Alaska RESPOND
VOLUNTEER EMERGENCY MEDICAL PROFESSIONALS

Status (completed by the DHSS EOC)
Date received:_____
Approved by:_____
Not approved by:_____

# Healthcare Facility Checklist for Mobilization of ALASKA RESPOND Volunteers

**Healthcare Facility Name:** _____
**Healthcare Facility Contact:** _____
**Healthcare Facility Contact Number:** _____
**Healthcare Facility Contact Email:** _____

**1. Has your healthcare facility exhausted your resources of licensed healthcare providers ?** Yes No

**2. Have your facility exhausted your community resources of licensed healthcare providers?** Yes No

**3. How many / type of licensed healthcare providers is your healthcare facility requesting?**

| | How Many? | If Available - Specialty Needed? |
|---|---|---|
| Mid-level Practitioner (Advanced Nurse Practitioner, Physician Assistant) | | |
| Behavioral Health Specialist (Counselor, Marriage Family Therapist, Psychologist, Social Worker) | | |
| Nurse | | |
| Physician | | |
| Respiratory Therapist | | |
| Other (Paramedic, Pharmacist, etc.) | | |

**4. Possible length of deployment:**

| Type of Healthcare Professional | 1 - 3 Days | 4 - 7 Days | 8 - 12 Days | 14 - 30 Days |
|---|---|---|---|---|
| | | | | |
| | | | | |

**5. Check the potential shift schedule the volunteers may work:**

| Type of Healthcare Professional | 8 hour Shift | 10 hour Shift | 12 hour Shift |
|---|---|---|---|
| | | | |
| | | | |

**6. Potential employment status:**

**Alaska Respond volunteers are not required to have personal malpractice or liability insurance.*

| **Type of Healthcare Professional** | **Volunteer**<br><br>*Not paid by the requesting facility or state of Alaska | **Requesting Facility Hire**<br><br>*Paid by the requesting facility | **State of AK Emergency Hire**<br>*Not longer than 30 days |
|---|---|---|---|
| | | | |
| | | | |

**7. After the volunteers arrive at your facility or community:**

Where do the volunteers report to?

Physical Address_____

Who do the volunteers report to?

Contact Person_____ Phone #_____

Will the volunteers shadow a staff person during their shift? Yes No

Will the volunteers need any special training before working? Yes No

If yes, describe_____

_____

**8. Will the requesting facility provide:**

Transportation (car rental, van / personnel picking up, etc.) Yes No

Notes: _____

Lodging (hotel, community facility, etc.) Yes No

Notes: _____

Meals Yes No

Notes: _____

**9. When do the volunteers need to report to your facility?** (Note: ASAP is not a time or date)

| **Type of Healthcare Professional** | **Date** | **Time** |
|---|---|---|
| | | |
| | | |

**10. Additional comments to the DHSS EOC:**

**For Official Use Only**

**Volunteers deployed to the facility**

| **Healthcare Professional** | |
|---|---|
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