

NHICS FORMS

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INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A



1. INCIDENT NAME		2. OPERATIONAL PERIOD		
		DATE:	FROM:	TO:
		TIME:	FROM:	TO:
3. SITUATION SUMMARY				-- NHICS 201 --
4. WEATHER/ENVIRONMENTAL IMPLICATIONS FOR PERIOD (INCLUDES AS APPROPRIATE: FORECAST, DAYLIGHT)				
1.				
2.				
3.				
4.				

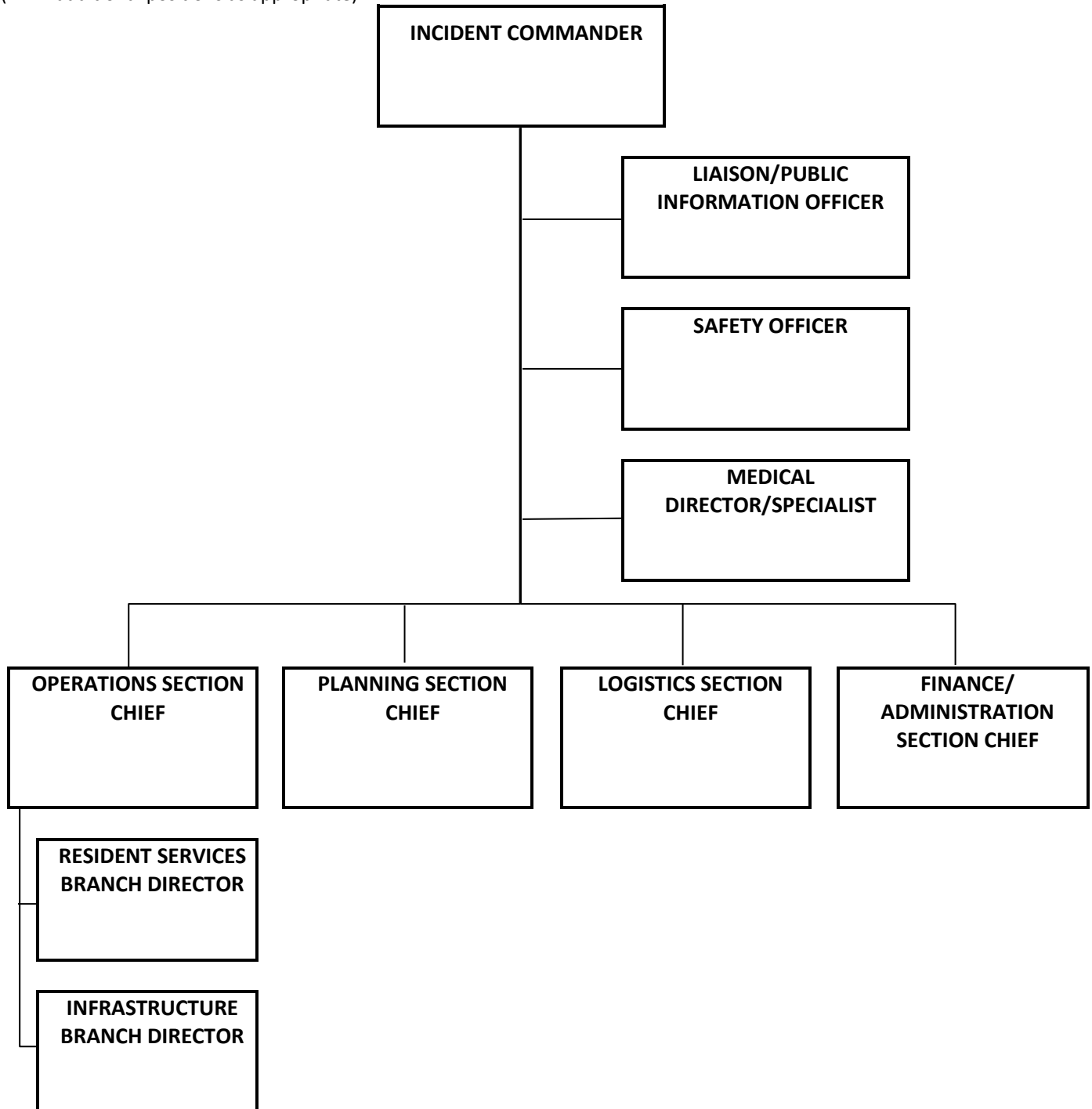
INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A



5. CURRENT ORGANIZATION

(Fill in additional positions as appropriate)



INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A



6. INCIDENT OBJECTIVES -- NHICS 202, 204--

6a. OBJECTIVES	6b. STRATEGIES/ TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO

7. HEALTH AND SAFETY BRIEFING IDENTIFY POTENTIAL INCIDENT HEALTH AND SAFETY HAZARDS AND DEVELOP NECESSARY MEASURES (REMOVE HAZARD, PROVIDE PERSONAL PROTECTIVE EQUIPMENT, WARN PEOPLE OF THE HAZARD) -- NHICS 202, 215A-- TO PROTECT RESPONDERS FROM THOSE HAZARDS

1. _____
2. _____
3. _____
4. _____

8. ATTACHMENTS (MARK IF EXTRA DOCUMENTATION IS ATTACHED)

<input type="checkbox"/> NHICS 251: FACILITY SYSTEM STATUS REPORT <input type="checkbox"/> NHICS 254: EMERGENCY ADMIT TRACKING <input type="checkbox"/> NHICS 255: MASTER RESIDENT EVACUATION TRACKING <input type="checkbox"/> NHICS 215A: INCIDENT ACTION PLAN (IAP) SAFETY ANALYSIS <input type="checkbox"/> TRAFFIC PLAN	<input type="checkbox"/> INCIDENT MAP <input type="checkbox"/> OTHER: _____ _____
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

9. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

INCIDENT ACTION PLAN (IAP) QUICK START

COMBINES NHICS FORMS 201+202+203+204+215A



INSTRUCTIONS

PURPOSE: Provides a faster approach to developing the IAP by combining NHICS Forms 201, 202, 203, 204 and 215A. You may use the IAP Quick Start during the early stage of an incident or if it is expected to be a short duration incident or it meets the needs of the incident at any time. If the full complement of NHICS Forms are needed, transition to their individual use.

ORIGINATION: Incident Commander or Planning Section Chief

COPIES TO: All IMT staff

NOTES: If additional pages are needed for any form page, use a blank NHICS IAP Quick Start and repaginate as needed. Additions may be made to the form to meet the organization's needs.

* Three versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF, Visio and Microsoft Word.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Situation Summary	Enter brief situation summary.
4	Weather/Environmental Implications for period	Enter forecast information.
5	Current Organization	Enter the names of the individuals assigned to each position on the Incident Management Team chart. Modify the chart as necessary.
6	Incident Objectives	
	6.a Objectives	Enter each objective separately. Adjust objectives for each operational period as needed.
	6.b Strategies/Tactics	For each objective, document the strategy/tactic to accomplish that objective.
	6.c Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	6.d Assigned to	For each strategy/tactic, document the Section or Branch assigned to that objective.
7	Health and Safety Briefing	Summary of health and safety issues and instructions.
8	Attachments	Attach additional NHICS forms and supporting documents as needed.
9	Prepared By	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.



NHICS 201 | INCIDENT BRIEFING

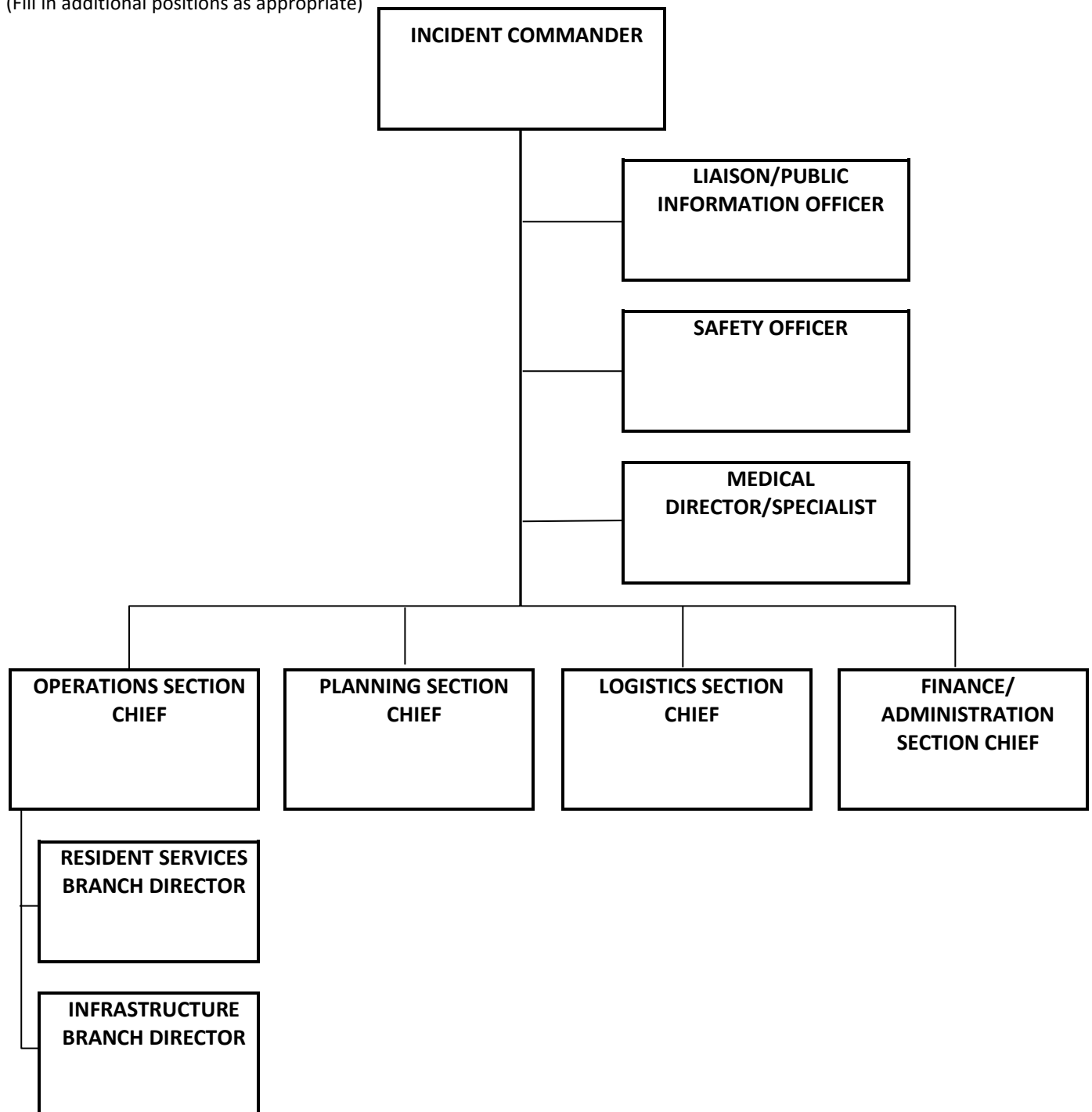
1. INCIDENT NAME		2. OPERATIONAL PERIOD		
		DATE:	FROM:	TO:
		TIME:	FROM:	TO:
3. SITUATION SUMMARY (for briefings or transfer of command)				
4. HEALTH AND SAFETY BRIEFING Identify potential incident health and safety hazards and implement necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. (Summary of NHICS 215a)				
1.				
2.				
3.				
4.				
5. MAP/ SKETCH (Attach sketch showing the total area of operations, the incident site/area/ impacted and threatened areas, and/or other graphics depicting situational status and resource assignment, as needed.)				
<input type="checkbox"/> See Attached				

NHICS 201 | INCIDENT BRIEFING



6. CURRENT ORGANIZATION

(Fill in additional positions as appropriate)



NHICS 201 | INCIDENT BRIEFING



7. INCIDENT OBJECTIVES

--

8. SUMMARY OF CURRENT AND PLANNED ACTIONS

TIME	ACTIONS

NHICS 201 | INCIDENT BRIEFING



9. SUMMARY OF RESOURCES REQUESTED AND ASSIGNED

RESOURCE	DATE/TIME ORDERED	ETA	DATE/TIME ARRIVED	NOTES (LOCATION/ ASSIGNMENT/ STATUS)

10. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

NHICS 201 | INCIDENT BRIEFING



INSTRUCTIONS

- PURPOSE:** Provides the Incident Management Team (IMT) with basic information regarding the incident, current situation, and the resources allocated to the response.
- ORIGINATION:** Incident Commander (or designee) for presentation to the staff or later to the incoming Incident Commander along with a detailed oral briefing.
- COPIES TO:** All IMT staff
- NOTES:** If additional pages are needed for any form page, use a blank NHICS 201 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.
- * Three versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF, Visio and Microsoft Word.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Situation Summary	Concise statement of the status and information regarding the current situation.
4	Health and Safety Briefing	Enter the summary of health and safety issues and instructions.
5	Map / Sketch	Attach as necessary: floor plans, maps, sketches of impacted area, or response diagrams. North should be at the top of the page unless noted otherwise.
6	Current Organization	Enter the names of the individuals assigned to each position directly onto the Incident Management Team (IMT) chart.
7	Incident Objectives	Enter the objectives used for the incident.
8	Summary of Current and Planned Actions	Enter the current and planned actions and time (24-hour clock) they may or did occur. If additional pages are needed, use a blank sheet or another NHICS 201, and adjust page numbers accordingly.
9	Summary of Resources Requested and Assigned	Enter information about the resources allocated to the incident. If additional pages are needed, use a blank sheet or another NHICS 201 (page 4), and adjust page numbers accordingly.

NHICS 201 | INCIDENT BRIEFING



NUMBER	TITLE	INSTRUCTIONS
	Resource	Enter the number and category, kind, or type of resource ordered.
	Date / Time Ordered	Enter the date (m/d/y) and time (24-hour clock) the resource was ordered.
	ETA	Enter the estimated time of arrival (ETA) to the incident (24-hour clock).
	Date / Time Arrived	Enter the date (m/d/y) and time (24-hour clock) the resource arrived.
	Notes	Enter notes such as the assigned location of the resource and/or the actual assignment and status.
10	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 202 | INCIDENT OBJECTIVES



1. INCIDENT NAME	2. OPERATIONAL PERIOD		
	DATE:	FROM:	TO:
	TIME:	FROM:	TO:
3. INCIDENT OBJECTIVES			
4. FACTORS TO CONSIDER Considerations in relationship to the objectives and priorities, including weather and situational awareness.			
5. NHICS 215A – INCIDENT ACTION PLAN (IAP) SAFETY ANALYSIS and/ or SITE SAFETY PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Approved Site Safety Plan Locations:			
6. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____	
	DATE/TIME: _____	FACILITY: _____	
7. APPROVED BY	PRINT NAME: _____	SIGNATURE: _____	
	DATE/TIME: _____	FACILITY: _____	

NHICS 202 | INCIDENT OBJECTIVES



INSTRUCTIONS

- PURPOSE:** Describes the basic incident strategy, incident objectives, command priorities, and safety considerations for use during the next operational period.
- ORIGINATION:** Planning Section Chief for each operational period as part of the Incident Action Plan (IAP).
- COPIES TO:** May be reproduced with the IAP and given to Command Staff, Section Chiefs, and all supervisory personnel at the Section and Branch level.
- NOTES:** If additional pages are needed, use a blank NHICS 202 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Incident Objectives	Enter clear, concise statements of the objectives for managing the response. Ideally, these objectives will be listed in priority order. These objectives are for the incident response for this operational period as well as for the duration of the incident. Include alternative and/or specific tactical objectives as applicable.
4	Factors to Consider	Enter considerations for the operational period, which may include tactical priorities or a general situational awareness for the operational period. It may be a sequence of events or order of events to address. General situational awareness may include a weather forecast, incident conditions, and/or a general safety message. If a safety message is included here, it should be provided by the Safety Officer.
5	NHICS 215A or Site Safety Plan Required	Safety Officer should check whether or not a Site Safety Plan is required for this incident.
	Approved Site Safety Plan Locations	Enter the locations of the approved Site Safety Plan.
6	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.
7	Approved by	If additional Incident Commander signatures are required, attach a blank page. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 203 | ORGANIZATION ASSIGNMENT LIST



1. INCIDENT NAME			2. OPERATIONAL PERIOD		
			DATE:	FROM:	TO:
			TIME:	FROM:	TO:
POSITION		NAME / AGENCY		CONTACT INFO (PHONE, CELL)	
3. INCIDENT COMMANDER AND STAFF					
INCIDENT COMMANDER					
LIAISON/PUBLIC INFORMATION OFFICER					
SAFETY OFFICER					
MEDICAL DIRECTOR/SPECIALIST					
4. OPERATIONS SECTION					
CHIEF					
RESIDENT SERVICES BRANCH					
INFRASTRUCTURE BRANCH					
5. PLANNING SECTION					
CHIEF					
6. LOGISTICS SECTION					
CHIEF					
7. FINANCE/ADMINISTRATION SECTION					
CHIEF					
8. AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)					
AGENCY		NAME		CONTACT INFO (PHONE, CELL)	
9. EXTERNAL AGENCY REPRESENTATIVE (IN NURSING HOME COMMAND CENTER)					
EXTERNAL LOCATION		NAME		CONTACT INFO (PHONE, CELL)	
10. PREPARED BY	PRINT NAME: _____		SIGNATURE: _____		
	DATE/TIME: _____		FACILITY: _____		

NHICS 203 | ORGANIZATION ASSIGNMENT LIST



INSTRUCTIONS

- PURPOSE:** Provides the Incident Management Team (IMT) personnel with information on the positions currently activated and the names of personnel staffing each position.
- ORIGINATION:** Planning Section Chief
- COPIES TO:** All IMT staff
- NOTES:** If assigned, document Assistants / Deputies to Command Staff as needed or resources allow. If additional pages are needed for any form page, use a blank NHICS 203 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Incident Commander and Command Staff	Enter the names and contact information.
4	Operations Section	Enter the names and contact information.
5	Planning Section	Enter the names and contact information.
6	Logistics Section	Enter the names and contact information.
7	Finance / Administration Section	Enter the names and contact information.
8	Agency Executive	Enter the name and contact information of the executive (e.g., Chief Executive Officer) with whom the Incident Commander interfaces.
9	External Agency Representative	Enter the external agency/organization names present in the Nursing Home Command Center and the names of their representatives.
10	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 204 | ASSIGNMENT LIST



1. INCIDENT NAME		2. OPERATIONAL PERIOD	
		DATE:	FROM: TO:
		TIME:	FROM: TO:
3. SECTION		4. BRANCH (if applicable)	
SECTION CHIEF		BRANCH DIRECTOR	
5a. SECTION / BRANCH OBJECTIVES	5b. STRATEGIES / TACTICS	5c. RESOURCES REQUIRED	5d. SECTION / BRANCH ASSIGNED TO



NHICS 204 | ASSIGNMENT LIST

6. ASSIGNED TO THIS OPERATIONAL PERIOD		
NAME	SECTION / BRANCH TITLE	SECTION / BRANCH LOCATION
7. SPECIAL INFORMATION / CONSIDERATIONS		
8. PREPARED BY PLANNING SECTION CHIEF	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

NHICS 204 | ASSIGNMENT LIST



INSTRUCTIONS

PURPOSE: Documents the strategies and tactics of each (activated) Section or Branch, resources required, and the composition of the Section or Branch assigned.

ORIGINATION: Planning Section Chief

COPIES TO: All IMT staff. Duplicate and attach as part of the IAP if not using the IAP Quick Start.

NOTES: An abbreviated NHICS 204 is included in the IAP Quick Start. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Section	Enter the name of the Section and Section Chief.
4	Branch (if applicable)	Enter the name of the Branch and Branch Director, if the form is for a specific Branch.
5	5a. Section/Branch Objectives	Utilizing the Incident Objectives (NHICS 202), develop objectives as they relate to the Section/Branch. Enter objectives to focus on for the designated operational period.
	5b. Strategies / Tactics	For each objective, document the strategies/tactics to accomplish that objective.
	5c. Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	5d. Section/Branch Assigned to	For each strategy/tactic, document the Section/Branch assigned to that strategy/tactic.
6	Assigned this Operational Period	Enter the names, titles of staff activated and location of the Section/Branch
7	Special Information /Considerations	Enter a statement noting any safety problems, specific precautions to be exercised, drop-off or pick-up points, or other information.
8	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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NHICS 205 | COMMUNICATIONS LIST



1. INCIDENT NAME							2. OPERATIONAL PERIOD		
							DATE:	FROM:	TO:
							TIME:	FROM:	TO:
3. INTERNAL CONTACTS									
NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS			

PURPOSE: PROVIDES INFORMATION ON ALL COMMUNICATION DEVICES ASSIGNED
ORIGINATION: LOGISTICS SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: CAN BE PREFILLED BEFORE INCIDENT AND UPDATED AS NEEDED



NHICS 205 | COMMUNICATIONS LIST

3. INTERNAL CONTACTS (CONTINUED...)						
NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS
4. EXTERNAL CONTACTS						
NAME	NHICS ASSIGNMENT	PHONE (PRIMARY & ALTERNATE)	FAX	E-MAIL	ALTERNATE COMMUNICATION DEVICE	COMMENTS
5. SPECIAL INSTRUCTIONS						
6. PREPARED BY LOGISTICS SECTION CHIEF		PRINT NAME: _____ DATE/TIME: _____		SIGNATURE: _____ FACILITY: _____		

PURPOSE: PROVIDES INFORMATION ON ALL COMMUNICATION DEVICES ASSIGNED
ORIGINATION: LOGISTICS SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: CAN BE PREFILLED BEFORE INCIDENT AND UPDATED AS NEEDED

NHICS 205 | COMMUNICATIONS LIST



INSTRUCTIONS

PURPOSE: Provides information on all telephone and other communication assignments for each operational period.

ORIGINATION: Logistics Section Chief and given to the Planning Section Chief for inclusion in the Incident Action Plan (IAP).

COPIES TO: All IMT staff.

NOTES: If additional pages are needed, use a blank NHICS 205 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Internal Contacts	Enter the appropriate contact information for internal contacts, hospital personnel, those in an activated Incident Management Team (IMT) position, and other key staff.
4	External Contacts	Enter the appropriate contact information for external agencies, organizations, key contacts.
5	Special Instructions	Enter any special instructions (e.g., using repeaters, secure-voice, private line [PL] tones, etc.) or other emergency communications. If needed, also include any special instructions for alternate communication plans.
6	Prepared by Logistics Section Chief	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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NHICS 206 | STAFF MEDICAL PLAN



1. INCIDENT NAME	2. OPERATIONAL PERIOD		
	DATE:	FROM:	TO:
	TIME:	FROM:	TO:
3. TREATMENT AREAS			
AREA NAME	LOCATION	TEAM LEADER & ALTERNATE CONTACT NUMBER	
4. RESOURCES ON HAND (numbers)			
STAFF	TRANSPORTATION DEVICES	MEDICATION	SUPPLIES
MD/DO	LITTERS		
PA/NP	PORTABLE BEDS		
RN/LPN	GURNEYS		
TECHNICIANS	WHEELCHAIRS		
ANCILLARY/OTHER	EVAC. ASSIST DEVICES		
5. TREATMENT RESOURCES (EXTERNAL)			
NAME	PHONE	ADDRESS	
MD/DO			
NEAREST HOSPITAL/EMERGENCY ROOM			

NHICS 206 | STAFF MEDICAL PLAN



TREATMENT RESOURCES (EXTERNAL) continued...			
NAME	PHONE	ADDRESS	
ALTERNATE HOSPITAL/EMERGENCY ROOM			
OCCUPATIONAL HEALTH CLINIC			
6. TRANSPORTATION			
AMBULANCE, BUS, VAN, PRIVATE VEHICLE, AIR	LOCATION	CONTACT NUMBER	LEVEL OF SERVICE
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS
7. ALTERNATE CARE SITE(S)			
FACILITY NAME	ADDRESS	CONTACT NUMBER	SPECIALTY CARE (SPECIFY)
8. SPECIAL INSTRUCTIONS			
9. PREPARED BY SAFETY OFFICER	PRINT NAME: _____	SIGNATURE: _____	
	DATE/TIME: _____	FACILITY: _____	
10. APPROVED BY	PRINT NAME: _____	SIGNATURE: _____	
	DATE/TIME: _____	FACILITY: _____	

NHICS 206 | STAFF MEDICAL PLAN



INSTRUCTIONS

PURPOSE: Addresses the treatment plan for injured or ill staff members and / or volunteers. The NHICS 206 provides information on staff treatment areas, resources (external), transportation services, and special instructions.

ORIGINATION: Safety Officer

COPIES TO: All IMT staff

NOTES: If additional pages are needed, use a blank NHICS 206 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Treatment Areas	Enter the name of the treatment area, the location, and the contact numbers.
4	Resources On Hand	Enter the number of listed resources that are available and assigned to the treatment areas.
5	Treatment Resources (External)	Enter the contact information for external treatment resources.
6	Transportation	Enter the information for transportation services available to the incident.
7	Alternate Care Site(s)	Enter the information for alternate care sites that could serve this incident.
8	Special Instructions	Note any special emergency instructions for use by incident personnel, including who should be contacted, how should they be contacted; and who manages an incident within an incident due to a rescue, accident, etc.
9	Prepared by Safety Officer	Enter the name and signature of the person preparing the form, typically the Safety Officer. Enter date (m/d/y), time prepared (24-hour clock), and facility.
10	Approved by	Enter the name of the person who approved the plan. Enter date (m/d/y), time reviewed (24-hour clock), and facility.

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NHICS 207 | INCIDENT MANGEMENT TEAM CHART



1. INCIDENT NAME	2. OPERATIONAL PERIOD		
	DATE:	FROM:	TO:
	TIME:	FROM:	TO:
3. CURRENT ORGANIZATION			
<p>(Fill in additional positions as appropriate)</p> <div style="text-align: center; margin: 20px 0;"> <div style="border: 1px solid black; padding: 10px; width: 200px; margin: 0 auto;">INCIDENT COMMANDER</div> <div style="display: flex; justify-content: center; align-items: center; gap: 20px; margin-top: 20px;"> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">LIAISON/ PUBLIC INFORMATION OFFICER</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">SAFETY OFFICER</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">MEDICAL DIRECTOR/ SPECIALIST</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">OPERATIONS SECTION CHIEF</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">PLANNING SECTION CHIEF</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">LOGISTICS SECTION CHIEF</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">FINANCE/ ADMINISTRATION SECTION CHIEF</div> </div> <div style="margin-top: 20px;"> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center; margin-bottom: 10px;">RESIDENT SERVICES BRANCH DIRECTOR</div> <div style="border: 1px solid black; padding: 10px; width: 150px; text-align: center;">INFRASTRUCTURE BRANCH DIRECTOR</div> </div> </div>			

NHICS 207 | INCIDENT MANGEMENT TEAM CHART



INSTRUCTIONS

- PURPOSE:** Provides a visual display of personnel assigned to the IMT positions.
- ORIGINATION:** Incident Commander or designee at the incident onset and continually updated throughout an incident.
- COPIES TO:** All IMT staff.
- NOTES:** Additions may be made to the form to meet the organization's needs. Two versions of the IMT Chart are available in NHICS 2016. Formats are Adobe Acrobat fillable PDF and Visio for customization.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Current Organization	Enter the names of the individuals assigned to each position on the Incident Management Team (IMT) chart. Modify the chart as necessary, and add any lines/spaces needed for Command Staff assistants, agency representatives, and the organization of each of the General Staff sections.

NHICS 214 | ACTIVITY LOG



1. INCIDENT NAME		2. OPERATIONAL PERIOD	
		DATE:	FROM: TO:
		TIME:	FROM: TO:
3. NAME		4. IMT POSITION	
5. ACTIVITY LOG			
DATE/TIME	MAJOR EVENTS, DECISIONS MADE AND NOTIFICATIONS		
6. PREPARED BY	PRINT NAME:	_____	SIGNATURE: _____
	DATE/TIME:	_____	FACILITY: _____

NHICS 214 | ACTIVITY LOG



INSTRUCTIONS

- PURPOSE:** Records details of notable activities for any Incident Management Team (IMT) position. Provide basic documentation of incident activity, and a reference for any After Action Report (AAR). Personnel should document how relevant incident activities are occurring and progressing, actions taken and decisions made.
- ORIGINATION:** All IMT staff
- COPIES TO:** Planning Section Chief. Individuals may retain a copy for their own records.
- NOTES:** Multiple pages can be used if needed. If additional pages are needed, use a blank NHICS 214 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Name	Print the name of the person for whom the activities are being documented.
4	IMT Position	Enter the Incident Management Team (IMT) position for which the activities are being documented.
5	Activity Log	Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date (m/d/y), as well as if the operational period covers more than one day. Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, information received, etc.
6	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 215A | INCIDENT ACTION PLAN SAFETY ANALYSIS



1. INCIDENT NAME			2. OPERATIONAL PERIOD	
			DATE:	FROM:
3. HAZARD MITIGATION				
3a. POTENTIAL/ACTUAL HAZARDS (BIOHAZARDS, STRUCTURAL, UTILITY, ETC.)	3b. AFFECTED SECTION OR BRANCH & LOCATION	3c. MITIGATIONS (E.G., PPE, BUDDY SYSTEM, ESCAPE ROUTES)	3d. MITIGATION COMPLETED (INITIALS/DATE/TIME)	
4. PREPARED BY SAFETY OFFICER	PRINT NAME: _____		SIGNATURE: _____	
	DATE/TIME: _____		FACILITY: _____	
5. APPROVED BY INCIDENT COMMANDER	PRINT NAME: _____		SIGNATURE: _____	
	DATE/TIME: _____		FACILITY: _____	

NHICS 215A | INCIDENT ACTION PLAN SAFETY ANALYSIS



INSTRUCTIONS

- PURPOSE:** Records the findings of the Safety Officer after completing an operational risk assessment and to identify and resolve hazard, safety, and health issues. When the safety analysis is completed, the form is used to prepare the Operations Briefing.
- ORIGINATION:** Safety Officer during the IAP cycle.
- COPIES TO:** Planning Section Chief. Duplicate and attach as part of the IAP.
- NOTES:** Issues identified should be reviewed and updated each operational period. If additional pages are needed, use a blank NHICS 215A and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Hazard Mitigation	
	3a. Potential / Actual Hazards	List the types of hazards and/or risks likely to be encountered by personnel or resources at the incident area relevant to the work assignment.
	3b. Affected Section / Branch and Location	Reference the affected sections, branches, and the location of the hazards.
	3c. Mitigations	List actions taken to reduce risk for each hazard indicated (e.g., restricting access, proper PPE for identified risk).
	3d. Mitigation Completed	Enter the initials, date, and time when the mitigation is implemented or the hazard no longer exists.
4	Prepared by Safety Officer	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.
5	Approved by Incident Commander	Enter the name and signature of the person approving the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 251 | FACILITY SYSTEM STATUS REPORT



1. INCIDENT NAME			2. OPERATIONAL PERIOD	
			DATE:	FROM:
				TIME: FROM: TO:
3. SYSTEM	4. STATUS		5. COMMENTS (If not fully functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)	
COMMUNICATIONS				
FAX	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
INFORMATION TECHNOLOGY SYSTEM (EMAIL/REGISTRATION/PATIENT RECORDS/TIME CARD SYSTEM)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
NURSE CALL SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
PAGING – PUBLIC ADDRESS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
TELEPHONE SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
TELEPHONE SYSTEM – CELL	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
VIDEO-TELEVISION-INTERNET-CABLE	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			
OTHER (SATELLITE PHONES, RADIO EQUIPMENT, ETC)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA			

NHICS 251 | FACILITY SYSTEM STATUS REPORT



INFRASTRUCTURE		
SYSTEM	STATUS	COMMENTS
CAMPUS ACCESS (ROADWAYS, BRIDGES, SIDEWALKS)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
FIRE DETECTION SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
FIRE SUPPRESSION SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
FOOD PREPARATION EQUIPMENT	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
ICE MACHINES	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
LAUNDRY/LINEN SERVICE EQUIPMENT	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
STRUCTURAL COMPONENTS (BUILDING INTEGRITY)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
OTHER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	

NHICS 251 | FACILITY SYSTEM STATUS REPORT



RESIDENT CARE		
SYSTEM	STATUS	COMMENTS
PHARMACY SERVICES	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
DIETARY SERVICES	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
ISOLATION ROOMS (POSITIVE/NEGATIVE AIR)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
OTHER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
SECURITY SYSTEM		
SYSTEM	STATUS	COMMENTS
DOOR LOCKDOWN SYSTEMS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
SURVEILLANCE CAMERAS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
CAMPUS SECURITY (LIGHTING, TRAFFIC CONTROLS)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
OTHER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	

NHICS 251 | FACILITY SYSTEM STATUS REPORT



UTILITIES, EXTERNAL SYSTEM		
SYSTEM	STATUS	COMMENTS
ELECTRICAL POWER- PRIMARY SERVICE	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
SANITATION SYSTEMS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
WATER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
NATURAL GAS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
OTHER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
UTILITIES, INTERNAL SYSTEM		
SYSTEM	STATUS	COMMENTS
AIR COMPRESSOR	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
ELECTRICAL POWER, BACKUP GENERATOR	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
FUEL STORAGE	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	

NHICS 251 | FACILITY SYSTEM STATUS REPORT



UTILITIES, INTERNAL SYSTEM (CONTINUED....)		
SYSTEM	STATUS	COMMENTS
ELEVATORS/ESCALATORS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
HAZARDOUS WASTE CONTAINMENT SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
OXYGEN	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	(NOTE BULK, H-TANKS, RESERVE SUPPLY STATUS)
PNEUMATIC TUBE	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
STEAM BOILER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
SUMP PUMP	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
WELL WATER SYSTEM	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
VACCUM (FOR PATIENT USE)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	

NHICS 251 | FACILITY SYSTEM STATUS REPORT



UTILITIES, INTERNAL SYSTEM (CONTINUED...)		
SYSTEM	STATUS	COMMENTS
WATER HEATER AND CIRCULATORS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
EXTERNAL LIGHTING	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
EXTERNAL STORAGE (EQUIPMENT)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
EXTERNAL STORAGE (VEHICLES)	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
PARKING LOTS	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	(POWER, PANIC ALARMS, ACCESS, EGRESS, LIGHTING)
OTHER	<input type="checkbox"/> FULLY FUNCTIONAL <input type="checkbox"/> PARTIALLY FUNCTIONAL <input type="checkbox"/> NONFUNCTIONAL <input type="checkbox"/> NA	
6. REMARKS (CRACKED WALLS, BROKEN GLASS, FALLING LIGHT FIXTURES, ETC.)		
7. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

NHICS 251 | FACILITY SYSTEM STATUS REPORT



INSTRUCTIONS

- PURPOSE:** Records the status of various critical facility systems and infrastructure. Provides the Planning and Operations Sections with information about current and potential system failures or limitations that may affect incident response and recovery.
- ORIGINATION:** Infrastructure Branch Director with input from facility personnel.
- COPIES TO:** Planning Section Chief, Operations Section Chief, Safety Officer, and Liaison/Public Information Officer
- NOTES:** The Infrastructure Branch conducts the survey and correlates results. Individual department managers may also be tasked to complete an assessment of their areas and provide the information to the Infrastructure Branch. If additional pages are needed, use a blank NHICS 251 and repaginate as needed. Additions and deletions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	System	System type listed in form.
4	Status	<p>Fully functional: 100% operable with no limitations</p> <p>Partially functional: Operable or somewhat operable with limitations</p> <p>Nonfunctional: Out of commission</p> <p>N/A: Not applicable, do not have</p>
5	Comments	Comment on location, reason, and estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.
6	Remarks	Note any overall facility-wide assessments or future potential issues such as skilled staffing issues, fuel duration, plans for repairs, etc.
7	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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NHICS 252 | SECTION PERSONNEL TIME SHEET



1. INCIDENT NAME	2. OPERATIONAL PERIOD	
	DATE: _____	FROM: _____ TO: _____
	TIME: _____	FROM: _____ TO: _____

3. TIME RECORD

#	EMPLOYEE (E)/ VOLUNTEER (V) NAME (PRINT)	E/V	EMPLOYEE NUMBER	NHICS ASSIGNMENT	DATE/TIME <u>IN</u>	DATE/TIME <u>OUT</u>	TOTAL HOURS	SIGNATURE (TO VERIFY TIMES)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								

* MAY BE USUAL NURSING HOME VOLUNTEERS OR APPROVED VOLUNTEERS FROM COMMUNITY

4. PREPARED BY	PRINT NAME: _____	SIGNATURE: _____
	DATE/TIME: _____	FACILITY: _____

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY
ORIGINATION: INCIDENT MANAGEMENT TEAM PERSONNEL AS DIRECTED BY THE INCIDENT COMMANDER
ORIGINAL TO: FINANCE/ADMINISTRATION SECTION CHIEF
COPIES TO: PLANNING SECTION CHIEF

NHICS 252 | SECTION PERSONNEL TIME SHEET



INSTRUCTIONS

- PURPOSE:** Records each section’s personnel time and activities.
- ORIGINATION:** Section Chiefs are responsible for ensuring that personnel complete the form.
- COPIES TO:** Finance/Administration Section Chief every 12 hours or every operational period.
- NOTES:** If additional pages are needed, use a blank NHICS 252 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Time Record	
	Employee (E) / Volunteer (V) Name (Print)	Print the full name of the personnel assigned.
	E / V	Enter employee (E) or volunteer (V).
	Employee Number	If employee of the organization, fill in employee
	NHICS Assignment	Enter assignment being assumed.
	Date / Time In	Enter time started in assignment.
	Date / Time Out	Enter time ended in assignment.
	Total Hours	Enter total number of hours in assignment.
	Signature	Employee/volunteer signature verifying that times are correct.
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 253 | VOLUNTEER REGISTRATION



1. INCIDENT NAME						2. OPERATIONAL PERIOD
			DATE:	FROM:	TO:	
			TIME:	FROM:	TO:	
3. REGISTRATION INFORMATION						
NAME (LAST NAME, FIRST NAME)	CERTIFICATION/ LICENSURE & NUMBER	ID NUMBER (DRIVERS LICENSE OR SSN)	ADDRESS (CITY, STATE, ZIP)	CONTACT INFO (PHONE, CELL)	REFERENCE CHECK	SIGNATURE
4. PREPARED BY	PRINT NAME: _____		SIGNATURE: _____			
	DATE/TIME: _____		FACILITY: _____			

PURPOSE: TO DOCUMENT VOLUNTEER INFORMATION FOR EACH OPERATIONAL PERIOD
ORIGINATION: LOGISTICS SECTION CHIEF OR DESIGNEE
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF AND PLANNING SECTION CHIEF

NHICS 253 | VOLUNTEER REGISTRATION



INSTRUCTIONS

- PURPOSE:** Documents volunteer sign in and sign out for each Operational Period.
- ORIGINATION:** Logistics Section Chief or designee
- COPIES TO:** Planning Section Chief and Finance/Administration Section Chief
- NOTES:** If additional pages are needed, use a blank NHICS 253 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Registration Information	
	Name	Enter the full name of volunteer.
	Certification / License and Number	If volunteer holds a certification or license, enter type and number.
	ID Number	Enter a Driver’s License number or Social Security Number.
	Address	Enter address.
	Contact Info	Enter phone number.
	Reference Check	References contacted, yes or no.
	Signature	Signature of volunteer verifying that information is correct.
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 254 | EMERGENCY ADMIT TRACKING



1. INCIDENT NAME					2. OPERATIONAL PERIOD	
	DATE: FROM:		TO:			
	TIME: FROM:		TO:			
3. AREA						
TRIAGE TAG OR MEDICAL RECORD #	NAME (LAST, FIRST)	SEX	DOB/AGE	ADMITTED FROM	ADMITTED TO	TIME
4. PREPARED BY	PRINT NAME: _____			SIGNATURE: _____		
	DATE/TIME: _____			FACILITY: _____		

PURPOSE: ACCOUNT FOR EMERGENCY ADMITS OR OTHERS SEEKING TEMPORARY SHELTER
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: PLANNING AND OPERATIONS SECTION CHIEF

NHICS 254 | EMERGENCY ADMIT TRACKING



INSTRUCTIONS

- PURPOSE:** Records the triage, treatment, and disposition of emergency admits seeking medical attention or transfer from an impacted facility.
- ORIGINATION:** Resident Services Branch Director or team members
- COPIES TO:** Planning Section Chief and Operations Section Chief
- NOTES:** Completed upon arrival of the first emergency admission and updated periodically. Copies are sent to the Planning Section Chief each hour and at the end of each operational period until disposition of the last victim(s) are known. If additional pages are needed, use a blank NHICS 254 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Area	Enter the triage or specific treatment area (e.g., Triage, Immediate Treatment Area).
	Triage Tag or Medical Record Number	Enter triage tag number or medical record number if available.
	Name	Enter the full name of victim.
	Sex	Enter sex: M for male/F for female.
	DOB / Age	Enter date of birth and age.
	Admitted from	Enter the name of the sending facility/location
	Admitted to	Enter the name of the facility accepting the admit
	Time	Enter the time of admission
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 255 | MASTER RESIDENT EVACUATION TRACKING



1. INCIDENT NAME						2. OPERATIONAL PERIOD	
						DATE: FROM: _____ TO: _____	
3. RESIDENT EVACUATION INFORMATION							
RESIDENT NAME				MEDICAL RECORD #			MED RECORD SENT <input type="checkbox"/> YES <input type="checkbox"/> NO
DISPOSITION	MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)	MEDICATION SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	
					MD/FAMILY NOTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER					ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RESIDENT NAME				MEDICAL RECORD #			MED RECORD SENT <input type="checkbox"/> YES <input type="checkbox"/> NO
DISPOSITION	MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)	MEDICATION SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	
					MD/FAMILY NOTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER					ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RESIDENT NAME				MEDICAL RECORD #			MED RECORD SENT <input type="checkbox"/> YES <input type="checkbox"/> NO
DISPOSITION	MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)	MEDICATION SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	
					MD/FAMILY NOTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER					ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. PREPARED BY	PRINT NAME: _____			SIGNATURE: _____			
	DATE/TIME: _____			FACILITY: _____			

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

NHICS 255 | MASTER RESIDENT EVACUATION TRACKING



INSTRUCTIONS

- PURPOSE:** Records the disposition of residents during a facility evacuation.
- ORIGINATION:** Resident Services Branch Director
- COPIES TO:** Operations Section Chief and Planning Section Chief
- NOTES:** Completed with information taken from each NHICS 260 - Resident Evacuation Tracking form. If additional pages are needed, use a blank NHICS 255 and repaginate as needed

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Resident Evacuation Information	
	Resident Name	Enter the full name of the resident.
	Medical Record #	Enter medical record number.
	Medical Record Sent	Indicate yes or no.
	Disposition	Indicate the resident's disposition.
	Mode of Transport	Indicate the mode of transport (CCT, ALS, BLS, Van, Bus, Car)
	Accepting Facility Name and Contact Info	Enter accepting (receiving) facility name and contact information
	Time Facility contacted & report given	Enter time prepared (24-hour clock).
	Transfer Initiated (Time/Transport Co.)	Enter time, vehicle company, and identification number.
	Medication Sent	Indicate yes or no.
	MD/Family Notified	Indicate yes or no.
Arrival Confirmed	Indicate yes or no.	
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 257 | RESOURCE ACCOUNTING RECORD



1. INCIDENT NAME		2. OPERATIONAL PERIOD					
		DATE:	FROM:			TO:	
		TIME:	FROM:			TO:	
3. RESOURCE RECORD							
TIME	ITEM/FACILITY TRACKING ID#	CONDITION	RECEIVED FROM	DISPENSED (TO/TIME)	RETURNED (DATE/TIME)	CONDITION (OR INDICATED IF NON-RECOVERABLE)	INITIALS
4. PREPARED BY		PRINT NAME: _____			SIGNATURE: _____		
		DATE/TIME: _____			FACILITY: _____		

PURPOSE: RECORDS THE REQUEST, DISTRIBUTION, RETURN AND CONDITION OF EQUIPMENT AND RESOURCES
ORIGINATION: IMT PERSONNEL AS DIRECTED BY SECTION CHIEFS
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF, LOGISTICS SECTION CHIEF, ORIGINATOR AND PLANNING SECTION CHIEF

NHICS 257 | RESOURCE ACCOUNTING RECORD



INSTRUCTIONS

- PURPOSE:** Documents the request, distribution for use, return, and condition of equipment and resources used to respond to the incident.
- ORIGINATION:** Logistics Section Chief and/or by Incident Management Team (IMT) staff
- COPIES TO:** Finance/Administration Section Chief, the Logistics Section Chief, the original requester of the resource, and the Planning Section Chief
- NOTES:** If additional pages are needed, use a blank NHICS 257 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Resource Record	
	Time	Enter the time (24-hour clock) and the request received.
	Item / Facility Tracking Identification Number	Enter the item and the facility tracking identification number.
	Condition	Enter the condition of the item when it was received.
	Received From	Enter whom the item was received from.
	Dispensed	Enter whom the item was dispensed to and the time (24-hour
	Returned	Enter the date (m/d/y) and time (24-hour clock) the item was
	Condition	Enter the condition the item was in when returned or indicate if non- recoverable.
	Initials	Enter initials of person processing item.
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 258 | FACILITY RESOURCE DIRECTORY



1. INCIDENT NAME	2. OPERATIONAL PERIOD				
	DATE:		FROM:	TO:	
	TIME:		FROM:	TO:	
3. CONTACT INFORMATION					
COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Agency for Toxic Substances and Disease Registry (ATSDR)					
Ambulance/EMS					
American Red Cross					
Biohazard Waste Company					
Buses					
Cab, City					
Emergency Management Agency					
CDC					
Clinics					
Coroner/Medical Examiner					
Dispatcher - 911					
Emergency Operations Center (EOC), Local					
Emergency Operations Center (EOC), State					
Engineers:					
HVAC					
Mechanical					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATOR: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258 | FACILITY RESOURCE DIRECTORY



COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Seismic					
Structural					
Environmental Protection Agency (EPA)					
Epidemiologist					
Family/Guardian	<i>SEE FAMILY/GUARDIAN CONTACT LIST</i>				
Fire Department					
Food Service					
Fuel distributor					
Fuel trucks					
Funeral Homes/Mortuary Services					
Generators					
HazMat Team					
Health Department, Local					
Heavy Equipment (e.g., Backhoes, etc.)					
Home Repair/Construction Supplies:					
Hospitals:					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATOR: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258 | FACILITY RESOURCE DIRECTORY



COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 contact)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Hotel/motel					
Housing, Temporary					
Ice, Commercial					
Laboratory Response Network					
Laundry/Linen Service					
Law Enforcement:					
City Police					
County Sherriff					
Highway Patrol					
Licensing & Certification District Office					
Licensing & Certification After-Hour Line					
Local Office of Emergency Services					
Long-Term Care Facilities:					
Media:					
Print					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258 | FACILITY RESOURCE DIRECTORY



COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Radio					
Radio					
TV					
TV					
TV					
Medical Gases:					
Medical Supply:					
Medication, Distributor:					
Moving Company:					
Pharmacy, Commercial:					
Poison Control Center					
Portable Toilets					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATION: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258 | FACILITY RESOURCE DIRECTORY



COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Radios:					
Amateur Radio Group					
Service Provider (e.g., Nextel)					
Walkie-Talkie					
Repair Services:					
Beds					
Biomedical Devices					
Gardeners/landscapers					
Glass					
Medical Equipment					
Oxygen Devices					
Radios					
Roadways/sidewalks					
Restoration Services (e.g., Service Master)					
Road Conditions	CALTRANS	1-800-427-7623			
Salvation Army					
Shelter Sites					
Staff	SEE STAFF CONTACT LIST				
Surge Facilities					

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATOR: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
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NHICS 258 | FACILITY RESOURCE DIRECTORY



COMPANY/AGENCY	COMPANY/AGENCY/ NAME (24/7 CONTACT)	TELEPHONE	ALTERNATE TELEPHONE	E-MAIL	FAX / WEBSITE
Traffic Control/Department of Transportation					
Trucks:					
Refrigeration					
Towing					
Utilities:					
Gas/Electricity					
Power					
Sewage					
Telephone					
Water, municipal					
Ventilators					
Water Vendor - Potable					
Water; non-potable					
Other:					
Other:					
Other:					
4. DATE LAST UPDATED					
5. PREPARED BY PLANNING SECTION CHIEF	PRINT NAME: _____ DATE/TIME: _____		SIGNATURE: _____ FACILITY: _____		

PURPOSE: LIST RESOURCES TO CONTACT DURING AN INCIDENT
ORIGINATOR: PLANNING SECTION CHIEF
COPIES TO: ALL IMT STAFF
NOTE: MAYBE PREFILLED AND UPDATED AT LEAST ANNUALLY

NHICS 258 | FACILITY RESOURCE DIRECTORY



INSTRUCTIONS

- PURPOSE:** Lists all methods of contact for nursing home resources for an incident.
- ORIGINATION:** Planning Section Chief
- COPIES TO:** All IMT staff, and posted as necessary.
- NOTES:** If this form contains sensitive information such as cell phone numbers, it should be clearly marked in the header that it contains sensitive information and is not for public release. If additional pages are needed, use a blank NHICS 258 and repaginate as needed.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Contact Information	
	Company / Agency	Type of company or agency.
	Company / Agency / Name	List the name of the company/agency. List the name of the point of contact if available.
	Telephone	Enter the telephone number.
	Alternate Telephone	Enter the alternate telephone number.
	Email	Enter the email, if available.
	Fax / Website	Enter the fax number and/or website.
4	Date Last Updated	If the document is completed prior to an incident, the last update should be entered (m/d/y). The directory should be updated at least annually.
5	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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NHICS 259 | FACILITY CASUALTY/FATALITY REPORT



1. INCIDENT NAME				2. OPERATIONAL PERIOD
				DATE: FROM: TO:
				TIME: FROM: TO:
3. REPORTED CASUALTY/FATALITY				
RESIDENT NAME				MEDICAL RECORD #
INJURY	TRANSFER DATE / TIME	RECEIVING FACILITY		EXPIRED DATE / TIME
RESIDENT NAME				MEDICAL RECORD #
INJURY	TRANSFER DATE / TIME	RECEIVING FACILITY		EXPIRED DATE / TIME
RESIDENT NAME				MEDICAL RECORD #
INJURY	TRANSFER DATE / TIME	RECEIVING FACILITY		EXPIRED DATE / TIME
RESIDENT NAME				MEDICAL RECORD #
INJURY	TRANSFER DATE / TIME	RECEIVING FACILITY		EXPIRED DATE / TIME
RESIDENT NAME				MEDICAL RECORD #
INJURY	TRANSFER DATE / TIME	RECEIVING FACILITY		EXPIRED DATE / TIME
4. PREPARED BY	PRINT NAME: _____		SIGNATURE: _____	
	DATE/TIME: _____		FACILITY: _____	

PURPOSE: DOCUMENT THE NUMBER OF INJURIES AND FATALITIES
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: COMMAND STAFF AND GENERAL STAFF

NHICS 259 | FACILITY CASUALTY/FATALITY REPORT



INSTRUCTIONS

- PURPOSE:** Records the number of residents injured and expired for each operational period.
- ORIGINATION:** Resident Services Branch Director or team
- COPIES TO:** Command Staff and General Staff
- NOTES:** If additional pages are needed, use a blank NHICS 259 and repaginate as needed. Additions may be made to the form to meet the organization’s needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Reported Casualty/Fatality	
	Resident Name	Enter the full name of the casualty/fatality.
	Medical Record #	Enter the medical record number.
	Injury	Describe the injury.
	Transfer Date/Time	Enter the transfer date and time.
	Receiving Facility	Enter the name of the facility accepting the casualty/fatality.
	Expired Date/Time	Enter the expiration date and time of the fatality.
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

NHICS 260 | RESIDENT EVACUATION TRACKING FORM



1. DATE		2. FACILITY NAME			
3. RESIDENT NAME			4. AGE	5. MEDICAL RECORD #	
6. SIGNIFICANT MEDICAL HISTORY			7. ATTENDING PHYSICIAN		
8. FAMILY/GUARDIAN NOTIFIED		<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME/CONTACT INFORMATION		
9. TRANSPORTATION EQUIPMENT		10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY):			
<input type="checkbox"/> HOSPITAL BED <input type="checkbox"/> GURNEY <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> AMBULATORY <input type="checkbox"/> SPECIAL MATTRESS		<input type="checkbox"/> IV PUMPS <input type="checkbox"/> OXYGEN <input type="checkbox"/> VENTILATOR <input type="checkbox"/> BLOOD GLUCOSE MONITOR <input type="checkbox"/> RESPIRATORY EQUIPMENT		<input type="checkbox"/> SERVICE ANIMAL <input type="checkbox"/> G TUBE PUMP <input type="checkbox"/> MONITOR <input type="checkbox"/> FOLEY CATHETER <input type="checkbox"/> OTHER	
11. SPECIAL NEEDS					
12. ISOLATION		<input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE:	REASON:	

13. EVACUATING LOCATION	
ROOM#	TIME
ID BAND CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO
BY	
MEDICAL RECORD SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
FACE SHEET/TRANSFER TAG SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
BELONGINGS	<input type="checkbox"/> WITH RESIDENT <input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE
VALUABLES	<input type="checkbox"/> WITH RESIDENT <input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE
MEDICATIONS	<input type="checkbox"/> WITH RESIDENT <input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE

14. ARRIVING LOCATION	
ROOM#	TIME
ID BAND CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO
BY	
MEDICAL RECORD RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
FACE SHEET/TRANSFER TAG RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
BELONGINGS RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
VALUABLES RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATIONS RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO

15. TRANSFERRING TO ANOTHER FACILITY/ LOCATION	
TIME TO STAGING AREA	TIME DEPARTING TO RECEIVING FACILITY
DESTINATION	DEPARTURE TIME:
MODE OF TRANSPORT	<input type="checkbox"/> AMBULANCE UNIT <input type="checkbox"/> HELICOPTER <input type="checkbox"/> BUS <input type="checkbox"/> OTHER: _____
ID BAND CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO
ID BAND CONFIRMED BY	
16. PREPARED BY	PRINT NAME: _____ SIGNATURE: _____
	DATE/TIME: _____ FACILITY: _____

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
 ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
 ORIGINAL TO: RECEIVING FACILITY
 COPIES TO: PLANNING

NHICS 260 | RESIDENT EVACUATION TRACKING FORM



INSTRUCTIONS

- PURPOSE:** Documents and accounts for residents transferred to another facility.
- ORIGINATION:** Resident Services Branch Director, Operations Section Chief and/or IMT staff as appropriate
- COPIES TO:** Planning Section Chief and the evacuating clinical location. Original is kept with the resident.
- NOTES:** The information on this form may be used to complete NHICS 255, Master Resident Evacuation Tracking Form. Additions or deletions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Date	Enter the date of the evacuation.
2	Facility Name	Enter the Facility Name the resident is leaving from.
3	Resident Name	Enter the resident's full name.
4	Age	Enter the resident's age.
5	Medical Record #	Enter the resident's medical record number.
6	Significant Medical History	Enter significant medical history.
7	Attending Physician	Enter the name of the resident's attending physician.
8	Family/Guardian Notified	Check yes or no; enter family/guardian contact information.
9	Transportation Equipment	Identify type of transportation equipment (e.g., wheelchair, gurney) needed.
10	Accompanying Equipment	Check appropriate boxes for any equipment being transferred with the resident.
11	Special Needs	Indicate if the resident has special needs, assistance, or requirements.
12	Isolation	Indicate if isolation is required, the type, and the reason.
13	Evacuating Location	Fill in information and check boxes to indicate originating room and what was sent with the resident (records, medications, and belongings).
14	Arriving Location	Fill in information and check boxes to indicate resident's arrival at new location and whether materials sent with the resident were received.
15	Transferring to another Facility/ Location	Document arrival and departure from the staging area, confirmation of ID band, and mode of transportation used.
16	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.