**Disaster Preparedness:**

A Guide for Chronic Dialysis Facilities
Second Edition

**Supplemental Appendix of Customizable Forms**



**Note:** This manual is intended as a guide and does not represent a comprehensive disaster preparedness program for your facility. As your specific needs may exceed the scope of the information presented here, you should also seek professional guidance from qualified risk managers, engineers, and technicians to create the best plan for your center. The Kidney Community Emergency Response Coalition (KCER) also provides resources for the development of facility-specific disaster plans.

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## Appendix A - Emergency Management Contact Form

The purpose of the Emergency Management Contact Form is to document the facility’s annual contact with the local emergency management agency. Communication with the local emergency management agency can ensure that local disaster aid agencies are aware of the dialysis facility’s patients’ needs in the event of an emergency and ensure that the agency is aware of the dialysis facility’s needs in the event of an emergency. This pre-emptive contact could facilitate the meeting of dialysis patient needs during a disaster. Dialysis facilities should provide education and data about their facility (location, number of patients, emergency contact information). Remember, using this form is only a recommended practice and just a “first step.” The facility
will need to build and maintain a relationship with the local emergency management agency and develop and practice your disaster plans in order to provide the highest quality patient care and safe working environment for staff.

|  |  |
| --- | --- |
| **Contact with Local Emergency Management:** | **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ |
| **Facility Name:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **CMS Certification Number:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name Of Person Completing This Form:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **List of resources and information sent to the local emergency management office:** |
| **□** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**□** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**□** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date the information was sent:** |  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Information was sent to:** | **Name/Title:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Agency:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Phone/Fax:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **E-Mail:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Other contact with the emergency management agency or emergency operations center (EOC)(e.g., phone calls/emails, including dates and who was involved):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Follow-up indicating information was received (e.g., returned fax verification, email responses, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Facility’s plan for annual communication:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Attach copies of letters, faxes, emails, or other documentation to this form.** |

##

## Appendix B - County Emergency Management Support Form

The purpose of the County Emergency Management Support Form is to communicate your facility’s status to the county Emergency Operations Center (EOC) serving your area. This information will enable emergency management to determine available resources and services that might be needed in the event of a disaster affecting the facility. It is recommended that facility’s forward this information to the county EOC on at least an annual basis and any time there is a change in the information.

Form Instructions:

|  |  |
| --- | --- |
| Important Concept Graphic | If you are responsible for multiple clinics, you must complete a separate form for each clinic. |

1. Complete the facility demographic information. Indicate whether the facility is deemed a “hub” or “critical facility” for emergencies.
2. Provide the name and contact information for the administrator, corporate contact, and Medical Director. Provide a minimum of two (main and alternate) contacts for each. Be sure to include **all** available emergency phone numbers and e-mail addresses.
3. List power utility providers and the number of the facility’s electric meter. This number can be found on the utility bill and will expedite the diagnostic process if the facility loses power.
4. Provide information regarding alternate power sources/generators available at the facility, including the type of fuel used to power the generator. If the facility does not have a permanent generator, indicate whether a transfer switch is installed for use of a temporary generator.
5. Complete information regarding water storage and hookup capabilities in the facility.
6. Provide the number of stations and total number of patients served in your facility.
7. Describe any other emergency protection the facility has (e.g., hurricane shutters).
8. Indicate all special instructions that may be helpful to the county EOC in facilitating services.
9. Indicate person completing the form and the date completed.
10. Include educational information regarding the needs of dialysis patients, such as the *Save a Life* brochure, which is available on [www.kcercoalition.com](http://www.kcercoalition.com).
11. Forward to the county EOC.
12. Retain a copy of this form and document any follow-up actions or responses.

|  |  |
| --- | --- |
| **Dialysis Facility Name:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **This Facility is a:** | □ Critical Facility □ Hub |
| **Facility Address:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Facility Phone/Fax:** | Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alternate Emergency Numbers:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Administrator Name/Contact Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Corporate Contact Name/Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medical Director Name/Contact Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Power Company:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Meter Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Permanent Generator?** □Y □N | **If NO, is Transfer Switch Installed/Available?** □Y □N |
| **Type of Fuel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Water Storage?**□Y □N  | **Gallons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **Water Hookup?** □Y □N |
| **Number of Dialysis Stations: \_\_\_\_\_\_\_\_\_\_** | **Number of Isolation Stations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Total Patients Served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Any Special Disaster Protections:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Comments/Special Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Form Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

##

## Appendix C - Emergency Contact Information Forms

Update these forms annually and with any changes.

|  |
| --- |
| **Community – Emergency Contact Information** |
| **Organization** | **Contact Name** | **Phone Number** |
| Ambulance |  |  |
| Fire Department |  |  |
| Fire Department: Non-Emergency |  |  |
| Police Department |  |  |
| Police Department: Non-Emergency |  |  |
| County Emergency Operations Center |  |  |
| State Emergency Management Agency |  |  |
| Hazardous Materials Handling/Information |  |  |
| Local Electric Company |  |  |
| Local Gas Company |  |  |
| Local Water Department |  |  |
| Nearest Hospital |  |  |
| Nearest Trauma Center |  |  |
| Poison Control |  |  |
| Public Health Department |  |  |
| Telephone Repair |  |  |
| Transportation Company |  |  |
|  |  |  |
|  |  |  |

Date of Last Form Update: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Facility – Emergency Contact Information** |
| **Department/Individual** | **Contact Name** | **Phone Number** |
| Management/After Hours |  |  |
| Facility Administrator (Home) |  |  |
| Facility Administrator (Cell) |  |  |
| Charge Nurse (Home) |  |  |
| Charge Nurse (Cell) |  |  |
| Alternative Dialysis Center |  |  |
| Building Inspector |  |  |
| Chief Technician (Home) |  |  |
| Chief Technician (Cell) |  |  |
| Medical Director (Home) |  |  |
| Medical Director (Cell) |  |  |
| Water Treatment Contractor |  |  |
|  |  |  |
|  |  |  |

Date of Last Form Update: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

## Appendix D - Hazard Vulnerability Analysis Tool

A hazard vulnerability analysis is usually the first step in disaster planning for an organization. The Hazard Vulnerability Analysis Tool is designed so organizations can evaluate their level of risk and preparedness for a variety of hazardous events. The following tool lists possible hazards that would require disaster planning and can be individually tailored to suit the needs of the organization.

List potential hazardous events for your organization.Evaluate and rate each event for probability, vulnerability, and preparedness using the following scales:

|  |  |
| --- | --- |
| **Ranking probability and vulnerability** | **Ranking preparedness**  |
| High = 3 Moderate = 2 Low = 1  | High = 1Moderate = 2 Low = 3  |

To calculate, multiply the ratings for each event: probability x vulnerability x preparedness = total score

### Example

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Probability** | **X** | **Vulnerability** | **X** | **Preparedness** | **= Total Score** |
| **3 2 1****High Low** |  | **3 2 1****High Low** |  | **1 2 3****High Low** | **12** |

The higher scores will represent the events most in need of planning. Using this method, 1 is the lowest possible score, while 27 is the highest possible score. *Remember the scale for preparedness is in reverse order from probability and vulnerability.*

* When evaluating probability, consider the frequency and likelihood an event may occur.
* When evaluating vulnerability, consider the degree with which the organization will be impacted, such as infrastructure damage, loss of life, service disruption, etc.
* When evaluating preparedness consider elements such as the strength of your preparedness plan and the organization’s previous experience with the hazardous event.

Based on the results, determine which values represent an acceptable risk level and which events require additional planning and preparation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Event** | **Probability** | **VulnerabilityLevel/DisruptionDegree** | **Preparedness** | **Score** |
|  | **High (3)** | **Moderate (2)** | **Low (1)** | **High (3)** | **Moderate (2)** | **Low (1)** | **High (1)** | **Moderate (2)** | **Low (3)** |  |
| Ice/Snow |  |  |  |  |  |  |  |  |  |  |
| Flooding |  |  |  |  |  |  |  |  |  |  |
| Earthquake |  |  |  |  |  |  |  |  |  |  |
| Hurricane |  |  |  |  |  |  |  |  |  |  |
| Hazardous Material Accident |  |  |  |  |  |  |  |  |  |  |
| Fire |  |  |  |  |  |  |  |  |  |  |
| Tornado |  |  |  |  |  |  |  |  |  |  |
| Volcano |  |  |  |  |  |  |  |  |  |  |
| Civil Disturbance |  |  |  |  |  |  |  |  |  |  |
| Mass Casualty Event |  |  |  |  |  |  |  |  |  |  |
| Terrorist Attack |  |  |  |  |  |  |  |  |  |  |
| Pandemic/Infectious Disease Outbreak |  |  |  |  |  |  |  |  |  |  |
| Electrical Failure |  |  |  |  |  |  |  |  |  |  |
| Communications Failure |  |  |  |  |  |  |  |  |  |  |
| Information Systems Failure |  |  |  |  |  |  |  |  |  |  |
| Water Failure |  |  |  |  |  |  |  |  |  |  |
| Transportation Interruption |  |  |  |  |  |  |  |  |  |  |
| Environmental Pollution/Altered Air Quality |  |  |  |  |  |  |  |  |  |  |

## Appendix E - Pandemic Planning Checklist

Follow the checklist below to develop your Pandemic Plan.

|  |
| --- |
| **Section 1** |
| □ | Identify members of the facility’s planning team, and set up a schedule to meet regularly |
| **Section 2** |
| □ | Discuss the roles and responsibilities of the following in pandemic planning and response: |
|  | □ | Facility pandemic planning committee/staff |
|  | □ | Patients |
|  | □ | Caregivers |
|  | □ | Local liaisons (public health, local hospital liaison, medical transporters, localemergency management agency, referring physician groups representatives) |
|  | □ | Representatives from other associated dialysis facilities and dialysis patient transportation providers |
|  | □ | Vendors of critical supplies |
| **Section 3** |
| □ | Review these resources for plan development |
|  | □ | The CMS Manual Disaster Preparedness: A Guide for Chronic Dialysis Facilities |
|  | □ | The HHS Pandemic Influenza Plan |
|  | □ | State and/or local influenza plans |
|  | □ | The KCER Coalition Pandemic Preparedness Team page at [www.kcercoalition.com](http://www.kcercoalition.com/Local%20Settings/Documents%20and%20Settings/ea5156/Desktop/www.kcercoalition.com) |
|  | □ | Your dialysis company’s pandemic plan |
|  | □ | The National Strategy for Pandemic Influenza Implementation Plan |
| **Section 4** |
| □ | Consider these key elements of a plan for your facility and include them in a written plan: |
|  | □ | **Communication Plan (Patients, Partners and Other Agencies)** |
|  |  | □ | Discuss coordination with other facilities, local clinicians, and other agencies |
|  |  | □ | Identify contacts for exchange of information such as facility status, situation in community with respect to disease rates, and resource requests |
|  |  | □ | Outline education plan for staff, patients, and caregivers |
|  |  | □ | Determine the education plan, and evaluate potential messages for inclusion in preparedness education, such as personal stockpiling, infection control, and caring for yourself or a family member with the flu |

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|  |
| --- |
| **Section 4 (Continued)** |
|  |  | □ | Discuss your communication goals during a response |
|  |  |  | □ | Facility operational status: Open or Closed? |
|  |  |  | □ | Where to obtain reputable information on available services (transportation) and infrastructure (hospital status), physician on-call schedules, etc. |
|  |  |  | □ | Where to learn what’s going on in your community (local emergency management agency, department of health, media, etc.) |
|  | □ | **Infection Control Plan** |
|  |  | □ | Basic prevention and infection control for staff and caregivers |
|  |  | □ | Strategies to socially distance persons to minimize transmission of flu (consider strategies on use of isolation rooms, cohorting dialysis machines, using isolation rooms at partnering facilities and/or potential for use of home hemodialysis to facilitate isolation) |
|  |  | □ | Proper type and use of masks and other personal protective equipment |
|  | □ | **Staffing Plan** |
|  |  | □ | Acknowledge potential for employee absenteeism and/or possible patient surge |
|  |  | □ | Determine critical number and type of staff to keep facility operational and safe |
|  |  | □ | Work on a plan with other facilities to share staff with like duties |
|  |  | □ | Cross-train duties as able. Provide re-training for clinical staff who may now be in management or other types of positions who may need to help with clinical duties in a pandemic |
|  |  | □ | Identify vascular surgeons in advance to deal with fistula issues in patients with influenza and new patients |
|  |  | □ | Develop plan for workforce support/resiliency and mental health support |
|  |  | □ | Develop plan to contact state agency to ask for temporary exception to any applicable staffing ratio requirements |
|  | □ | **Supplies/Resources Plan** |
|  |  | □ | Review current supply level of critical items (such as dialysate) and work with vendors on how to maintain  |
|  |  | □ | Identify supplies that are used outside the provision of dialysis to care for people with flu. This could include saline, syringes, gloves, masks, gauze, bleach, etc. If these items are unavailable, it may impact the provision of dialysis to some degree |
|  |  | □ | Define items that can be stockpiled, including appropriate antibiotics to deal with vascular access infections or other medications |
|  |  | □ | Determine current supply per week and estimate the need during a pandemic per week of operation |
|  |  | □ | Maintain current and alternate list of vendors |
|  | □ | **Transportation Plan for Employees and Patients** |
|  |  | □ | Identify major transportation providers and alternatives (rail, buses, medical transport, volunteers, churches, community agencies) and incorporate their plans into your own plan |

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|  |
| --- |
| **Section 4 (Continued)** |
|  | □ | **Utilities Plan** |
|  |  | □ | Meet with local utility companies and review their plan and get contact information |
|  |  | □ | Review critical needs to operate the facility with local utility company representatives |
|  |  | □ | Discuss prioritization for restoration or maintenance of utilities and how the utility company has incorporated dialysis facility needs into their plan |
|  | □ | **Treatment Plan** |
|  |  | □ | Review with physician groups and Medical Director treatment changes that might be possible/necessary, such as decreasing from three treatments per week to two for some patients  |
|  |  | □ | Determine in advance what level of service the facility would provide at each level of staff absenteeism. Discuss how policies and procedures would change |
|  |  | □ | Determine how to handle new or additional patients |
|  | □ | **Vaccine and Antiviral Use Plan** |
|  |  | □ | Identify vendor source, first and second priority status, and corporate status on stockpiling |
| **Section 5**  |
| □ | Participate in local disaster planning efforts with the local emergency management agency |
| **Section 6**  |
| □ | Commit to a regular schedule of training and performing exercises or mock disaster drills and then (re)evaluating plans |

##

## Appendix F - Preparedness Assessment

|  |  |  |  |
| --- | --- | --- | --- |
|  | **DateCompleted** | **DateReviewed** | **Name/Title of Individuals Responsible for Completion** |
| **Administrative** |
| Establish incident command structure – Chain of command and lines of authority |  |  |  |
| Establish liaison with State and local Emergency Management Agencies – confirm contacts on a regular schedule (e.g., quarterly) |  |  |  |
| Establish alternate command center |  |  |  |
| Identify a meeting place for all personnel if facility is not accessible |  |  |  |
| Establish Memorandum of Understanding (MOU) with other stakeholders/facilities |  |  |  |
| Schedule/complete mock drill and performance assessment of drill |  |  |  |
| Assign responsibility to staff member to notify the ESRD Network if the facility is impacted by a disaster (not operating normally, building damage, etc). |  |  |  |
| Plan for building and staff security and protection |  |  |  |
| **Supplies** |
| Examine vendor alternatives and contacts |  |  |  |
| Plan for office supply inventory needed to continue operations (3 – 5 days of supplies on hand) |  |  |  |
| Determine needed stockpile of clinical supplies |  |  |  |
| Plan for the security and protection of supplies |  |  |  |

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|  |  |  |  |
| --- | --- | --- | --- |
|  | **DateCompleted** | **DateReviewed** | **Name/Title of Individuals Responsible for Completion** |
| **Utilities** |
| Develop plan for loss of water and power: generator/fuel, potable waterpotable water |  |  |  |
| Plan for removal of biohazards and other facility waste |  |  |  |
| **Record Protection** |
| Backup plan in place for electronic records |  |  |  |
| Develop plan to protect all medical records |  |  |  |
| Plan for off-site/distant storage |  |  |  |
| **Financial** |
| Mechanism to track organization costs during disaster or emergency situations |  |  |  |
| Develop business continuity plan – Include ability to complete payroll, pay vendors |  |  |  |
| Determine the needed cash to have on hand |  |  |  |
| Identify funding sources if normal payment structures are interrupted |  |  |  |
| **Communication** |
| Determine alternate communication system for both staff and patients (cell phones, pagers, satellite phones) |  |  |  |
| Coordinate with local and state Emergency Management policy on communicating with other health facilities |  |  |  |
| Establish telephone tree and communicate to staff |  |  |  |
| Coordinate with local and state Emergency Management Agencies on information dissemination (media releases, etc.) |  |  |  |
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|  |  |  |  |
| --- | --- | --- | --- |
|  | **DateCompleted** | **DateReviewed** | **Name/Title of Individuals Responsible for Completion** |
| **Surge Capacity** |
| Define surge capacity for your organization: maximum caseload, scope of services, length of treatment |  |  |  |
| Identify actions to increase surge capacity, including lodging for additional staffing |  |  |  |
| Identify which staff will be available to the facility during a disaster |  |  |  |
| Communicate plans with local healthcare facilities regarding scope of service and facility ability to deal with surge |  |  |  |
| Develop condensed admission requirements (state-specific requirements should be researched prior to disaster) |  |  |  |
| Develop and maintain patient tracking system |  |  |  |
| **Staff** |
| Develop disaster orientation program for all staff |  |  |  |
| Establish a continuing all-hazard education schedule |  |  |  |
| Compile and maintain a current list of staff emergency contact numbers |  |  |  |
| Establish protocols for communication of staff with office/supervisors  |  |  |  |
| Develop/establish altered job descriptions/duties identified for each discipline |  |  |  |
| Instruct and assist staff to develop personal/family disaster plans  |  |  |  |
| Plan for food, lodging, transportation, fuel, and mental health resources for employees in need in the recovery phase |  |  |  |
|  |  |  |  |

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|  |  |  |  |
| --- | --- | --- | --- |
|  | **DateCompleted** | **DateReviewed** | **Name/Title of Individuals Responsible for Completion** |
| **Patient Education** |
| Provide educational materials to assist patients in preparing for emergencies and to provide self-care if organization personnel are not available (where applicable) |  |  |  |
| Ensure patients are informed of local/state evacuation plan, back-up facility and alternate facility number  |  |  |  |
| Instruct and assist patients to develop personal/family disaster plans |  |  |  |
| Ensure patients are informed of the potential for care to be delayed or unavailable in a disaster |  |  |  |
| Review emergency take off procedure (clamp and cap) |  |  |  |
| **Transportation** |
| Develop plans for transportation interruptions and road closures  |  |  |  |
| Arrange alternate transportation plan (include plans for patients and staff) |  |  |  |
| Develop plan for gasoline allocation  |  |  |  |
| Identify gas stations that can operate during power outages |  |  |  |
|  |  |  |  |

##

## Appendix G - Patient Identification Card

A lavender Patient Identification Card example is provided below. To download and print these cards, visit [www.kcercoalition.com](http://www.kcercoalition.com/Local%20Settings/Documents%20and%20Settings/am1303/Local%20Settings/Temporary%20Internet%20Files/Content.Outlook/VU1O4EV5/www.kcercoalition.com).



##

## Appendix H - Sample Facility Preparedness Questionnaire

|  |  |
| --- | --- |
| On a scale of 1 to 5 (1= not prepared, 5=very prepared), how prepared do you feel your facility and patients are for a disaster? | 1 2 3 4 5 |
| On a scale of 1 to 5 (1 = not prepared, 5=very prepared), how prepared do you think you are, personally, at home? | 1 2 3 4 5 |
| Are any of the facility staff planning to evacuate? |  YES NO |
| If so, have their evaluation plans and location of their evacuation site been documented and shared with management? | YES NO |
| Does the facility have a disaster manual? | YES NO |
| Do you know the personal plan of each patient (e.g., evacuate to a shelter, leave the area, or remain in their home)? | YES NO |
| Is there a designated shelter in your area for dialysis patients? | YES NO |
| Do the patients have instructions regarding the emergency renal diet (3-day disaster diet)? | YES NO |
| Were the instructions given verbally? | YES NO |
| Were the instructions given in writing? | YES NO |
| Is there a plan in place to provide patients with a copy of their most recent treatment orders, medication lists, and care plans before a disaster? | YES NO |
| Have patient contact lists been recently updated? | YES NO |
| Have patient allergy and medication lists been recently updated? | YES NO |
| Does the facility have a plan for contacting patients both before and after a disaster? | YES NO |
| Is there a designated person in the facility responsible for contacting patients? | YES NO |
| Is there also a back-up person for this role? | YES NO |
| Does the facility have a designated backup facility? | YES NO |
| If so, do both patients and staff know the name of the facility’s name and location? | YES NO |
| Do the patients know how to contact the facility/backup facility post-disaster? | YES NO |
| Are there plans in place for protection of both medical records and equipment/building? | YES NO |
| Is the facility aware that the local ESRD Network and State Survey Agency should be contacted following a disaster and provided an update on the facility status (open/closed), damage, and special needs? | YES NO |
| Is staff aware of how to contact the local ESRD Network and State Survey Agency? | YES NO |
| Does staff have appropriate identification/documentation to travel in the event of a curfew? (Don't forget about new hires.) | YES NO |
| Do patients have identification as dialysis recipients? | YES NO |
| Have arrangements been made for staff housing, fuel, or food post-disaster? | YES NO |
| Is there a designated staff person to assess damage post-disaster? | YES NO |
| Are all attending physicians aware of the facility’s disaster plan? | YES NO |
| Does the facility have a disaster phone tree? | YES NO |

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|  |  |
| --- | --- |
| Does the Medical Director know who to contact in the event the facility’s telephones are inoperable? | YES NO |
| Does the local ESRD Network have your emergency contact numbers? | YES NO |
| Are arrangements in place to obtain additional supplies? | YES NO |
| Does the facility have written disaster standing orders for each patient? | YES NO |
| Does the facility have a non-electric phone available? | YES NO |
| Does the facility have a recently serviced generator? | YES NO |
| Is the tank full? | YES NO |
| Does the facility have an agreement to obtain a generator and know how soon it could arrive? | YES NO |
| Does the facility have an agreement with a company to ensure a fuel supply for the generator after a disaster? | YES NO |
| In the event that a generator is not available or is not operable, are the staff and patients familiar with the hand-cranking procedure? | YES NO |
| Were the patients recently trained on this activity? | YES NO |
| Does the facility have appropriate and up-to-date water testing materials? | YES NO |
| Are there alternate staff at the facility who know how to do water testing? | YES NO |
| In the event there is no water supply for the city, does the facility have the means to hook up a water tanker? | YES NO |
| Is an agreement in place for obtaining potable water after a disaster? | YES NO |
| Does the facility have a plan for securing refrigerated medications? | YES NO |
| Have provisions been made for infectious waste? | YES NO |

##

## Appendix I - Sample Patient Preparedness Questionnaire

|  |  |
| --- | --- |
| On a scale of 1 to 5 (1= not ready, 5= very ready) do you think you are ready for a disaster? | 1 2 3 4 5 |
| Has anyone from your clinic given you information about disasters?If so, what have you received?  |  YES NO |
| Do you have a disaster kit at home?If so, what is in the kit? | YES NO |
| Do you have a supply of medications to use in emergencies? | YES NO |
| Do you know about the emergency renal diet (3-day disaster diet)? What are the things you aren’t supposed to eat or drink? | YES NO |
| Do you know how to hand crank your machine if the power goes off? Describe the process. | YES NO |
| In an emergency could you take yourself off the machine?Describe the process. | YES NO |
| If you had to evacuate from your home, would you go to a shelter? | YES NO |
| Do you know that shelter’s location? | YES NO |
| Do you know if there is a shelter that is special for dialysis patients? | YES NO |
| Are you registered at that shelter? | YES NO |
| Have you thought about leaving the area? If so, where would you go?  | YES NO |
| If you have pets, do you know what you would do with them in a disaster?If so, what is your plan? | YES NO |
| Do you have a way to get to treatment if the transportation you usually use isn't available?If so, what is your plan? | YES NO |
| Has your clinic given you phone numbers so that you can contact someone to set up treatment after a disaster? | YES NO |
| Do you know how to find a dialysis facility if yours is closed? How would you do this?  | YES NO |

##

## Appendix J - Sample Quality Improvement Plan

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Problem or Process to Improve** | **Measure** | **Baseline Result** | **Root Cause(s)** | **Action(s) and Person(s) Responsible** | **Goal(s)** | **Time Frame** | **Evaluation Process** |
| *Measure identified for improvement.* |  | *Enter the baseline (current) result for measure including date and %.* | *Enter cause(s) that have been identified by your facility that contribute(s) to the facility’s current performance rate. (Enter each cause on a separate line below).* | *For each identified cause, describe the action step(s) the facility will use to achieve improvement. Indicate who in your facility is responsible for each action step.* | *Enter the goal to be achieved including date (e.g., “To improve our baseline of % to* *% by .* | *For each action step, indicate the beginning date (date action step was started) and the end date (date action step to be completed).*  | *Describe how the facility will continuously evaluate each action step taken to see if improvement is being achieved. (e.g., tracking tools, meetings, monitoring) Include who will be responsible for evaluation and compliance****.***  |
| Dialysis facility staff unaware of disaster plans for nursing home patients, and no documentation of plans in patient chart. | The percentage of nursing home patients with documented disaster plans.**Numerator:** # of nursing home patients with documented plan**Denominator:** Total # of nursing home patients  | Only 3 out of 8 nursing home patients had disaster plans documented in chart (38%). | Infrequent communication with nursing homes.No assigned staff member to obtain and document information from Nursing Home. | Use Quarterly Update Tool to document nursing home plans.Social worker will be responsible for reviewing and documenting contact with Nursing Home and disaster plans.  | To increase percentage of disaster plans for nursing home patients documented in patient chart to 90%. | Begin: 9/1/11End: 12/1/11 | The social worker will conduct follow-up audit of charts for nursing home patients in December to determine progress. If goal not met, the social worker will review and revise actions. |
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Date QIP Developed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

## Appendix K - Drill Critique Form

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| --- | --- |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Critique Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Time Drill Began: \_\_\_\_\_\_\_\_\_\_\_\_ | Time Drill Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| **Communications** |
| Was the disaster signal heard in all areas? |  YES NO |
| Was the Fire Department notified (simulation)? |  YES NO |
| If YES, time of notification: |   |
| **Evacuation Team Personnel** |
| Did team members report to their assigned areas? |  YES NO |
| Did team members carry out all assigned duties? |  YES NO |
| If applicable, were the elevators brought to the main lobby and deactivated? |  YES NO |
| Were evacuation techniques demonstrated? |  YES NO |
| **Containment of Fire** |
| Were all doors closed but not locked? |  YES NO |
| Were all windows closed? |  YES NO |
| Was a fire extinguisher taken to fire location (if applicable)? |  YES NO |
| **Patient Education** |
| Was emergency take off demonstrated? |  YES NO |
| Was there a previous review of *Preparing for Emergencies: A Guide for People on Dialysis* and the emergency diet? |  YES NO |
| **Communication Procedures** |
| Was contact information current? |  YES NO |
| Were key phone numbers available and distributed? |  YES NO |
| **Evacuation/Relocation** |
| Were corridors and exits clear? |  YES NO |
| Did the evacuation proceed in a smooth and orderly manner (simulated)? |  YES NO |
| Did visitors to the building take part in the drill? |  YES NO |
| **Utilities (Simulated)** |
| Were electric and gas appliances turned off? |  YES NO |
| Was the ventilation system shut down? |  YES NO |
| Was the oxygen valve shut off? |  YES NO |
| Were all water treatment machines and other ancillary equipment shut off? |  YES NO |
| **Availability of Emergency Packs** |
| Were the emergency packs complete and all supplies in-date?  |  YES NO |
| Were the emergency packs accessible to staff and patients? |  YES NO |

(Continued on next page)

|  |
| --- |
| **Contaminated Water** |
| Dialysate into bypass (simulated)? |  YES NO |
| Was the water shut off (simulated)? |  YES NO |
| Was ascorbic acid available for chloramine breaking through the carbon tanks? |  YES NO |
| **Hazardous Spills** |
| Were spill kits available? |  YES NO |
| Were ANSI respirators with appropriate filters available? |  YES NO |
| **Remarks and Recommendations** |
|  |

##

## Appendix L - Drill Attendance Roster Form

|  |  |
| --- | --- |
| Drill Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Scenario: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ANNOUNCED or UNNANOUNCED (circle) | Drill Conducted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Staff Participating** | **Title** |
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| **Patients Participating** |  |
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## Appendix M - Disaster Drill Evaluation and Action Form

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| --- | --- | --- | --- | --- | --- | --- |
| **Area for Improvement** | **Facility Action** | **Who is Responsible** | **By When** | **Others Needed** | **Specific Resources Needed** | **Status/ Outcome** |
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## Appendix N - Emergency Equipment/Supply Record

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| Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Requested By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Date** | **QTY** | **Items/Description/Serial #** | **Received By** |
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| Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ |
|  (Signature) (Printed Name) (Date) |

##

## Appendix O - Emergency Dialysis Patient Record

|  |  |
| --- | --- |
| Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone Number: ( ) |
| Medicare? *□* Yes □ No  | Other Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number: ( ) | Usual Dialysis Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Treatment Modality (Check One): | *□* Hemo*□* CAPD*□* IPD*□* CCPD*□* Transplant |

Treatment Log

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Services Provided** | **Observations/Notes** | **Staff Name** |
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##

## Appendix P - Dialysis Treatment Supply Checklist

Use the following guide to help you determine what supplies are necessary to dialyze patients.

|  |  |  |
| --- | --- | --- |
| **Product** | **Description** | **Quantity** |
| Master list of patients |  |  |
| Alcohol wipes |  |  |
| Basic/comprehensive first aid kits |  |  |
| Blood pressure cuff |  |  |
| Catheter caps |  |  |
| Clamps |  |  |
| Dialysate Bicarbonate Concentrate  |  |  |
| Dialysate Acid Concentrate  |  |  |
| Dialysis tubing A & V |  |  |
| Dialyzers |  |  |
| Fistula needles |  |  |
| Gloves (latex) |  |  |
| Gloves (vinyl) |  |  |
| Heparin |  |  |
| IV infusion lines |  |  |
| Normal saline, 0.9% |  |  |
| Writing pens |  |  |
| Port caps |  |  |
| Povidine iodine |  |  |
| Power adapters |  |  |
| Standard treatment packs (or supplies needed if packs not used) |  |  |
| Stethoscope |  |  |
| Syringes with needles |  |  |
| Tape |  |  |
| Thermometer |  |  |
| Transducer protectors |  |  |
| Treatment forms |  |  |
| Xylocaine |  |  |

## Appendix Q - Emergency Succession for Decisions

Use this form to designate individuals in charge during a disaster. Instruct staff that if the first person is not present or available, they should go to the next person listed. Determine the appropriate contact order for your senior staff including the Medical Director, charge nurse, technicians, social workers, and dietitians.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name/Position** | **Email Address** | **Business Phone** | **Cell Phone** | **Home Phone** | **Pager** |
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##

## Appendix R - Sample Public Service Announcement (PSA)

Use this sample PSA as a starting point and adapt it to meet the facility and patient needs. Complete SHADED areas to customize your PSA.

|  |
| --- |
| **Introduction** |
| This is an announcement from FACILITY NAME , located at FACILITY STREET ADDRESS . |
| **To Our Employees** |
| DO/DO NOT report to work. |
| Our Dialysis Center is temporarily OPEN/TEMPORARILY CLOSED. |
| Facility Staff should report to LOCATION WHERE STAFF SHOULD REPORT . |
| **To Our Patients** |
| Our Dialysis Center is OPEN/CLOSED TEMPORARILY. |
| You SHOULD REMAIN AT HOME UNTIL WE NOTIFY YOU TO COME IN or SEEK DIALYSIS AT AN ALTERNATE CENTER. |
| Follow the emergency renal diet (3-day disaster diet). |
| These local centers are operating: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you have a life-threatening injury or illness, report to the nearest emergency room. |
| **Other Information** |
|  |

Signed By: Date:

##

## Appendix S - Damage Assessment Form

Use this form to list employees responsible for damage assessment.

|  |
| --- |
| **Considerations for the damage assessment:*** Personal safety first!
* Use professional consultants (structural engineers, fire department, etc) as indicated.
* Use licensed vendors such as electrical and plumbing contractors.
 |
| **Staff Person** | **Tasks** | **Telephone** |
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| **Team Title** | **Team Member** | **Telephone** |
| Structural Engineer |  |  |
| Plumber |  |  |
| Electrician |  |  |
| Generator Vendor |  |  |
| Fuel Supplier |  |  |
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##

## Appendix T - Record for Temporary Disaster Staff Members

|  |  |
| --- | --- |
| **Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Professional Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **City/State/ZIP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Professional License Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **State of Licensing**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CPR Certified**? YES / NO |
| **Usual Facility of Employment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) (City/State) |
| **Authorized By**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Date(s) Worked** | **Inclusive Hours Worked** |
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| **Approved By**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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##  Appendix U - Volunteer Management Log

|  |  |
| --- | --- |
| **Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Volunteer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Affiliation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **City/State/ZIP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Skills**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- | --- | --- |
| **Date** | **Inclusive Hours Worked** | **Tasks Performed** |
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Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_