

Florida Emergency Support Function 8 Facility Assessment Form

For Information Only – Use existing local Emergency Operations Center for requesting needed resources

Facility: _____ Facility Type _____

Address: _____ County: _____

Contact Person

Name: _____ Date/Time: _____

Source (i.e.: Facility, Local Emergency Operations Center), Other _____ Method of Contact: _____

Number used to contact (if applicable): _____

1. **Structure:** **Fully Functional** **Partially Functional** **Non Functional**
Roof leaking Roof missing
Windows out Walls Collapsed

2. **Power:** **Grid (Utility) Power** **On Generator** **No Power**
Intermittent Time left on fuel supply ___
As of _____ date _____ time
HVAC operational Yes / No

3. **Water:** **Normal Operations** **Boil Water** **No Water**

4. **Communications:** **Fully Functional** **Partially Functional** **Non Functional**

5. **Replenishables:** **No Shortages Identified** **Adequate but Limited** **Critical Shortage**
(i.e.: Blood supply, O2, Pharmaceuticals, Medical supplies, Food, ice and water for patients)

6. **Operations:** **Fully Functional** **Partially Functional** **Non Functional**
(i.e.: ER, Critical Care, Labor & delivery, Neonatal, Pediatrics, OR, Recovery, Psych, Dialysis, Inpatient, Med/Surg, Out-patient, Lab, Long term care, Pharmacy, X-Ray)

7. **Morgue / Mortuary:** **Fully Functional** **Partially Functional** **Non Functional**

8. **Sanitation Systems** **Fully Functional** **Partially Functional** **Non Functional**

9. **Radiation/Oncology**
 Fully Functional **Partially Functional** **Non Functional** **Not Applicable**

10. **Transportation to off site services (i.e.: Dialysis treatment)**
 Available / functional **Not available / non functional** **Not Applicable**

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Additional Information

1. Impact

Is facility open: _____yes _____no

Type of Impact: ___ Elevator Damage ___ Flooding ___ Floor Damage ___ Foundation Damage
___ Mechanical Damage ___ Power Out ___ Roads Blocked ___ Roof Damage
___ Sewer System Out ___ Wall Damage ___ Water System Out
___ Window damage

Severity of Impact: ___ Major ___ Minor ___ Some Impacts

Evacuation Status

Completed:___ In Process: ___ Not Evacuating:___ Planning: ___ Return: ___ Undecided
Number Evacuated:___ Start Date: _____ End Date:_____
Return State Date: _____ Return End Date:_____ Evacuation Destination:_____
Destination Location:_____ City: _____ Zip: _____
County: _____ State: _____ Contact Person #: _____
Cell #: _____ Number of Residents Evacuated:_____

Out of Service Start Date _____ Out of Service End Date _____

2. Power Company Name:_____ Company Account # :_____

3. Water Company Name: _____ Company Account # _____

4. Communications Additional Information:

5. Facility Needs (Assistance)

___ Food ___ Generator ___ Generator Fuel ___ Ice ___ Medical Assistance ___ Oxygen
___ Medical/Non-Medical Equipment ___ Equipment ___ Portable Toilets ___ Security Personnel
___ Solution ___ Transportation ___ Ventilators ___ Water

5. Facility Needs (Assistance) - Continued

Staff: ER, ICU, Med Surg, Pediatrics, Neonatal: Amount / Type Needed _____
Physicians: Type _____
Other:

EOC Tracker #: _____ Status of Assistance Request: _____

6. Available Beds

Provider:_____
Beds (male): _____ Beds (female): _____ Total Available Beds: _____
Hospital Beds : ___ Adult Psychiatric ___ Burn ___ Child Psychiatric ___ Pediatric
___ Obstetric ___ Long Term Care ___ Critical Care ___ Medical/Surgical
___ Rehabilitation

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Number of each Bed type: _____

Special Resident Characteristics

Facility Census: _____ Type of Characteristic: _____
Number of Residents w/ Characteristic: _____

7. Morgue / Mortuary capacity: _____

8. Sewer Company Name: _____ **Sewer Company Account:** _____

9. Radiation / Oncology additional Information

10. Transportation to off site services additional information

Additional comments: