Form 2 - State Medical Needs Shelter Pre- and Post- Facility Survey

Pre-event Assessment *(Documentation of Building Survey completed immediately prior to the shelter opening.)*		**Post-event Assessment** *(Documentation of Building Survey completed immediately after the shelter is closed.)*	
Name of Event:		Name of Event:	
Walk through date & time		Walk through date & time	
Name of MCC representative:		Name of host facility designee:	
Facility Manager/ Nurse Manager name		Facility Manager/ Nurse Manager name	
Area of Shelter	**Notes:** *(Document any obvious areas of wear & tear as well as any areas of damage)*	**Area of Shelter**	**Notes:** *(Document any areas of damage)*
Bathroom:		Bathroom:	
Kitchen:		Kitchen:	
Office:		Office:	
Storage Area:		Storage Area:	
Registration area:		Registration area:	
Eating area:		Eating area:	
Activities area:		Activities area:	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Sheltering Room- or Room # ____		Sheltering Room- or Room # ____	
Other: _____		Other: _____	
Other: _____		Other: _____	

SMNS Nurse Manager (Optional)	Date	SMNS Nurse Manager (Optional)	Date
Facility Representative	Date	Facility Representative	Date
SMNS Facility Manager	Date	SMNS Facility Manager	Date

Official Use Only