Submit to: ICEMADutyOfficer@cao.sbcounty.gov
Fax: (909) 388-5825

Resource Request: Medical and Health FIELD/HCF[2] to Op Area

RR MH (11AUG11)

REQUESTOR TO COMPLETE

1. Incident Name:	2a. DATE:	2b. TIME:
3. Requestor Name, Agency, Position, Phone / Email:	2c. Requestor Tracking #: (Assigned by Requesting Entity)	
4a. Describe Mission/Tasks:	4b. Delivery/Reporting/Staging Information:	

5. ATTACH ADDITIONAL ORDER SHEETS, IF NEEDED ☐	GENERAL: SUPPLY/EQUIPMENT ☐	PERSONNEL ☐	OTHER

6. ORDER ***SUPPLY/EQUIPMENT/PERSONNEL REQUEST DETAILS***

ITEM #	Priority (See Below)[3]	DETAILED SPECIFIC ITEM DESCRIPTION: Supplies/Equipment (Rx: 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 Supplies/Equipment: Food, Water, Generators) Personnel (Be specific: List Probable Duties, Required License, Specific Experience (ED/ICU/OR, Hospital/Clinical, etc.) Other (Mobile Field Hospital; Ambulance Strike Team; Alternate Care Supply Cache; Facility-Tent, Trailer, Size, etc.)	Quantity Requested	Expected Equipment/ Staff Duration of Use:
	S			
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	S			
	S			
	S			

REVIEW

7. Requesting entity must confirm that these 3 requirements have been met prior to submission of request

N(	Is the resource(s) being requested nearly exhausted or exhausted?
N(	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?
N(	Entity is unable to obtain resource from other non-traditional sources?

8. COMMAND/MANAGEMENT REVIEW AND VERIFICATION (SIGNATURE INDICATES VERIFICATION OF NEED AND REQUEST'S APPROVAL)

NAME:	POSITION:	SIGNATURE or equivalent

[2] HCF = Health Care Facility

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