



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Healthcare Facility Emergency Power Resilience Playbook

Appendix Content

E-mail completed form to: laemsadutyofficer@lans.lacounty.gov
or fax: **number will be provided at time of event**

Resource Request Medical and Health: FIELD/HCF ² To Op Area				
1. Incident Name:		2a. DATE:		2b. TIME:
3. Requestor Name, Agency, Position, Address, Phone / Email:			2c. Requestor Tracking Number: Facility code+3 digit number (Assigned by requesting entity)	
4. Describe Mission/Tasks:				
5. ORDER SHEET(S) - ATTACH ADDITIONAL IF NEEDED		☐	☐	☐
		SUPPLIES	PERSONNEL	EQUIPMENT
6. ORDER MEDICAL & HEALTH REQUEST DETAILS				
Item #	Priority ³	Detailed Specific Item Description: Vital characteristics, brand, specs, diagrams, and other info. (Rx: Drug Name, Dosage Form, UNIT OF USE PACKAGE or Volume, etc.) (Attach product information pages, photos, In-House purchase order documentation)	Qty	Expected Duration of Use (does not apply to supplies)
7. Requesting facility must confirm that these 3 requirements have been met prior to submission of request				
☐ Is the resource(s) being requested exhausted or nearly exhausted?				
☐ Facility is unable to obtain resources within a reasonable time frame (based upon priority level below) from vendors, contractors, MOU/MOA's or corporate office?				
☐ Facility is unable to obtain resource from other non-traditional sources?				
8. COMMAND/MANAGEMENT REVIEW AND VERIFICATION (NAME, POSITION, AND SIGNATURE - SIGNATURE INDICATES VERIFICATION OF NEED AND APPROVAL)				

1-When EMS DOC activated MH-RR to be sent to Operations Section Coordinator

2-HCF = Health Care Facility

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