County of Santa Clara
MEDICAL HEALTH BRANCH
RESOURCE REQUEST FORM #9A

DATE:_____ **TIME OF REQUEST:**_____ **REQUESTING FACILITY:**_____

CONTACT:_____ **PHONE:**_____ **FAX:** _____

NATURE

- ☐ SUPPLY
- ☐ EQUIPMENT
- ☐ MEDICAL GUIDANCE
- ☐ PERSONNEL
- ☐ OTHER:

FACILITY TYPE

- ☐ CITY
- ☐ HOSPITAL
- ☐ ALLIED HEALTHCARE
- ☐ PUBLIC HEALTH
- ☐ HHS DEPT.
- ☐ DEOC REQUEST
- ☐ OTHER

BILLING

BILL TO:

ORGANIZATIONAL AUTHORIZATION ID (PO, Facility Resource Request ID, etc.)

DESCRIBE THE RESOURCE REQUESTED

Directions: Include quantity, need by, deliver location, duration, specifications, etc. Use one form per request.

STATEMENT OF REQUESTOR

I certify that that the resources requested are currently not available and that our organization has exhausted all appropriate means to procure such resources. I understand that my organization is responsible for all costs related to filling this request.

NAME: _____ SIGNED:_____ DATE: _____

MHOAC/EMS DUTY CHIEF/DEOC/MEDICAL HEALTH BRANCH USE

TRACKING

TIME RECEIVED:_____ INIT:_____

DISPOSITION:

- ☐ REQUEST FILLED_____
- ☐ REQUEST NOT FILLED_____
- ☐ REFERRED TO EOC_____
- ☐ RETURNED TO REQUESTOR_____

DISPOSITION

- ☐ REQUEST FILLED ON BEHALF OF THE VENDOR AT THEIR COST
- ☐ REQUEST FILLED – REFLECT BILLING TO:

GL ACCOUNT #:_____ OTHER #: _____
BUDGET UNIT:_____ COST CENTER:_____
INTERNAL ORDER #:_____ TRACKING ID:_____
RIMS REFERENCE #:_____ BY:_____

☐ **CLOSED REQUEST: DELIVERY INFORMATION ENTERED INTO LOG**

NOTES

AUTHORIZATION

Based on the nature of the emergency, I approve this resource request based upon a prudent and reasonable assessment of the request and available resources at the time of the request.

NAME _____ SIGNED:_____ DATE: _____

DEOC ID#:

DEOC PHONE – 408.794.0700
Revised September 2009

EMS DUTY CHIEF PHONE – 408.998.3438