Board of Chosen Freeholders
County of Burlington
New Jersey

Department of: HEALTH

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MEDICAL NEEDS SHELTER OPERATION
Situational Report
SEND TO LOCAL EMERGENCY OPERATIONS CENTER AND RETAIN COPY AT SHELTER

Reporting to: ________________________________ **From:** ___________________________

Date: ______________________________________ **Time:** ____________________________

Location: ____

Population of Persons with Functional needs residing in shelter: ______________________

Contact Person: _____________________________**Contact Number**: ___________________

Is number of Medical Staff sufficient at time of Report: ______**YES** _____ **NO**

If "No" -report your needs below.

REPORT NEEDS IN THIS SECTION

Food/Water/Nutritional Issues: ____

____

Immediate Staffing Needs/Issues/Supplies: ____

____

Immediate Request for Assistance/Resolution/Supplies: _____________________________

____

Shelter Operations Issues: ____

____

Medical Issues: ____

____

Security Issues: ____

____

Other: ____