

Status (completed by the DHSS EOC)

Date received:

Approved by:

Not approved by:

**Checklist for Mobilization of ALASKA RESPOND Volunteers**

**Community/Facility:**

**Contact:**

**Contact Number:**

**Contact Email:**

**1. Have you exhausted your resources of licensed healthcare providers ?** Yes No

**2. Have you exhausted your community resources of licensed healthcare providers?** Yes No

**3. How many / type of licensed healthcare providers are you requesting?**

|  |  |  |
| --- | --- | --- |
|  | **How Many?** | **If Available -**  **Specialty Needed?** |
| Mid-level Practitioner (Advanced Nurse Practitioner, Physician Assistant) |  |  |
| Mental Health Specialist (Counselor, Marriage Family Therapist, Psychologist, Social Worker) |  |  |
| Nurse |  |  |
| Physician |  |  |
| Respiratory Therapist |  |  |
| Other (Paramedic, Pharmacist, etc.) |  |  |

**4. Possible length of deployment:**

|  |  |  |
| --- | --- | --- |
| **Type of Healthcare Professional**  **1 - 3 Days** | **4 - 7 Days** | **8 - 12 Days 14 - 30 Days** |
|  |  |  |
|  |  |  |

**5. Check the potential shift schedule the volunteers may work:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Healthcare Professional** | **8 hour Shift** | **10 hour Shift** | **12 hour Shift** |
|  |  |  |  |
|  |  |  |  |

**6. Potential employment status:**

*\*Alaska Respond volunteers are not required to have personal malpractice or liability insurance.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Healthcare Professional** | **Volunteer**  \*Not paid by the requesting entity or State of Alaska | **Requesting Entity Hire**  \*Paid by the requesting entity | **State of AK Emergency Hire**  \*Not longer than 30 days |
|  |  |  |  |
|  |  |  |  |

**7. After the volunteers arrive :**

Where do the volunteers report to?

Physical Address

Who do the volunteers report to?

Contact Person Phone #

Will the volunteers shadow a staff person during their shift? Yes No

Will the volunteers need any special training before working? Yes No

If yes, describe

**8. Will you provide:**

Transportation (car rental, van / personnel picking up, etc.) Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lodging (hotel, community facility, etc.) Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meals Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. When do the volunteers need to report?** (***Note: ASAP is not a time or date***)

|  |  |  |
| --- | --- | --- |
| **Type of Healthcare Professional** | **Date** | **Time** |
|  |  |  |
|  |  |  |

**10. Additional comments to the DHSS EOC:**

**For Official Use Only**

**Volunteers deployed**

|  |  |
| --- | --- |
| **Healthcare Professional** | **Name** |
|  |  |
|  |  |
|  |  |
|  |  |

Revised 04/07/16