

FOR FLEET MEDICAL DIRECTORS, MARITIME SAFETY & RISK MANAGERS, CRUISE OPERATIONS, MASTERS & PORT CAPTAINS

CRUISE LINE & COMMERCIAL MARITIME MEDICAL READINESS

DUTY OF CARE, PROLONGED FIELD CARE HORIZONS, AND MASS CASUALTY MITIGATION AT SEA

An executive briefing for the operators who own the medevac horizon: what fails at sea, what the evidence says the first crew on scene must do, what a defensible shipboard standard costs, and how to prove it was in place.

VESSEL REGISTRATION BLOCK · FLEET BINDER AND BRIDGE

VESSEL NAME	IMO / OFFICIAL NUMBER	FLAG STATE / PORT OF REGISTRY

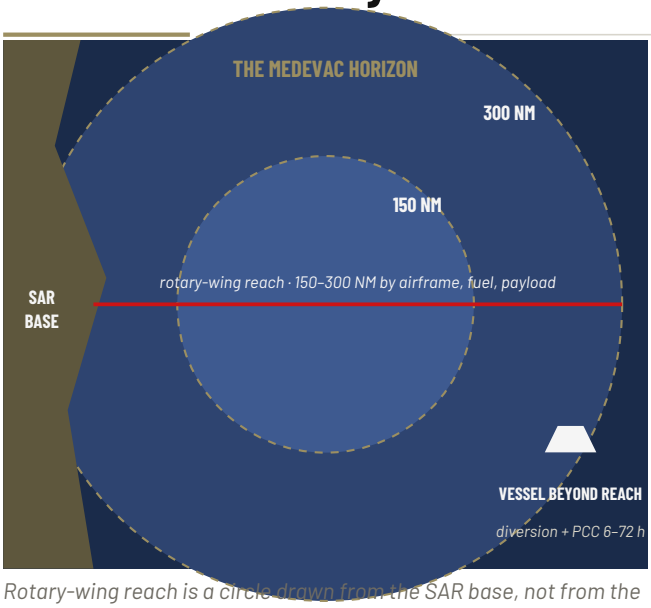
PASSENGER / CREW CAPACITY	MEDICAL DIRECTOR / SAFETY LEAD	AUDIT DATE

DESIGNATED PERSON ASHORE (DPA) AND CONTACT	TELEMEDICAL SERVICE (TMAS) AND CONTACT

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Evidence-based trauma standards · IMO/WHO International Medical Guide for Ships · MLC 2006 Reg. 4.1 · USCG 46 CFR · OSHA 1910.151 · NFPA 3000

SECTION 01

The isolation reality: when outside help is hours, or days, away



Rotary-wing reach is a circle drawn from the SAR base, not from the ship. Outside it, and inside it in weather, the plan is diversion and prolonged care.

On land about 84% of Americans live within an hour of a Level I or II trauma center and the ambulance arrives in single-digit minutes. At sea the nearest surgeon is the one at the end of a satellite call. Rotary-wing search and rescue assets — United States Coast Guard and their international counterparts — work inside an effective radius on the order of **150 to 300 nautical miles**, set by airframe, fuel and payload, and the whole radius collapses when the weather closes: sea state, convective squalls and night hoisting can hold a launch for **24 to 72 hours**. Beyond the horizon, or inside it in bad weather, the vessel is the hospital.

The exsanguination reality. A severed femoral or brachial artery can take an adult into irreversible shock in as little as two to three minutes. That is not a number the ship's doctor can influence from four decks away; it is decided by the watchstander who is standing there, with what is on the bulkhead beside them.

150–300 nautical miles of effective rotary-wing SAR radius, by airframe, payload and fuel	**24–72 h** launch delay in sea state, squalls and night hoisting conditions	**2–3 min** from an uncontrolled arterial wound to irreversible shock — the watchstander's window	**4 h** the turning point from acute hemorrhage control to prolonged casualty care

The 4-hour turning point

The first hour is bleeding control, airway, chest seals, shock recognition and warmth — the same MARCH sequence used ashore, executed by crew with the Tier 1 kit on their body and the Tier 2 station on the bulkhead. From about four hours the problem changes character: the tourniquet that saved the leg now threatens it; the burn that was covered now needs fluids and a surface-area estimate; the casualty needs pain control, nursing, wound care and hourly reassessment for the remainder of a diversion that may last three days. Shipboard readiness is therefore two systems, not one: a decentralized first-minute system for the whole crew, and a prolonged-care system for the medical officer and the telemedical service behind them. This paper describes both, and the packaging, tiers, compliance framework and audit discipline that keep them ready in salt air.

WHAT THIS PAPER ASKS OF A FLEET

Stage bleeding control and chest seals within 60 seconds of every work space; carry a prolonged-care capability sized to the longest diversion on the route; harden every kit against the sea; inspect on a schedule and keep the log. The companion operational standard, MTC-MAR-001 (16 pages, fillable), carries the item-level bills of materials, the extrication procedures and the inspection grids.

SECTION 02

High-consequence marine hazards and multi-casualty dynamics



Engine-room trauma and burn station on a machinery-space pillar: hydrogel dressings, dual tourniquets, eyewash, splint — within reach of the watch. Illustration.

A ship concentrates five hazard environments inside a steel hull with vertical access, and a single failure in any of them produces several casualties at once — a steam line lets go across a watch, a gangway collapses under a queue, a galley fire spreads through a mess deck. Each environment has its own injury pattern and its own reach problem, and each needs staged equipment that matches it.

The common denominator is time-to-equipment, not equipment volume: a well-stocked infirmary eight decks up is worth less in the first three minutes than a sealed case on the bulkhead of the compartment where people get hurt.

ENVIRONMENT	INJURY PATTERN	WHAT THE ARCHITECTURE MUST PROVIDE
1 · Engine room and machinery spaces	High-pressure hydraulic and fuel injection injuries — surgical emergencies that look trivial; superheated steam and flash burns; rotating-shaft entrapment, crush, traumatic amputation; noise and heat that hide the casualty	Tier 2 burn and trauma station at each level; dual tourniquets; hydrogel burn dressings; the rule that an injection injury is never squeezed, soaked or dismissed — it is diverted
2 · Confined spaces and vertical hoisting	Atmosphere casualties in holds, ballast tanks and chain lockers; falls; the casualty who must come up through a 28-inch scuttle with a spine and an airway to protect	Entry control on the 1910.146 model — atmosphere tested, rescuer on air, attendant outside; a flexible roll-up litter and a hoist plan drilled on the actual scuttle; airway rule for the vertical lift
3 · Passenger and weather decks	Gangway and tender-transfer falls; heavy-weather trauma across a dining room; slips on wet decks; cardiac arrest in a crowd	Public-access bleeding control co-located with every AED on passenger decks; crew who can reach and use it; a casualty collection plan per deck
4 · Galley, laundry and hotel services	Scalds, fryer and steam burns, lacerations, fire and smoke in the most crowded work spaces aboard	Burn station with cooling and dressings at the galley exit; bleeding control station at the mess; smoke-inhalation evacuation route rehearsed
5 · Small craft, tenders and man overboard	Immersion hypothermia in any water temperature; non-fatal drowning; propeller and impact trauma; the casualty recovered to a rocking boat	Submersible or dry-bag packs in every tender and rescue boat; hypothermia wraps; a horizontal-recovery rule for the immersed casualty

Multi-casualty dynamics aboard

Triage at sea is triage without a second ambulance. Walking casualties go to a collection point with a crew member; the rest are sorted by breathing, perfusion and mentation; the reds get the tourniquets, seals and airway positioning first; and the count goes to the bridge and the telemedical service every few minutes, because the diversion decision and the request for a helicopter are made on that count. The companion standard carries the START sequence and the collection-point layout.

SECTION 03

Marine-hardened MARCH: evidence-based trauma standards at sea

MARCH is the order in which things kill: massive hemorrhage, airway, respiration, circulation, hypothermia and head. The sequence does not change at sea; the conditions around it do. Wet skin defeats adhesives, a rolling deck makes positioning a two-person job, salt and heat attack the hardware, and the casualty stays with the crew for hours instead of minutes. The five cards below are the shore doctrine with the marine corrections applied.

	THE STANDARD	THE MARINE CORRECTION
M Massive hemorrhage	Windlass limb tourniquet 2–3 in. above a visible wound on bare skin, never over a joint; high and tight only when the wound is hidden or the scene is still dangerous, converted at the first safe moment; hemostatic gauze packed to the vessel for junctional wounds, three minutes of pressure, pressure dressing over it	Devices with non-corroding fasteners, sealed against salt until used; hemostatic agents that do not react exothermically on wet tissue; the tourniquet time recorded on the device and the casualty card, because the handover is hours away
A Airway	Recovery position for the unconscious breathing casualty; chin lift or jaw thrust; nasopharyngeal airway only under the ship's medical standing orders	Recovery position braced against the roll; continuous watch for vomiting on a moving deck; airway managed before any vertical hoist and the lift stopped if the casualty vomits
R Respiration	Vented seal on every penetrating chest wound, entry and exit; burp the seal if breathing worsens; injured side down if it eases breathing	Skin dried and, where needed, hair clipped before the seal; a second seal or an occlusive dressing under a loose wrap when the first will not hold on wet skin; watch through pressure changes on a hoist
C Circulation and shock	Reassess every intervention; pelvic binder for the crushed pelvis; recognize shock by pulse, skin and mentation; no unproven fluid strategy	Permissive-hypotension targets and any fluid only under telemedical direction; oral rehydration for the conscious casualty on a long diversion; the dehydrated seafarer bleeds worse
H Hypothermia and head	Every trauma casualty is insulated and wrapped; head injury is protected from further movement	Immersion cools a casualty even in 80 °F water, and a wet deck with wind does the same in the tropics; wet clothing off, active warming on the trunk, reflective outer wrap; the trauma triad — cold, acidosis, coagulopathy — arrives faster at sea than in an ambulance

THE MARCH LINE, AS SOLD · prices verified on tactical-medicine.com, 26 Sep 2026



C-A-T® Gen 7 tourniquet
North American Rescue · $28.99



QuikClot Combat Gauze®
Teleflex · kaolin, no exotherm · $39.99



HyFin® Vent chest seal twin pack
North American Rescue · $15.99



SAM® Pelvic Sling
SAM Medical · $89.99



Hypothermia Prevention & Management Kit
North American Rescue · active heat + shell · $124.95

DOCTRINE NOTE — TOURNIQUET PLACEMENT

Deliberate placement is two to three inches above a visible wound on bare skin, never over a joint. High and tight — proximal third of the limb, over clothing — is for the wound you cannot see or the compartment you cannot yet stay in; it is converted to deliberate placement at the first safe moment. Crew never loosen a tourniquet; conversion on a long diversion is the medical officer's decision under telemedical direction (p. 7).

SECTION 04

Why standard first-aid kits fail at sea



Watertight, floatable hard case with pressure-equalizing valve, opened: colour-coded modules in the MARCH sequence, indicator card in the lid. Product photograph.

A shore kit is packaged for a climate-controlled cabinet. Aboard, it lives in salt-laden air at 80 to 100 percent humidity, cycles from an air-conditioned passageway to a 120 °F machinery space, and is opened by wet hands. Within a season the things that must work first — the tourniquet windlass, the seal adhesive, the sterile barrier on the gauze — are the things that have failed. The fix is not a bigger kit; it is packaging engineered for the environment and an audit that reads its indicators.

The MED-TAC International marine packaging protocol puts each module in heavy-gauge vacuum foil, the modules in a watertight crush-resistant polymer case with a pressure-equalization valve, the case in a bracket the crew can open one-handed, and a humidity-and-temperature indicator inside the lid so the quarterly audit is a glance, not an unpacking.

STRESS FACTOR	WHAT IT DOES TO A STANDARD KIT	MARINE-HARDENED STANDARD
Atmospheric salinity	Corrodes metal windlasses, shears, grommets and cabinet hinges within about six months unsealed; a corroded windlass clip is a tourniquet that will not lock	Devices vacuum-sealed until use; polymer or stainless hardware; stainless brackets; a corrosion check line on the audit grid
Humidity and condensation	Breaks the sterile paper barrier on gauze and dressings; softens and lifts chest-seal adhesive so it will not bond to wet skin; wicks into packaging in a cold-to-warm transition	Foil-in-foil packaging for every sterile item; desiccant in the case; a colour humidity indicator read at each shift change
Temperature cycling	Machinery-space heat above 120 °F stiffens and cracks nitrile, liquefies hydrogel burn dressings, delaminates hemostatic packaging and shortens the life of everything with a printed date	Insulated case liners in hot spaces; hemostatic gauze and seals rotated on the audit schedule regardless of printed date; a temperature indicator strip beside the humidity strip
Immersion, spray, roll	A soaked soft bag on a tender deck is pulp in an hour; loose supplies are on the deck when the ship rolls	IP67-class hard cases on decks and in tenders; roll-top dry bags for the crew module; colour-coded MARCH modules removable as a unit; pictographic instructions on the lid

MARINE-HARDENED CONTAINERS AND BURN CARE, AS SOLD · prices verified on tactical-medicine.com, 26 Sep 2026



Maritime Watertight Trauma & First Aid Kit
North American Rescue · hard case · $734.99



Elite Bags SAILS waterproof roll-top
Elite Bags · $69.00



MARINER Response Kit
North American Rescue · weather-resistant · $339.00



BurnTec burn dressing kit
hydrogel dressings · $259.99

SECTION 05

Scalable shipboard architecture: from watchstander to MCI vault

Three tiers, one logic: the watchstander carries what stops one bleed; the bulkhead station holds what a compartment needs for the next casualties and the hour after; the vault holds what the ship needs when the count reaches double digits or the diversion runs into its second day. Prices below are the live catalog prices on the date shown; the item-level bills of materials are in MTC-MAR-001.

TIER	TARGET	CONTENTS	DEPLOYMENT	CATALOG ANCHORS (LIVE)
Tier 1 Watchstander and crew IFAK	Bridge officers, engineering watch, deck and security leads, galley managers	Windlass tourniquet, hemostatic gauze, vented chest seal twin pack, 6 in. pressure bandage, nitrile gloves, shears, marker — in a sealed, water-resistant pouch	On the person, bridge console, engine control room rack; under 3 seconds to hand	MED-TAC Immediate Trauma Kit w/ pouch $74.95 · Lightning-X MOLLE medic pouch $17.50 · Elite Bags SAILS dry bag $69.00
Tier 2 Watertight bulkhead and deck station	Machinery spaces, galley and mess, mooring decks, promenades, tenders and rescue boats	Multi-casualty bleeding modules (2–4 tourniquets), hydrogel burn dressings, hypothermia wraps, splints, pelvic binder, marine-grade shears, pictographic card	Surface-mounted bracket beside the AED; 60-second reach from every work position in the compartment	MARINER Response Kit $339.00 · Maritime Watertight Trauma & First Aid Kit $734.99 · Amphibious Trauma Kit $649.00
Tier 3 Shipboard MCI vault and vertical evacuation	Ship's hospital, medical locker, damage-control and rescue teams	Mass-casualty bundles (8+ tourniquets), full MARCH airway and circulation reserve under standing orders, flexible hoist litter, bi-fold litter, junctional and pelvic devices, prolonged-care nursing and wound-care reserve, triage tags	Central medical staging; a second cache at the after steering or damage-control locker so no compartment is a ship-length from resupply	Naval Boat Response Aid Kit $679.99 · NAR-5 Search and Rescue Aid Kit $1,299.99 · Sked® Basic Rescue System from $698.39 · RAVEN 90C bi-fold litter $749.99

TIERS 1 AND 2, AS SOLD · prices verified on tactical-medicine.com, 26 Sep 2026



MED-TAC Immediate Trauma Kit w/ pouch
Tier 1 · $74.95



Lightning-X MOLLE medic pouch
Tier 1 carrier · $17.50



Maritime Watertight Trauma & First Aid Kit
Tier 2 · $734.99



Amphibious Trauma Kit (submersible)
Tier 2 · tenders · $649.00

TIER 3, AS SOLD · prices verified on tactical-medicine.com, 26 Sep 2026



Naval Boat Response Aid Kit
Tier 3 · $679.99



NAR-5 Search and Rescue Aid Kit
Tier 3 · $1,299.99



Sked® Basic Rescue System
Tier 3 · vertical hoist · from $698.39



RAVEN Model 90C bi-fold litter
Tier 3 · corridors and stairs · $749.99

Sizing rule. One Tier 1 kit per watchstander and per crew lead; one Tier 2 station per compartment where people work, and one per 200–250 ft of passenger corridor beside the AED; one Tier 3 vault per ship, two on vessels over about 200 m or with a passenger complement above 1,000. The quarterly audit on p. 9 is where the count is verified.

SECTION 06

Managing the holding window: telemedical assistance at sea



The telemedical decision tree: stabilize, report, decide medevac or divert, and manage the tourniquet clock on the diversion.

Every flag state provides or designates a Telemedical Assistance Service (TMAS); CIRM in Rome and the United States Coast Guard flight surgeon are the two the industry meets most. The service does three things a ship cannot do for itself: it turns the medical officer's report into a treatment plan, it advises the master on the diversion-versus-medevac decision, and it documents the standard of care that was delivered. The decision tree at left is the shape of that conversation.

Tourniquet reassessment. A tourniquet is reassessed within two hours of application. Conversion to a hemostatic pressure dressing is considered only under direct telemedical physician direction, and only when the casualty is not in shock, the wound is visible and can be monitored, bleeding is controllable by packing and pressure, and the limb is not amputated. A tourniquet that has been in place six hours or more is not released outside a facility that can manage the consequences.

Holding-window priorities

PROBLEM	WHAT THE SHIP DOES	WHAT THE TELEMEDICAL SERVICE DECIDES
Hemorrhagic shock	Reassess every tourniquet and dressing hourly; keep warm; oral rehydration if conscious and able to swallow; nothing by mouth with an abdominal wound	Fluid strategy and targets (radial pulse, mentation); tranexamic acid as soon as possible, no later than 3 h after injury, where the ship carries it under standing orders
Burns	Cool with running water at least 10 minutes, ideally 20, watching large burns for chilling; cover with hydrogel or clean dry dressing; estimate surface area with the rule of nines or a Lund-Browder chart; watch the airway after steam or smoke	Fluid plan from surface area and weight; airway risk; whether the burn alone justifies diversion
Wound care and infection	Irrigate with clean water or saline; dress and re-dress on schedule; document the wound with photographs; watch for spreading redness, fever, foul discharge — faster in marine wounds	Antibiotic choice from the ship's medicine chest with marine pathogens in mind — Vibrio vulnificus, Aeromonas, Mycobacterium marinum — and the surgical-triage threshold
Pain, nursing, nutrition	Analgesia per the medicine chest and standing orders; turning, pressure-area care, hydration, bladder and bowel care; a written hourly log	Dose adjustment; sedation limits; when the casualty can eat
The diversion decision	The master weighs distance, weather, port capability and the casualty's trend	A recommendation on urgency, the receiving facility and the medevac request

Everything in this section sits under the ship's medical officer and the telemedical physician; the crew's contribution is the hourly log, the reassessment and the honesty of the numbers on the call. The item-level prolonged-care table is in MTC-MAR-001, p. 12.

SECTION 07

Mitigating operational liability under admiralty and flag-state law



The ship's medical officer on the satellite handset with the telemedical service, casualty warmed and elevated: the standard of care, documented. Illustration.

The regulatory floor for medical care at sea is old, layered and largely silent on the question that decides outcomes: how many seconds it takes a crew member to reach bleeding control in the compartment where the injury happened. The frameworks below set the minimum; a documented, decentralized standard exceeds it and is the evidence an operator will need when a casualty becomes a claim.

The corporate risk perspective. Under the Jones Act a seafarer may sue the employer for negligence, and every seafarer is owed maintenance and cure without regard to fault; under general maritime law the shipowner warrants a seaworthy vessel, and courts have treated inadequate medical equipment and untrained crew as unseaworthiness. None of that is defeated by a locked infirmary. What the operator can put in front of a court is a standard, a training record and an inspection log.

FRAMEWORK	WHAT IT REQUIRES	WHAT A DECENTRALIZED STANDARD ADDS
MLC 2006, Regulation 4.1	Health protection and medical care on board comparable, as far as possible, to that available to workers ashore; a medicine chest, medical equipment and a medical guide; a person in charge of medical care; access to telemedical advice	Point-of-injury access in the compartments where seafarers actually work; a drilled crew; a maintained log
IMO / WHO International Medical Guide for Ships (3rd ed.)	Clinical guidance and the recommended medicine chest for vessels without a doctor	The trauma equipment the guide assumes is available, hardened and staged
USCG 46 CFR (by vessel class)	First-aid kits, lifesaving equipment and, on passenger vessels, medical spaces and personnel by class and route	Kits that survive the environment they are carried in; inspection evidence for the class survey
OSHA 29 CFR 1910.151 / 1910.146	Trained first-aid personnel and adequate supplies where no clinic is near; permit-required confined-space entry and rescue	Confined-space rescue drilled with the actual litter and scuttle; supplies at the point of work
NFPA 3000	Whole-community planning for hostile events, including casualty collection and public bleeding control	Passenger-deck bleeding-control stations and a collection plan the port and the ship's security plan can share

What "reasonable care" looks like on paper: a written standard naming the tiers, compartments and reach rule, adopted by the company and the master; a training record for the crew expected to use the equipment, validated by the medical officer; the inspection log on p. 9 with lot numbers, indicator readings and corrective actions; and incident documentation — interventions, times, telemedical contacts, handover — kept with the ship's medical log.

THIS IS NOT LEGAL ADVICE

Admiralty obligations, flag-state rules and class requirements differ by vessel, route and registry, and no equipment program is a guarantee against a claim. Have counsel and the P&I club review the standard the company adopts; this paper is the operational content those reviews expect to find in place.

SECTION 08

Operational verification: the 60-second walkaround and the quarterly audit

Two controls keep a hardened kit hardened: a quarterly audit that opens nothing and reads everything, and a shift-change walkaround that takes a minute. Both are fillable here; print the page, complete it, and file it with the ship's medical log — the log is the evidence on p. 8.

VESSEL | QUARTER / DATE | AUDITOR (NAME, RANK) | MASTER'S INITIALS

Quarterly inspection grid

STATION	SEAL INTACT	EARLIEST EXPIRY	INDICATOR (H/T)	PASS	FAIL	INITIALS
Bridge / navigation deck Tier 2 station	☐			☐	☐	
Engine control room (ECR) trauma and burn station	☐			☐	☐	
Galley / mess deck station (burn pack status)	☐			☐	☐	
Tender / rescue boat submersible packs	☐			☐	☐	
Central infirmary mass-casualty reserve (full inventory)	☐			☐	☐	
Passenger-deck public-access stations (all)	☐			☐	☐	
Mooring deck / weather deck stations	☐			☐	☐	
Hoist litter and vertical-evacuation kit	☐			☐	☐	
Watchstander Tier 1 kits (spot-check 5)	☐			☐	☐	
Telemedical contact card and medical log	☐			☐	☐	

60-second shift-change walkaround

- ☐ **Bulkhead seals** unbroken and intact on every station on the watch route
- ☐ **Humidity indicator** in the safe range (blue / dry) on every case; temperature strip within range
- ☐ **Tourniquet windlasses and retention clips** undamaged and free of corrosion on the spot-checked Tier 1 kits
- ☐ **Tamper-evident pull-tags** verified against the deck master log
- ☐ **Rapid-access brackets** clear of physical obstructions; AED indicator green beside each station

WATCH OFFICER SIGNATURE | TIME | REPORTED TO (MEDICAL OFFICER / DPA)

DISCREPANCIES · CORRECTIVE ACTION · RESTOCK ORDERED (ITEM, LOT, DATE)

MED-TAC INTERNATIONAL CORP. MARITIME FLEET PROCUREMENT

ABOUT MED-TAC INTERNATIONAL

A South Florida-based tactical and emergency medical supply house founded, owned and operated by medical, public safety and military professionals. Service-Disabled Veteran-Owned Small Business (SDVOSB), SAM registered, CAGE 9VFL3, UEI YU3ZMJ44REA5. Kits assembled in the USA from FDA-regulated and CE-compliant components; every device sourced from the manufacturer or an authorized distributor with lot traceability. Technical author Marco R. Torres, MD, NRP — physician and medical educator — has fifteen years in tactical medicine as a flight medic, as a paramedic, and in high-threat protection operations, and seven years teaching EMS. A U.S. Navy veteran, he is founder of MED-TAC International and ALKEONHealth.com.

FLEET PROCUREMENT TERMS

Net 30 only for government agencies, government fleets and public authorities; commercial operators and all other buyers pay in full at order. Quotes valid 45 days. RFQ turnaround within 24–48 business hours from a bill of materials or a vessel profile. Container packing, IMO-compliant labeling and port delivery per quote; North American Rescue items ship only to U.S. ports and APO/FPO addresses. Lead time per customer requirements.
Not on a GSA Schedule. Free CONUS shipping on orders over $200; APO/FPO shipping free.

B2B AND FLEET RFQ PORTAL
tactical-medicine.com/pages/medical-logistics-rfq-services ›

INSTITUTIONAL MEDICAL PROCUREMENT
tactical-medicine.com/pages/institutional-procurement ›

DEDICATED MARITIME CATALOG
tactical-medicine.com/collections/maritime ›

LEGAL DISCLAIMER & COMPLIANCE STATEMENT

Equipment recommendations are based on clinical function, evidence-based trauma standards and field experience. This white paper is educational and operational guidance for vessel operators; it does not replace the ship's medical officer, the flag state's medicine-chest requirements, telemedical direction, the IMO/WHO International Medical Guide for Ships, class or flag inspection, or the judgment of trained personnel on scene. Interventions beyond bleeding control, positioning and warming require the ship's medical standing orders. Standards cited were current when published and change; verify before relying on them. Nothing here is legal advice on admiralty or flag-state obligations. No government endorsement is implied. © 2026 MED-TAC International Corp. All rights reserved; free to share unmodified within your organization.

DIRECT PROCUREMENT TOUCHPOINTS

Protocol download: tactical-medicine.com/pages/maritime-mci-protocol
Maritime readiness hub: tactical-medicine.com/pages/cruise-ship-medical-emergency-solutions
B2B and fleet RFQ portal: tactical-medicine.com/pages/medical-logistics-rfq-services
Institutional procurement: tactical-medicine.com/pages/institutional-procurement
Dedicated maritime catalog: tactical-medicine.com/collections/maritime
Fleet quotes: the RFQ portal above · Customer service: (850) 409-9628 · tactical-medicine.com
Correspondence and returns (mailing address only — not a walk-in location):
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