



Florida Kidney Disaster Coalition Emergency Management Support Form

Purpose:

The purpose of the enclosed County Emergency Management Support form is to communicate your facility status to the county Emergency Management office servicing your area. This information will enable 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 you forward this information to the Emergency Support Function 8 Desk (ESF 8; Health and Medical Services) at your county Emergency Management office on an annual basis and/or any time there is a change in this information. Additionally, you may want to re-submit this form prior to the advent of Florida's Hurricane Season (June 1 – November 30).

Instructions:

*****If you cover multiple clinics please be sure to complete a separate form for each clinic!***

1. Complete the facility demographic information. Indicate whether or not your facility is deemed a "hub" or "critical facility" for emergencies.
2. Complete Administrator, Corporate, and Medical Director names and contact information. Provide a minimum of 2 (main + alternate) contacts for each section. Be sure to include **all** available emergency phone numbers and e-mail addresses.
3. List your power utility provider (i.e. FPL, TECO, etc.) 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.
4. 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.
5. Complete information regarding water storage and hookup capabilities in your facility.
6. Provide the number of stations and total number of patients served in your facility.
7. Describe any other hurricane protection your facility has (i.e. hurricane shutters)
8. Indicate any/other special instructions that may be helpful to the county 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.



COUNTY EMERGENCY MANAGEMENT SUPPORT FORM

DIALYSIS CLINIC NAME: _____

IS THIS CLINIC A "CRITICAL FACILITY" OR "HUB"? Y N

CLINIC ADDRESS: _____

CLINIC PHONE/FAX: _____

EMERGENCY ALTERNATE NUMBERS: _____

ADMINISTRATOR NAME/CONTACT INFO: _____

CORPORATE CONTACT NAME/NUMBER: _____

MEDICAL DIRECTOR NAME/CONTACT INFO: _____

POWER COMPANY & METER #: _____

PERMANENT GENERATOR? Y N TYPE OF FUEL: _____

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

WATER STORAGE? Y N GALLONS _____

WATER HOOKUP? Y N

NUMBER OF STATIONS: _____

TOTAL PATIENTS SERVED: _____

TYPE OF HURRICANE PROTECTION: _____

COMMENTS/SPECIAL INSTRUCTIONS: _____

COMPLETED BY: _____ DATE: _____