EMERGENCY MANAGEMENT SUPPORT FORM INSTRUCTIONS

Purpose:

This form is provided to all local dialysis facilities, who can use this form to provide their status to their local emergency management agency and/or county emergency operations center. This information will enable local emergency management to determine what resources are available and what services might be needed in the event of a disaster affecting dialysis facilities. This form should be updated at least annually.

Instructions for dialysis facilities:

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 will 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. Indicate any/other special instructions that may be helpful to the county EOC office in facilitating services in the event of an emergency/disaster.
8. Indicate person completing the form and the date completed.
9. Forward to your county emergency management agency, local emergency operations cente, or other staff person as directed by your local disaster officials.

EMERGENCY MANAGEMENT SUPPORT FORM
DIALYSIS

DIALYSIS CLINIC NAME: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

EMERGENCY ALTERNATE NUMBERS: _____

CLINIC MGR/ADMINISTRATOR CONTACT INFO: _____

_____

MEDICAL DIRECTOR: _____

CONTACT INFO: _____

CORPORATE NUMBERS: _____

CORPORATE EMERGENCY CONTACTS:

_____

POWER COMPANY & METER #: _____

PERMANENT GENERATOR? Y □ N □ TYPE OF FUEL _____

IF NO, IS TRANSFER SWITCH INSTALLED/AVAILABLE? Y □ N □

COMMENTS/SPECIAL INSTRUCTIONS: _____

_____

_____

COMPLETED BY: _____ DATE: _____

Contact with local emergency management **Date** _____

Facility Name: _____

CMS Provider Number _____

Name of person filling out this form _____

List of resources and information we sent to the local emergency management office:

☐ _____

☐ _____

☐ _____

☐ _____

Date the information was sent: _____

Information was sent to: Name/Title: _____

Agency: _____

Address: _____

Phone/Fax: _____ / _____

Email: _____

Follow-up information received (i.e., return fax verification, email communication response, etc):

Facility's plans for annual communication includes: