hotspot. Stopping to fix it is inevitably too much of an inconvenience: "Well, it's not too bad, I don't want to stop right now – I'll take care of it at the next break." Well, then next becomes the next, becomes the next, and before you know it, 15 miles later, and the tiny little itch has become a broken and bleeding sore that makes each step an agonizing ordeal.

Pathophysiology

Blisters are caused by the repeated action of a frictional force on a particular area of skin. The mechanism of blister formation involves the separation of layers of epidermal cells in the stratum spinosum of the skin. The initial symptoms may be as simple as the sensation of heat. As the layers of spinosum separate, the uppermost cells remain relatively intact, forming a blister roof covered by the stratum corneum and stratum granulosum. A cleft develops under the blister roof, which quickly fills with a low-protein, electrolyte rich fluid as a result of hydrostatic pressure. The underlying basal layer and associated epidermal-dermal interface are usually unaffected. Fortunately, healing and recovery occurs quickly, in as little as 48 hours.

Control of frictional forces which act on the foot

Like so many other medical problems encountered in the wilderness, preventive medicine is key. By attempting to control two of the factors of force and friction, it is possible to reduce the chances of developing blisters. Frictional forces are the product of a "normal" force and the coefficient of friction. In the context of the biomechanics of walking, normal force can be generalized to mean the force between the insole and the foot. It is determined by the weight

of the hiker, and the weight of what is being carried. The coefficient of friction depends on the characteristics of two surfaces that are in contact, such as skin and sock.

Reducing the magnitude of normal forces on the feet starts with the simple matter of reducing the carried load. This can be as easy as taking a few pounds out of one's pack, or a bit more complicated by taking off a few pounds of adipose tissue. The second method to minimize the normal force is through the use of padded insoles or arch supports. Technically, this does not actually reduce the normal force itself, but it does help to evenly distribute the pressure over the plantar surface of the foot. This reduces areas of high load on particular points on the foot, which may be susceptible to blister formation.

Reducing frictional forces is accomplished by increasing or decreasing the ease by which two surfaces can rub against one and other. If the coefficient of friction is small, the resulting frictional forces will be minimized, reducing the chance of blister formation. The other way to attack the problem is to maximize the frictional forces, so there is little-to-no movement of the surface in contact with the skin, so that little frictional force is generated.

Other risk factors for blister formation

The nature of the skin at the point of friction also plays a role in blister formation. Relatively thin skin is unlikely to blister, but instead develops abrasions as a result of frictional forces. Skin with thicker stratum corenum and stratum spinosum layers may be more resistant to blistering because their increased resilience and cohesiveness. Moisture is also a consideration. Dry skin tends to have a lower incidence of blisters, due to a decreased coefficient of friction. Moist skin results in the highest incidence. Wet skin, however, once again results in a lower incidence of blisters, probably due to the lubricating effects on the surface of the skin.

Techniques for prevention of blisters

The fundamental concept in prevention is to stop frictional forces from acting against the surface of the skin of the foot. This begins with ensuring that a proper fit is obtained with any set of footwear. Shoes or boots that are too tight can increase the contact points of friction on the foot. Those that are too loose can allow for excess movement which can allow for generation of frictional forces.

Along similar lines, an ample "break-in" time should be afforded to a new set of footwear, which will increase its flexibility, thereby reducing the possible points of friction against the foot. A "break-in" period also conditions the skin of the foot itself, which can make blisters less likely to form due to the change in nature of the underlying skin.

Specific methods for blister prevention can target frictional forces against the foot. The first method is to place a barrier between the footwear being worn and a potential point of blister formation. The barrier needs to have an adhesive of some sort that allows it to remain fixed to the skin, so that any friction occurs between the barrier and the footwear. Adhesive bandages, Moleskin, Spenco Second Skin, and various adhesive tapes including the ubiquitous Duct Tape are all examples of adhesive barriers that can be used to mask friction-prone areas of the foot and prevent blisters.

The use of barriers assumes that they remain in place despite the action of frictional forces acting against them, as well as conditions such as heat and moisture that can increase inside footwear during activity. Use of a skin adhesive such as tincture of benzoin or Mastisol can help keep the barrier affixed in place. Finally, these barriers are best utilized as preventive measures, as adhesives applied to an existing blister can result in a de-roofing injury when the barrier is removed.

Use of various sock and insole combinations is another method for decreasing the incidence of blisters. This method attempts to exploit the varying coefficients of friction of sock, insole and footwear in order to minimize frictional forces against the skin of the foot itself. Studies indicate that a smooth, thin, snug fitting synthetic sock worn against the skin will tend to move with the foot, while a thick, woven sock will tend to move with the footwear. As a result, friction occurs between the two layers of socks, and greatly reduces the generation of frictional forces against the skin. Multi-sock systems can also address the issue of moisture control, where perspiration can be wicked away from the surface of the skin by synthetic fibered socks.

Various lubricants and antiperspirants have been studied as agents that can help prevent blisters. The use of these products has demonstrated variable degrees of success. For short durations of exercise, petroleum jelly and drying powders may be of benefit, but studies show that for longer periods of time, the incidence of blisters actually increased, as use of these products tends to increase the coefficient of friction between surfaces after about 1 hour.

Antiperspirants containing aluminum chloride hexahydrate show some efficacy. In a study of US Military Academy cadets, those who used this type of antiperspirant for 5 days had a reduced incidence of blisters after a 21-kilometer (13-mile) hike. It is possible that this product produces a mild irritation which blocks sweat ducts, thus reducing the amount of perspiration that can form on the skin surface.

Treatment

Treating a blister as soon as possible allows for improved outcomes and reduced chances for complication. In the early stages of formation, when the patient is feeling the sensation of heat, there is still an opportunity to prevent progression of the blister. Placing padding around and over the so-called "hot-spot" can stop the abrasive process that will ultimately lead to the development of a blister.

Once a blister has formed, the best dressing that can be applied is the blister roof itself. While minor blisters may be left intact, those with considerable fluid accumulation may be drained to help reduce pressure and pain. Afterwards, the area should be covered with a protective dressing, including surgical bandages, pads, or hydrocolloid dressings. Generally speaking, antibiotics are not indicated for minor blisters, unless signs or symptoms exist of a developing cellulitis or systemic infection.

To sum it up…

Friction blisters are the bane of many a backcountry traveler. Frictional forces, caused by excess weight or from the coefficient of friction between two surfaces are the mechanisms that lead to blister formation. Reducing these mechanisms through conditioning, barriers, sock-footwear systems, and aluminum drying agents are all strategies that can be employed to prevent blisters. In the event of formation, sizeable blisters should be drained and protected in order to alleviate pain and discomfort, while reducing the risk of infection. Proper care of friction blisters deserves careful attention, since no other minor ailment has such a great potential to negatively impact the enjoyment of adventure sports in the outdoors.

Suggested Reading

1. Knapik JJ, Reynolds KL, Duplantis KL, Jones BH. Friction Blisters: Pathophysiology, Prevention and Treatment. Sports Med. 1995, 20(3):136-147.

2. Brennan FH. Managing Blisters in Competitive Athletes. Current Sports Med Reports. 2002; 1:319-322.

3. Knapik JJ, Hamlet MP, Thompson KJ, Jones BH. Influence of boot-sock systems on frequency and severity of foot blisters. Mil Med. 1996; 161(10):594-8.

Safety First

Stick Around!

By Walt Sanders, Safety Officer

I don't know why I think this might be an appropriate topic for our Newsletter, except perhaps, because we are all included in the table; and, because Safety is really prevention and knowing what you are up against gives you an advantage in prevention.

We have such good people on this team, I don't want anyone to be lost do to a preventable demise! So do take note, if you are a probable potential victim in any of these categories, please do undertake measures to keep yourself on the team as long as possible. We want you with us.

Total Odds of Dying, any cause: 1 in 1

Heart disease: 1 in 5

Cancer: 1 in 7

Stroke: 1 in 24

Motor vehicle accident: 1 in 84

Suicide: 1 in 119

Falling: 1 in 218

Firearm assault: 1 in 314

Pedestrian accident: 1 in 626

Drowning: 1 in 1,008

Motorcycle accident: 1 in 1,020

Fire or smoke: 1 in 1,113

Bicycling accident: 1 in 4,919

Air/space accident: 1 in 5,051

Accidental firearm discharge: 1 in 5,134

Accidental electrocution: 1 in 9,968

Alcohol poisoning: 1 in 10,048

Hot weather: 1 in 13,729

Hornet, wasp, or bee sting: 1 in 56,789

Legal execution: 1 in 62,468

Lightning: 1 in 79,746

Earthquake: 1 in 117,127

Flood: 1 in 144,156

Fireworks discharge: 1 in 340,733

(Source: Natl. Safety Council, 2003 data.)

Stay safe and stick around, Walt.

July 5, 2006

Dear SKCDT, ODMT and SFBAY DMAT Members,

The Seattle King County Disaster Team, in collaboration with the Oregon Disaster Medical Team and the San Francisco Bay Area Disaster Medical Assistance Team will continue its annual, training and humanitarian mission to rural Haiti in February 2007 and June 2007. This mission is done in concert with the Twinning Program of the Roman Catholic Church sponsored through a parish in Maryland. Team members have participated in this mission over the past eight years.

The mission is to provide primary care services to several mountain communities in the Grand Anse Province of western Haiti. The mission will staff four teams, two in February 2007 and two in June 2007. Each team will have twelve members and will provide one week of primary care. The dates for the mission are listed below. All teams will travel into Haiti on a Saturday, and return to the US on the following Sunday. Some individuals may prefer to stay for both weeks of the mission in either February or June. This is acceptable. There will be a $30 increase in the down-payment if you stay for two weeks to cover the additional week of evacuation insurance.

Team One:	**February 3-11, 2007**
Team Two:	**February 10-18, 2007**
Team Three:	**June 2-10, 2007**
Team Four:	**June 9-17, 2007**

Each team will provide five days (Monday through Friday) of clinical services at an austere rural dispensary in the community of Leon, Haiti. The two days after the clinical days are for travel and for some sightseeing/shopping. Each year we also provide a community outreach component that requires some members to outreach into surrounding communities to identify and refer ill patients to the clinic and/or hospital.

Each team will have twelve members; three physicians, two PAs or NPs, four RNs, paramedics or EMTs, two pharmacists, and one medical laboratory technologist. All team members are required to be flexible in their roles and may be asked to help out in a variety of ways in the patient treatment process. This includes helping in the pharmacy, lab, eyeglass program and the patient referral process.

Interested team members must commit to the full nine days of the mission, and must be individually responsible for their expenses during the mission. The personal cost of the mission is about $950.00 for the entire nine days. This includes all travel, food, and lodging.

A sample agenda for the nine days of the mission is outlined below. All team members are expected to participate in a full nine-day mission, and will travel as a team to and from Haiti.

Saturday	Travel to Miami through Port-Au-Prince (PAP) to Leon (We will be traveling on a morning flight into PAP in order to take an afternoon flight into Leon)
Sunday	Clinic setup, relaxation and acclimation
Monday to Friday	Clinical days in Haiti
Saturday	Sightseeing and shopping in Jeremie
Sunday	Travel to Port-Au-Prince and then to Miami

There are many SKCDT, ODMT and SFBAY DMAT members that have participated in this mission in the past eight years. These individuals could provide you with a realistic and candid description of the mission. We can also provide you with some additional written information about the country/mission if needed. Questions about personal health and safety, needed skill sets, language, culture, and packing supplies are common. All of this information will be provided in extensive detail if you decide to participate in the mission.

Haiti is the poorest country in the Western Hemisphere. Medical conditions there are austere. Team members must have the physical and mental endurance to function in this environment. Although medical evacuation insurance will be provided, medical care in Haiti is very limited and cannot be guaranteed. For the most part, your team will be your primary medical care if needed.

A passport and current immunizations are required. There will be a weight restriction on your personal baggage due to the use small aircraft for in-country transport. These details will be explained further if you decide to participate.

Team members will be selected on a first come first serve basis keeping in mind the required, fixed composition of the teams. SKCDT, ODMT and SFBAY DMAT members will be given the first opportunity to participate in the mission. Please submit your registration ASAP. Positions not filled by team members will then be filled through an open recruitment process as a means of successfully completing the mission and potentially recruiting new members to the DMATs.

To facilitate planning and minimize last minute cancellations, we are requiring a $275 non-refundable down payment ($300 if you are staying for two weeks) to hold your position for the mission. (Remember, this is first-come-first-serve, so don't wait until the last minute if you want to participate.) Once payment is received, we will confirm your participation on one of the mission teams. You are not confirmed to participate until you receive a written confirmation. Following confirmation, the down payment will not be refundable. If the team member cannot participate for any reason, the down payment will be

forfeited. Forfeited down payments will be used to purchase medical supplies for the mission.

The down payment is used to cover the cost of lodging and food in Jeremie on return, airfare to and from Jeremie, gratuity to house-staff at the rectory where the teams stay in Leon, host gift for Pere Jean Farda (our host in Leon), travel evacuation insurance, and transportation between airports in Port-Au-Prince. Pharmaceutical supplies are supported through the Parish Twinning program, and food/shelter in Leon is provided by Pere Jean-Farda and the St. Paul's Catholic Church in Leon. **The affiliation with the Catholic Church is critical to the success of the mission; however, this is not an evangelical mission. Our mission is medical!**

In addition to the down payment, each team member will be responsible for paying for the cost of their own airfare to and from Port-Au-Prince. This cost is generally $600-700 from Seattle. All team members will be asked to coordinate their own travel. We will let you know what flight to take into and out of Haiti to coordinate with the team. Travel to and from Miami is flexible, but the teams should plan on entering Haiti as a team. Customs, airport chaos, and linguistic barriers make passage through the Port-Au-Prince airport challenging. It is much better to do this as a team. The details of transportation will be worked out as the time draws closer.

If you want to participate in this mission, please complete the attached Haiti 2007 Registration Form. The information on this form is required to promote communication during the preparation for the mission, ensure safety during the mission, acquire individual traveler's insurance and ensure clearance through the Haitian Ministry of Health. <u>In addition to the registration form and the $275 (or $300 if you are staying two weeks) deposit, please send a two by two inch photo (passport sized) of yourself, copy of your professional license and a copy of your diploma from your professional school.</u> (This information is needed to get clearance through the Ministry for Health.) Submitting all of the information at one time will facilitate our preparations for the mission. No confirmation of participation will be provided until a completed application and all requested information is submitted and a confirmation letter is returned.

Advanced planning and flexibility of the team members is critical to the success of this mission. Most team members find this mission to be both professionally and personally rewarding. As an emergency response team, the mission helps to build cohesiveness and creativity in team operations. I hope that you will seriously consider this unique training opportunity.

Each team member is liable for any risks they incur on the trip. The SKCDT takes great caution in ensuring risks are minimal.

Feel free to contact Andy Stevermer (address below) if you have any questions about this mission.

Sincerely,

Bill Engler
SKCDT Commander

Andy Stevermer
Home: 206-363-8743
Work: (206) 615-2266
FAX: (206) 615-2481
Cell: (206) 396-1180
Email: astevermer@aol.com

HAITI 2007 REGISTRATION FORM

TEAM MEMBER INFORMATION

First Name: ______________________________ Middle Initial:____

Last Name: ______________________________

Professional Discipline: __________________

Email Address: ________________________

Mailing Address: _________________________________
____

City: ______________________ State: _________ Zip: ____________

Home Phone: ____________________________

Work Phone: ____________________________

FAX: ____________________________

Cell Phone: ____________________________

Birthdate: __________________

Social Security Number: ________________________

Passport Number: ________________________

Do you speak French? Yes ☐ No ☐ Some ☐

Previous visits to Haiti? Yes ☐ No ☐

Please indicate the Mission Position You Are Registering For:

- ☐ **Team One:** **February 3-11, 2007**
- ☐ **Team Two:** **February 10-18, 2007**
- ☐ **Team Three:** **June 2-10, 2007**
- ☐ **Team Four:** **June 9-17, 2007**

Do you have any medical conditions that you feel the team leader or the team's physician should know about? ____
____

EMERGENCY CONTACT INFORMATION

Emergency Contact First Name: ______________________________
Emergency Contact Last Name: ______________________________
Emergency Contact Relationship: ______________________________
Emergency Contact Mailing Address: ______________________________
____
Emergency Contact City: _____________ State: ______ Zip:________
Emergency Contact Home Phone: ______________________________
Emergency Contact Work Phone: ______________________________
Emergency Contact Cell Phone: ______________________________
Emergency Contact Email Address: ______________________________

Submit this form with your $275 non-refundable deposit ($300 if you are requesting two weeks) made out to the S.K.C.D.T., a two inch personal photograph (does not have to be a fancy picture), and credentialing materials (copy of current license and professional school diploma to:

Andy Stevermer
17312 Ninth Ave. N.E.
Seattle, WA 98155