

Status (completed by the DHSS EOC)

Date received:

Approved by:

Not approved by:

**Healthcare Facility Checklist for Mobilization of ALASKA RESPOND Volunteers**

**Healthcare Facility Name:**

**Healthcare Facility Contact:**

**Healthcare Facility Contact Number:**

**Healthcare Facility Contact Email:**

**1. Has your healthcare facility exhausted your resources of licensed healthcare providers?** Yes No

**2. Has your facility exhausted your community resources of licensed healthcare providers?** Yes No

**3. How many / type of licensed healthcare providers is your healthcare facility requesting?**

|  |  |  |
| --- | --- | --- |
|  | **How Many?** | **If Available -**  **Specialty Needed?** |
| Mid-level Practitioner (Advanced Nurse Practitioner, Physician Assistant) |  |  |
| Behavioral 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 facility or state of Alaska | **Requesting Facility Hire**  \*Paid by the requesting facility | **State of AK Emergency Hire**  \*No longer than 30 days |
|  |  |  |  |
|  |  |  |  |

**7. After the volunteers arrive at your facility or community:**

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 the requesting facility provide?**

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

Notes:

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

Notes:

Meals Yes No

Notes:

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

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

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

**Volunteers deployed to the facility**

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