RESOURCE REQUEST QUICKSHEET

During DOC open hours – DOC staff will acknowledge receipt of this ResReq within 15 min

| **INSTRUCTIONS:** 1. Use separate QuickSheet for different types of items. See box # 1a to right.
2. Submit this QuickSheet to MHOAC:
MHOAC Email: CoastalValleysEMSAgency@sonoma-county.org
MHOAC Fax: (707) 744-4609
MHOAC Phone: (877) 311-2008 GUEST CODE: 486636# | **This QuickSheet is for:**
1a **(only ONE resource type per Quicksheet)**
☐ Staff/MRC ☐ Supplies
☐ Equipment ☐ Rx ☐ Other | **1b** **Incident Name:**
2a **Date:** / /
2b **Time:** : ☐AM ☐PM | **2c** **Page:**

___
of
___ |

3a Requestor Agency:	**3b** Requestor Facility Type: ☐Hospital ☐Clinic ☐SNF ☐ Other, specify:	**3c** Requesting Agency Tracking Number (optional):
3d Name:	**3e** Position /Title:	**3f** Contact Phone ( ) - x
3g Alt. phone #: ( ) - x	**3h** Email:	

4a <u>Deliver</u> to Point of Contact (POC) Name:	**4b** Delivery Location (include address, location e.g., loading dock, back of bldg, etc.)
4c Point of Contact phone #: ( ) - x	

4d Requestor must confirm these <u>4 requirements</u> are met prior to submitting this request. Checking each box confirms the requirement is met:
- ☐ 1. We are unable to obtain resources within a reasonable time frame based upon priority level indicated from vendors, contractors, MOU/MOUs, department, or corporate office providers.
- ☐ 2. We are requesting each resource because it is nearly exhausted or is now exhausted.
- ☐ 3. We are unable to obtain resources from other non-traditional sources.
- ☐ 4. SitRep has been submitted to DOC.

4e This Request is approved by - Name: _____ Title: _____

5. ORDER | 6. DOC USE ONLY

Line #	Priority	Detailed Specific Item or Staff	Quantity	Unit: [each, box, case, pkg, - n/a for staff]	How long will you need this item?	Quantity Approved	Approved By	Quantity Filled	Back Ordered	ETA	Facility Notified	Delivered
	Emergent: <12hr Urgent: >12hr Sustainment /Low Priority	**Description:** Vital characteristics, brand, specs, diagrams, & other info. **RX:** Drug Name, Dosage Form, UNIT OF USE, Package or Volume, Strength, etc. **EQUIPMENT:** Name, Capabilities, Output, Capacity **STAFF -** License: RN/MD/EMT-1/Pharmacist/LVN/EMT-P/NP/PHN/DVM/PA/RCP/MFT/DDS Experience: 1=current hospital, 2=Current clinical 3=current license 4=clinical education Required Skills: PALS, Current ICU, ICS training, Languages, etc. Preferred skills/training				*Approval by Ops Chief/Dir*				*Date & Time*		
A	☐ E ☐ U ☐ S											
B	☐ E ☐ U ☐ S											
C	☐ E ☐ U ☐ S											
D	☐ E ☐ U ☐ S											
E	☐ E ☐ U ☐ S											