Health and Human Services Agency

Only Complete if Requesting Resources

Submit

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Resource Request: Medical and Health FIELD/HCF to Op Area

REQUESTOR TO COMPLETE

1. Incident Name:		**2a. Date:**	**2b. Time:**
3. Requestor Name, Agency, Position, Phone/Email:		**2c. Requestor Tracking #:** (assigned by Requesting Entilty)	
4a. Describe Mission/Tasks:	**4b. Delivery/Reporting/Staging Information:**		
5. Attach Additional Order Sheets, If Needed	☐ **SUPPLY/EQUIPMENT**	☐ **PERSONNEL**	☐ **OTHER**

6. Requesting entity must confirm that all 3 requirements below have been met prior to submission of request

- ☐ **Is the resource(s) being requested nearly exhausted or exhausted?**
- ☐ **Entity is unable to obtain resources within a reasonable time frame (based upon priority level indicated) from vendors, contractors, MOU/MOA's, department, or corporate office providers)?**
- ☐ **Entity is unable to obtain resource from other non-traditional sources?**

7. SUPPLY/EQUIPMENT/PERSONNEL REQUEST DETAILS

ITEM #	Priority (see Below)[1]	DETAILED SPECIFIC ITEM DESCRIPTION: Supplies/Equipment (Be Specific) (Drug Name, Dosage Form, Unit of Use Pack or quantity, Prod Info Sheet, In-House PO, etc., Medical supplies - Item name, Size, Brand, etc. General - Item name, Size) Personnel (Be Specific) (List probable Duties, Required License, Specific Experience i.e. ED/ICU/OR, Hospital/Clinical, etc.) Other (Be Specific) (Mobile Field Hospital; Ambulance Strike Team; Alternate Care Supply Cache; Facility-Tent, Trailer, Size, etc.)	Quantity Requested	Expected Equipment/ Staff Duration of Use:

REVIEW

8. COMMAND/MANAGEMENT REVIEW AND VERIFICATION (Signature Indicates Verification of Need and Request's Approval)

NAME:	POSITION:	SIGNATURE or equivalent

[1]Priority: (E)mergent <12 hours, (U)rgent >12 hours or (S)ustainment

Complete this form and click on the "SUBMIT" button on the top. It will be emailed to the Shasta County MHOAC Program at DOC45@co.shasta.ca.us.