




































Winlink Templates in Standard Library (version 1.0.119.0)

-  **Standard_Forms** - 0 files,
 -  **User Information** - 4 files,
 - How to change a Winlink Account Call.txt
 - HTML Form Features.txt
 - ICS Forms Modification.txt
 - White List & Spam Control.txt
 -  **AK STATE Forms** - 2 files,
 - AK ARES ICS213.txt
 - AK ISNAP.txt
 -  **ARC Forms** - 9 files,
 - ARC 204 Work Assignment.txt
 - ARC 213 Message.txt
 - ARC 6409 Requisition Form.txt
 - ARC 6409-B Disaster Receipt Form.txt
 - ARC Daily Shelter Report.txt
 - ARC ICS213.txt
 - ARC Requisition 6409.txt
 - ARC Safe & Well Form.txt
 - ARC Staff Request.txt
 -  **ARRL Forms** - 4 files,
 - ARRL ARES FSD125-2.txt
 - ARRL ARES FSD157.txt
 - ARRL ARES FSD212.txt
 - ARRL ARES FSD89.txt
 -  **CA STATE Forms** - 3 files,
 -  **BLOOD BANK Forms** - 1 files,
 - CA Blood Bank Order Form.txt
 -  **CESN Forms** - 1 files,
 - CESN Winlink Check In.txt
 -  **LA COUNTY Forms** - 6 files,
 - Burn Resource CHECKLIST.txt
 - DRC EQUIPMENT CHECKLIST.txt
 - LA Bed Availability Report.txt
 - LA Resource Request.txt
 - LPC Inventory CHECKLIST.txt
 - M-SS Cache Inventory.txt
 -  **SDG ARES ACS_Forms** - 3 files,
 - SDG ARES Casualty Report.txt
 - SDG ARES Check In.txt
 - SDG ARES Hospital Status.txt
 -  **SDG ARES Forms** - 2 files,
 - SDG ARES Casualty Report.txt
 - SDG ARES Hospital Status.txt
 - CA Blood Bank Net Roster.txt
 - CA Blood Bank Order Form.txt

- CESN Winlink Check In.txt
-  **CANADIAN Forms** - 6 files,
 -  **BC Forms** - 5 files,
 - BC Checkin.txt
 - BC EOC Expenditure Authorization.txt
 - BC Initial Impact Assessment Form.txt
 - BC Radiogram.txt
 - BC Resource Request.txt
 -  **BC SA Forms** - 3 files,
 - BC SA 212 Health Welfare.txt
 - BC SA 214 Activity Log.txt
 - BC SA FIA 730.txt
 - Halifax ICS202.txt
 - Halifax ICS205.txt
 - Halifax Message Form.txt
 - Halifax Message.txt
 - IMS Form 213.txt
 - IMS1001 IAP.txt
-  **FEMA Forms** - 3 files,
 - FEMA Mission Assignment.txt
 - FEMA Resource Request.txt
 - FEMA Ressource Rrequest.txt
-  **FL STATE Forms** - 4 files,
 - Clay County Extended Shelter.txt
 - Clay County ICS213.txt
 - Clay County Shelter.txt
 - Hillsborough Bed Report.txt
-  **FMRE Forms** - 5 files,
 - FMRE RNE F1 Evento.txt
 - FMRE RNE F2 Anuncio.txt
 - FMRE RNE F3 Temblor.txt
 - FMRE RNE F4 Huracan.txt
 - FMRE RNE F5 Reporte.txt
-  **GENERAL Forms** - 14 files,
 - Bulletin.txt
 - Damage Assessment.txt
 - Hospital Bed Report.txt
 - Hospital Status.txt
 - Incident Action Plan.txt
 - Incident After Action Report.txt
 - Incident Status Report.txt
 - Information.txt
 - Narrative Situation Report.txt
 - Quick Message.txt
 - Quick WEB EOC Resource Request.txt
 - Race Tracker.txt
 - Welfare Message.txt
 - Winlink Check In.txt
-  **HI STATE Forms** - 1 files,
 - HI Checkin.txt

-  **HICS Forms** - 5 files,
 - HICS Shelter Log.txt
 - HICS205A.txt
 - HICS213.txt
 - HICS214.txt
 - HICS254.txt
-  **IARU Forms** - 1 files,
 - IARU Message Form.txt
-  **ICS USA Forms** - 12 files,
 - ICS205-10 Row.txt
 - ICS205-20 Row.txt
 - ICS205.txt
 - ICS205A.txt
 - ICS206.txt
 - ICS210.txt
 - ICS213.txt
 - ICS213RR.txt
 - ICS214.txt
 - ICS214A.txt
 - ICS217A.txt
 - ICS309.txt
-  **IHS Forms** - 1 files,
 - Field Patient Report.txt
-  **OH STATE Forms** - 1 files,
 - POD General Message.txt
-  **OR STATE Forms** - 9 files,
 -  **QUARTERLY_Test** - 4 files,
 - Instructions.html
 - Quarterly Test Message.txt
 - Quarterly Test Report.txt
 - READ ME.txt
 - Oregon Activate Deactivate.txt
 - Oregon Declaration Emergency.txt
 - Oregon ICS213.txt
 - Oregon Public Event.txt
 - Oregon Request Assistance.txt
 - Oregon SITREP.txt
 - Oregon Winlink Check In.txt
 - Oregon_SITREP_Viewer.html
 - OR_State_RR.txt
-  **OTHER MEDICAL Forms** - 4 files,
 - CIRM.txt
 - Field Patient Report.txt
 - Hospital Bed Report.txt
 - Hospital Status.txt
-  **RADIOGRAM RRI Forms** - 4 files,
 - Multi Client Work Sheet.txt
 - RadioGram Work Sheet.rtf
 - Radiogram.txt

- Radiogram_Initial.html
-  **SATERN Forms** - 1 files,
 - SATERN ICS213.txt
-  **SHARES Forms** - 3 files,
 - SHARES Message Form2.txt
 - SHARES Radio Interference.txt
 - SHARES Spotrep-2.txt
-  **TX STATE Forms** - 1 files,
 - TX STAR Form.txt
-  **VA STATE Forms** - 3 files,
 - REC-4.txt
 - VA Local SITREP.txt
 - VA Resource Request.txt
-  **WA STATE Forms** - 6 files,
 - EyeWarn Form.txt
 - WA Emergency Workers Activity.txt
 - WA ICS213RR.txt
 - WA ISNAP.txt
 - WA R4 EOC Sitrep.txt
 - WA RR WebEOC.txt
-  **WEATHER Forms** - 7 files,
 - Hurricane Report.txt
 - Hurricane_Report_Initial.html
 - Local Weather Report Viewer.html
 - Local Weather Report.html
 - Local Weather Report.txt
 - Severe WX Report.html
 - Severe WX Report.txt
-  **WI STATE Forms** - 1 files,
 - Uniform Disaster Situation Report.txt

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/ICS%20USA%20Forms/10lineICS205_Initial.html[5/1/20 7:57:29 AM]

AFTER ACTION REPORT General	
<div>Send to <i>whomever is responsible for gathering such information within your organization.</i></div> <div>Click to add an agency or group name</div> <div>Form Info</div>	
Report Date/Time:	Incident - Event Date:
Incident - Event Name:	
Location:	
Your Name:	Call Sign:
Your Normal Internet Email:	
Telephone (optional):	
What was your assignment or role on this incident - event?	
Give a brief re-cap of the incident - event & describe any major occurrences that you were involved with.	
FEEDBACK - Recommendations (Be Brief and Professional)	
Ver 6.4	

No	Precedence Routine	HX	Org Station	Check	Org Location	Time	Date
ALASKA State ARES GENERAL MESSAGE Vers 9							
1. Incident Name:							
2. To (Name/Position):							
3. From (Name/Position):							
4. Subject:				5. & 6. Date/Time:			
7. Message:							
8. Approved By:				Position/Title:			
Contact AG6SV for form information							



ARC ICS 204 Work Assignment

1. Incident Name	2. Incident/DR Number:	3. Operational Period	
		to	
		to	

AD Operations:	District:
District Director:	Group:
Team Leader:	Activity:
Work Location:	Address:
Arrival Time:	

Name (First and Last)	Contact Information	Work Assignment																
<table><tr><th>Resources Assigned: Supplies</th><th>Quantity</th></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>		Resources Assigned: Supplies	Quantity															
Resources Assigned: Supplies	Quantity																	

Special Instructions and Equipment

Prepared by:	Date:



Disaster Receipt Form – Form 6409-B

[Form 6409B Instructions](#)

DR# (if applicable): DR Name: Date: Requisition # :

Requestor Name :	Signature:
Title :	Phone:

Delivery Information

Site POC Name : Phone: Email:

Address:

City: State: Zip:

Description of product(s) and/or service(s)

Stock No.	Quantity	Unit of measure (EA/PK/CS/BX)	Total QTY (each)	Description	Date needed

Note:

Acknowledgement by person receiving product(s) and/or service(s).	
I hereby certify that I have received all product(s) and/or service(s) listed above. If all product(s) and/or service(s) have not been received, provide explanation in the space below.	
Discrepancies:	
Received by Print Name:	
Received by Signature:	
Date:	Time of arrival:
Group:	



American
Red Cross

ARC Disaster Requisition - FORM 6409

Form 6409

Instructions

DR# (if applicatable): DR Name: Date: Requistion # :

Requestor Name :

Signature:

Title :

Phone:

Delivery Information

Site POC Name : Phone: Email:

Address:


City: State: Zip:

Description of product(s) and/or service(s)

Stock No.	Quantity	Unit of measure (EA/PK/CS/BX)	Total QTY (each)	Description	Date needed

Special Instructions :

The following information must be filled in by the APROVER ONLY:	
Approval includes verification of need; need consistent with Service Delivery Plan and budget.	
Approver Name :	Signature:
Title :	Phone:
Procurement Method (This section is optional) :	
Account string to charge: - - - - - -	
Procurement tool to use: Donation ReQuest Concur Invoice P-card Transfer Loan	
Other: (Explain) :	



American
Red Cross

American Red Cross Staff Request Form

[Form Info](#)

DR#:Date of Request :

Request for Skilled DRO Workers						
G/A/P Positions/Specialty Track: SA and Above	DRO Scheduled hours	How many workers?	Where do these workers report?	For how many days?	First day workers needed	Who do they report to?
	to					
	to					
	to					
Request for Virtual Workers	During these hours	How many workers?	How many days?	First day needed	Who do they report to?	Contact Phone/Email
	to					
	to					
Request for EBVs						
	to					
	to					

Printed Name and Signature of Person Submitting Request	Date Requested	Email Address used on this DRO
Requestor's Position	DRO Phone Number	Work Location
Approver Name and Signature	Approver's Position	Approver DRO Phone Number

Staff Services Only:

Date & Time Received in Staff Services:	Volunteer Connection Data Entry:
	Date & Time:SS Worker's Name:

DCS JT DMWT Staff Request Form V3.1

NATIONAL TRAFFIC SYSTEM MONTHLY REPORT				FSD125-2	Ver 8
For use by Section or Local NTS nets only					
1. Net Name:					
		JAN	2017		
		FEB	2018		
		MAR	2019		
2. Net Abbreviation:	3. Month:	APR	4. Year:	2020	
		MAY			
5. Nr. of Sessions:		6. Nr. of Messages Handled:			
7. Nr. of Check-ins:		8. Manager's Call:			
9. NTS Liaison is Maintained With:			Net:		
10. Approving Name:			Call:		
Comments:					
If not sent electronically you should:					
Mail to: ARRL Section Traffic Manager or American Radio Relay League Section Manager 225 Main Street Newington, Connecticut 06111					
You may print or save this form from your Sent Items folder of Express					

Amateur Radio Emergency Service - ARRL PUBLIC SERVICE ACTIVITY REPORT FSD-157 1/04 VER 8		
This is a modified ARES form for radio delivery by Express users. Text portion of message is formatted and easy to read for normal email.		
Amateur Radio donates thousands of staff hours of supplementary public service communications in civil emergencies, official drills and events such as parades and marathons each year. Such events show Amateur Radio in its best light, and it is critically important that ARRL bring documentation of this public service work to the attention of the Congress, the FCC, and other public officials. Your information below is an important addition to the record. Please complete and return this form to the Public Service Branch at ARRL Headquarters.		
Attach photos of amateurs in action, newspaper clippings, or other data if available		
1. Nature of Activity (Select One) Communications Emergency Alert Special Exercise Test or Drill	Communications Emergency - Amateurs supplied communications to replace or supplement normal communications means. Alert - Amateurs were deployed for emergency communications, but emergency situation did not develop. Special exercise - Amateurs supplied communications for a parade, race, etc. Test or drill - A training activity in which amateurs participated.	
2. Brief Description of Activity:		
3. Places or Areas Involved:		
4. Number of Amateurs Participating:		
5. Event Start Date/Time:		6. Event End Date/Time:
7. Duration of Event in Hours:	8. Total Person-Hours:	9. Number of Repeaters Used:
10. Estimated Staffing Cost: (19\$/Hr per Person)		
11. Estimated Cost of Equipment Used: (Ht's, Mobiles, Computers, Antennas, Etc.)		
12. Total Estimated Cost of Service: (Add lines 10 & 11)		
13. Nets and/or Frequencies Used : (Including Repeater Call Signs)		
14. Number of Messages Handled:		
15. Names of Agencies Receiving Communications Support:		
16. List Calls Signs of Amateurs Who Were Major Participants:		
17. Other Comments:		
Name of Amateur Radio Organization Providing Service:		
Location of Organization: (City)		State:
Your Name:	Call Sign:	E-Mail:
Address:		ARRL Appointment: (If Any)
Telephone: (Days)		Phone: (Evenings)
I attest that the information provided above is true to the best of my knowledge, and that if my printed name is approval.		
Approving Name:		Date/Time:

MONTHLY DEC - EC REPORT <i>Amateur Radio Emergency Service</i> FSD 212 Ver 4.1				
JAN	2017			
FEB	2018			
MAR	2019			
APR	2020			
MAY				
Jurisdiction		Month	Year	
		NA		
		Plus		
		Minus		
		Same		
Total Number of ARES Members		Changes Since Last Month		
Local Net Name		Total Sessions		
NTS Liaison Maintained With (net name)				
Number of Drills - Tests - Training this Month		Person Hours		
Number of Public Service Events this Month		Person Hours		
Number of Emergency Operations this Month		Person Hours		
Total Number of ARES Operations this Month		Total Person Hours		
Comments:				
Report by (name)		EC DEC Other	Title	Other
				Call
Send to your SEC or DEC as appropriate by 2nd of the month.				

NATIONAL TRAFFIC SYSTEM AREA & REGION NET REPORT FSD-89 Ver 6

Net	Cycle	Net Session
Month		Traffic Handled
Managers		Average Per Session
Frequencies		Total Time in Session (Min)
Times		Rate (Traffic/Time)

Days

UTC	Net Control Stations by Session				Liaison Stations
	1	2	3	4	
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

Representation (Areas list Regions; Regions list Sections Represented)		
Section/Region	Nr. of Times	Call Rep Section/Region
	-- 1 2 3 4	
	-- 1 2 3 4	
	-- 1 2 3 4	
	-- 1 2 3 4	
	--	

		-- 1 2 3 4	
% of Section or Region Representation		Approving Name	
% of TCC Function Representation		Call	Date
Comments: (Be brief)			
You may print or save this form from your Sent Items folder of Express			

INITIAL IMPACT ASSESSMENT FORM

Vers 1.4

Send to: Vancouver Island PREOC

Location:

Exercise Report
Regular (Actual Report)

Precedence: Emergency
Priority
Routine

- 1A) Is EOC Activated?
Primary Site Activated
Alternate Site Activated
Not Activated
- 1B) EOC Activation status?
Level 3
Level 2
Level 1

1C) State of Local Emergency Declared? Yes No

1D) EOC Comments: (i.e. Number of staff /status of EOC etc)

1E) First Responders Status: (Include details pertaining to personnel and Apparatus)

- 2) Priority Needs (3 only)
- 1)

2)

/

3)

/

People Impacted (Estimated/Confirmed):

3A	# Displaced	3B	# Injured	3C	# Fatalities	3D	Evacuations?	3E	# Evacuated
							Yes		

Critical Infrastructure

Provide impact description and Estimated Time to Repair (ETR)

		Impacted?	Comments	ETR
4A	Water	No		/
4B	Sanitation	No		/
4C	Gas	No		/
4D	Electricity	No		/
4E	Telephone	No		/
4F	Internet	No		/
4G	Cellular Network	No		/
4H	Text Messaging	No		/
4I	SAT Phone	No	(Include SAT phone number in comments)	/

Amateur Radio Station

4J) Status: On Air
Damaged ETR:

Callsign:

Winlink address:

5A) If potable water system is unusable, estimated days remaining of water:

5B) Estimated days remaining of food:

6) Primary Transportation Route - available into community and at least one alternate route:

/

7) Medical - Hospitals/Clinics:

/

8A) Shelter - estimated % of homes uninhabitable:

8B) Estimated percentage of Rapid Damage Assessment completed:

9) Comments:

/

Report
Originator:

Organization:

Functions	
Save Initial Impact Assessment data	Save form data to disk that can be loaded later
Submit	Create RMS Express message
Reset Form	Delete all field entries

BC ARES <i>Winlink Check In Form</i>		
<div>Test Exercise</div> REAL EVENT		
Date/Time		
Net Control Form sent to	VE7PEP - PECC	Other:
Sender Call Sign		
Assigned Location		
<div>We will keep active on these PREOC voice frequencies</div> <div><div><div>VIR VHF/UHF</div><div>147.570 Simplex</div><div>148.685 Simplex</div><div>Island Trunk Repeater System</div><div>444.925 (+5MHz T100Hz)</div><div>D-Star VE7VIC</div><div>Other:</div></div><div><div>HF</div><div>3.735 LSB (Night Time)</div><div>7.060 LSB (Day Time)</div><div>Off Air</div><div>We are shutting down all radios at this time</div></div></div>		
We have access to a CMS Winlink Gateway	Yes	No
Comments		
		Version 1.1 VA7MPG

Health and Welfare Information
BC EDS Operations

NTS 212 TSA

Salvation Army
Emergency Disaster
Services
British Columbia

Health and Welfare Information Request Form

Use this form for inquiry. This inquiry will be sent to the disaster area, where SATERN personnel will attempt to locate the person or persons inquiring about.

Please provide as much information as possible.

Person making the inquiry	
First Name	Last Name
Address	City
Province	Post Code
Email Address	Phone/Mobile

Person whom the inquiry is about	
First Name	Last Name
Address	City
Province	Postal Code
Email Address	Tel. Number
	Cell Phone
Additional information about the person:	

RADIO OPERATOR ONLY		
Relay Operator:	Rcvd:	All times are in 24 Hr format.
Radio Operator:	Rcvd:	Sent:

Health and Welfare Information

BC EDS Operations

Salvation Army
Emergency Disaster
Services
British Columbia

NTS 214 TSA

1. Incident Name:	2. Date Prepared:	3. Time Prepared:
4. Unit Name:	5. Unit Leader/Pos:	6. Operation Period:

7. Personnel Roster Assigned		
Name	ICS Position	Home Base

8. Activity Log	
Time	Major Events

9. Prepared by (Name and Position)

RADIO OPERATOR ONLY

Relay Operator:	Rcvd:	<i>All times are in 24 Hr format.</i>
Radio Operator:	Rcvd:	Sent:

BC RADIOGRAM							
Number	Precedence R EMERGENCY P W	Handling Instructions (Help) --- HXA HXB HXC HXD	Station Of Origin	Check	Place of Origin	Time	Date
						Change to Time/Date to UTC	
<div>Message Subject:</div> <div>TO:</div> <div>Name:</div> <div>Position:</div> <div>Organization:</div> <div>Phone: E-mail:</div>							
<div>MESSAGE TEXT (ARL Message Numbering Help.)</div>							
<div>Name/Position; Organization:</div> <div>Operator Note:</div>							

BULLETIN Winlink	
Click to add agency/group name	Form Info
For (Name/Group)	Bulletin Nr.
From (Name/Group)	Date/Time
Subject	Information Read Soon READ NOW
Select	
Bulletin	
Ver 14.2	

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO. 1138.1

SUBJECT: BURN RESOURCE CENTER REQUIRED
EQUIPMENT/SUPPLIES/PHARMACEUTICALS

FACILITY:

EQUIPMENT	REQUIRED MINIMUM QUANTITY*	ACTUAL QUANTITY	PHARMACEUTICALS	REQUIRED MINIMUM QUANTITY*	ACTUAL QUANTITY
Video equipment for bronchoscope	1 each		Silver Sulfadiazine 1% Any Size	14,400grams	
Fluid Infusion Warmer	3 each		Bacitracin (28.4 gm tube)	36 each	
IV Pumps (dual channel)	12 each		Cyanide Antidote Kit or CyanoKit	5 kits	
Thermal Mylar Blanket	24		Midazolam 5mg/ml	360 vials/ampules	
Thermal Blanket Forced Air Warming Blanket (Bair Hugger™)	2 each		Naloxone 0.4mg/ml	360 vials/ampules	
Video laryngoscope (Glidescope) with Pediatric & Adult blades	2 each		Morphine Sulfate 10mg/ml	720 vials/ampules	
Cauterizer (Bovie)	1		Lactated Ringers Solution 1 liter bags	250 bags	
Cautery Disposable Tips	12		D5 Lactated Ringers Solution 500 cc bags	100 bags	
Cautery Grounding Pads	24				
BURN WOUND CARE SUPPLIES					
SUPPLIES		REQUIRED MINIMUM QUANTITY*		ACTUAL QUANTITY	
Burn Debridement/ Escharotomy Tray		24 trays			
Dry Burn Dressing (32X36)		600 each			
Gauze Bandage Rolls (Kerlix) 4"		400 each			
Tubular Elastic Net Bandage (Burn Net) (Size #1, 5, 6, 7, 10, 22)		36 each size			
*or equivalent					
Notes/Comments					
Approved by Name:					

Received by:

EFFECTIVE: 03-15-12
REVISED: 07-01-19
SUPERSEDES: 04-01-19

Express Sending Station: {var MsgSender}

San Diego Blood Bank (SD CA) - Blood / Inventory Order Form			Form Info
Hospital Services Department 619 400-8250 Fax 619 725-3017 WB1OOD@winlink.org			
Requesting Hospital:			
Hospital Technician Name:		Date/Time:	
Leuko-Reduced Red Blood Cells (RBCL)			
	Stock Level	Actual	Order
O Positive			
O Negative			
A Positive			
A Negative			
B Positive			
B Negative			
AB Positive			
AB Negative			
TOTAL			
Leuko-Reduced Irradiated Red Blood Cells (RBCLI)			
	Stock Level	Actual	Order
O +, cmv-			
O -, cmv-			
A +, cmv-			
A -, cmv-			
TOTAL			
Leuko-Reduced Platelets (APLT)			
	Stock Level	Actual	Order
Platelets A/T			
Platelets Irr			

TOTAL					
Special Instructions:					

Frozen Plasma (200-399ml)			
	Stock Level	Actual	Order
O			
A			
B			
AB			
TOTAL			

Single Cryo (CAF) Pooled Cryo (CAF PL)			
	Stock Level	Actual	Order
CAF A			
CAF AB			
CAF PL A			
TOTAL			

Additional Comments from Requesting Hospital

California Emergency Services Net Winlink Check In

OES CESN Ver 12.3

Sending To:

You can change or add prior to posting.

Date/Time:

Organization:

Sending Callsign:

Operator Name:

Operator Callsign:

Session Type:

Winlink Packet

Winlink Telnet

Winlink Winmor

Winlink Ardop

Winlink Vara HF

HF Band if Used:

None

80 Meters

40 Meters

30 Meters

20 Meters

Gateway Used:

VHF/220/UHF Frequency (if Used):

Packet Digi/Node (if Used):

Message: (Be brief)

This message is in your SENT ITEMS folder for archive and printing. Contact: Jim Price W6SIG with form questions.

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/CA%20STATE%20Forms/CESN%20Forms/CESN_Winlink_Check_In_Initial.html[5/1/20 7:57:42 AM]



CENTRO INTERNAZIONALE RADIO MEDICO (C.I.R.M.)
 (Medical Assistance Form)
 The International Radio Medical Centre

NAME :		INTERNATIONAL CALL SIGN :	
FLAG STATE :		VESSEL TYPE: <small>Select</small>	
POSITION OF VESSEL :		PORT OF DEPARTURE :	
PORT OF DESTINATION :		EXPECTED DAYS TO DESTINATION :	
SEAFARER INFORMATION			
NAME AND SURNAME		DATE OF BIRTH :	RANK : <small>Select</small>
NATIONALITY		SEX <small>MALE</small>	
PERSONAL MEDICAL HISTORY Mention any medical problem of the patient with special reference to drug or other allergies, chronic illness, medications etc.			
ANY OTHER RELEVANT INFORMATION			
COMPLAINT DESCRIPTION Describe the symptoms, location of pain, associated symptoms etc. If an accident mention how & where the accident took place?			
VITALS			
BLOOD PRESSURE		PULSE RATE	BODY TEMPERATURE
WEIGHT IN KGS		HEIGHT IN CM	RESP-RATE MIN

Keep the medicine chest up to date. Ensure compliance with your Flag State. If possible do not administer any medicines before consulting C.I.R.M or qualified doctor.

The international Radio Medical Center (C.I.R.M) is the Italian Telemedical Maritime Assistance Service (TMAS). Our Mission is to provide round the clock free telemedical assistance to patients onboard ships flying any flag of any nationality all over the world. We suggest contacting C.I.R.M promptly in all cases of ill or injured persons, possibly before any treatment. This to avoid complication of pathologies or modifications in their course by inappropriate treatment. A Quick way to get in touch with us is to fill out the form and email it to us at telesoccorso@cirm.it. Alternatively you can call us at +39 06 59290263.

Version 1.1

For form use and information contact Ray, WD4SEN

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/FL%20STATE%20Forms/Clay_County_Extended_Shelter_Initial.html[5/1/20 7:57:44 AM]

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/FL%20STATE%20Forms/Clay_County_Shelter_Initial.html[5/1/20 7:57:45 AM]

RADIOGRAM WORK SHEET FOR MULTIPLE CLIENT MESSAGES - WELFARE BASED

For use on events that have a high outbound traffic load. This can help you if you have many clients.
Copy & paste this work sheet below the line into any text editor, & make copies.
You can modify the copied text as desired if not adequate for the event.

When finished, give to Radio Operator or designated person. This radiogram is one way, you can not obtain a reply.

Going To (Their Name):

From (Your Name):

Their Street Address:

Signature/Date:

City:

State:

Zip Code (USA or Canada):

Country:

Their Telephone (10 digits only):

Their Email:

Message you wish to Send (You may select up to two):

___ ARL ONE: Everyone safe here. Please do not worry.

___ ARL TWO: Coming home as soon as possible.

___ ARL THREE: I am in _____ hospital. Receiving excellent care and recovering fine.

___ ARL FOUR: Only slight property damage here. Do not be concerned about reports.

___ ARL FIVE: I am moving to a new location. Send no further mail or communications. Will inform you of new address when relocated.

___ ARL SIX: I will contact you as soon as possible.

___ ARL SIXTY FOUR: Have arrived safely at _____.

___ Custom Message 15 words or less:

Below is for Amateur Radio Operator use:

Time/Date (UTC) accepted: _____

RO Notes: _____



American
Red Cross

Daily Shelter Report

[Form Info](#)

Date Incident/ DR # Shelter Name/County

SHELTER INFORMATION

Shelter Address

Shelter Phone Number (s)

SHELTERING STAFF

POSITION	NAME	PHONE
Shelter Manager		
Day Shift Supervisor		
2nd Shift Supervisor		
Night Shift Supervisor		

Total Number of Sheltering Workers	Day Shift	2nd Shift	Night Shift
------------------------------------	-----------	-----------	-------------

OTHER FUNCTIONS OR ACTIVITIES STAFF

# Disaster Health Services	# Casework and Recover Planning
# Disaster Mental Health	# Feeding
# Disaster Spiritual Care	Other #

SHELTER POPULATION

Age Groups (years)	0-3	4-7	8-12	13-18	19-65	65 +
Nighttime Population Submitted Last Night						
Daytime Population Today						
Total NEW Shelter Dormitory Registrations Since Last Night:						

OPERATIONAL REPORTING

	Breakfast	Lunch	Dinner	Snacks/Drinks	Blankets	Comfort Kits	Clean-up Kits	Other Bulk Storage	Signage Kits	
# Used Today										
# Available Tomorrow										
# Needed Tomorrow										

NOTES

Preparer Name:

Preparer Signature:

Initial Damage Assessment / Windshield Survey

Click Setup for your group

Click to add your agency or group

Jurisdiction

Mission or Incident #

Exercise

Event

Selected Other? Describe

Survey Area

Survey Team

Start Date of Event

Date of this Survey

	Affected 10 %	Minor 25 %	Major 50 %	Totaled 100 %	Total Number	\$ Loss
CATEGORY	#	#	#	#	COUNT	\$ Estimate
HOUSES						
APARTMENT COMPLEX						
MOBILE HOMES						
RESIDENTIAL HIGH RISE BUILDING						
COMMERCIAL HIGH RISE BUILDING						
PUBLIC BUILDINGS						
SMALL BUSINESS						
FACTORIES / INDUSTRIAL COMPLEX						
ROADS						
BRIDGES						
ELECTRICAL DISTRIBUTION						
SCHOOLS						
Total Dollar Amount:						

Comments (if needed-be brief)

Use your jurisdictions guidelines or these generic suggestions on habitable buildings. On other facilities get direction as needed

AFFECTED: Structure currently habitable. Cosmetic damage e.g. missing shingles. Generally less than \$100 in damage. 0 to 6 inches of water in single-family dwelling. MINOR: Structure currently uninhabitable. Will require minor repairs to be made habitable. 7 to 24 inches of water in structure and 0 to 6 inches of water in a mobile home. MAJOR: Structure currently uninhabitable. Will require major repairs to be made habitable. 25 to 47 inches of water in a single-family dwelling or apartment. 7 to 23 inches of water in a mobile home. TOTALED: Structure permanently uninhabitable. Cannot be repaired. 48 or more inches of water in a single-family dwelling or apartment. 24 or more inches of water in a mobile home

Ver 11.1

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: DRC EQUIPMENT CHECKLIST LIST
ITEMS DEPLOYED TO OTHER FACILITIES

(HOSPITALS)
REFERENCE NO. 11022.2

RELEASING DRC:

RECEIVING FACILITY:

PURPOSE: To provide a mechanism for Disaster Resource Centers (DRC) to track DRC resources deployed to other facilities.
POLICY: The DRC shall utilize this checklist to document items deployed to other facilities.

Items	Quantity On Hand (Alt+Click to Edit)	Number Checked Out
Blankets/Sleeping Bags		
CBRNE Monitoring Equipment		
Chairs		
Cots: Temps Beds		
Simpler Life		
Junkin Cots		
Disposable Linen		
Electrical Cords		
Combine Chairs & various: Evacuation Equip		
E-Z UP® Tents		
Gas Cans with Fuel		
HAM Radio		
In-Line Heating System (for tents)		
Isolation HEPA Filters		
Medical/Surgical Supplies		
Miscellaneous Supplies (rope, barrier tape, work gloves, buckets, megaphone, etc.)		
Outdoor Lighting		
Pharmaceutical Cache		
Portable Fans		
Portable Honda Generators		
Portable Sinks/Hand Washing Stations		
Portable Toilets		

Post - Decontamination Clothes

EFFECTIVE: 07-01-06
REVISED: 04-01-18
SUPERSEDES: 07-01-17

SUBJECT: DRC EQUIPMENT CHECKLIST LIST
ITEMS DEPLOYED TO OTHER FACILITIES

REFERENCE NO.
11022.2

Items	Quantity On Hand	Number Checked Out
Tables (6-8 feet long)		
Tents (18x24)		
Tents (10x10)		
Tent Lighting		
Towable Generator (various types)		
Towing Vehicle		
Trailers		
Ventilators		
Vortran® Portable Vents		
Vortran® Portable Vents		
Weight Tubes		
Other Supplies:		
Communication Equipment – Walkie Talkies, Phones, etc.		
Batteries – as need for each piece of equipment		
Security Equipment – as needed per facility		
Notes/Comments		

Released by:

Date released:

Received by:

Facility:

Returned by:

Date returned:

Returned Items received by:

EFFECTIVE: 06-01-08
REVISED: 04-01-18
SUPERSEDES: 07-01-17

STATE OF WASHINGTON
EMERGENCY WORKER DAILY ACTIVITY REPORT Ver 4

County in Which Mission Took Place		Mission #	
Mission Name		Date From	Date To
Unit Name		Address	

Indicate Actual Incident Check In and Out Times			Date		Date		Date		Page	Of
#	Emergency Worker Name	Card #	In	Out	In	Out	In	Out	Total Hours	Round Trip Miles
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/WA%20STATE%20Forms/Emergency_Workers_Activity_WA_Initial.html[5/1/20 7:57:48 AM]

EYEWARN Situation Report (SITREP) vers 5
Clark County Washington

Routine

Welfare

Priority

EMERGENCY

YES

NO

Is This An Exercise Message?

Precedence

TO EOC Situation Unit

LOCATION CRESA

NCS

LOCATION

1. Date/Time	2. Report Type <div><div>Initial</div><div>Update</div><div>Final</div></div>	3. Activation Type <div><div>Self-Activation</div><div>CRESA Activation</div></div>	4. Mission Number
--------------	---	---	-------------------

5. Type of Incident

6. Total Number of Zip Codes Reporting

7. Total Check-ins

8. Question(s)

9. INFRASTRUCTURE DAMAGE

B = Bridges

C = Cell Towers

H = Hospitals

P = Power Lines/Towers

R = Roads

S = Schools

10 Other Local Damage

Note If relaying this report by voice radio, only say the line numbers and not their title.

Relay Operator	Rcvd	Sent	(24 Hr format)
Radio Operator	Rcvd	(24 Hr format)	
Contact K7GJT for form info		www.eyewarn.net	

DEPARTMENT OF HOMELAND SECURITY
Federal Emergency Management Agency
MISSION ASSIGNMENT (MA)

I. TRACKING INFORMATION (FEMA Use Only)

State	Resource Request Number
Program Code/Event Number	Date/Time Received

II. REQUESTING ASSISTANCE (To be completed by Requestor) See Attached

Assistance Requested

Delivery Location	Internal Control Number	Date/Time Required	
Initiator/Requestor Name	24 Hour Phone Number	Email Address	Date
Site POC Name	24 Hour Phone Number	Email Address	Date

III. INITIAL FEDERAL COORDINATION (Operations Section)

Action to:	ESF/OFA: RSF/OFA: Other:	Date/Time	Priority Lifesaving High	Life Sustaining Normal
------------	--------------------------------	-----------	--------------------------------	---------------------------

IV. DESCRIPTION (Assigned Agency Action Officer)

Statement of Work

Assigned Agency	Projected Start Date	Estimated Projected End Date
New or Amendment to MA #:	Total Cost Estimated	Total Required this Obligation Cycle
ESF/OFA/RSF Action Officer	Phone Number	Email

V. COORDINATION (FEMA Use Only)

Type of MA: Direct Federal Assistance State Cost Share (0%, 10%, 25%) Federal Operations State Share (0%)			50
State Cost Share Percent %		State Cost Share Amount: \$	
Fund Citation: 20 -06- -6- XXXX-250 -D		Appropriation code: 70X0702	
Mission Assignment Manager (Preparer)		Date	
**FEMA Project Manager/Branch Director (Program Approval)		Date	
**Comptroller/Funds Control (Funds Review)		Date	
VI. APPROVAL			
*State Approving Official (Required for DFA)		Date	
**Federal Approving Official (Required for all)		Date	
VII. OBLIGATION (FEMA Use Only)			
Mission Assignment Number	Amount This Action \$	Date/Time Obligated	
Amendment Number	Cumulative Amount \$	Initials	
FEMA FORM 1660-0002			Ver 1.5.1 KE4LWT

DEPARTMENT OF HOMELAND SECURITY O.M.B. No. 1660-0002
Federal Emergency Management Agency
RESOURCE REQUEST FORM (RRF)

I. REQUESTING ASSISTANCE (To be completed by Requestor)

1. Requestor's Name	2. Title	3. Phone No.
4. Requestor's Organization	5. Fax No.	6. E-Mail

II. REQUESTING ASSISTANCE (To be completed by Requestor)

1. Description of Requested Assistance:

2. Quantity	3. Priority Lifesaving Life Sustaining High Normal	4. Date and Time Needed	
5. Delivery Site Location		6. Site Point of Contact (POC)	
		7. 24 Hour Phone No	8. Fax No.
9. State Approving Official Signature		10. Date and Time	

III. SOURCING THE REQUEST - REVIEW/COORDINATION (Operations Section Only)

1.Reviews OPS Review by: LOG Review by: Other Coordination: Other Coordination: Other Coordination:	2. Source: Donations Requisitions Procurement Interagency Agreement Mission Assignment Other (Explain)	3. Assigned to: ESF/OFA: RSF/OFA: Other: Date/Time
4. Immediate Action Required: YES NO		

IV. STATEMENT OF WORK (Operations Section Only)

1. OFA Action Officer	2. 24 Hour Phone #	3. Fax #
4. FEMA Project Manager	5. 24 Hour Phone #	6. Fax #
7. Statement of Work		

8. Estimated Completion Date		9. Estimated Cost	
V. ACTION TAKEN (Operations Section Only)			
Accepted	Rejected	Requestor Notified	
Reason / Disposition			
TRACKING INFORMATION (FEMA Use Only)			
ECAPS/NEMIS Task ID:	Resource Request #	Program Code/Event #	Originated as verbal
Received by (Name)	State		
FEMA FORM 010-0-7			Ver 1.9 KE4LWT

Federacion Mexicana de Radio Experimentadores, A.C

Red Nacional de Emergencia - Evento RNE F1 Ver 8

Simulacro

Moderada

Urgente

EMERGENCIA

Winlink Banda

VHF

UHF

80

40

Nombre

Indicativo

Descripcion del Evento

Lugar

Requerimientos

Mensaje

Sugerir solicitar una confirmación de lectura

www.fmre.mx

Federacion Mexicana de Radio Experimentadores, A.C
Red Nacional de Emergencia - Anuncio RNE F2 Ver 6

Para (Nombre o Grupo)

De (Nombre o Grupo)

Indicativo

Asunto

Informacion
Leer En Breve
LEER AHORA

Importancia

Anuncio

www.fmre.mx

Federacion Mexicana de Radio Experimentadores, A.C	
Red Nacional de Emergencia - Temblor RNE F3 Ver 6	
Simularco TEMBLOR	
Tipo	
Indicativo	Nombre
AREA AFECTADA	
Estado	Ciudad/Poblacion
Colonia/Delegacion	Otra
Su calle	(opcional)
CONDICIONES DEL EVENTO OBSERVADO O SENTIDO	
Escala de Intensidad Mercalli Modificada	
INTENSIDAD DEL TEMBLOR	
II Muy Debil III Debil IV Ligero V Moderada VI Fuerte	
En su Area?	
<div>?</div> SI	<div>?</div> SI
Hay Lesionados?	Hay Fallecidos?
Informacion Adicional	
<p>II.MUY DEBIL.- Es sentido bastante notable por las personas en interiores, especialmente en los pisos superiores de los edificios Mucha gente no lo reconoce como un temblor. Automoviles detenidos pueden oscilar ligeramente. La vibracion es similar al paso de un Camion.</p> <p>III. DEBIL.- Sentido adentro por muchos, al aire libre por pocos durante el día. Por la noche, algunos son despertados por platos, ventanas, puertas perturbadas; Las paredes hacen sonidos al agrietarse . Sensación como si un camion pesado golpeara el edificio. Automóviles detenidos oscilan notablemente.</p> <p>IV. LIGERO.- Sentido por casi todo el mundo; Muchos son despertados. Algunos platos y ventanas rotas. Objetos inestables volcados. Sentidos por todos, muchos asustados. Algunos muebles pesados movidos; Algunos pedazos de yeso caído. Daño leve.</p> <p>V. MODERADO.- Daños insignificantes en edificios bien diseñados y contruidos; Daño leve a moderado en estructuras comunes bien construidas; Considerable daño en estructuras mal construidas o mal diseñadas; Algunas chimeneas rotas.</p> <p>VI. FUERTE.- Daño ligero en estructuras especialmente diseñadas; Daños considerables en edificaciones comunes con colapso parcial. Daño grande en estructuras mal construidas. Caída de chimeneas, apilados de fábricas, columnas, monumentos, paredes. Muebles pesados volcados.</p> <p>VII. MUY FUERTE.- Daños considerables en estructuras especialmente diseñadas; Estructuras de bastidor bien diseñadas tiradas de plomada. Daños grandes en edificios sustanciales, con colapso parcial. Los edificios se desplazaron de las cimentaciones.</p> <p>VIII. SEVERO.- Algunas estructuras de madera bien construidas, destruidas; La mayoría de las estructuras de mampostería y armazón con cimientos, destruidas. Rieles doblados.</p> <p>IX. VIOLENTO.- Pocas estructuras de albañileria, si es que ninguna, permanecen de pie. Puentes destruidos. Los rieles se doblaron mucho..</p>	

Federacion Mexicana de Radio Experimentadores, A.C

Red Nacional de Emergencia - Huracan RNE F4 Ver 7

Si es posible, registre un reporte final después del paso del Huracan, para reportar cualquier novedad relevante de su reporte inicial y/o comentarios finales.

Hora Local:

Fecha:

Reporte:

Simulacro
Reporte Inicial
ACTUALIZACION

Radioaficionado:

Nombre:

Ciudad:

Municipio/Delegacion:

Estado:

Pais:

SU COORDENADAS GEOGRAFICAS

Latitud: (si la sabe)

Longitud: (si la sabe)

Grid Localizador: (si lo sabe)

SU SERVICIOS AFECTADOS

Funcionando Bien
Sin Servicio
Intermitente

¿Su Servicio de Corriente Electrica?

Sin Servicio
Fijo y Celular
Solo Fijo
Solo Celular

¿Su Servicio Telefonico?

Su Numero:

EN SU AREA

?
SI

?
SI

¿Hay Lesionados?

¿ Hay Fallecidos?

Velocidad de Viento:

KM/h
MP/h
Nudos

Saffir-Simpson Escala de Huracanes - Categoria

C1 - Minimo
C2 - Moderado
C3 - Extensivo
C4 - Extremo
C5 - Catastrofico

Norte
NorEste
Este
Sureste

Direccion del Viento:

Debil
Moderada
Fuerte
Muy Fuerte

Intensidad de la Lluvia:

Llene lo mas que pueda y utilice el area de COMENTARIOS para informacion adicional.

COMENTARIOS

Categoria	Velocidad del Viento	Mareas de Tempestad Altura	Danos
1	119 - 153 kph	1.2 - 1.5 m	Minimo Elementos normalmente no estructurales
2	154 - 177 kph	1.8 - 2.4 m	Moderado Techos de materiales ligeros, danos en ventanas y puertas, algunos arboles caidos
3	178 - 209 kph	2.7 - 3.7 m	Extensivo Danos estructurales menores en residencias, en bodegas, algunas fallas en nueros, danos en puertas y ventanas
4	210 - 249 kph	3.9 - 5.5 m	Extremo Danos estructurales, desprendimiento de techos ligeros, explosion de ventanas y puertas
5	> 249 kph	> 5.5 m	Catastrofico Danos estructurales severos, destruccion total casas moviles, evacuacion masiva de areas residenciales entre 8 y 16 km de las csota podria ser requerida

Federacion Mexicana de Radio Experimentadores, A.C

Red Nacional de Emergencia - Reporte RNE F5 Ver 8

INCIDENTE o EVENTO POSTERIOR AL REPORTE DE ACCION

Su retroalimentacion ayuda a realizar mejoras.

Envie a quien sea responsable de recabar esta informacion dentro de su organizacion.

Fecha/Hora Reporte :

Fecha de Evento - Incidente:

Nombre del incidente - evento:

Ubicacion:

Su nombre:

Indicativo:

Su correo electronico:

Telefono(opcional):

Cual fue su asignacion o rol en este incidente -evento?

Haga un resumen del evento - incidente y; describa algunas actividades en las que estuvo involucrado.

RETROALIMENTACION - Recomendaciones (Sea breve y profesional)

www.fmre.mx

INCIDENT RADIO COMMUNICATIONS PLAN						(Halifax ICS205)	Ver 2.1
1. Incident Name:				2. Date / Time Prepared:		3. Operational Period:	
						Date From:	Date To:
						Time From:	Time To:
4. System/Type	Channel	Function	Frequency/Tone	Assignment	Remarks		
5. PREPARED BY (Communications unit)				SIGNATURE (Name)			

HICS205A - COMMUNICATIONS LIST Vers 9
HICS - Hospital Incident Command System

1. Incident Name

Page Of Facility

2. Operational Period (#):

Date From To

Time From To

All Contacts
Internal Contacts Only
External Contacts Only

3. Select Type of List

Default is ALL Contacts. Create a seperate list for **Internal** and **External** Contacts if desired and **Submit**

[Paste Assignment Data from a Spreadsheet](#)

Agency/Assignment/Name	Radio Ch # Frequency	Radio Call	Fax	Email	Cell Phone	Phone	ID # of Device Issued & Comments

4. Special Instructions

5. Prepared by (CUL) Date Time

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HICS254 - DISASTER VICTIM / PATIENT TRACKING
HICS - Hospital Incident Command System

1. Incident Name

Page Of

2. Operational Period (#):

Date From

To

Time From

To

3. Area (Triage or Specific Treatment Area)

[Paste Field Data Below from a Spreadsheet](#)

Field Tag Number	Medical Record #	Name (Last Name, First Name)	Sex	DOB - Age (Use numbers only)	Triage Category	Location of Procedures (CT, X-ray, Etc)	Procedure Time	Disposition	Disposition Time

4. Prepared By:	Date	Time:	Facility:
-----------------	------	-------	-----------

Hillsborough County AVAILABLE HOSPITAL BEDS

Hospital Name:

Filing Date/Time:

Total Licensed:	Adult ICU:	Burn:	Operating Room:	Med/Surg/Tele:	Pediatric ICU:	Pediatric Med/Surg:	OB/Gyn:	NICU Level 2:

NICU Level 3:	Neg Flow Isolation:	Adult Psychiatric:	Adult Substance Abuse:	Child Psychiatric:	Child Substance Abuse:	Comp Med Rehab:	Long Term:	Skilled Nursing Unit:

Electricity Problem:	Water Available:	Physical Damage:
Yes	Yes	Yes
No	No	No

Comments

Version 2.0 W4BGH

HOSPITAL BED REPORT General	
Click to add your agency or group	Form Info
As of Time: Date:	
Name of Reporting Facility:	
Contact Person:	
Contact Phone Number:	
Contact Email Address:	
Type	Available Notes
Emergency Beds	
Pediatrics	
Medical / Surgery	
Psychiatry	
Burn	
Critical Care	
TOTAL:	
DEFINITION: Physical Available Beds = Staffed + Un-staffed Beds	
Additional Comments:	
Version 9.1	

HOSPITAL STATUS REPORT (Short HICS 251)

[Click to add your agency or group name to title](#)[Form Info](#)

Report Type (check one)							
Initial		Update #		Final			
1. Incident Name			2a. Date:	2b Time:			
3a. Facility Name			3b. Facility Type	Hospital	Clinic	LTCF	Other, specify:
4a. Contact Name			4b. Contact Phone				X
4c. Cell Phone			4d. Contact Email Address				
5. FACILITY OPERATING STATUS							
Normal		Modified partially functional - no assistance needed (explain)		Limited partially functional,- Some assistance needed (explain)			
UNKNOWN		Impaired- major assistance needed (explain)		Not functional major assistance needed (explain)			
Check ability to provide essential care services	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
6. COMMUNICATIONS							
Email	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Landline Phone	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Fax	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Internet	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Cell Phone	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Satellite Phone	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Amateur Radio	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
7. UTILITIES							
Power	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Water	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Sanitation	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
Heating/Ventilation/AC	NORMAL	MODIFIED	LIMITED	IMPAIRED	NOT FUNCTIONAL	UNKNOWN	
8. EVACUATION							
Evacuating?	YES	NO	IF Yes, evacuation is: Anticipated In progress Completed				
Partial Evacuation	YES	NO	IF Yes, evacuation is: Anticipated In progress Completed				
Total Evacuation	YES	NO	IF Yes, evacuation is: Anticipated In progress Completed				
Shelter in place	YES	NO	IF Yes, evacuation is: Anticipated In progress Completed				
9. IMPACT/CASUALTIES--provide estimated numbers and any comments:							
Immediate injuries = Critical care needed RED	Estimated #						
Delayed injuries = Moderate care needed YELLOW	Estimated #						

Minor injuries = Care not needed immediately GREEN	Estimated #	
Fatalities BLACK = Deceased	Estimated #	
10. ADDITIONAL INFORMATION:		
Internal disaster plan activated?	YES NO	Facility Command Center activated?
Emergency generator power in use?	YES NO	Will you send Resource Request within 4 hours?
Version 1.3		

HALIFAX MESSAGE FORM			
Default Address(s) to Send Message To:		Separate multiple address(s) with a semicolon;	
ACTION Precedence:	<div><div>Routine</div><div>Priority</div><div>IMMEDIATE</div></div>	INFO Precedence:	<div><div>None</div><div>Routine</div><div>Priority</div><div>IMMEDIATE</div></div> <div>Date-Time-Group:</div>
FROM:			
TO:			
INFO:			
NUMBER:			
MESSAGE			
ORIGINATING NAME:			
Version 14.1			

HURRICANE REPORT

Fill in as much information as possible. This form will send the message formatted as plain text.

If WX4NHC is active and accepting traffic, click to add address.

Report Time in UTC UTC Date Report Status First Report Update Report Final Report

Sender Are you the Reporting Observer? Yes NO, means you are sending for another observer

Reporting Observer Email

Reporting Observer Phone Number

Geographic Area of Observed Event

City	County
State	Country
Latitude (if known)	Longitude (if known)

<div>Estimated</div> <div>Measured</div>	
Measurements	List Any Weather Instruments Used

Wind Speed	Unknown	Gust Speed	Unknown	Wind Direction	---
	MPH/h		MPH/h		N
	KM/h		KM/h		NE
	Knots		Knots		E
					SE

Barometric Pressure	Unknown
	Inches
	Millibars

Comments: (brief information to help quantify the intensity of this event).

IARU MESSAGE <i>International</i>						
NUMBER	PRECEDENCE	STATION OF ORIGIN	WORD COUNT	PLACE OF ORIGIN	FILING Time	FILING DATE
	Routine					
					Change to Local Time / Date	
Use the template "Amateur Radio RADIOGRAM Text Creator", if you want to send traffic into the USA NTS/RR1 network. Located in RADIOGRAM_RR1 Forms						
TO:						
Special Delivery Instructions						
FROM:						
Radio operator use:						
RECEIVED FROM		DATE	TIME	SENT TO	DATE	TIME
				Express Ver 43 (Original credits to OE3VRW)		

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6. Approved by (CUL) Name:	Date/Time:	IAP Page:
----------------------------	------------	-----------

COMMUNICATIONS LISTICS205A Ver 11.1		
Form Info		
1. Incident or Event Name		2. Operational Period
		DATE From To
		TIME From To
3. Basic Local Communication InformationPage #		
Assignment	Name	Method(s) of contact: radio frequency, phone, cell #, etc.
4. Approved by (CUL)		Date/Time

Medical Plan ICS 206 Vers 13.1		
<div>1. Incident Name:</div> <div>2./3. Date/Time Prepared:</div> <div>4.Operational Period:</div> <div>Form Info</div>		
5. Incident Medical Aid Stations		
Medical Aid Stations	Location	Paramedics
		YES NO --
		YES NO --
		YES NO --
		YES NO --
		YES NO --
6. Transportation		
A. Ambulance Services		
Name	Address and Phone	Paramedics
		YES NO --
		YES NO --
		YES NO --
		YES NO --
		YES NO --
B. Incident Ambulances		
Name	Location	Paramedics
		YES NO --
		YES NO --

		YES NO --
		YES NO --
		YES NO --

7. Hospitals

Name	Address	Travel	Phone	Helipad	Burn Center
		AIR GND --		YES NO --	YES NO --
		AIR GND --		YES NO --	YES NO --
		AIR GND --		YES NO --	YES NO --
		AIR GND --		YES NO --	YES NO --
		AIR GND --		YES NO --	YES NO --

8. Medical Emergency Procedures (Be brief)

9. Prepared by (MUL):

10: Reviewed by (Safety Officer):

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/ICS%20USA%20Forms/ICS210_Initial.html[5/1/20 7:58:08 AM]

	----- Available Assigned OUT OF SERVICE				77
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8. Comments

RESOURCE REQUEST MESSAGE				ICS 213 RR																																																																	
1. Incident Name				2. Date/Time		Form Info																																																															
3. Resource Request Number																																																																					
REQUESTER																																																																					
4. Order <i>Use additional forms when requesting from a different source or vendor to fill request (s)</i>																																																																					
<table><tr><td colspan="4">Detailed Item Description; Vital characteristics, brand, specs, experience, size, etc.</td><td colspan="3">Needed Date/Time (local 24 hr)</td></tr><tr><td>Qty</td><td>Kind</td><td>Type</td><td>Item Description</td><td>Requested</td><td>Estimated</td><td>Cost</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							Detailed Item Description; Vital characteristics, brand, specs, experience, size, etc.				Needed Date/Time (local 24 hr)			Qty	Kind	Type	Item Description	Requested	Estimated	Cost																																																	
Detailed Item Description; Vital characteristics, brand, specs, experience, size, etc.				Needed Date/Time (local 24 hr)																																																																	
Qty	Kind	Type	Item Description	Requested	Estimated	Cost																																																															
5. Delivery/Reporting Location																																																																					
6. Substitutes and/or Suggested Sources																																																																					
7. Requested by Name/Position				8. Priority	Low	Routine																																																															
URGENT																																																																					
9. Section Chief Name for Approval																																																																					
LOGISTICS																																																																					
10. Logistics Order Number																																																																					
11. Supplier Phone/Fax/Email																																																																					
12. Name of Supplier				12A Point of Contact																																																																	
13. Notes																																																																					

14. Name of Auth Logistics Rep		15. Date/Time	79
16. Order Was Requested By		<i>Indicate Unit / Section or Person who is to get this order.</i>	
FINANCE			
17. Reply/Comments from Finance			
18. Finance Section Chief Name		19. Date/Time	
ICS 213RR v. 14.2			

WASHINGTON STATE RESOURCE REQUEST MESSAGE (ICS 213RR WA) Vers 8.1						
Grayed Areas to be Filled in by Logistics Section Only						
1. Mission # & Incident Name			2. Requesting Agency			
3. Date & Time (mm/dd/yy - 0000)			4. Requester Tracking #			
5. Order (Detailed Item Description. Vital characteristics, brand, specs, experience, size, etc.) Needed Date/Time						
a. Qty	b. Kind	c. Type	d. Item Description	e. Requested	f. Estimated	g. Cost
6. Personnel/Support Needed						
7. Duration Needed						
8. Requested Delivery/Report Location						
9. Delivery/Reporting Location POC (Name and Contact Info)						
10. Suitable Substitutes &/or Suggested Sources				11. Priority : Life Saving Incident Stabilization Property Preservation		
12. Resource Status			13. Requester willing to provided funding : Yes No			
a. Have all commercial resources been exhausted: Yes No			if No Explain:			
b. Have all local resources been exhausted: : Yes No						
c. Have all mutual aid resources been exhausted: Yes No						
14. Requested by Name/Position				Phone/Email		
15. Request Authorized by						
16. EOC/ECC Logistics Section Tracking #						
17. Name of Supplier/POC (Phone/Fax/Email)						

18. Notes (Be Brief)		81
19. Typed Name of Authorized Logistics Rep		20. Date/Time (mm/dd/yy - 0000)
21. Order Placed by ----- a. Other		
22. Elevate to State? -----		23. State Tracking #
		24. Mutual Aid Tracking #
25. Reply/Comments from Finance		
26. Finance Section Typed Name		27. Date/Time (mm/dd/yy - 0000)
Original to Documentation Unit Copies to Logistics Section, originating ESF/Agency, & Finance & Administration Section.		

COMMUNICATIONS RESOURCE AVAILABILITY WORKSHEET ICS217A Vers 14.1					Frequency Band --		Description		
Form Info									
Work sheet Incident or Event Name Date/Time (optional)									
Paste Field Data Below from a Spreadsheet									
#	Channel Configuration	Channel Name/Trunked Radio System Talkgroup	Eligible Users	RX Freq N/W	RX Tone/NAC	TX Freq N/W	TX Tone/NAC	Mode A, D or M	Remarks
1									
2									
3									
4									
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19									

To Email or Radio Call (Can be changed prior to posting)

From Team Name Date/Time

Patient Name Patient Age Patient Gender

Male
Female

Patient Village Other

Patient Complaint / Problem

Care Already Given

Meds Already Given

Type of Care Requested

Caregiver Contact

Additional Information

This form if sent to a normal internet address, will have plain text properly formatted in message body.

IMS Form 213-R

No	Precedence Routine	Handling	Station of Origin	Check	Place of Origin	Time	Date Change Time/Date to UTC
RADIO MESSAGE		1. Incident Name			2. Operational Period		
3. To (Name/Position):							
4. From (Name/Position):							
5. Subject:				6. Date/Time Prepared:			
7. Message:							
8. Name Signature of Sender			9. Position/Contact info of Sender			10 Date/Time Sent	
RECEIVED FROM		DATE	TIME	SENT TO		DATE	TIME

CONSOLIDATED INCIDENT ACTION PLAN (IMS1001) Emergency Management Ontario Vers 4			
Form Info			
1. Incident Name		2. Operational Period:	
		Date From	Date To
		Time From	Time To
Site Level IAP	3. Type of Incident Action Plan		EOC-Level IAP
<div>NO</div> <div>YES</div> <div>Incident Command</div> <div>Additional Details</div>	<div>NO</div> <div>Incident Support</div> <div>Area Command</div> <div>Incident Command</div> <div>Additional Details</div>		
4. Current Situation [From IMS 201]			
5. Mission [From IMS 202]			
6. Objectives for this Operational Period [From IMS 202]			
7. Strategies to Achieve Objectives [From IMS 215G]			
8. Tactics (Optional) [From IMS 215G]			
9. Weather Forecast for Operational Period [From IMS 202]			
10. General Safety Message [From IMS 215A or 202]			
11. Key Media Messages [From IMS 202]			
12. Future Outlook			
13. Briefing / Planning Cycle			
14. Organization Assignment [From IMS 203]		Incident or EOC Commander	
		Command Model	
Safety Officer		Information Officer	

Operations Section Chief		Planning Section Chief	
Liason Officer (s)			
Logistics Section Chief		Legal Advisor	
Fin / Admin Section Chief		Other	

15. Detailed Forms (are attached as necessary)		
<div>NO YES</div>	<div>NO YES</div>	<div>NO YES</div>
Incident Objectives [IMS 202]	Organization Assigment List [IMS 203]	Resources Assignment List [IMS 204]
<div>NO YES</div>	<div>NO YES</div>	<div>NO YES</div>
Incident Telecommunications Plan [IMS 205]	Medical Plan [IMS 206]	Incident Map
<div>NO YES</div>		
Traffic Plan	Other Attachments	
16. Prepared By (Planning Section Chief) Name		
17. Approved By (Incident or EOC Commander) Name Date /Time		

IAP (Incident or Event Action Plan)

Click to add your agency or group

Form Info

Incident Name:

Date/Time:

Prepared by:

Title:

Report Type:

Initial

Update

Final

1	Type of Incident And give a geographical location and start DATE of occurrence	
2	Area of Operations And indicate the limits of Commands responsibility?	
3	Objectives What does Command want to achieve?	
4	Current Status What is currently happening? Updates from last report?	
5	Upcoming Tactics What is the plan to accomplish the objectives?	
6	Assignments Who is filling what positions? Who is doing what tasks?	
7	Safety Issues Are there any hazards and if so, what is being done about them?	
8	Resources Assigned, available and still needed	
9	Communications Describe the communications links or methods	

INCIDENT STATUS REPORT test		
Click to add your agency or group		Form Info
1. Incident Name:		2. WebEOC Incident (as applicable):
3. Incident Date/Time:		4. Report Version (Check one): Initial Update Final
5. Type of Incident (Check all that apply):		
Severe Storm/Flood	Pre-Planned Event	HAZMAT
Severe Winter Weather	Dam/Levee	Utility Disruption
Public Health	Active threats/ Civil Disturbance	Earthquake
Fire	Aircraft Disaster	Other (Specify):
6. Situation Summary as of Time of Report:		
7. Future Outlook/Goals/Needs/Issues:		
8. County Emergency Operations Center (EOC) Status (Check one):		
Closed	Activated Hours of Operation:	Monitoring (minimal staffing) Hours of Operation:
9. Local Disaster Declaration Status (Check one):		
No declaration/Declaration not anticipated	Declaration anticipated	Local disaster declaration Date/time of declaration:
10. Number of Confirmed Incident Injuries:		11. Number of Confirmed Incident Fatalities:
12. Number and Location(s) of Shelters Established:		
13. Have Evacuations Been Implemented?		
No / None anticipated	Yes (If yes, describe):	Evacuations anticipated (Describe):
14. Date/Time of Report:	15. Report Submitted By:	16. Contact Info:
Version 2.2		

INFORMATION FORM Ver 8.1
WINLINK

Click to add your agency or group

Event or Use Name

Description or Form Information

Form Creation Date/Time

Form Info

Create whatever Column Name you want for each category

#			
1			
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Sender's Comments or Additional Information

Oregon ARES Digital Network Quarterly Report Template Instructions

Contact KF7RSF with questions

Overview:

This procedure tests the County EOC OADN equipment and provides a report to the Section Emergency Coordinator.

Send a Quarterly Test Message from the County EOC through an Oregon HF Pactor Gateway, send the same Quarterly Test Message through a non-Oregon HF Pactor Gateway, prepare the Quarterly Test Report and send the Quarterly Test Report through a VHF Packet Gateway.

It may be useful to print a copy of the Quarterly Test Report to record contact information.

Oregon Gateway:

Use the Quarterly Test Message Template and connect to an Oregon based HF RMS Gateway station and send the Quarterly Test Message. The message is addressed to TEST. This message does not need to be sent to the SEC, ASEC, DEC, etc.

The Winlink system will forward a copy of the message back to the sending station so you know the message was successfully sent. You may have to check for messages in a separate session to receive the TEST message from the Winlink system.

Be sure to update the HF Channel Selector table to see current stations. Try to send to W7ODN or K7ODN first but any Oregon station is fine. This is a test of the County EOC equipment, not the OADN gateways.

Record the following information from the Winlink Express screen for the Quarterly Test Report:

- Station Contacted Call Sign (W7ODN, K7ODN or other Oregon Station):
- Date of Contact:
- Time of Contact:
- Frequency:
- Throughput observed (bytes/minute):

Non-Oregon Gateway:

Use the Quarterly Test Message Template and connect to any non-Oregon based HF RMS Pactor Gateway station and send the Quarterly Test Template.

Record the following information from the Winlink Express screen for the Quarterly Test Report:

- Station Contacted Call Sign:
- Date of Contact:
- Time of Contact:
- Frequency:
- Throughput observed (bytes/minute):

Complete the Quarterly Test Report Template using the information recorded during the two above tests.

Send the Quarterly Test Report:

If possible, connect to a neighboring county's VHF RMS Gateway using the path connection indicated in the Quarterly Test Report Template.

If you are unable to connect to a neighboring county RMS Packet Gateway, update the VHF RMS Packet Connectivity Test information in the Quarterly Test Report Template to indicate there is not an RMS Packet Gateway accessible outside your county from your county EOC. Try to send the report via any available VHF RMS Gateway.

If no VHF Gateway is available, update and send the Quarterly Test Report via any HF Gateway or Telnet.

Contact KF7RSF with any questions.

ISNAP - Incident Snapshot for Counties / Tribal Nations Ver 5			
1. Date: Time:	2. ISNAP Version: <div>Initial Update FINAL</div>	3. Incident Type:	4. State Mission Number:
5. Affected Jurisdictions:			6. Reporting Jurisdiction
7. Point of Contact:		8. EOC Status:	9. County Status:
10. Briefly describe the situation:			

*Overall Incident Impact to Municipality, Department, District, or Agency: (see page below for rating guidelines)

Select one of these statuses (Red, Yellow, Green, or Black) in the 'Status' column box(es), as appropriate with guidelines.

	Red - Critical	Yellow - Significant	Green - Limited	Black - Unknown
11. Impacts	12. Status	13. Comments		
14. Government	15. <div>Black Green Yellow RED</div>	16.		
17. Transportation	18. <div>Black Green Yellow RED</div>	19.		
20. Utilities	21. <div>Black Green Yellow RED</div>	22.		
23. Medical	24. <div>Black Green Yellow RED</div>	25.		

26. Communications	27. <div>Black Green Yellow RED</div>	28.
29. Public Safety	30. <div>Black Green Yellow RED</div>	31.
32. Environment	33. <div>Black Green Yellow RED</div>	34.

Guidelines for Status Ratings - ISNAP Form

(The following is not transmitted nor copied to the form submitted.)

Category	Issue	Check all that are Impacted.	Suggested Threshold for "Red"
Government	Intact line of succession.	Elected Officials unavailable.	Red = Box Checked.
Transportation	Damage or shutdown to major transportation system(s) <i>with overlapping system impacts.</i>	Freeway/Highway Mass Transit Ferry Airport Seaport Freight Rail Passenger Rail Arterials Fuel Pipeline	Red = One or more boxes are checked, causing an imminent life safety issue or escalation to the event.
Utilities	Breadth of damage/outage to utilities.	Natural Gas Water Sewer Electric	Red = Any one box checked.
Medical	Capacity overwhelmed and/or critical medical infrastructure destroyed.	EMS Hospital Fatality Management	Red = Any one box checked.
Communications	Capacity overwhelmed and/or critical communications infrastructure damage and/or System shutdown.	Landline Cell Internet TV Commercial Radio Ham Radio	Red = Any TWO boxes checked.
Public Safety	Capacity overwhelmed.	Fire Police Public Safety Communications Public Safety Radio 911 System	Red = Any one box checked.
Environment	Overwhelming damage or imminent life safety	Air Quality Water Quality	Red = Any one box checked.

	issue.	Landslide/Avalanche HAZMAT Flood/Dam Failure	
--	--------	--	--

[Back up to the TOP of page.](#)

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: BED AVAILABILITY REPORT

(HOSPITALS)
REFERENCE NO. 1122.1

Hospital Name:

Hospital Service Level: GREEN = Normal Operations Time of HSL:

BED AVAILABILITY		# Available Immediately	# Available within 24 Hours Complete only when checked	# Available within 72 Hours Complete only when checked
1	Medical/Surgical			
2	Telemetry			
3	Adult ICU			
4	Pediatric ICU			
5	Neonatal ICU			
6	Pediatric Ward			
7	Obstetrics/Gynecology			
8	Trauma			
9	Burn			
10	Negative Pressure/Isolation			
11	Psychiatric			
12	Operating Room			
13				
14				
15	Ventilator			
16	Mass Decontamination Facility Available	YES NO		

Report Completed by:
PHONE NUMBER
DATE Time :

Additional Comments:

FAX COMPLETED FORM TO THE MEDICAL ALERT CENTER
AT (562) 906-4300
OR
SEND TO LAC-MAC VIA WINLINK

WITHIN 60 MINUTES OF REQUEST

EFFECTIVE: 06-01-08
REVISED: 04-01-18
SUPERSEDES: 07-01-17

Express Sending Station: {var MsgSender}

Version 0.7.1

Resource Request: Medical and Health

FIELD/HCF² to Op Area

RR MH (05/24/2011)

PAGE

OF

R E Q U E S T O R T O C O M P L E T E	1. INCIDENT NAME		2a: Date	2b: Time	
	3. REQUESTOR Name: Agency: Position: Phone : Email:		2C. Requestor Tracking Number# Facility code-3 digit number (assigned by requesting entity)		
	4. DESCRIBE MISSION				
	5. ORDER SHEETS - ATTACH ADDITIONAL SUPPLIES EQUIPMENT PERSONNEL OTHER				
	6. ORDER SUPPLY / EQUIPMENT / PERSONNEL REQUEST DETAILS				
ITEM#	PRIORITY (SEE BELOW) ³	DETAILED SPECIFIC ITEM DESCRIPTION: Supplies/Equipment (Rx: Drug Name, Dosage Form, UNIT OF USE PACK or Volume, Prod Info Sheet, In-House PO, photos, etc. Medical Supplies: Item name, Size, Brand, etc. General Supplies/Equipment: Food, Water, Generators) Personnel Type & Probable Duties (Required License, MD, RN, PharmD, ICU/OR Experience, Hospital/Clinical Experience, etc.) Other (Mobile Field Hospital; Ambulance Strike Team; Alternate Care Supply Cache; Facility-Tent, Trailer, Size, etc.)		Quantity Requested	EXPECTED EQUIPMENT / STAFF DURATION OF USE

				98
R E V I E W	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) Name: Position: Signature:			
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				
Express Sending Station: {var MsgSender}				Version 0.3.8

file:///M:/Winlink%20Form%20May%202020/Standard_Forms/WEATHER%20Forms/Local%20Weather%20Report.html[5/1/20 7:58:23 AM]

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO. 1106.1

SUBJECT: LPC INVENTORY AND
CHECKLIST FOR ITEMS DEPLOYED

RELEASING LPC:

RECEIVING FACILITY:

Items	Quantity On Hand (Alt+Click to Edit)	Number Checked Out
Adenosine Injection (6mg/vial)		
Albuterol Inhaler (20mg/inhaler)		
Albuterol Oral Inhalation Solution (2.5mg/3ml/dose)		
Amiodarone Injection (50mg/ampule)		
Atropine Injection (0.4mg/ml) 20ml multi-dose vial		
Calcium Chloride 10% Injection (1gm/10ml) Pre-Filled Syringe		
Cefazolin Injection (1gm/vial)		
Cephalexin Tablet (500mg/tablet)		
Ciprofloxacin Capsule (500mg/capsule)		
Diphtheria-Tetanus (Td) Adsorbed Dose Injection (0.5ml/dose) - Adult		
Diphtheria-Tetanus Toxoid (DT) Injection (0.5ml/dose) - Ped		
Dextrose 50% Injection (50ml syringe)		
Diphenhydramine Injection (50mg/ml vial)		
Dopamine Injection (200mg/vial)		
Doxycycline Capsules (100mg/tablet)		
Epinephrine Injection 1:1,000 (1mg/ml/ampule)		
Epinephrine Injection 1:1,000 30ml vial		
Epinephrine Injection 1:10,000 (1mg/10ml) Pre-Filled Syringe		
Glucagon Injection (1mg/vial)		
Haloperidol Injection (5mg/vial)		
Haloperidol Tablet (5mg/tablet)		
Insulin Regular Injection (100units/ml - 10ml vial)		
Lactated Ringers Solution Injection (1000ml/bag)		
Lidocaine Injection 2% (10mg/ml) Pre-Filled Syringe		

Lidocaine Injection 1% (20ml/vial)

EFFECTIVE: 10-15-06
REVISED: 07-01-19
SUPERSEDES: 04-01-19

SUBJECT: DRC EQUIPMENT CHECKLIST LIST
ITEMS DEPLOYED TO OTHER FACILITIES

REFERENCE NO.
11022.2

Items	Quantity On Hand	Number Checked Out
Magnesium Sulfate Injection (1gm/2ml)		
Naloxone Injection (2mg/vial)		
Nitroglycerin Tablets or Spray (0.4mg/tablet or spray - 100 doses)		
Ondansetron Injection (2mg/vial)		
Polymyxin Bacitracin Ointment (0.9gm/packet)		
Potassium Chloride Injection (40mEQ/20ml)		
Sodium Bicarbonate Injection (44.6mEQ/50 ml) Pre-Filled Syringe		
Sodium Chloride 0.9% Injection (100ml/bag		
Sodium Chloride 0.9% Injection (1000ml/bag)		
Sodium Polystyrene- Oral Powder (454gm/container)		
Tetracaine Hydrochloride Ophthalmic Solution 0.5% (2ml/bottle) or Proparacaine Hydrochloride Ophthalmic Solution 0.5% (15ml/bottle)		
Other Supplies:		
Notes/Comments		

Released by:

Date released:

Received by:

Facility:

Returned by:

Date returned:

Returned Items received by:

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO. 1107.1

FACILITY:

Bandages and Dressings	Quantity On Hand		Number Checked Out
Adhesive strip, 1" X 3"	100/box	5 boxes	
Alcohol pads	200/box	5 boxes	
Bandage elastic (Ace wrap) 2"	10/box	2 boxes	
Bandage elastic (Ace wrap) 4"	10/box	2 boxes	
Bandage elastic (Ace wrap) 6 "	10/box	2 boxes	
Bandage, gauze non sterile (kerlix) 4" X 10'	96/case	1 case	
Bandage, gauze non sterile 4" X 4"	200/pkg, 10 pkgs/case	1 case	
Bandage 4" X 4" sterile	2/pkg, 1200 pkgs/case	2 case	
Bandage 2" X 2" sterile	2/pkg, 3000 pkgs/case	1 case	
Eye pad, oval sterile	50/box	2 boxes	
Eye shields	Each	50	
Morgan Lens	12/box	4 boxes	
Petroleum gauze 5" X 9" (Xeroform)	50/box	2 boxes	
Vaseline gauze	50/box	1 box	
Gauze Pad 5" X 9" sterile	400/case	1 case	
Tape 1" transparent	12/box 10 boxes/case	1 case	
Transparent dressing (Tegaderm) 4" X 4"	50/box	2 boxes	
Non-adhesive (Telfa) Gauze (Various Sizes)	100/box	10 boxes	
Wound packing gauze	10 bottles/case	1 case	
Triangular bandages	12/box	8 boxes	
Disposable ice packs	24/case	10 cases	
Surgical Supplies	Quantity On Hand		Number Checked Out

Scalpel with blade, disposable #10	Each	48	
Scalpel with blade, disposable #15	Each	48	
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0	50 pairs/box	4 boxes each size	
Surgical scrub brushes with betadine	144/case	1 case	

EFFECTIVE: 07-01-06
REVISED: 04-01-18
SUPERSEDES: 07-01-17

[Jump to Supply Type](#)

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO.
1107.1

Surgical Supplies	Quantity On Hand		Number Checked Out
Suture set (disposable)	20/case	3 cases	
Suture removal kit	50/case	1 case	
Suture (nylon sutures various sizes)	12/box	6 boxes	
Steri-strips (assorted sizes)	50/box	3 boxes	
Disposable skin stapler and remover	72/case	3 cases	
Orthopedic Supplies	Quantity On Hand		Number Checked Out
Splint, cardboard 12"	25/case	1 case	
Splint, cardboard 18"	25/case	1 case	
Splint, cardboard 24"	25/case	1 case	
Splint, cardboard 34"	25/case	1 case	
Splint, fiberglass 3"	5/case	1 case	
Splint, fiberglass 4"	5/case	1 case	
Splint, fiberglass 5"	5/case	1 case	
IV Sets, Needles and Syringes	Quantity On Hand		Number Checked Out
IV start kits	Each	200	
IV catheter, 18 gauge	50/box	2 boxes	
IV catheter, 20 gauge	50/box	2 boxes	
IV catheter, 22 gauge	50/box	2 boxes	
IV catheter, 24 gauge	50/box	1 box	

IV administration set, adult	48/box	2 boxes	
IV administration set, pediatric	48/box	2 boxes	
IV piggyback tubing	50/box	1 box	
Needle disposable, 18 gauge	100/box	3 boxes	
Needle disposable, 22 gauge	100/box	3 boxes	
Needle disposable, 25 gauge	100/box	3 boxes	
Butterfly needles 25 gauge	50/box	1 box	
Syringe, 1ml	100/box	3 boxes	
Syringe, 3 ml	100/box	5 boxes	

Jump to Supply Type

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO.
1107.1

IV Sets, Needles and Syringes	Quantity On Hand		Number Checked Out
Syringe, 5 ml	100/box	2 boxes	
Syringe, 10 ml	100/box	2 boxes	
Syringe, 20 ml	25/box	1 box	
Syringe, 35cc, for wound irrigation	Each	25	
Syringe/needle, U100 insulin syringe 28 gauge, 1cc, 1/2" needle	100/box	1 box	
Syringe/needle, 3 ml, 22gauge X 1 1/2"	100/box	2 boxes	
Syringe/needle, 1 ml, 25 gauge X 5/8"	100/box	1 box	
Syringe/needle 1 ml, 29 gauge X 1/2" (May substitute U100 insulin syringe, 28G X 1/2" or tuberculin syringe 26G X 3/8")	200/box	1 box	
Sharps container	8/case	1 case	
Airway Management	Quantity On Hand		Number Checked Out
Bag-valve-mask, adult	12/case	1 case	
Bag-valve-mask, pediatric	6/case	2 cases	
Airway adjunct, OP Airway	-	50 assorted size	
Airway adjunct, NP Airway	-	50 assorted sizes	

Cricothyrotomy / Shiley 4	Each	5	
Endotracheal tube, cuffed 8mm	10/box	2 boxes	
Endotracheal tube, cuffed, 7.5mm	10/box	4 boxes	
Endotracheal tube, cuffed 7mm	10/box	2 boxes	
Endotracheal tube, cuffed, 6mm	10/box	2 boxes	
Endotracheal tube, cuffed 2.5mm	10/box	1 box	
Endotracheal tube, cuffed 3mm	10/box	1 box	
Endotracheal tube, cuffed, 4mm	10/box	2 boxes	
Endotracheal tube, cuffed, 4.5mm	10/box	2 boxes	
Endotracheal tube, cuffed, 5mm	10/box	2 boxes	
Endotracheal tube, cuffed, 5.5mm	10/box	2 boxes	
Endotracheal tube, non-cuffed, 2.5mm	10/box	1 box	
Endotracheal tube, non-cuffed, 3mm	10/box	1 box	

Jump to Section

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO.
1107.1

Airway Management	Quantity On Hand		Number Checked Out
Endotracheal tube, non-cuffed, 4mm	10/box	1 box	
Endotracheal tube, non-cuffed, 5mm	10/box	1 box	
Endotracheal tube holders	Each	50	
Intubation kit, incl. Blades, medium handle, stylet and case including magill forceps	Each	1 kit	
Intubation kit (Pediatrics) , incl. Blades, medium handle, stylet and case including magill forceps	Each	1 kit	
Nasal cannula, adult	50/case	2 cases	
Nasal cannula, pediatric	50/case	2 cases	
O2 mask with tubing, pediatric	Each	25	
O2 mask with tubing, adult	Each	50	
O2 mask - non-rebreather, adult	Each	25	

Nebulizers - hand held	50/case	2 cases	
Nebulizers - masks	50/case	2 cases	
Ventilator circuits	10/case	2 cases	
Suction machine, portable	Each	3 each	
Suction catheters 10 French	50/case	1 case	
Suction catheters 12 French	50/case	1 case	
Suction catheters 14 French	50/case	1 case	
Yankauer suction	20/case	2 cases	
Suction tubing	Each	100	
Suction Canisters	Each	100	
NG Tubes	Each	50	
Thoracostomy Tubes, assorted sizes	-	10 various sizes	
Pleurivac & Heimlich valves	1/each	10	
Infection Control Supplies	Quantity On Hand		Number Checked Out
Cover/Isolation gowns	100/case	3 cases	
Splash guard for wound irrigation	Each	100	
Masks surgical	50/box 6 boxes/case	24 cases	
Face shield with eye shield	25/box 4 boxes/case	1 case	

Jump to Section

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO.
1107.1

Infection Control Supplies	Quantity On Hand		Number Checked Out
Masks N-95	35/box 6 boxes/case	18 cases	
Patient exam gloves, small	100/box	2 boxes	
Patient exam gloves, medium	100/box	4 boxes	
Patient exam gloves, large	100/box	4 boxes	
Shoe covers	150 pairs/case	2 cases	
Surgical caps	100/box 6 boxes/case	1 case	

Wipes, disposable	40/box	4 boxes	
Hand sanitizer gel	8 oz	12 bottles	
Child face masks (various sizes)	75/box	4 boxes	
Miscellaneous Supplies	Quantity On Hand		Number Checked Out
Bags, plastic 30 gallon, 8 mil	100/pkg	1 pkg	
Batteries, C for laryngoscope handle	Each	6	
Batteries, D for flashlights	Each	24	
Blankets lightweight	Each	48	
Clipboards	Each	48	
Diapers, disposable large	120/case	1 case	
Diapers, disposable medium	168/case	1 case	
Diapers, disposable small	216/case	1 case	
Diapers, disposable, large, peds	120/case	3 cases	
Diapers, disposable, medium, peds	168/case	3 cases	
Diapers, disposable, small, peds	216/case	3 cases	
Emesis basins, plastic	250/case	1 case	
Facial tissues	30boxes/case	4 cases	
Flashlights	Each	12	
Gloves work type leather/canvas	Each	12	
OB kits, disposable	Each	5	
Paper towel rolls	Each	12	
Patient ID bands	250/box	1 box	

Jump to Section

SUBJECT: M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED

REFERENCE NO.
1107.1

Miscellaneous Supplies	Quantity On Hand		Number Checked Out
Styrofoam cups	25/bag 40 bags/case	1 case	
Tongue depressors, non-sterile	500/box	1 box	
Disposable temperature strips	100/ Box	5 boxes	

(TempaDots)			
Crutches (assorted sizes)	1 pair	50 pairs	
Body bags	5/case	20 cases	
Non-Disposable Medical Supplies	Quantity On Hand		Number Checked Out
Blood pressure multi-cuff kit with adult, pediatric, infant and thigh cuff	Each	2	
Glucometer kit with lancets, test strips and battery	Each	2	
Portable otoscope/ophthalmoscope set with batteries	Each	2	
Pulse oximetry, portable	Each	2	
Stethoscope	Each	12	
Tourniquets 1"	100/pkg	1 pkg	
Trauma/paramedic scissors	Each	6	

Notes/Comments

Released by:

Date released:

Received by:

Facility:

Returned by:

Date returned:

Returned Items received by:

Oregon State Resource Request Request for State Resources	
Winlink Status - Select Status	
Title – Request for State Resources	
4. OERS Incident Number-	(4 digit year - 4 digit number)
5. Request Date -	(auto-generated but editable, format MMDDYY)
6. Request Time	(auto-generated, editable, Military 4 digit no delimiters , ie. 1345
7. Verbal Request-	
8. Requesting Name -	Person entering the request should be the EM or delegated by the EM.
9. Winlink Call Sign-	(Call Sign of originating station)
10. Requestors Title -	(Title or Position of Requestor)
11. Jurisdiction- Select JURISDICTION	
12. Requesting Organization Contact Information- Contact information in the organization that needs the resource (this is not necessarily the tribe/county sending the request).	
13. Requesting Priority- ROUTINE	
14. Request Status- DRAFT	
15. Requesting Organization- Name of Organization requesting the resource (this is not necessarily the tribe/county sending the request).	
Resource Request (Use one request per resource type)	
16. Size-	Unit of issue
17. Amount/Quantity-	
18. Report to: Location- An address where the resource is to be delivered.	
19. Report to: Point of Contact-	Name of contact at the Report to: location.
20. Type of Resources - Assistance	

21. Request Summary-	
22. Date Required at Site-	editable MMDDYY
23. Time Required at Site-	(4-digit Military time, no delimiter, ie. 1455)
24. Duration of Assignment -	
25. Other Mission Critical Information -	
26. Operating Environment/Conditions - This will tell responding personnel what will be required during the response	
27. Required Licenses, Credentials, etc. - For example is an electrician's license required for the installation?	
Related Tracking Information	
28. Tracking Information-	
29. Organization -	
30. Remarks -	
31. List of attached files- (Name & Attachment Description) Commonly used only for medical supply lists. Text Field	

----- ARES EXERCISE -----		----- ARES EXERCISE -----		----- ARES EXERCISE -----	
OREGON <i>Activation - Deactivation Report</i> <small>Vers 7.1</small>					
ARES EXERCISE		Report Type: Activation Deactivation			
OERS Incident Name & Number:					
1. Requester:			2. Position:		
3. Agency:			4. Jurisdiction:		
5. Time, Date of Activation:					
6. Reason for Activation:					
7. Expected Duration of Activation:					
8. Station Type: EOC					
9. Call sign used for Voice is:			Call sign for Data is:		
10. Station Physical Location:					
11. VHF Frequencies			12. UHF Frequencies		
13. HF Frequencies: Primary 3964 kHz +/- 5 kHz LSB Voice Secondary 7248 kHz +/- 5 kHz LSB Voice Data Frequencies as chosen by Winlink Express FEMA Channels 5330.5 kHz Dial Frequency USB Voice Local frequency:					
14. Winlink (Amateur Service) E-Mail traffic will be monitored at least times per hour with acknowledgments. SHARES E-Mail traffic will be monitored at least times per hour with acknowledgments.					
15. SHARES Calls in use:					
16. Number of Operators at Station Location:					
17. Other Information:					
18. Authorizing Signature and Title:					
19. Operator Issuing Message:					

EXERCISE
REAL EVENT

OREGON Declaration of Emergency Vers 7

To: Governor, State of Oregon
Through: Director, Office Oregon Emergency Management

From:

TO

CC

If known, enter call or email of your DEC in CC.

1. Name of County

2. Type of Incident

3. Beginning Date and Time of Incident

CONTINUING
ENDED

4. Incident is ? If Incident has Ended - Enter End Date/Time

5. Brief Description of Problem and Type of Assistance Needed

6. Brief Initial Assessment of Damage, Number of Injuries - Deaths (No Victim Names)

7. Brief List of Actions Pending or Taken by County and/or other Local Governments

8. Request Date and Time - Form Filled Out

9. Name of Authorizing Official (s)

Note: Send an initial SITREP Report, seperate from this form as soon as possible.

Winlink Senders Call

EXERCISE
REAL EVENT

OREGON *Public Event* Vers 8

TO

CC

If known, enter call or email of your DEC

1. Agency/Group Requesting Assistance	
2. Person Requesting Services	
3. Position of Requester	
4. Name & Description of Event	
5. Location of Event	
6. Start Date and Time of Event	7. Expected Event Duration
8. Brief Description of Support Services Provided 9. Number of Operators	
10. Other Information or Comments	
11. Name & Call of Person Submitting Report Call Sign	
12. Position of Person Submitting Report	

EXERCISE
REAL EVENT

OREGON *Situation Report SITREP* Vers 7

TO

CC

If known, enter call or email of your DEC

1. To
Agency Name and Office Routing

2. SITREP

3. Categories with Brief Description

4. Event Name

Initial Report

Sequential Number

Final Report

5. . If Report is "Sequential Number" then increment # here

6. Brief Situation Summary

7. Past 24 Hours Brief Summary

8. Next 24 Hours Planned Actions

9. Efforts by Other Agencies or Organizations

10. Date and Time Approved

11. Authorizing Officials Name

12. Authorizing Officials Position

*Note: In a real event content is prepared by Emergency Management, not ARES.
SITREP's can be done hourly, or every 2 to 4 hours, event dependent.*

POINT OF DISPENSE GENERAL MESSAGE FORM (Medical) Vers 7

1. Incident Name

2. To (Name / Position)

3. From (Name / Position)

4. Subject 5. Date 6. Time

7. Message Priority LOW 7A. This concerns a Vaccine NO

Vaccine Name	Doses Remaining	Time

8. Message (Be brief and accurate)

9. Approved By Position

POINT OF DISPENSE GENERAL MESSAGE FORM (Medical) Vers 7

1. Incident Name

2. To (Name / Position)

3. From (Name / Position)

4. Subject 5. Date 6. Time

7. Message Priority 7A. This concerns a Vaccine

Vaccine Name	Doses Remaining	Time

8. Original Message

{var Message}

9. Approved By Position

10. Reply (Be brief and accurate)

11. Replied By Date & Time

Position Facility

QUICK MESSAGE	
Attn:	
From (Name/Group):	Date/Time:
Subject:	
Message	
Ve10.1	

Click to add agency or group name (it will remain as such until you change it)

Message No.	Originating Station	Place of Origin	Time Filed	Destination
-------------	---------------------	-----------------	------------	-------------

Resource Request Data Input Form

1.	Request - Limit 50 Char. {Mission Name}	2.	Date	3.	Time Reported	4.	Originating Agency Id Number
----	--	----	------	----	---------------	----	---------------------------------

5.	Requesting Official Name and Contact Info	6.	Request - Detailed Description REF Box 1 (20 Words MAX)
----	--	----	---

Resource Details

Request Priority (Precedence)

7.	Life Safety/Immediate (A) (4 hrs) A	Priority (B) (12 hr) B	Routine (C) (24 hrs) C	Long-Term (D) (96 hrs) D	Extended (E) (over 96 hrs) E
----	---	------------------------------	------------------------------	--------------------------------	------------------------------------

Resource Name (what are you requesting)

8. Resource: Other

Deliver To Location Below, and POC if different from Box 5. Request Official Contact Info:

9.

Status: Should be New Request unless you are VERY sure of what you are selecting.

10. Status: New Request

Amateur Radio Use Only

Acknowledging	WebEOC	WebEOC	WebEOC
11. Callsign:	12. Tracking#	13. Date Filed:	14. Time Filed:

[Form idea by Ken Humbertson WØKAH]

WA Region 4 - EOC SITREP Report Vers 5

Select Origination EOC:

- Region 4
- Clark
- Cowlitz
- Skamania
- Wahkiakum

To: Date:

Incident Name: Mission #:

Report #: Time:

Reporting Period: EOC Email:

EOC Manager: EOC Phone:

Situation Overview (Be brief)

Community Impacts

Missing: # Confirmed Dead:

Injured: # Homeless:

Impacted Area/Damage Assessment:

Transportation Status:

Utility Status:

Secondary Incidents:

Weather:

Damage/Disaster Costs Summary:

Other:

Response Operations

Incident Management:	
Evacuation Status:	
Shelter Status:	
Hospital Status:	
Resource Status:	
Emergency Ops Center Status:	
Business Continuity Activities:	
Future Outlook/Planned Actions:	
Other:	
Public Information	
Public Information:	
Issued Advisories & Guidance:	
Reference Information:	
Other:	
Prepared By:	Approved By (EOC Manager):

Race Tracker

Ver. 3.1

Race/Event Name:

Send to:

Aid/Check Point:

Subject:

(subject is created for you with 1st entry)

The entry boxes above will remain with what you enter the first time. You overwrite to change.

Bib or Rider #:

Click box to add Time:

(you can accept or modify the time)

Now select ONE to create an Entry:

Number of Entries

Comments:

Amateur Radio RADIOGRAM Text Creator								Read Help and Instructions!	
Number SVC (Handler use)	Precedence R EMERGENCY P W FSTP Emergency not in use at this time.	Handling Instructions NONE HXA HXB HXC HXD HX Help	Station Of Origin Change if not you.	Check	Place of Origin	Time	Date	Change to Local Time / Date Default is UTC	
TO:									
Name:			Call Sign:						
Address:									
City / Town:			State or Province:			2 Letter Codes Zip:			
Country:									
Phone:			Extension:		E-mail:				
Op Note about this Radiogram:									
MESSAGE TEXT Check: ARL Message Numbering Help									
Signature (name) of person for whom message originated:									
Operator Note:									
>>> NOW CLICK HERE and select a Liaison Station <<<									
Contact KB1TCE about this form: Ver 9.6									

I. TEAM	Jurisdiction:	Designation:	Date:
---------	---------------	--------------	-------

II. STAFF	ROLE	NAME (Last, First, MI)	ORGANIZATION
a.	TEAM LEADER		
b.			

c.			
d.			
e.			

SURVEY MTR 1	MAKE		MODEL		SERIAL
DETECTORS	EXT or DET (D1)		INT or DET 2 (D2)	DET 3 (D3)	DET 4 (D4)
MODEL					
SERIAL					

SURVEY MTR 2	MAKE		MODEL		SERIAL
DETECTORS	EXT or DET 1 (D1)		INT or DET 2 (D2)	DET 3 (D3)	DET 4 (D4)
MODEL					
SERIAL					

[illegible]

**** Remember to include units with readings: (uR/hr = micro R/hr, mR/hr = milli R/hr)**

Version 1.1 Direct questions on form use to: N4KIT

Revised 10/20/2014

WASHINGTON STATE RESOURCE REQUEST (WebEOC Format) Vers 2

Request For Assistance or Resources

Blue boxes are required fields

Date (mm/dd/yyyy): Time (hh:mm):

Creator:

Requesting Agency:

County:

City / Tribe:

Requester Tracking #

State Tracking #

Generated by State

Priority: Incident Stabilization Set by Logistics or Operations Only

Overall Status: Unassigned

Requestor Name: Phone: (XXX-XXX-XXXX)

FAX: (XXX-XXX-XXXX) Email: (email@xxx.xxx)

Resource Requested: Enter a one or two word description (ie: Generator or Debris Removal)

Detailed Description:

Detailed description of Capability Needed (What do you want to accomplish?)

Request Specific Resources

Description/Kind: Size/Type: Quantity:

Delivery Location Name:

On-site Point of Contact POC: POC Phone Number: (XXX-XXX-XXXX)

POC Email:

format example: 08/05/2015 / 1500

Required delivery (Date and Time): (Enter date and time needed. ASAP is not an answer.)

Duration Needed:

Delivery Needed: Yes No

Address: (Street, City, Zip)

Description using landmark or LAT/LON:

- Yes No Have all local resources been exhausted or predicted to be exhausted in the near future?
- Yes No Has mutual aid been exhausted or predicted to be exhausted in the near future?
- Yes No Have all commercial resources been exhausted or predicted to be exhausted in the near future?
- Yes No Is the originating jurisdiction/agency willing to pay for the assistance?

Form Info

DISASTER:	Task #	COUNTRY:	
UNIT:		COMMUNITY:	
PERIOD:	Single Day	Cumulative	thru

LOCATION DETAILS (building, address, route)	CONTACT NUMBERS (phone, fax, e-mail):

FACILITY TYPE:	Feeding Operations	Command Post	Assistance Center	Staging Area	Shelter
	Mobile Fixed	Phone Bank	Distribution Center	Warehouse	Other

DISASTER FOOD SERVICES:		MASS SHELTERING:	
Prepared Meals (hot and cold)	5202	Lodging Provided	5221
Drinks (coffee, soda, juice, water)		MEDICAL / SANITATION:	
Snacks (donuts, cakes, chips)	5206	Medical Services Provided	
		Showers Provided	

EMERGENCY FINANCIAL AID:		
Client Interviews		6310
Referrals to Other Agencies		6410
Total Cases Opened		
Total Individuals Assisted		5125
FINANCIAL ASSISTANCE:		
Vouchers	# Issued	Total Cost
Cleanup / Reconstruction		
Clothing		5231
Energy		5238
Furniture		5233
Gift Cards / Debit Cards		5245
Groceries		5207
Housing (Rent / Mortgage)		5223
Transient Lodging (Hotel)		5222
Transportation		5241
Other (specify)		
TOTALS:		

IN-KIND DISTRIBUTION:	
Blankets (per item)	
Bibles, Brochures, Tracts (per item)	
Cleanup Kits (per kit)	5236
Cleaning / Rebuild (per order)	
Comfort Kits (per kit)	5236
Clothing (per item)	5230
Furniture (per item)	5232
Groceries / Food Boxes (per order)	5207
Ice (per bag)	
Infant Supplies (per order)	
Tarps / Plastic Sheeting (per item)	
Toys (per order)	5250
Water (per gallon or case)	
NOTES: (254 char max)	

EMOTIONAL & SPIRITUAL CARE		
Spiritual Care Provided Prayer)		6310

FINANCE ADMINISTRATION		
Personnel	Number on Site	Hours Served

Adult Seekers		2405		Officers		4350		4350
Youth Seekers (Under Age 14)		2415		Employees		4360		4360
Mental Health Care Provided (CISM)		6310		Volunteers		4130		4130
				Totals				
	#		ATTENDANCE					
Worship Services		2360		2360				
Memorial Services		2350		2350				

SUBMITTED BY:		
NAME	TITLE	DATE SUBMITTED

FOR COMMAND USE ONLY:			
Current	Operational Assets	Unduplicated Totals	
	Mobile Canteens		4325
	Other S.A. Vehicles		4320
	Assistance Centers		
	Command Posts		
	Distribution Centers		
	Feeding Facilities		
	Phone Banks		
	Shelters		
	Staging Areas		
	Warehouses		
	Other S.A. Facilities		
	Govn't EOCs*		4330
	Govn't DRCs*		4340
* where The Salvation Army has representation			
Notes:			

Precedence Routine	Org Station	Org Location	Time	Date
Salvation Army Team Emergency Radio Network				
SATERN General Message ICS213				
1. Incident Name:				
2. To:				
Phone:	Email:	Town, State, Country:		
3. From:				
Phone:	Email:	Town, State, Country:		
4. Subject:		5. & 6. Date/Time:		
7. Message:				
8. Sent By:		Operator Name :		
Version 2 WA5EEZ				

Precedence {var Priority}	Org Station {var OrgStation}	Org Location {var OrgLocation}	Time {var msgTime}	Date {var msgDate}
Salvation Army Team Emergency Radio Network				
SATERN General Message ICS213				
1. Incident Name: {var Incident_Name}				
2. To (Name/Position): {var To_Name}				
Phone: {var To_Phone} Email: {var To_Email} Town, State, Country: {var To_TSC}				
3. From (Name/Position): {var From_Name}				
Phone: {var From_Phone} Email: {var From_Email} Town, State, Country: {var From_TSC}				
4. Subject: {var Subjectline} 5. & 6. Date/Time: {var DateTime}				
7. Message:				
{var Message}				
8. Sent by: {var Approved_Name}				
9. Reply:				
10. Sent By: Operator Name : Date/Time:				
Version 2 WA5EEZ				

CASUALTY REPORT FORM
San Diego County ARES - ACS

[Form Info](#)

Exercise
REAL EVENT

Select Incident-Event Location

Report Time Date Verified By

Tracking #		Destination	
Extent of Injury	Minor Delayed IMMEDIATE	Describe	
Ambulance			
Additional Comments on this Casualty if Any			

Tracking #		Destination	
Extent of Injury	Minor Delayed IMMEDIATE	Describe	
Ambulance			
Additional Comments on this Casualty if Any			

Tracking #		Destination	
Extent of Injury	Minor Delayed IMMEDIATE	Describe	
Ambulance			

Additional Comments on this Casualty if Any

Senders comments if any

SEVERE WEATHER REPORT				
Sender				
Report Date/Time (local)		Report Version (Select one): Initial Update Final Message		
Fill in what you can. This form sends data as plain text to your recipient(s).				
Reporting Party Name				
Reporting Party Phone Number				
Reporting Party Email Address				
EVENT AREA				
State/Province/Region		County		
City		Other		
GPS Coordinates if available				
OBSERVED EVENT CONDITIONS				
Check All That Apply.				
Flood: Choose				
Hail: Choose				
High Wind Speed: Choose		View Wind Speed guidelines		
Tornado / Funnel Cloud: Choose				
Wind Damage: Choose				
Winter Precipitation: Choose				
Snow: Choose				
Freezing Rain: Choose				
Heavy Rain: Choose		Time period: Report 1" or greater in an hour and every inch thereafter, 2 inches or greater storm total.		
Additional Information or Damage Descriptions (Be Brief)				

NCC SHARES RADIO INTERFERENCE REPORT Ver 4

Send to NCCSHARES@DHS.GOV If you need assistance call 1-703-235-5329

1. Information Concerning SOURCE of Interference

a. Call Sign, Bearing or Other Identification

b. Measured Frequency in kHz

To be completed by SPO: Assigned Freq. in kHz RFA SER.

c. Class of Emission and Nature of Traffic Transmitted

d. Measured Bandwidth of Interfering Signal

e. Signal Strength

f. Date and Time Interference Started (indicate which time zone, e.g. EST or EDT)

Date Interference Started Time Time Zone (e.g. EST, EDT...)

Duration in Minutes or Hours

2. Information Concerning Station RECEIVING Interference

a. Call Sign, Bearing or Other Identification

b. Measured Frequency in kHz

c. Class of Emission and Nature of Traffic Transmitted

d. Authorized Bandwidth and Measured Bandwidth

e. Geographical Location (street address or city and state; format for lat/lon: ddmssN dddmssW - degrees, minutes, seconds, no decimals; North or South, East or West)

REMARKS

3. Information Concerning Person or Office Submitting Report

POC INFO

Name

Address

Phone

Email

This template generates a formatted text message only for email sending

SHARES HF RADIO PROGRAM MESSAGE FORM			Ver 9
Message Sent To: (seperate multiple address with semicolon;)			
Originating Station:		Operator Name:	Optional Msg #:
TIME / MONTH / YEAR: (Zulu)		(can be overwritten)	
FROM: Name:		Agency:	City:
Telephone:		State:	
TO: Name:		Agency:	City:
Telephone:		State:	
<div>Routine Message</div> <div>Exercise</div> <div>ACTUAL EVENT</div> <div>Para 1: This is a SHARES:</div>			
Para 2: Message Follows:			
<div>End Of Message</div> <div>Over</div> <div>Message Status:</div>			
Originating Station Remarks:			
For form use/info contact: Dan Midyett / NNB4DW / NCS361			

SHARES SPOTREP-2 Ver 9.3		UNCLASSIFIED
For Non-Express recipients, this form is sent as plain text in the message body.		
<div>R</div> <div>FM</div> <div>TO</div> <div>INFO (CC)</div> <div>Calls or E-mails entered into the TO or INFO fields above, can be multiples separated by a semicolon ;</div>		
<div>1. City/State/Territory:</div> <div><div><div>---</div><div>YES</div><div>NO</div></div><div>2. LandLine works?</div><div>Comments</div></div> <div><div><div>---</div><div>YES</div><div>NO</div></div><div>3. Cell Phone Works?</div><div>Comments</div></div> <div>4. AM/FM Broadcast Stations Status</div> <div>5. TV Stations Status</div> <div>6. Public Water Works Status</div> <div>7. Commercial Power Status</div> <div><div><div>---</div><div>YES</div><div>NO</div></div><div>8. Internet Working?</div><div>Comments</div></div>		
<div>Additional Comments</div> <div>Brief summary of current situation - expected outage times, major observations, etc.</div>		
POC		
For form use or info contact: Dan Midyett/NNB4DW/NCS361		

SHELTER LOG Vers 8

[Form Info](#)

This form sends plain text only in the message body and easy to read. Most recipients will not be using Winlink Express.

General Log
Manager Log

Date

Incident/DR #

Shelter Name/Location

Date & Time	Name	Log Entry	Follow-Up Action
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>
			<div>Required</div> <div>Completed</div>

[Adapted from National Mass Care Strategy](#) - DCS Shelter Log for Winlink System Delivery.

Situation Report **SITREP**
General

Vers 8

Click to add your agency or group name

Form Instructions

ExerciseREAL EVENTInitial Report

This form is also sent as plain text in the message body, for non Winlink Express users.

To Email/Radio Call

Seperate multiple address with semicolon ; You can add/change prior to posting if needed.

1. To	Individual, Agency Name and/or Office Routing
2. Event Name	
3. Event Type and Location or Area with Brief Description	
4. Current Situation Summary	
5. Current Operational Period Planned Actions	
6. Next Operational Period Planned Actions	
7. Efforts by Other Agencies or Organizations	
8. Date and Time Approved	You may overwrite or click to create a new date/time.
9. Authorizing Officials Name	Position or Title
This form is also sent as plain text in the message body, for those not using Winlink Express.	

STATE OF TEXAS ASSISTANCE REQUEST (STAR) Vers 9

Incident Name Initial Request Date/Time
Requesting County Request #

NO
YES

Is this RR Tied to Another Request? Other Tracking Numbers

Requested Item Description

Qty	Unit	Item Name	Item Description	Cost	Demob?
					NO

Justification - Purpose for Request?

When is this Resource Needed? Estimated Needed Time Frame of Item?

Delivery Information - Way Point Information

Point of Contact Name	Phone # (s)	Facility Name	Zip
Facility Address	City	State	
Additional Instructions			

Final Destination

Point of Contact Name	Phone # (s)	Facility Name	Zip
Facility Address	City	State	
Additional Instructions			

Requester Information

Requested by Position / Name	Email	Phone # (s)

If the person receiving does not have Winlink Express, the info is readable in the message body text.

2400 Wright Street PO Box 7865 Madison, WI 53707-7865		WISCONSIN EMERGENCY MANAGEMENT DEPARTMENT OF MILITARY AFFAIRS UNIFORM DISASTER SITUATION REPORT		Telephone: (608) 242-3232 (800) 943-0003 FAX (608) 223-6525	
NAME OF PERSON SUBMITTING REPORT		STREET ADDRESS		CITY	ST
ZIP		PHONE NO			
EMAIL		TYPE OF INCIDENT/EMERGENCY		DATE & TIME OF INCIDENT	
DATE REPORTED		VERSION Select Version			
LOCATION OF INCIDENT					
WEM REGION Select Version		COUNTY		OTHER LOCATION DETAILS (ATTACH A MAP SHOWING LOCATIONS)	
CITY		TOWNSHIP		VILLAGE	
ESTIMATED NUMBER OF INDIVIDUALS IMPACTED					
SHELTERED		DEATHS		INJURIES	
HOMELESS		EVACUATED			
PRIVATE SECTOR DAMAGE ESTIMATES					
ESTIMATED NO. OF RESIDENTIAL HOMES				ESTIMATED DOLLAR AMOUNT	
PERCENT COVERED BY INSURANCE					
AFFECTED		MINOR		MAJOR	
DESTROYED		TOTAL RESIDENTIAL			
ESTIMATED NO. OF BUSINESSES				ESTIMATED DOLLAR AMOUNT	
PERCENT COVERED BY INSURANCE					
AFFECTED		MINOR		MAJOR	
DESTROYED		TOTAL BUSINESS			
FARM BUILDINGS DAMAGED?		CROPS AFFECTED?		LIVESTOCK LOST?	
YES NO		YES NO		YES NO	
TOTAL AGRICULTURAL COSTS		TOTAL PRIVATE SECTOR DAMAGE			
PUBLIC SECTOR DAMAGE ESTIMATES					
A) DEBRIS CLEARANCE		B) PROTECTIVE MEASURES		C) ROAD SYSTEMS	
D) WATER CONTROL FACILITIES					
E) PUBLIC BLDGS & RELATED EQUIPMENT		F) PUBLIC UTILITY SYSTEMS		G) OTHER	
TOTAL PUBLIC SECTOR DAMAGE					
DESCRIBE LOCAL ACTIONS TAKEN OR TO BE TAKEN. INCLUDE NAMES AND PUBLIC OFFICIALS INVOLVED IN THE RESPONSE EFFORTS.					
DESCRIBE OUTSIDE ASSISTANCE NEEDED OR BEING REQUESTED.					
ADDITIONAL COMMENTS (INCLUDE ECONOMIC OR OTHER IMPACTS ON AFFECTED COMMUNITIES).					
DOES THE COUNTY INTEND TO APPLY FOR ASSISTANCE FROM THE WISCONSIN DISASTER FUND? YES NO					
Version 1.0					

Virginia Local Situation Report
VA SitRep Ver 8

If sending this message via Peer-to-Peer, only one recipient is permitted in the "TO:" field, and no recipients are permitted in the "CC:" field.

Items in RED are required

TO:

CC:

If known, enter call sign or E-mail of your DEC

00. Incident:

Use same Incident Name throughout event

AGENCY OVERVIEW

Initial
Update
Final

01. Sitrep Status:

02. Sitrep #:

(Note: Sitrep number must be manually incremented when using this form)

Accomack County
Albemarle County
Alexandria City
Alleghany County

03. Political Subdivision:

04. As of:

04a: Report Prepared Date/Time:

Civil Disturbance/Riots
Dam - Slowly Developing
Dam - Rapidly Developing
Dam - Failure Imminent

05. Emergency Type:

06. Provide Brief Description of Emergency:

LOCALITY STATUS

None
Declared
Terminated
Rescinded

07. Current Emergency Declaration Status:

07a. Date/Time Emergency Declared:

07b. Date/Time Emergency Terminated:

07c. Date/Time Declaration Rescinded:

Closed
Open - Monitoring
Open - Virtual
Open - Partial

08. Current EOC Status:

08a. Date/Time EOC Opened:

08b. Date/Time EOC Closed:

Open
Closed
Rescinded

09. Government Offices Status:

-
- ☐ Open
- ☐ Closed
- ☐ Delay
- ☐ Early Release

10. School System Status (K-12):

-
- ☐ Open
- ☐ Closed
- ☐ Delay
- ☐ Early Release

11. Current Shelter Status:

-
- ☐ Closed
- ☐ Full
- ☐ Open

12. Evacuation Status:

- None
- ☐ Voluntary
- ☐ Mandatory

13. Additional Status Information:

14. Estimated Number Evacuated:

15. Areas Evacuated:

16. Amateur Radio Status:

-
- ☐ Inactive
- ☐ Active

17. Number of People in Impacted Area:

CASUALTY REPORT

18. Injured:

19. Missing:

20. Dead:

SIGNIFICANT ISSUES

21. Impact Summary:

22. Provide a synopsis of significant issues being faced by the locality:

23. Anticipated Issues:

EMERGENCY SUPPORT FUNCTIONS

24. ESF 1 - Transportation:

Please include rail, bus, airports, non-state maintained roads, waterways, and major road closings.

25. ESF 2 - Communications:

26. ESF 3 - Public Works and Engineering:

- 27. ESF 4 - Firefighting:
- 28. ESF 5 - Emergency Management:
- 29. ESF 6 - Mass Care, Housing, and Human Services:
- 30. ESF 7 - Logistics:
- 31. ESF 8 - Health and Human Services:
- 32. ESF 9 - Search and Rescue:
- 33. ESF 10 - Hazardous Materials Response:
- 34. ESF 11 - Agriculture and Natural Resources:
- 35. ESF 12 - Energy:
- 36. ESF 13 - Public Safety and Security:
- 37. ESF 14 - Recovery:
- 38. ESF 15 - External Affairs:
- 39. ESF 16 - Military Affairs:
- 40. ESF 17 - Volunteers and Donations:

GENERAL

- 41. Additional Comments:
- 42. Prepared By:
- 43. Job Title:
- 44. Call Back Number:

45. Fax Number:

46. Email:

In a real event, content is to be authored by Emergency Management, not ARES. SITREPs can be done hourly, or 2 to 4 hours, event dependent.

Contact KW6GB for form use and information

Quick Health & Welfare - Status or Information Message

Vers 16

This form is used to send information or a status report to family members or friends via Winlink E-Mail.

Suggest more than one E-Mail address to increase the chances that someone will get this message.

>> NO REPLY is expected, nor can be processd. The requester needs to be informed this is a ONE WAY outbound message.. <<

[Operator Info - Read Please](#)

From Name	Date / Time (Local)
To Email (s)	
Incident / Event Location or Region / Area Name	

Message

The message is formatted as plain text in the body of the sent email, and easy to read by the recipient (s).

Winlink Check In

Click to add your agency or group name to title

Form Info

This is for an initial check in via Winlink Express. Also sent as plain text in message body for non-Express users.

Date/Time	Status	Exercise	Band	-N/A- VHF 220 UHF 80 Mtrs	Session	Telnet Arden/Mesh WebMail Packet Winmor
Send To:						
Entries will remain until you change or clear them.						
Calls Signs of Initial Operator (s)						Sender

Location

Comments (be brief)

Ver 18.1