

**EMERGENCY DISASTER PLAN FOR
ADULT DAY PROGRAMS, ADULT
RESIDENTIAL FACILITIES, RESIDENTIAL
CARE FACILITIES FOR THE CHRONICALLY
ILL AND SOCIAL REHABILITATION FACILITIES**

INSTRUCTIONS:

Post a copy in a prominent location in facility, near telephone.
Licensee is responsible for updating information as required.
Return a copy to the licensing office.

NAME OF FACILITY	ADMINISTRATOR OF FACILITY
FACILITY ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ()

I. ASSIGNMENTS DURING AN EMERGENCY (USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

NAME(S) OF STAFF	TITLE	ASSIGNMENT
1.		DIRECT EVACUATION AND PERSON COUNT
2.		HANDLE FIRST AID
3.		TELEPHONE EMERGENCY NUMBERS
4.		TRANSPORTATION
5.		OTHER (DESCRIBE)
6.		

II. EMERGENCY NAMES AND TELEPHONE NUMBERS (IN ADDITION TO 9-1-1)

FIRE/PARAMEDICS	POLICE OR SHERIFF
RED CROSS	OFFICE OF EMERGENCY SERVICES
PHYSICIAN(S)	POISON CONTROL
HOSPITAL(S)	AMBULANCE
DENTIST(S)	CRISIS CENTER
LONG TERM OMBUDSMAN	OTHER AGENCY/PERSON

III. FACILITY EXIT LOCATIONS (USING A COPY OF THE FACILITY SKETCH [LIC 999] INDICATE EXITS BY NUMBER)

1.	2.
3.	4.

IV. TEMPORARY RELOCATION SITE(S) (IF AVAILABLE, SUBMIT LETTER OF PERMISSION FROM RENTER/LEASEE/MANAGER/PROPERTY OWNER)

NAME	ADDRESS	TELEPHONE NUMBER ()
NAME	ADDRESS	TELEPHONE NUMBER ()

V. UTILITY SHUT—OFF LOCATIONS (INDICATE LOCATION(S) ON THE FACILITY SKETCH [LIC 999])

ELECTRICITY _____

WATER _____

GAS _____

VI. FIRST AID KIT (LOCATION)

VII. EQUIPMENT

SMOKE DETECTOR LOCATION (IF REQUIRED) _____

FIRE EXTINGUISHER LOCATION (IF REQUIRED) _____

TYPE OF FIRE ALARM SOUNDING DEVICE (IF REQUIRED) _____

LOCATION OF DEVICE _____

VIII. AFFIRMATION STATEMENT

AS ADMINISTRATOR OF THIS FACILITY, I ASSUME RESPONSIBILITY FOR THIS PLAN FOR PROVIDING EMERGENCY SERVICES AS INDICATED BELOW. I SHALL INSTRUCT ALL CLIENTS/RESIDENTS, AGE AND ABILITIES PERMITTING, ANY STAFF AND/OR HOUSEHOLD MEMBERS AS NEEDED IN THEIR DUTIES AND RESPONSIBILITIES UNDER THIS PLAN.

SIGNATURE	DATE
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