

Pinellas County Emergency Management 2016 Healthcare Facility Evacuation Transportation Request

Place a copy of this form in your PLAN

Facility Name: _____

Street Address: _____

City: _____

Emergency Contact: Name: _____

Cell #: _____

2nd Emergency Contact: Name: _____

Cell #: _____

Evacuation Level of Facility: _____ **Hospitals Only** ➡ Critical Care: _____ Gen Med: _____

Average Census: _____

PRIMARY Mutual Aid Evacuation Location(s): (Must be inside Pinellas County if using EM buses)

1. Facility Name: _____

Street Address: _____

City: _____

Phone: _____

2. Facility Name: _____

Street Address: _____

City: _____

Phone: _____

Total Patients to be transported by EM provided vehicles: _____

**** (Facility Staff must be available to help load patients on to buses.)****

- 1) Ambulatory (Can use bus): _____
- 2) Is able to be transferred from a wheelchair to bus seat: _____
- 3) Wheelchair Bound (those that must remain in a wheelchair): _____
- 4) Ambulance (includes Bariatric, Ventilator, Bedbound) : _____
- 5) Number of your staff members to accompany Patients: _____

Please note the following:

- County provided transportation will not leave the county
- We will not provide transportation to public shelters
- You must use whatever transportation assets you have first
- If buses or ambulances are dispatched to your facility for evacuation of your Patients, you may be charged for the use.
- Transportation resources are limited; School buses will be used as available and have limited wheelchair capability. Ambulances will be scheduled on a case-by-case basis.

Do you have a contract with Wheelchair Transport or Care Ride? YES or NO (Circle One)

Is your facility requesting county transportation assistance during an evacuation? Yes ____ No ____

If No, transportation is provided by: _____ Phone #: _____

Administrator Signature (required)

Date

❖ Please send a completed signed/dated form to EMA:
FAX --- 727-464-4024 or EMAIL ----- emahc@pinellascounty.org