

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* :	
<input type="checkbox"/> normal, routine operational, conventional state: facility NOT impacted	
<input type="checkbox"/> contingency state: facility operations partially impacted , or managed on alternate power source	
<input type="checkbox"/> emergency state: facility operations fully impacted	
Note: <ul style="list-style-type: none"> 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 (EELs) – Please complete all fields – do not leave blank.	
1b. Is the facility structural status impacted?	Check one: <input type="checkbox"/> Yes <input type="checkbox"/> No
1c. Is the facility power system impacted?	Check one: <input type="checkbox"/> Yes <input type="checkbox"/> No
1d. Is the facility water system impacted?	Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No
1e. Is the facility sewer system impacted?	Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No
Structural Damage	
2a. Select the option that best represents the integrity of the facility:	Select only One Option: <input type="checkbox"/> No damage: facility sustained no damages

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Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).



	<input type="checkbox"/> Affected: facility with minimal damage to the exterior and or contents of the facility <input type="checkbox"/> Minor: encompasses a wide range of damage that does not affect the structural integrity of the facility <input type="checkbox"/> 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 <input type="checkbox"/> Planning: preparing to evacuate from the facility within the next 12 hours <input type="checkbox"/> Departure in progress: currently evacuating the facility <input type="checkbox"/> Fully evacuated: facility evacuated all patients <input type="checkbox"/> 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 <input type="checkbox"/> Normal operations: facility is unaffected and did not evacuate or shelter-in-place <input type="checkbox"/> Full evacuation: facility evacuated all patients <input type="checkbox"/> Partial evacuation: select patients evacuated to other facilities (note: decompression by discharge is not included in partial evacuation) <input type="checkbox"/> 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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NHSN
 National Healthcare
 Safety Network

re-entry status of the facility:	<input type="checkbox"/> Planning: preparing to re-enter the facility <input type="checkbox"/> Re-entry in progress: implementing re-entry process into the facility <input type="checkbox"/> Re-entry complete: all required elements to re-enter the facility completed <input type="checkbox"/> 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 <input type="checkbox"/> Commercial power: sold by utility company <input type="checkbox"/> Generator power: device convert mechanical energy into electrical power <input type="checkbox"/> Mixed commercial and generator power: both commercial and mechanical energy <input type="checkbox"/> No power: facility is without commercial and generator power
4b. Generator Fuel Status Specify how many hours of fuel the generator has for the facility	Select Only One option <input type="checkbox"/> 24 – 48 hours <input type="checkbox"/> 48 – 72 hours <input type="checkbox"/> 72 – 96 hours <input type="checkbox"/> > 96 hours
4c. Generator Fuel Type Select the type of fuel the facility generator needs for operation	Select Only One option <input type="checkbox"/> Diesel <input type="checkbox"/> Gasoline <input type="checkbox"/> Natural gas <input type="checkbox"/> Dual fuel system (both liquid fuel and natural gas) <input type="checkbox"/> Unknown
4d. HVAC Generator Status Is the facility HVAC* system on generator backup power? <i>*Heating, ventilation, and air conditioning (HVAC)</i>	Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No
Water System	
5a. Normal Water Supply Select the option which best represents the water supply for your facility?	Check One: <input type="checkbox"/> Usual water supply

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 National Healthcare Safety Network	<input type="checkbox"/> Secondary water supply <input type="checkbox"/> Unknown
5b. Dialysis Reliable Water Supply Do you have a water source to dialyze patients?	Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sewer System	
6a. Sewer Status Is the facility sewer system functioning (e.g., are toilets flushing)?	Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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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