FOR FIREARMS INSTRUCTORS, COMMERCIAL RANGES & GUN CLUBS

RANGE SAFETY OFFICER BALLISTIC TRAUMA READINESS CHECKLIST & EMERGENCY ACTION PLAN

Standardized 60-second gunshot wound protocol, four-tier facility trauma staging matrix, fillable 911 dispatch standard, and a complete range emergency action plan.

Developed under the clinical direction of Marco R. Torres, MD, NRP — physician and medical educator, U.S. Navy veteran, and founder of MED-TAC International and ALKEONHealth.com. The companion checklist to his book, The Firearms Instructor's Medical Response Guide.

FACILITY IDENTIFICATION

Complete on screen or by hand. Keep one copy at the counter and one in each bay.

FACILITY NAME	
PHYSICAL STREET ADDRESS	
CHIEF RANGE SAFETY OFFICER (CRSO)	
FACILITY MEDICAL OFFICER / SME LEAD	
EMERGENCY DISPATCH (911 / LOCAL NUMBER)	
FACILITY TYPE	☐ Indoor range ☐ Outdoor range ☐ Complex / mixed ☐ Dynamic bays
EFFECTIVE DATE / ANNUAL REVIEW DATE	

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Educational protocol for trained range staff. It does not replace hands-on training, medical direction, or local EMS protocols.

EXECUTIVE SUMMARY

The first 180 seconds decide the outcome

Range safety discipline prevents almost every injury a range will ever see. The rare failure — a negligent discharge on the draw, a ricochet, a catastrophic malfunction, a medical collapse on the bench — arrives without warning and is decided by what the people on the firing line do in the next three minutes. This document turns that reaction into a drilled, staffed, documented procedure: who calls the cease-fire, who treats, who calls 911, who meets the ambulance, and what is on the wall when they reach for it.

Why three minutes

A high-flow arterial bleed from the thigh or upper arm can be fatal within minutes, before any ambulance can arrive. Battlefield and civilian trauma reviews consistently identify uncontrolled bleeding as the leading cause of potentially survivable death, and the interventions that reverse it — a tourniquet, packed hemostatic gauze, a vented chest seal — are simple enough for trained range staff to perform in seconds. The timeline below is the standard this document drills to.

0–15 s	**CEASE FIRE AND MAKE SAFE** Cease-fire called and acknowledged; all firearms unloaded, actions open, benched or holstered; range declared cold. Nobody enters a lane while a weapon is unsecured.
15–60 s	**CONTROL THE BLEEDING** Care lead reaches the casualty with an on-body IFAK. Direct pressure, then tourniquet for limb bleeding (placement rules on page 3). Time written on the tourniquet.
60–120 s	**CHEST AND AIRWAY** Expose the torso; vented chest seal on any penetrating chest wound, front and back. Recovery position or sit-up-and-lean-forward for airway.
120–180 s	**DISPATCH AND MARSHAL** Comms lead reads the 911 dispatch card (page 5) including coordinates and gate code. Marshalling lead is at the gate with the access key, in a high-visibility vest, before EMS is on the road.

Why carriers, counsel, and boards ask for this

A written medical emergency action plan, trained range safety officers, and wall-mounted hemorrhage control within reach of every firing point are what an insurance underwriter, a plaintiff's attorney, and an OSHA inspector each look for after an incident. OSHA 29 CFR 1910.151 requires trained personnel and readily available first-aid supplies where no clinic is in near proximity; NFPA 3000 sets the public access bleeding control model most facilities are measured against. Documented drills and inspection logs (pages 13–14) are the evidence that the plan exists in practice, not only on paper. This document is not legal advice; review it with counsel and your carrier.

WHO	USE THIS DOCUMENT FOR
Range owner / operations director	Staging matrix (p. 4), facility audit (p. 14), EAP master (pp. 15–16), liability review (p. 12)
Chief RSO / RSOs	60-second protocol (p. 3), 911 card (p. 5), wound protocols (p. 7), drills (p. 13)
Firearms instructors and match directors	Roles, cease-fire commands, air-ambulance LZ (p. 6), incident form (pp. 17–18), the book behind this checklist (p. 20)
Purchasing	Line-item specifications with NSNs (pp. 10–11)

UNIVERSAL RANGE EMERGENCY PROCEDURE

The 60-second live-fire gunshot wound protocol

CEASE FIRE! CEASE FIRE! CEASE FIRE!

"UNLOAD AND SHOW CLEAR. HOLSTER OR BENCH ALL FIREARMS. STEP BACK FROM THE FIRING LINE." The range is cold. Nobody moves toward the casualty until every firearm on the line is secured.

1 CALL THE CEASE-FIRE

Any person on the range can call it. The RSO repeats it three times, loud, and gets verbal acknowledgment from each firing point.

2 MAKE THE RANGE COLD AND SAFE

All firearms unloaded, actions open, benched or holstered. No responder approaches a shooter who is still holding an unsecured weapon. If the casualty is holding a firearm, the RSO secures it before care begins.

3 ASSIGN ROLES — SAY THE NAMES OUT LOUD

Care lead (lead RSO): enters the lane with the on-body IFAK. **Comms lead** (second RSO): calls 911 from the dispatch card and alerts the front desk. **Marshalling lead** (assistant RSO or a designated shooter): takes the gate key and vest to the main entrance to meet EMS.

4 CONTROL THE BLEEDING

Direct pressure with both hands while the kit is opened. **Limb bleed you can see:** tourniquet directly on skin 2–3 in above the wound, never over a joint (if that lands on the knee or elbow, go above the joint). **Bleeding source not obvious, or clothing in the way:** high and tight on the limb over clothing, then reassess. Tighten until the bleeding stops and the distal pulse is gone. Write the time on the strap. Do not loosen it.

5 CHEST AND TORSO

Expose the wound, wipe the skin, apply a vented chest seal. Roll the casualty and check the back for an exit wound; seal it. If breathing gets worse after sealing, lift one edge of the seal ("burp") to release trapped air, then reseal.

6 JUNCTIONAL AND EVERYTHING ELSE

Groin, armpit, neck: pack the wound with hemostatic gauze directly onto the bleeding source and hold firm pressure for at least 3 minutes, then wrap. Cover the casualty with a blanket — blood loss makes people cold, and cold makes bleeding worse.

7 HAND OFF

Tell EMS what happened, what you found, what you did, and the tourniquet time. Hand over the incident form (page 17) as soon as it is started.

Tourniquet placement follows current MED-TAC International doctrine and TCCC/C-TECC guidance: on skin 2–3 in above a visible wound; high and tight when the source is not apparent; never across a joint. A second tourniquet goes side-by-side, just above the first, if bleeding continues.

FOUR-TIER ARCHITECTURE

Range medical kit staging matrix

Gear that is not within reach in the first minute is not part of the response. The four tiers place bleeding control on the RSO's body, on the wall at every group of lanes, at the counter with the AED, and on the vehicle that reaches the far berm. Tick what is in place; the gaps become the purchase list on pages 10–11.

TIER 1 RSO duty belt IFAK — mandatory on-body

	CONTENTS	QTY	LOCATION / STATION ID
☐	CoTCCC-recommended tourniquet (C-A-T Gen 7 or SOFTT-W) in a rigid retention holder		
☐	Hemostatic gauze (QuikClot Combat Gauze Z-Fold or Celox Rapid)		
☐	4 in emergency trauma dressing, flat-fold		
☐	2 pairs nitrile exam gloves		
☐	7.25 in trauma shears and a permanent marker		
☐	Vented chest seal (one pair)		

TIER 2 Firing line / bay wall-mounted bleeding control stations

	CONTENTS	QTY	LOCATION / STATION ID
☐	One station every 4–6 lanes indoors, or one per bay outdoors, in high-visibility housing		
☐	Two tourniquets, twin-pack vented chest seals, 6 in pressure dressings, compressed and hemostatic gauze		
☐	Foil or multi-layer survival wrap		
☐	Gloves, shears, marker, and a laminated one-page instruction card		
☐	Serialized tamper seal, inspected monthly (page 14)		

TIER 3 Clubhouse, armory, instructor and range-master incident station

	CONTENTS	QTY	LOCATION / STATION ID
☐	Stocked multi-casualty trauma bag (e.g., MED-TAC Firearms Instructor Medical Backpack; Range Trauma Kit hard case)		
☐	AED with adult and pediatric pads, spare battery, and a rescue kit (razor, towel, shears, mask)		
☐	Burn dressings for suppressor and muzzle contact burns; rigid eye shields		
☐	Emergency eyewash and a lead-removal hand-wash station		
☐	Copy of this EAP, incident forms, and spare hearing and eye protection for arriving EMS		

TIER 4 Range vehicle / perimeter evacuation kit

	CONTENTS	QTY	LOCATION / STATION ID
☐	Ruggedized weatherproof hard case (NANUK-type) mounted in the range vehicle or UTV		
☐	Poleless litter (400 lb class) or basket litter for extraction from berms and long-range positions		
☐	Duplicate Tier 2 contents plus blanket, headlamp, and a second 911 card		
☐	Gate key and high-visibility vest for the marshalling lead		

FILLABLE 911 DISPATCH CARD

Range emergency dispatch standard

Fill the fixed fields once, print, laminate, and post at the range counter, in each bay station, and in the range vehicle. The comms lead reads it top to bottom. Dispatchers get the address and coordinates first because the call can drop; everything else follows.

READ IN ORDER — FIXED FIELDS				
"911 Dispatcher, this is		**calling from**		**."**
"We are located at		**in**		**."**
"Our GPS coordinates are latitude		**longitude**		**."**

SAY AT THE TIME OF THE CALL — LIVE INFORMATION
"We have an emergency involving a: [ ] gunshot wound [ ] blast or malfunction injury [ ] medical collapse / cardiac arrest."
"Number of casualties: _____. Exact location inside the facility: bay / lane / yard line _____."
"The range is COLD. All weapons are secured and unloaded."
"Bleeding control is IN PROGRESS. _____ tourniquet(s) applied at _____ (time)." or "CPR is in progress and an AED is on the patient."
"Do not hang up. Tell me when the unit is dispatched and which route they are taking."

EMS INGRESS — FIXED FIELDS		
"Enter via the		**gate."**
"Our marshalling coordinator		**will be at the gate in a high-visibility vest to escort you to the casualty."**
"Gate lock combination / access code:		**"**
"Nearest helicopter landing zone (if needed):		**"**

Security note: the laminated card with the gate code stays inside staff-controlled areas (counter, bay stations, range vehicle). Do not post it in public view.

AFTER THE CALL

Comms lead stays on the line, then calls the front desk, then the CRSO and range owner from the phone tree on page 16. Send someone to clear the vehicle path from the gate to the firing line before the ambulance arrives.

DISPATCHER WILL ASK	HAVE THIS ANSWER READY
"Is the patient awake and breathing?"	Yes / no. If no: "CPR is in progress, AED is on." Do not guess.
"Where is the wound?"	Body region and side (right thigh, left chest). Number of wounds if known.
"Is the bleeding controlled?"	"Tourniquet on at ___ (time)" or "packed, pressure held." Say if it is bleeding through.
"Is the scene safe?"	Range is cold, weapons secured, no active threat. If that is not true, say so.
"Who will meet the ambulance?"	Name the marshalling coordinator, the gate, and the vest color.

REMOTE RANGE PROTOCOL

Air ambulance and landing zone protocol

Rural rifle and pistol clubs where ground transport exceeds 25–45 minutes should plan for air medical transport before the first incident: identify the landing zone, confirm the coordinates with the regional air medical provider, and put both on the 911 card. The dispatcher decides whether a helicopter launches; the range decides whether it can land safely.

REQUIREMENT	STANDARD	YOUR LZ
Size and surface	At least 100 ft × 100 ft, level (under 5–7° slope), firm, free of loose gravel, targets, barricades, brass, and debris that rotor wash can lift.	
Approach and departure	Clear paths into and out of the wind; no trees, berms, poles, or wires on the approach. Report any wires to the crew on the radio or phone.	
Daytime marking	Windsock, high-visibility panels, or a vehicle at each corner. Smoke only if the crew requests it and the area is fire-safe.	
Night marking	Corner lights or chemical lights in a box or inverted "Y"; vehicle headlights aimed low across the deck, never at the aircraft.	
Perimeter	200 ft security perimeter; all spectators, members, and vehicles held back; hats and loose items secured; eye and ear protection on.	
Approaching the aircraft	Only after the crew signals; from the front or the side within the pilot's view, from the downhill side on a slope, crouched, never toward the tail rotor.	
Casualty preparation	Tourniquet time and interventions written down; casualty on a litter with eye protection and blanket; loose items removed.	

Ground transport gap plan

When both ground EMS and air are more than 30 minutes out, the range becomes the treatment facility. Reassess the tourniquet, keep the casualty warm and horizontal, monitor breathing every few minutes, and keep the incident form current so the handoff is complete.

Nearest ground EMS station and typical response time	
Regional air medical provider and direct number	
Primary LZ description and coordinates (DD)	
Alternate LZ	
Nearest trauma center and helipad	

LZ SURVEY NOTES (DATE, SURVEYED BY, PROVIDER CONFIRMATION)

CLINICAL PROTOCOLS

Wound-specific protocols for firearms incidents

Each protocol assumes the range is cold and the roles on page 3 are assigned. They are written for trained range staff working at the bleeding-control level; anything beyond that is EMS.

A

Extremity ballistic trauma (thigh, upper arm, forearm)

Direct pressure while the kit opens. Tourniquet on skin 2–3 in above the wound, never over a joint; high and tight if the source is hidden. Tighten until bleeding stops and the distal pulse is gone; write the time. If bleeding continues, a second tourniquet side-by-side just above the first. Pressure dressing over the wound. Do not loosen a tourniquet on the range.

B

Penetrating chest or torso

Expose, wipe, and apply a vented chest seal to every hole, front and back. Sit the conscious casualty up if they breathe easier that way. If breathing worsens after sealing — increasing distress, one-sided chest movement, falling alertness — burp the seal by lifting an edge, then reseal. Tell EMS the time of sealing; needle decompression is a provider skill, not an RSO skill.

C

Junctional bleeding (groin, armpit, neck)

A limb tourniquet cannot reach these. Pack hemostatic gauze directly onto the bleeding source, filling the wound, then hold firm pressure for at least 3 minutes (follow the product's instructions). Anchor with an elastic pressure wrap. For the neck, pack and hold pressure without wrapping around the airway.

D

Suppressor and muzzle contact burns

Suppressors and barrels reach temperatures that cause deep contact burns in seconds. Cool the burn under clean, cool running water for at least 10 minutes, ideally 20, remove rings and watches, cover with a sterile non-adherent burn dressing, and keep the casualty warm. No ice, no ointments. Hand, face, or full-thickness burns go to EMS.

E

Eye injury and blast fragmentation

Do not touch, rinse, or press on the globe, and do not remove embedded fragments. Tape a rigid eye shield over the injured eye with zero pressure on the eye itself. Keep the casualty upright and calm; no eye patch that presses on the globe. Every penetrating eye injury goes to EMS.

F

Unresponsive casualty / sudden cardiac arrest

Not breathing or only gasping: start chest compressions, send for the AED, and follow its prompts (page 9). Breathing but unresponsive with no major bleeding: recovery position, monitor, and keep warm.

Consistent with current TCCC and C-TECC guidance and MED-TAC International doctrine. Local EMS protocols and medical direction govern anything beyond bleeding control, chest seals, positioning, and CPR/AED.

ENVIRONMENTAL HEALTH

Lead exposure and hygiene protocols for shooting ranges

Every discharge releases lead: from the primer (lead styphnate) as airborne particulate, and from bullet fragmentation on impact as dust that settles on the firing line, benches, brass, and hands. Lead is absorbed by inhalation and by ingestion from contaminated hands. Chronic exposure affects the blood, kidneys, nervous system, and reproduction, and it accumulates. The controls below are the minimum for staff who spend their working day on the line.

CONTROL	STANDARD	IN PLACE
Ventilation	Indoor ranges: laminar downrange airflow across the firing line with filtered exhaust, verified by measurement; HVAC emergency shutoff and restart marked. Outdoor: position the line upwind of the berm where possible.	☐
Cleaning and berm maintenance PPE	NIOSH-approved P100 (HEPA) respirator (fit-tested for employees), disposable coveralls, nitrile gloves; wet methods or HEPA vacuum only — never dry sweeping or compressed air.	☐
Hand and face hygiene	Lead-removal soap or wipes at every exit from the line; wash hands, forearms, and face before eating, drinking, or leaving. Standard soap does not remove lead well.	☐
No eating, drinking, smoking, or vaping on the line	Posted rule; enforced for staff, members, and guests.	☐
Clothing and take-home lead	Staff change shoes and outer clothing before leaving; contaminated laundry washed separately. Children and pregnant visitors are the highest-risk group.	☐
Medical surveillance (employees)	OSHA 29 CFR 1910.1025 requires exposure monitoring where employees may be exposed; at or above the action level (30 µg/m^3 airborne, 8-hour TWA) medical surveillance including blood lead level (BLL) testing applies. Baseline BLL for full-time RSOs is good practice regardless.	☐
Ammunition choice	Lead-free or fully encapsulated primers and projectiles cut exposure at the source for training-heavy facilities.	☐

Staff exposure log

STAFF MEMBER	ROLE / HOURS ON LINE PER WEEK	BASELINE BLL DATE	LAST BLL DATE	RESPIRATOR FIT TEST

Blood lead results are confidential medical records; keep this log separate from the public EAP binder.

SUDDEN CARDIAC ARREST

Range automated external defibrillator (AED) protocol

At most facilities the most likely life-threatening emergency is not a gunshot wound but a cardiac arrest: an older member on the bench, exertion under recoil and heat, or a startle event. Survival falls with every minute defibrillation is delayed, so the AED belongs where staff can reach an unresponsive person with it in under a minute — not locked in an office.

UNRESPONSIVE AND NOT BREATHING NORMALLY

Send for the AED and call 911. Start chest compressions now: center of the chest, at least 2 in deep, 100–120 per minute. Switch rescuers every 2 minutes. Turn the AED on the moment it arrives and do what it says.

STEP	ACTION
1	Range cold. Casualty on their back on a firm surface. Check response and breathing for no more than 10 seconds.
2	Compressions start immediately; a second person opens the AED, powers it on, and exposes the chest.
3	Dry the chest; shave dense hair under the pad sites with the kit razor; remove medication patches; move the pad away from an implanted device bump. Place pads as pictured on the pads.
4	Pediatric pads or pediatric mode for children under 8 years or about 55 lb if available; otherwise use adult pads.
5	Stand clear for analysis. If a shock is advised, make sure nobody is touching the casualty and press the button (or let a fully automatic unit deliver it). Resume compressions immediately after.
6	Continue cycles of 2 minutes of CPR and AED analysis until EMS takes over or the casualty breathes normally.
7	Marshalling lead meets EMS; comms lead records the time of collapse, first shock, and handoff on the incident form.

AED readiness and maintenance

	CHECK	INTERVAL	LAST DONE	BY
☐	Status indicator shows ready; unit powers on and self-tests	Monthly		
☐	Electrode pads sealed and in date (adult and pediatric)	Monthly; replace by expiry		
☐	Battery in date; spare battery on hand	Monthly; replace by expiry		
☐	Rescue kit present: razor, towel, shears, gloves, barrier mask	Monthly		
☐	Location signed and known to all staff; retrieval under 60 s from every firing point	Semi-annual walk test		
☐	Staff CPR/AED training current; AED registered with local EMS where required	Per certification cycle		

AED model / serial:

CPR and AED steps follow current American Heart Association guidelines (2025).

PROCUREMENT SPECIFICATIONS

Category 1: hemorrhage control and IFAK line items

Salient characteristics for purchasing, with national stock numbers where they exist. Enter the quantity per tier and total; the totals feed the sourcing desk on page 21. Tourniquets and hemostatics must come from the original manufacturer or an authorized distributor — counterfeit tourniquets fail under load.

	LINE ITEM	SALIENT CHARACTERISTICS	NSN / REFERENCE	T1	T2	T3	T4
☐	**Limb tourniquet**	CoTCCC-recommended windlass tourniquet; one-handed application; time-write area; rigid retention holder for belt carry. Reference: C-A-T Gen 7; SOFTT-W. Blue trainers for drills only.	C-A-T Gen 7: 6515-01-521-7976 SOFTT-W (black): 6515-01-696-4522				
☐	**Hemostatic gauze**	Kaolin- or chitosan-based, Z-folded, sterile, vacuum-sealed. Reference: QuikClot Combat Gauze Z-Fold (CoTCCC-recommended); Celox Rapid Z-Fold.	Combat Gauze Z-Fold: 6510-01-562-3325				
☐	**Vented chest seals**	Twin pack, vented, hydrogel adhesive for wet skin. Reference: HyFin Vent twin pack (NSN); HyFin Vent Compact; HALO Vent.	HyFin Vent twin pack: 6510-01-642-6212				
☐	**Pressure dressings**	4 in (belt) and 6 in (station) emergency trauma dressing with pressure bar; flat-fold.	Per manufacturer				
☐	**Compressed gauze**	Sterile compressed gauze for packing and bulk dressing.	Per manufacturer				
☐	**Nasopharyngeal airway**	28 Fr with lubricant; station and Tier 3 only, trained staff.	Per manufacturer				
☐	**Survival wrap / blanket**	Foil or multi-layer casualty blanket sized for an adult.	Per manufacturer				
☐	**Gloves**	Nitrile exam gloves, individually packaged pairs; large/extra-large.	Per manufacturer				
☐	**Shears and marker**	7.25 in stainless trauma shears; permanent marker for tourniquet time.	Per manufacturer				

NSNs verified against Army and NAR listings at publication; confirm generation and NSN at order.

CATEGORY 1 SOURCING NOTES

PROCUREMENT SPECIFICATIONS

Category 2: stations, AED, burn and eye care, evacuation

	LINE ITEM	SALIENT CHARACTERISTICS	NSN / REFERENCE	T1	T2	T3	T4
☐	**Wall-mounted bleeding control station**	High-visibility, alarm-capable metal or clear polycarbonate cabinet with tamper seal; contents per Tier 2. Reference: NAR public access station cabinets; TRAMEDIC Wall Kit; MOJO Bleeding Control Station.	Per manufacturer				
☐	**Range trauma kit (Tier 3)**	Stocked multi-casualty bag or case: 4+ tourniquets, hemostatics, chest seals, dressings. Reference: MED-TAC Instructor Backpack; Range Trauma Kit.	Per manufacturer				
☐	**AED**	Semi- or fully automatic AED with adult and pediatric pads, spare battery, rescue kit, wall cabinet with alarm. Reference: ZOLL AED Plus / AED 3; Philips HeartStart OnSite.	Per manufacturer				
☐	**Burn dressings**	Sterile hydrogel burn dressings in 4 × 4 in and 8 × 8 in or roll formats. Reference: BurnTec dressing and kits; Burn Free dressings.	Per manufacturer				
☐	**Eye shields**	Rigid polycarbonate eye shield with tape or garter; no pressure on the globe.	Per manufacturer				
☐	**Eyewash**	Sealed-cartridge or gravity-fed emergency eyewash station at Tier 3; inspected per manufacturer.	Per manufacturer				
☐	**Lead-removal wash**	Lead-removal soap or wipes at every line exit and in the Tier 3 station.	Per manufacturer				
☐	**Litter**	Poleless folding litter (400 lb class) or basket litter with drag strap. Reference: QuickLitter; Phantom Litter.	Per manufacturer				
☐	**Vehicle hard case**	Weatherproof hard case with foam or dividers, vehicle-mounted. Reference: NANUK 904 vehicle trauma system.	Per manufacturer				
☐	**Training devices**	Blue training tourniquets (same generation as fielded), trainer hemostatic gauze, wound-packing task trainer, CPR manikin.	Per manufacturer				
☐	**Signage and marking**	Reflective bleeding-control and AED signage visible from every firing point; serialized tamper seals.	—				

Station count worksheet

Indoor: one Tier 2 station per 4–6 lanes. Outdoor: one per bay or firing point cluster, plus the Tier 4 vehicle kit for anything beyond a 60–90 second round trip from the nearest station.

AREA	LANES / POINTS	FARTHEST POINT ROUND TRIP	STATIONS	AED	VEHICLE KIT

SEND THE TOTALS FOR A RANGE KIT QUOTE

RFQ / BOM upload: tactical-medicine.com/pages/medical-logistics-rfq-services ›

COMPLIANCE REVIEW

Range liability, OSHA 1910.151, and insurance

This page is a compliance review for the range operator, not legal advice. Take it to counsel and your carrier with the completed EAP.

AUTHORITY	WHAT IT SAYS	WHAT A RANGE DOES ABOUT IT
OSHA 29 CFR 1910.151(b)	"In the absence of an infirmary, clinic, or hospital in near proximity to the workplace which is used for the treatment of all injured employees, a person or persons shall be adequately trained to render first aid. Adequate first aid supplies shall be readily available."	Trained staff on every shift; supplies staged per the four tiers; training and inspection records kept.
"Near proximity" (OSHA letters of interpretation)	OSHA has interpreted near proximity as about 3–4 minutes for workplaces where serious injuries such as severe bleeding or cardiac arrest are possible, and up to 15 minutes for low-hazard settings.	A live-fire range is a serious-injury workplace: bleeding control and an AED within the 3–4 minute window on every firing line.
OSHA 29 CFR 1910.1025 (lead)	Exposure monitoring, engineering controls, PPE, hygiene facilities, and medical surveillance where employees may be exposed to lead.	Page 8 controls; written program for staff.
NFPA 3000®	Program standard for active shooter / hostile event response: planning, public access bleeding control, integrated response with public safety.	Bleeding control stations, EAP, and drills coordinated with local EMS and law enforcement.
Duty of care vs. Good Samaritan protection	Good Samaritan statutes generally protect volunteers who act in good faith without compensation; they vary by state and may not cover paid staff acting within their job. Employees and contracted RSOs act under the facility's duty of care.	Train and document to the standard in this EAP; confirm coverage of staff, volunteers, and contractors with counsel and the carrier.
Insurance carrier expectations	Underwriters commonly ask for a written EAP, staff training records, documented drills, equipment inspection logs, and incident reporting.	Pages 13–18 are that file. Send the completed EAP to the carrier at renewal.

Compliance self-check

	ITEM	EVIDENCE ON FILE
☐	Written medical EAP reviewed within 12 months (this document)	
☐	Trained first-aid / bleeding control staff on every operating shift	
☐	CPR/AED-trained staff on every operating shift; AED registered where required	
☐	Bleeding control and AED reachable within 3–4 minutes from every firing point	
☐	Semi-annual medical drills documented (page 13)	
☐	Monthly inspection logs for stations and AED	
☐	Lead program for employees (page 8)	
☐	Incident reporting form in use (page 17)	
☐	Counsel and carrier have a copy of the current EAP	

DRILL STANDARD

RSO medical drill standard and four scenario scripts

Semi-annual practical drills for all range staff and volunteer RSOs, run on a cold range with training tourniquets (blue) and a manikin or role-player. Time every drill against the standard below; a drill that misses a time is repeated, not logged as complete.

MEASURE	STANDARD	SCENARIO 1	SCENARIO 2	SCENARIO 3	SCENARIO 4
Cease-fire to cold range	< 15 s				
Time to effective tourniquet	< 45 s				
Time to 911 call started	< 90 s				
Marshalling lead at gate	< 120 s				
AED on patient (Scenario 4)	< 60 s				
Incident form started	< 5 min				

#	SCENARIO	SCRIPT AND WHAT IT TESTS	DATE RUN	PASS
1	**Negligent discharge on the draw**	Handgun draw-from-holster round into the upper thigh; heavy arterial bleeding. Tests cease-fire, role assignment, tourniquet placement (2–3 in above the wound), and the 911 card.		☐
2	**Muzzle sweep during a transition**	Lateral chest entry wound during a rifle-to-pistol transition. Tests exposure, front-and-back check, vented chest seal, positioning, and the exit-wound search.		☐
3	**Squib load and catastrophic malfunction**	Slide or cylinder failure with facial lacerations, embedded fragments, and eye injury. Tests eye shield, no-pressure rule, bleeding control on the face and hands, and evidence preservation of the firearm.		☐
4	**Senior shooter collapses on the bench**	Unresponsive 68-year-old during a target change. Tests recognition, compressions, AED retrieval under 60 s, pad placement, and CPR cycles until handoff.		☐

Drill log

DATE	SCENARIO	STAFF PRESENT	LEAD EVALUATOR	TIMES MET (Y/N)	CORRECTIVE ACTIONS

10-POINT FACILITY INSPECTION

Evacuation corridor and access audit worksheet

Walk it with a stretcher in mind. EMS crews arrive with a wheeled gurney, in the dark, at a facility they have never seen. Everything on this list removes a minute from the time it takes them to reach the casualty and get out.

	INSPECTION ITEM	STATUS / CORRECTIVE ACTION	DUE
☐	**1.** Firing line to exit: a clear corridor at least 44 in wide, free of gear bags, ammo cans, target stands, and cords.		
☐	**2.** Range access gate and building: street number visible from the public road in reflective 4 in characters, lit at night.		
☐	**3.** Gate key or combination: staged in a staff lockbox; combination printed on the 911 card and known to every RSO on shift.		
☐	**4.** Path from parking to the firing line: firm, smooth, ramped where needed, passable by a wheeled gurney.		
☐	**5.** Emergency lighting: battery-backup floodlights covering bays, corridors, and the gate during a power failure.		
☐	**6.** Hearing and eye protection for EMS: spare sets at the counter; the range stays cold until EMS has left.		
☐	**7.** Ventilation emergency shutoff: HVAC emergency switch marked and known; procedure to clear smoke or dust.		
☐	**8.** Communications: hardwired landline or verified cellular signal at every firing point; radio for remote bays.		
☐	**9.** Bleeding control station visibility: reflective signage visible from every stall and bay; nothing stored in front.		
☐	**10.** Tamper seals: serialized seals on every station and the AED cabinet, checked and logged monthly.		

Monthly station and seal inspection log

STATION / AED ID	DATE	INSPECTOR	SEAL NO.	EARLIEST EXPIRY	RESTOCKED

Audit completed by:

Date:

EAP MASTER TEMPLATE — PAGE 1 OF 2

Range emergency action plan

Print both pages for the range clipboard and the range binder. Review annually and after any incident.

Facility

Facility name and legal entity	
Physical address	
Mailing address (if different)	
GPS coordinates — decimal degrees (DD)	
GPS coordinates — degrees, minutes, seconds (DMS)	
Driving directions from the nearest major highway intersection	

Medical resources

Nearest Level I / II trauma center (name, distance, drive time, helipad Y/N)	
Nearest emergency department (name, distance, drive time)	
Local EMS provider and non-emergency dispatch number	
Local law enforcement / sheriff and dispatch number	
Regional air medical provider and direct number	
Poison control: 1-800-222-1222 · Other	

On-site equipment

AED location(s) and model	
Tier 2 station locations (bay / lane IDs)	
Tier 3 incident station location	
Range vehicle / Tier 4 kit location and keys	
Landing zone (primary / alternate)	

EAP MASTER TEMPLATE — PAGE 2 OF 2

Chain of command, phone tree, and RSO medical roster

Emergency chain of command and phone tree

ROLE	NAME	PHONE	ALTERNATE	ALT. PHONE
Chief Range Safety Officer				
Range owner / general manager				
Facility medical officer / SME				
Legal counsel				
Insurance carrier / agent (policy no.)				
Maintenance / facilities				
Match director / event lead				

Certified RSO medical roster

NAME	RSO CERT. DATE	CPR/AED EXPIRES	BLEEDING CONTROL / TECC EXPIRES	ON-BODY IFAK ISSUED

Approval

ROLE	NAME	SIGNATURE	DATE
Range owner / GM			
Chief RSO			
Medical officer / SME			

RANGE FORM MTC-RSO-INC — PAGE 1 OF 2

Incident report and after-action review

Start this form as soon as the casualty is stable enough for a second person to write. Hand a copy to EMS, keep the original in a restricted file (it contains personal medical information), and complete the after-action review within 72 hours.

Casualty

Name	
Date of birth	
Member number / guest of	
Emergency contact and phone	

Incident

Date and exact time of injury	
Bay / lane / yard line	
Firearm type, caliber, ammunition	
Activity at the time (drill, course of fire, target change, other)	
Mechanism of injury (as observed)	

Injury description

LOCATION	ENTRY	EXIT	BLEEDING (NONE / MINOR / MAJOR)	OTHER FINDINGS
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Interventions

INTERVENTION	TIME	LOCATION ON BODY	BY (NAME)	NOTES
Tourniquet 1				
Tourniquet 2				
Wound packing / hemostatic				
Pressure dressing				
Chest seal (front / back)				
AED: shock advised / delivered				
CPR started				
Other				

RANGE FORM MTC-RSO-INC — PAGE 2 OF 2

EMS handoff, evidence, statements, and review

EMS handoff

Responding agency and unit number	
Paramedic / crew lead name	
Time of transfer of care	
Destination hospital	
Air medical (provider, aircraft, LZ used)	

Firearm and evidence preservation

Once the range is cold, leave the involved firearm in the condition it was found (benched, action open if it was made safe) unless it presents an immediate hazard. Do not clear a malfunction, disassemble, or clean it. Photograph the bench, the firearm, the ammunition, and the lane before anything is moved. Law enforcement decides custody.

ITEM	SECURED BY	TIME	RELEASED TO (AGENCY / OFFICER)	TIME
Firearm				
Ammunition / magazines				
Spent cases / fragments				
Photographs / video				
Range log / lane assignment				

Witness statements

WITNESS (NAME / ROLE)	CONTACT	STATEMENT TAKEN BY	DATE

After-action review (within 72 hours)

What went right	
What to fix (assign owner and date)	
Equipment used / to restock	

ROLE	NAME	SIGNATURE	DATE
Incident commander (RSO)			
Chief RSO / range owner			

FAQ

Questions from range owners, RSOs, and instructors

Q. Why can't we rely on the standard first-aid box on the wall?

A consumer first-aid kit is built for cuts and scrapes: adhesive bandages, antiseptic wipes, burn cream. It has nothing that stops arterial bleeding or seals a chest wound. A range needs tourniquets, hemostatic gauze, pressure dressings, and vented chest seals within reach of the firing line, plus the people trained to use them.

Q. Will visible tourniquets on the firing line alarm our recreational members?

Visible, professional medical equipment reads the same way a fire extinguisher or an AED does: the facility takes safety seriously. Pair the stations with a short members' bleeding control session and the equipment becomes a selling point, not a warning sign.

Q. Should RSOs carry gear on the belt or keep it at the counter?

Both. The RSO carries a tourniquet, pressure dressing, gloves, and shears on the belt for the first seconds; the wall stations cover every group of lanes; the counter kit and AED back them up. A tourniquet three bays away does not exist in the first 60 seconds.

Q. What are the inspection and expiration intervals?

Inspect tourniquets monthly for UV fading, frayed stitching, cracked windlass or clip, and dust; replace anything that has been deployed, sun-baked, or is out of the manufacturer's service life. Sterile dressings, hemostatic gauze, and chest seals carry printed expiration dates — log the earliest date per station and replace on date. AED pads and batteries have their own expiry; check the status indicator monthly.

Q. How much training does an RSO need?

At minimum a hands-on bleeding control course and CPR/AED; a TECC-aligned course for the chief RSO and anyone who runs drills. Refresh with the semi-annual drills on page 13; skills fade in months without practice.

Q. Does a written EAP change our liability?

It changes what you can prove. After an incident, the questions are whether trained people and adequate supplies were in place and whether the plan was practiced. A completed, drilled EAP answers those with records; confirm the rest with counsel and your carrier.

Q. Where do I learn the why behind each step?

In the book this checklist comes from: *The Firearms Instructor's Medical Response Guide* by Marco R. Torres, MD, NRP. It is written for instructors with no medical background and walks through every protocol in this document. See page 20.

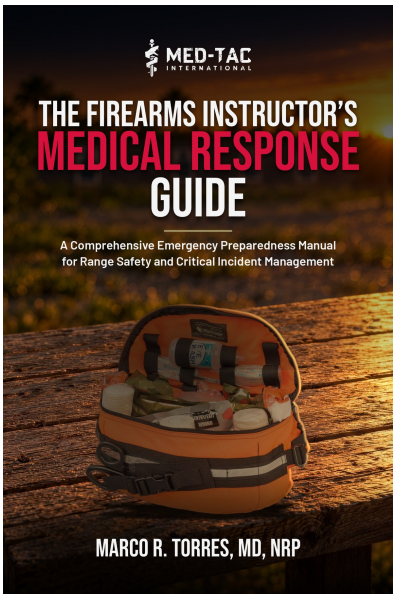
Q. Can MED-TAC International help set this up?

Yes. Range readiness consultation, station placement, kit standardization, and instructor-led bleeding control and TECC-aligned training are quoted through the range page and the RFQ desk on page 21.

QUESTIONS FOR OUR CONSULTATION

THE BOOK BEHIND THIS CHECKLIST

The Firearms Instructor's Medical Response Guide



By Marco R. Torres, MD, NRP · Foreword by Randy Nunez · Paperback, 218 pages

This checklist is the short version. The book is the full playbook behind it, written for firearms instructors and range safety officers with no medical background, with every "why" answered before the "how."

WHAT THE BOOK ADDS

- 15 chapters in five parts: foundations, preparedness, response protocols, specific emergency scenarios, and post-incident procedures
- Gunshot wound management, trauma care in range environments, environmental emergencies, and cardiac and respiratory emergencies
- Legal considerations and liability, pre-incident planning, and communication with EMS
- Scene preservation, documentation, psychological support, and after-action learning
- A quick reference guide, a range medical buyer's guide by tier, and the RSO hub of free tools

GET THE BOOK
tactical-medicine.com/instructor-guide ›

SCAN FOR THE BOOK

Where each part of this checklist goes deeper

IN THIS CHECKLIST	IN THE BOOK
60-second protocol and wound protocols (pp. 3, 7)	Ch. 7 Immediate Response Procedures · Ch. 8 Trauma Management in Range Environments · Ch. 10 Gunshot Wound Management
Staging matrix and procurement specifications (pp. 4, 10–11)	Ch. 4 Essential Medical Equipment and Supplies · Appendix F Range Medical Buyer's Guide
911 dispatch card and air ambulance (pp. 5–6)	Ch. 9 Communication and Coordination
Lead exposure and AED (pp. 8–9)	Ch. 5 Range-Specific Medical Hazards · Ch. 12 Cardiac, Respiratory, and Other Medical Emergencies
Liability, OSHA, and insurance (p. 12)	Ch. 2 Legal Considerations and Liability
Drills, facility audit, and EAP master (pp. 13–16)	Ch. 3 Emergency Response Framework · Ch. 6 Pre-Incident Planning and Risk Assessment
Incident report and after-action review (pp. 17–18)	Ch. 13 Scene Preservation and Documentation · Ch. 14 Psychological Response and Support · Ch. 15 Learning and Improvement

EQUIP THE INSTRUCTOR, NOT JUST THE WALL

The MED-TAC Firearms Instructor Medical Backpack is built to the book's Tier 3 standard: a red Vanquest FATPack-Pro LARGE with four C-A-T Gen 7 tourniquets (two outside the pack), QuikClot Combat Gauze, HyFin Vent chest seals, pressure dressings, and burn, eye and hypothermia care. It and every kit in the book's buyer's guide are at tactical-medicine.com/range.

RANGE HUB: EVERY KIT FROM THE BOOK, SORTED BY TIER
tactical-medicine.com/range ›

DIRECTORY

Professional assistance and range audit

Send the completed staging matrix and station count worksheet for a range kit quote, or request an on-site or remote range medical readiness assessment. Quotes include line-item pricing and the vendor documentation a range board or carrier asks for.

RANGE HUB: KITS BY TIER, FREE TOOLS, CONSULTATION
tactical-medicine.com/range ›

RANGE SOURCING AND BULK KITTING DESK (RFQ / BOM UPLOAD)
tactical-medicine.com/pages/medical-logistics-rfq-services ›

BLEEDING CONTROL STATIONS, KITS, AND COMPONENTS
tactical-medicine.com/collections/massive-hemorrhage ›

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

THE BOOK: THE FIREARMS INSTRUCTOR'S MEDICAL RESPONSE GUIDE
tactical-medicine.com/instructor-guide ›

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REGISTRATION
SDVOSB · SAM Registered · CAGE 9VFL3 · UEI YU3ZMJ44REA5 · Kits Assembled in the USA

SCAN: RANGE HUB AND THE BOOK'S KITS

STANDARDS & TERMS	
Clinical	CoTCCC-recommended trauma devices; C-TECC civilian guidelines; MARCH sequence (Massive hemorrhage, Airway, Respiration, Circulation, Hypothermia/Head); AHA 2025 CPR and AED guidance.
Regulatory	NFPA 3000® Active Shooter/Hostile Event Response Program; OSHA 29 CFR 1910.151 medical services and first aid; OSHA 29 CFR 1910.1025 lead.
Payment	Government purchase cards, credit cards, purchase orders, ACH/EFT. Net 30 for verified government agencies and public school districts; quotes valid 45 days.
Shipping	Free CONUS shipping on orders $200+. Free APO/FPO shipping on every order, no minimum.
Documentation	Packing list with lot numbers and expiration dates; authorized-source statement on request.

Document control: MTC-RSO-001 · Revision 1.1 · Effective 2026–2027. Educational protocol for trained range staff; it does not replace hands-on training, medical direction, local EMS protocols, or legal advice. "CoTCCC-recommended" describes inclusion on the Committee on TCCC recommended-device lists; it is not an approval or certification. © 2026 MED-TAC International Corp.