SAMPLE: County/Parish Emergency Management Support Form

Purpose

The purpose of this County/Parish Emergency Management Support form is to communicate your facility status to the county/parish Emergency Management office servicing your area. This information will enable local Emergency Management to determine what resources are available and what services might be needed in the event of an emergency affecting your facility.

We recommend that this information is forwarded to the Emergency Support Function 8 Desk (ESF 8; Health and Medical Services) at your county/parish Emergency Management Office on an annual basis and/or any time there is a change in this information.

Louisiana ESRD Providers

It may be beneficial to re-submit this information prior to the Hurricane Season (June 1–November 30). Remember, although your parish may not have an ESF 8 Desk, every parish has an Emergency Management Office. Contact information for your local emergency management is located within your HSAG: ESRD Network 13 Disaster Resource materials on the web site (www.hsag.com/ESRDNetwork13).

Instructions:

1. Complete the facility demographic information and be sure to include all available emergency contact names and phone numbers in the order of call preference.
2. Complete Clinic Manager/Administrator information, including name and any/all emergency contact numbers.
3. Complete Medical Director Information, including name, office back line phone number and alternate emergency number.
4. Complete Corporate/chain affiliation information, if applicable.
5. List your power utility provider and the number of your electric meter. This number can be found on your utility bill and may expedite the diagnostic process if your facility loses power.
6. Complete information regarding alternate power sources/generators available at your facility, including the type of fuel used to power the generator. If you do not have a permanent generator, indicate whether you have a transfer switch installed for use of a temporary generator.
7. Complete information regarding water storage and hookup capabilities in your facility.
8. Indicate any/other special instructions that may be helpful to the county/parish EOC office in facilitating services in the event of an emergency/disaster.
9. Indicate person completing the form and the date completed.
10. Forward to your county Emergency Management office, ATTN: ESF 8 (if applicable).

This material was prepared by HSAG: ESRD Network 13, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government.
OK-ESRD-13G014-06012016-01

HSAG HEALTH SERVICES ADVISORY GROUP
ESRD Network 13

COUNTY/PARISH EMERGENCY MANAGEMENT SUPPORT FORM

Dialysis Clinic Name		
Physical Address		
Main Phone Number	**Main Fax Number**	
Emergency Alternate Numbers		
Power Company	**Meter Number**	
Permanent generator?	**Type of Fuel**	
☐ Yes ☐ No		
If no…is transfer switch installed/available?		
☐ Yes ☐ No		
…water storage?	**Gallons**	
☐ Yes ☐ No		
…water hookup?		
☐ Yes ☐ No		
Contact Information (name/phone/email)		
Local Clinic Manager		
Local Administrator		
Local Medical Director		
Corporate Office		
Corporate Emergency Contact(s)		
Comments/Special Instructions		

Completed By:	Date: