FILL IN THE REQUESTED INFORMATION BELOW AND SEND IT TO YOUR LOCAL OFFICE OF EMERGENCY MANAGEMENT. <u>DO NOT SEND A COPY OF YOUR PLAN.</u> UP-DATE AND SUBMIT THIS SHEET <u>ANNUALLY.</u>

BASIC HEALTH CARE FACILITY INFORMATION

FACILITY NAME: _____ PHONE: _____

STREET ADDRESS: _____ FAX: _____

CITY: _____ZIP: _____

PRIMARY 24 HOUR POINT OF CONTACT:

NAME: _____ WORK PHONE: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ CELL PHONE: _____

PAGER: _____

ALTERNATE 24 HOUR POINT OF CONTACT:

NAME: _____ WORK PHONE: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ CELL PHONE: _____

PAGER: _____

NUMBER OF BEDS AT THIS FACILITY: _____

NUMBER OF FULL TIME EMPLOYEES: _____ NUMBER OF PART TIME EMPLOYEES: _____

NUMBER OF VEHICLES AVAILABLE FOR EMERGENCY EVACUATION: _____

NAME OF YOUR FACILITY'S PAIRED FACILITY: _____

THIS FACILITY HAS AN EMERGENCY GENERATOR: YES: ☐ NO: ☐

DATE: _____ PRINTED NAME: _____

SIGNATURE: _____

SAVE