Form Approved
OMB No. 0920-0666
Exp. Date: 00/00/00
www.cdc.gov/nhsn
Revised 5_08_2025

Daily Facility Operating Status

Facility Information
Facility ID Number:
Reporting for Date: Month/Day/Year: ____/_____ /_____; HH:_____ MM:_____

Status Indicator – Facility Operational Status
1a. Check the appropriate **facility operational status*:** ☐ normal, routine operational, conventional state: facility **NOT impacted** ☐ contingency state: facility operations **partially impacted**, or managed on alternate power source ☐ emergency state: facility operations **fully impacted**
Note: • If facility reports normal / routine / conventional state in place – **do not complete the remainder of this form**. However, complete once operational status changes. • If either contingency or emergency state reported proceed to complete this form.

Essential Elements of Information (EEIs) – Please complete all fields – do not leave blank.	
1b. Is the facility **structural status** impacted?	**Check one:** ☐ Yes ☐ No
1c. Is the facility **power system** impacted?	**Check one:** ☐ Yes ☐ No
1d. Is the facility **water system** impacted?	**Check One:** ☐ Yes ☐ No
1e. Is the facility **sewer system** impacted?	**Check One:** ☐ Yes ☐ No
Structural Damage	
2a. Select the option that best represents the integrity of the facility:	**Select only One Option**: ☐ **No damage**: facility sustained no damages

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	☐ **Affected**: facility with minimal damage to the exterior and or contents of the facility ☐ **Minor**: encompasses a wide range of damage that does not affect the structural integrity of the facility ☐ **Destroyed:** the facility is a total loss, or damaged to such an extent that repair is not feasible
Evacuation Status. Please note the evacuation process applies ONLY to patients	
3a. Select the option which best describe the facility evacuation status:	**Select only one option** ☐ **Planning**: preparing to evacuate from the facility within the next 12 hours ☐ **Departure in progress:** currently evacuating the facility ☐ **Fully evacuated:** facility evacuated all patients ☐ **Not applicable:** did not evacuate
Evacuation Type. Please note the evacuation process applies ONLY to patients	
3b. Select the option which best represents the evacuation type of the facility:	**Select only one option** ☐ **Normal operations:** facility is unaffected and did not evacuate or shelter-in-place ☐ **Full evacuation:** facility evacuated all patients ☐ **Partial evacuation:** select patients evacuated to other facilities (note: decompression by discharge is not included in partial evacuation) ☐ **Shelter-in-place:** facility did not evacuate and is weathering the storm
Evacuation Start Time and End Time. Please note the evacuation process applies ONLY to patients	
3c.*Enter Evacuation Date and Start time *Note: Only complete if your facility evacuated	**Enter the date and time the evacuation started, using format:** Month/day/year: _____/_____/_____ ___ : ___ hh mm
3d. *Enter Evacuation Date and End time *****Note: only complete if your facility evacuated and evacuation completed.	**Enter the date and time the evacuation ended, using format**: Month/day/year: _____/_____/_____ ___ : ___ hh mm
Re-entry Status	
3e. Select the option which best represents the	**Select only one option**

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re-entry status of the facility:	☐ **Planning:** preparing to re-enter the facility ☐ **Re-entry in progress**: implementing re-entry process into the facility ☐ **Re-entry complete:** all required elements to re-enter the facility completed ☐ **Not applicable:** did not evacuate
Generator Power Status Type	
4a. Generator Power Status Select the option which best describes the type of power the facility is currently using:	**Select Only One option** ☐ **Commercial power:** sold by utility company ☐ **Generator power:** device convert mechanical energy into electrical power ☐ **Mixed commercial and generator power:** both commercial and mechanical energy ☐ **No power**: facility is without commercial and generator power
4b. Generator Fuel Status Specify how may hours of fuel the generator has for the facility	**Select Only One option** ☐ 24 – 48 hours ☐ 48 – 72 hours ☐ 72 – 96 hours ☐ > 96 hours
4c. Generator Fuel Type Select the type of fuel the facility generator needs for operation	**Select Only One option** ☐ Diesel ☐ Gasoline ☐ Natural gas ☐ Dual fuel system (both liquid fuel and natural gas) ☐ Unknown
4d. HVAC Generator Status Is the facility HVAC* system on generator backup power? **Heating, ventilation, and air conditioning (HVAC)*	**Check One:** ☐ Yes ☐ No
Water System	
5a. Normal Water Supply Select the option which best represents the water supply for your facility?	**Check One:** ☐ Usual water supply

	☐ Secondary water supply ☐ Unknown
5b. Dialysis Reliable Water Supply Do you have a water source to dialyze patients?	**Check One:** ☐ Yes ☐ No ☐ Unknown
Sewer System	
6a. Sewer Status Is the facility sewer system functioning (e.g., are toilets flushing)?	**Check One:** ☐ Yes ☐ No ☐ Unknown
Other	
7a. Immediate Needs* Does the facility have ANY immediate needs impacting its ability to receive or care for patients to the capacity needed that is not being met by the normal request process? *Note: Please contact your local/state emergency manager or ESF8 contact to complete a resource request.	**Check One:** ☐ Yes ☐ No ☐ Not Applicable
7b. If yes, to Immediate Needs Describe facility immediate needs (Field cannot contain more than 2000 characters):	
Description – Other Immediate Needs	

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