**Annex 12**

**Forms**

**Forms and Information Sheets**

For reimbursement purposes, accurate record keeping is essential during POD operations.

Documentation shall be completed during POD operations to ensure identification of staffing/volunteers, patient information to include medication/vaccination information, and incident/injury.

Completed forms shall be given to the Documentation Tracking Unit Leader for filing. Example copies of suggested forms are listed below. These forms are provided; however, they may be modified or replaced with local forms.

**Required Forms**

Staff/Clinic and Volunteer Sign-In Sheet: 12-2 and 12-4

Clinic Staff Emergency Information Form: 12-3

Name, Address, Patient History (NAPH): 12-5 and 12-6

Incident/Injury report: 12-7 and 12-8

*DEA Form 222*

Inventory Sheet for SNS supplies: 12-9

Medication Instruction Sheet – when applicable

Immunization/Vaccination Sheet – when applicable, available from SDDOH/CDC

Vaccination Consent Form – when applicable, available from SDDOH/CDC

**Optional Forms**

Shift Schedule\*

Incident Briefing, ICS Form 201

Incident Objectives, ICS Form 202

Organization Assignment List, ICS Form 203

Medical Plan, ICS Form 206

Organizational Chart, ICS Form 207

Incident Status Summary, ICS Form 209

Check In List, ICS Form 211

General Message, ICS Form 213\*

Unit Log, ICS Form 214\*

Demobilization Plan, ICS Form 221

Demobilization Checkout, ICS Form 221, page 1

Instructions for Demobilization, ICS Form 221

Resource Order Form, ICS Form 308

Other forms as identified to help recoup costs or assist with documentation\*

ICS forms can be found at: http://training.fema.gov/EMIWeb/IS/ICSResource/ICSResCntr\_Forms.htm

| **Staff/Clinic Sign-In Sheet** |
| --- |
| Clinic Location: |  |  |  | Date: |  |
| Agency | Name | Job Assigned | Time in | Time Out |  |
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**Clinic Staff Emergency Information Form**

**Date last updated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Personal Information** |
| Agency Affiliation |  |
| Professional certification or license |  |
| First name |  |
| Middle name |  |
| Last name |  |
|  |  |
| Gender |  |
|  |  |
| Home address |  |
|  |
|  |  |
| Home phone |  |
| Cellular phone |  |
|  |  |
| Home e-mail address |  |
| Birthday (MM/DD/YYYY) |  |
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| **Medical Information** |
| Doctor’s name |  |
| Address |  |
|  |
| Phone number |  |
| Blood type |  |
| Medical conditions |  |
| Allergies |  |
| Current medications |  |
| **Emergency Information** |
| Emergency contact’s name |  |
| Relationship |  |
| Address |  |
|  |
| Phone number(s) |  |

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Volunteer Sign-In Sheet** |
| --- |
| Clinic Location: |  |  |  | Date: |  |  |
| Name | Phone | Department | Skills, competencies | Assigned to: | Time In | Time Out |
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| --- | --- |
| **NAPH (name, address, patient history) Form**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_  | Contact Phone Numbers |
| Home: ( ) |
| Cellular: ( ) |
| Work: ( ) |
| I am picking up medications for myself. I agree to take them as prescribed. I am picking up medications for others in my household. I am authorized to sign for these people, and I agree to provide the medications and instructions to all of them. Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| AEnter the name and date of birth of each person to receive medication.**Enter weight for any person under 90 Lbs.*****The person picking up the medications should be listed 1st*** | B | C |
| 1 | Name *(Last, First)* | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *1**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
| 2 | Name *(Last, First)*: | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *2**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
| 3 | Name *(Last, First)*: | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *3**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
|  | **NAPH (name, address, patient history) Form (continued)** |  |
| 4 | Name *(Last, First)*: | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *4**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
| 5 | Name *(Last, First)*:  | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *5**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
| 6 | Name *(Last, First)*: | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *6**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |
| 7 | Name *(Last, First)*: | 🗸if you have any of the following conditions:🞏 Pregnant or nursing🞏 Kidney failure/dialysis🞏 Taking birth control pills🞏 Difficulty swallowing tablets | 🗸 if you have an allergy to:🞏 Cipro (ciprofloxacin)🞏 Vibramycin (doxycycline)🞏 Penicillin |
| Date of Birth: Age: Weight if less than 90 pounds: | *7**SNS Medication Label Here* |
| *For Office Use Only* adult: [ ]  Doxy [ ]  100 mg child: [ ]  Doxy Dosage:  |
|  [ ]  Cipro [ ]  500 mg [ ]  Cipro |

 **Screener:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Dispenser:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Incident Report**

|  |  |
| --- | --- |
| [ ]  | An incident is an event that caused injury to a person or damage to equipment, facilities, or materials. |
| [ ]  | A near miss is an event that potentially could have caused injury to a person or damage to equipment, facilities, or materials. |
| Form completed by:       | Person involved in incident:       |
| Witness(es):       |
| Employee's occupation:       |
| Date of incident:       | Time of incident:       | [ ]  A.M. | [ ]  P.M. | Date reported:       |
| Department and location where incident occurred:       |
| Worker's shift on day of injury, from:       | [ ]  A.M. | [ ]  P.M. | to:       | [ ]  A.M. | [ ]  P.M. |
| Nature of injury (such as strain, cut, or bruise):       |
| Body parts affected (such as left hand or right ankle):       |
| Medical treatment required: | [ ]  None | [ ]  First aid/Med express | [ ]  Hospital or physician |
| Name of hospital or attending physician:       |
| Was employee hospitalized overnight as a patient? | [ ]  Yes | [ ]  No |
| Did employee leave work because of the injury? | [ ]  Yes | [ ]  No | If yes, what time:       | [ ]  A.M. | [ ]  P.M. |
| Date employee returned to regular duty:       | Date employee returned with light-duty restrictions:       |
| Describe incident fully (use back of sheet if necessary, or sketch on back of sheet if needed to clarify):       |
| List all equipment, machinery, materials, or chemicals employee was using when incident occurred:       |
| Identify factors you believe contributed to or caused the incident:       |

**Incident Report (continued)**

|  |
| --- |
| **Complete this section if an injury occurred or equipment was damaged.** |
| Were proper procedures being followed when incident occurred? | [ ]  Yes | [ ]  No |
| If no, explain:       |
| Was employee wearing proper personal protective equipment? | [ ]  N/A | [ ]  Yes | [ ]  No |
| If no, explain:       |
| Are changes in equipment necessary to prevent recurrence? | [ ]  Yes | [ ]  No |
| If yes, explain:       |
| Employee signature: | Date:       |
| Supervisor signature: | Date:       |

Please forward this form to the Clinic Safety Officer as soon as possible following the incident or near miss.

Note: If an employee or volunteer receives medical treatment from a hospital or physician, additional forms need to be filled out and forwarded to the Clinic Safety Officer along with the incident report so that a workers’ compensation claim can be filed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Safety Officer --- Send copies to:** | [ ]  Documentation Tracking Unit | [ ]   | [ ]   | [ ]   |

**Inventory Sheet**

|  |
| --- |
| **If individual items from the Push Package are issued to the State, indicate which items below.** |
| **Initial** | **Item Description** | **NDC/ Product Number** | **Lot Number** | **Qty** |
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**Provisionary CDC Strategic National Stockpile Authority**

(PRINT NAME AND TITLE)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized Receiving Authority**

(PRINT NAME AND TITLE)

**If control Schedule II Substances are transferred:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized Receiving DEA Registrant**

(PRINT NAME AND TITLE)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(SIGNATURE AND DATE)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(SIGNATURE AND DATE)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(SIGNATURE AND DATE)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(DEA REGISTRATION NO.)