HOSPITAL SAFETY CENTER

THE EMERGENCY MANAGEMENT COORDINATOR'S HANDBOOK FOR HOSPITALS

MARY RUSSELL, EdD, MSN
EARL R. WILLIAMS, HSP

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HCPro

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Mary Russell, EdD, MSN, Author
Earl R. Williams, HSP, Author
Owen W. MacDonald, Senior Managing Editor
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About the Authors

Mary Russell, EdD, MSN

Mary Russell, EdD, MSN, is involved in a spectrum of emergency preparedness planning and response activities at the local, county, regional, and state levels in Florida. Russell's experiences have included emergency responses to events such as a hospital explosion and fire resulting in evacuation; major hurricanes; wildfires; tornadoes; chemical incidents; transportation-related mass-casualty incidents; a terrorist attack involving anthrax; contamination of food and water supplies; and outbreaks of influenza, norovirus, and other biological agents, among other threats.

As an emergency room nurse who has also served in the Hospital Incident Command System structure of her community hospital, she is fully aware of the need to constantly prepare, conduct exercises, and learn from every experience. Her background includes serving as the 2006–2007 chairperson for the Healthcare Emergency Response Coalition (HERC) for Palm Beach County, FL, which includes membership from all 15 hospitals in the county and other emergency response partners. Together, they have worked on strategic planning and shared activities, including participation in countywide and regional drills in addition to responding to real disasters.

Russell currently works for the Florida Department of Health's Office of Public Health Preparedness as a senior hospital project manager for hospital preparedness projects (including the development of hospital toolkits for emergency evacuation, radiological emergency response, and chemical emergency response), helps with state healthcare work force planning, and serves on catastrophic health and medical planning and medical surge capability teams. On weekends, she works per diem night shifts in the emergency department as a registered nurse at Boca Raton Community Hospital. She also volunteers for Palm Beach County's Medical Reserve Corps. Her perspective allows her to understand federal and state guidance and align it with local planning and response.

Russell has a multidisciplinary educational background, including a bachelor's degree in physical therapy from Russell Sage College in Troy, NY; a master's in nursing from the Lienhard Graduate School of Nursing at Pace University in Pleasantville, NY, and a doctorate

in education from Florida International University in Miami. She has worked in numerous settings, including critical care, burn units, community health settings, and other areas of practice beyond the emergency department setting.

In addition, Russell is certified in the Department of Homeland Security's Homeland Security Exercise and Evaluation Program (HSEEP) training and has multiple National Incident Management System certifications. She also has completed a range of basic through advanced disaster courses, including basic awareness-level, operations-level, and advanced courses in disaster burn care, disaster life support, psychological first aid, hazardous materials, biological prevention and response radiological response, triage training, and incident response to terrorist bombings.

Earl R. Williams, HSP

Earl R. Williams, HSP, is the safety manager at BroMenn Healthcare, an acute care and trauma center in Normal, IL. There, Williams developed BroMenn's safety program, including initiating its first incident command system to face the Y2K rollover threat, and updated the emergency management program to keep pace with evolving threats and regulations.

Shortly after graduating from high school, Williams entered the United States Air Force (USAF). During his career in the USAF, he worked on jet engines, obtained his pilot license, attended the USAF Air War College for Instructors becoming a certified training instructor, and received extensive training on emergency management, emergency response, nuclear, and chemical warfare. He taught freshman level classes in leadership, human relations, military science, management, communications, health, and physical education. He is a veteran of the Vietnam War, and upon returning from his duties overseas, Williams worked in emergency response and deployment of resources, and became a certified emergency medical technician working with local ambulance services and hospitals.

After retiring from the USAF, Williams began his career in healthcare after obtaining a position with Carle Foundation Hospital and Clinic, an acute care and trauma center. Williams became the interim director of security before moving into the hospital safety field. In his safety position, he developed Carle's first ever safety program and worked closely

with the local emergency and disaster services agency (ESDA) performing multiple community drills. While with Carle, Williams obtained degrees in science and business administration.

Upon leaving Carle, Williams joined OSF Saint Francis Medical Center, an acute care and trauma facility, in Peoria, IL. At OSF St. Francis, Williams worked with local chapters of the Occupation Health & Safety Administration, Environmental Protection Agency, county and city ESDAs, and the health department. He developed a medical incident command system similar to today's National Incident Management System and Hospital Incident Command System. Williams collaborated with local emergency entities to develop and execute a number of community exercises. Williams also worked with the Illinois Emergency Management Administration critiquing community drills, and served as president of the local chapters of the American Society for Safety Engineers, and the American Industrial Hygiene Association, the Risk and Insurance Management Society.

During his healthcare career, Williams has given national lectures, received calls from around the country relative to safety and emergency management, and has been quoted in national publications. Today, Williams still works as a safety manager, performs consulting work, and collaborates with Homeland Security Region 10 and 11.

Introduction

Hospital emergency management coordinators (EMCs), you are needed now more than ever.

In the past few years alone, substantive advancements in accreditation, regulatory standards, and federal guidance have set high expectations for hospitals to advance their level of all-hazards and hazard-specific planning, response, and recovery capabilities. Deciphering these changes—let alone implementing them at your facility—may seem like a daunting task. This handbook has two goals: to clarify what is expected of hospitals in today's environment, and to establish the role of EMC as an effective way for hospitals to achieve compliance and a higher level of capabilities at the same time.

Perhaps you are already in the role of EMC. Maybe your institution doesn't use that particular title, or maybe your facility divides emergency management responsibilities among you and other individuals within your organization, and emergency management is not your only concern. Such shared responsibility for emergency management will compete for your time, but it may also be more effective in helping you reach organizational goals, as you'll see in later chapters.

Whatever the case may be, you are reading this book because you are searching for information to help you do your job well. Undoubtedly, you are interested in learning more about the field of hospital emergency management, what skills you'll need in order to prepare yourself for such a role, and what accomplishments will be expected of you once you are in it.

This handbook is intended to highlight the EMC as the person in the hospital setting who is always thinking about preparedness, both as the point person within the organization as well as the liason to external emergency response partners. The Joint Commission (formerly JCAHO) wants hospitals to be in a constant state of readiness, and the EMC role embodies this philosophy.

The role is a dynamic one. You are never really finished with your work. There continue to be new threats, new guidance, new equipment, and new training, and there is always

another level of preparedness your organization can achieve. The upside of the role is that you'll never be bored and you just might become the hero within your organization. Staff members appreciate when leaders demonstrate their commitment to safety by making sure they get the training and support they need. This includes conducting enough exercises for employees to gain competency in various emergency response skills, and ensuring that responders' health and safety needs are paramount during a major response.

To all current EMCs, and to those interested in becoming one, this book is for you.

Chapter Overview

Chapter 1 gives an overview of the current emergency management expectations for hospitals. It explains the latest National Preparedness Guidelines from the U.S. Department of Homeland Security, in addition to the latest Joint Commission accreditation standards. This chapter also includes an explanation of common terminology used in emergency management.

Chapter 2 details the role and responsibilities of a hospital EMC, and includes a sample job interview form to help readers explore their own level of preparedness for such a position. Chapter 2 also details ways to quickly get up to speed on emergency management issues, including recommended resources, Web sites, and online courses that offer certification programs.

Chapter 3 defines essential core planning documents such as the hospital's hazard vulnerability analysis, emergency management plan, emergency operations plan, and hazard-specific standard operating guidelines that you'll need to review and update in order to meet the new standards. It will also help you review how your hospital implements the National Incident Management System objectives and uses the Hospital Incident Command System response model.

Chapter 4 focuses on communications as a critical area within the hospital. A checklist of available technologies will help you summarize your facility's current equipment capabilities to support both internal and external communication needs. Chapter 4 also describes alert notification methods and event notification systems.

Chapter 5 explores how to gauge your hospital's current par levels of resources and assets, discusses agreements for resupply, and suggests alternative strategies you can use when your access to resupply becomes restricted.

Chapter 6 emphasizes how hospitals' safety and security are everyone's responsibility, and that situational awareness training will help staff members detect unauthorized access and suspicious objects, as well as understand threats to which the organization might be vulnerable. It discusses measures for controlling access onto the hospital campus and within the building, managing hazardous materials incidents, and surging security support.

Chapter 7 discusses staff responsibilities, specifically the role of the EMC in preparing departments and the organization overall in terms of personal and family preparedness, specific competencies, readiness to manage a partial or total patient evacuation (including relocation to other sites), and how to support staff members with credentialed and prepared volunteers.

Chapter 8 is dedicated to utilities management, including the EMC's need to prepare the organization for a loss of power, HVAC, or water, and for critical shortages (e.g., fuel).

Chapter 9 summarizes the major issues associated with patient clinical and support activities in terms of rapidly and appropriately caring for the ill and injured in a disaster and maintaining continuity of care for inpatients.

Chapter 10 offers guidance on approaching your administration to ensure support for your emergency management program, and discusses grant opportunities to support training and necessary equipment. A self-evaluation checklist will help you gauge your own level of performance.

EMERGENCY MANAGEMENT: GUIDING AUTHORITIES

CHAPTER 1

Communities recognize hospitals as critical infrastructure because they serve the vital function of caring for the ill and injured on an everyday basis as well as during disasters. A number of agencies provide proactive recommendations and standards for hospitals to advance emergency response and preparedness capabilities, as well as manage any kind of incident ranging from small to catastrophic, also known as a *scalable approach*. These agencies include, but are not limited to:

- U.S. Department of Homeland Security (DHS), *www.dhs.gov*
- Federal Emergency Management Agency, *www.fema.gov*
- U.S. Department of Health & Human Services, *www.hhs.gov*
- Centers for Disease Control and Prevention, *www.cdc.gov*
- Occupational Safety & Health Administration, *www.osha.gov*
- National Fire Protection Association, *www.nfpa.org*
- National Institute for Occupational Safety and Health, *www.cdc.gov/niosh*
- The Joint Commission, *www.jointcommission.org*

The Joint Commission

Hospitals are most familiar with the accreditation requirements that The Joint Commission posts annually. Effective January 1, 2009, emergency management will have its own chapter within the *Comprehensive Accreditation Manual for Hospitals* that will include requirements that involve the entire organization.[1]

The Joint Commission continues to list four phases of emergency management planning:

- **Mitigation:** actions taken to reduce vulnerability of the organization to an incident by lessening the severity and impact
- **Preparedness:** actions taken to advance both capacity (space and resources) and capability (trained and exercised staff members who can carry out the plans for their organization)
- **Response:** actions taken during an emergency to manage treatment of casualties, maintain responder health and safety, and protect the organization
- **Recovery:** actions taken to restore the organization to normal operations and services

Both mitigation and preparedness actions take place prior to a disaster; response occurs during the incident; and recovery happens after the event. It is no longer enough to simply prepare for emergencies and disaster events. The Joint Commission requires hospitals to define planning through the continuum of an event from before it occurs (pre-event phase), during the incident (event phase), and throughout the recovery period (post-event phase). Hospitals keep themselves in business by being able to continue to offer services during a disaster. Having a strong continuity of operations plan or business recovery plan will help you anticipate issues associated with complex disasters that can put extreme stress on an organization.

The Joint Commission has defined a number of critical areas for hospitals to manage during an emergency response, regardless of the type of event:[2]

- Communication
- Resources and assets
- Safety and security
- Staff roles and responsibilities (including disaster volunteers)
- Utilities management
- Patient clinical and support activities

Subsequent chapters of this handbook will discuss each of these critical areas in detail. The Joint Commission requirements align with recently updated federal guidance, as well. Emergency management coordinators (EMCs) should review Joint Commission materials in addition to federal agency resources specific to emergency preparedness. Seek out information that applies to all types of response agencies and then specific health and medical information within those sites.

The U.S. Department of Homeland Security

One of the more recent changes is for hospitals to understand that they need to be part of a larger emergency management system. No longer can hospitals and EMCs plan only for their own organization—they need to be aware of local, county, regional, and state planning activities and agencies that can provide resources to them in a major disaster. Knowing the appropriate pathways for communication with your local, county, or regional emergency operations center is critical in order to request help or to report updates on your hospital's status. EMCs have an internal hospital-specific role, but they are also the representative of the hospital who interacts with external agencies, as well as other hospitals and emergency medical services.

In 2008, DHS published the National Response Framework (NRF) that serves as a guide for all response agencies at every level in the United States, including hospitals, to use common training, language, and responses as an all-hazards approach to disasters.[3] The goal of developing a unified national response to disasters will support a more effective response among agencies, including hospitals.

DHS has also provided direction to states through the National Preparedness Guidelines to use a capabilities-based planning process to define critical tasks and activities in order to achieve the national mission areas of "Prepare, Prevent, Protect, Respond, and Recover."[4] Those tasks and activities include:

- Preparation for unexpected events and response missions
- Prevention of injuries and property damage due to unintentional or intentional mechanisms
- Protection of citizens, visitors, and critical infrastructure

- Response in an immediate, effective, and coordinated manner, focused on the victims
- Recovery, quickly and with continuity of operations

The DHS guidelines are similar to The Joint Commission's phases of emergency management, including mitigation, preparedness, response, and recovery.

The Homeland Security Presidential Directive (HSPD)-5 enables coordination and mutual assist partnerships through the implementation of the National Incident Management System (NIMS) across federal, state, tribal, and local responder levels.[5] Responders work together using a unified approach to incident management, a standard organizational command structure, standardized interoperable and coordinated communications, joint training, and an emphasis on preparedness and mitigation by reducing vulnerabilities to threats.

The following is a list of national priorities for emergency preparedness, according to DHS:[6]

- Expanding regional collaboration
- Implementing NIMS and the NRF
- Strengthening information-sharing and collaboration capabilities
- Strengthening interoperable communications capabilities
- Strengthening chemical, biological, radiological, nuclear and explosive detection, response, and decontamination capabilities
- Strengthening medical surge and mass prophylaxis capabilities
- Implementing the National Infrastructure Protection Plan
- Strengthening planning and citizen preparedness capabilities

This strengthens a systemwide common process for incident management and continual readiness for any type, size, or cause of disaster. Readiness enables more effective communication, collaboration, and coordination among partners to be able to work efficiently together.

Partners include the following:

- Other hospitals
- First-responder agencies, such as law enforcement and fire rescue
- Emergency management, such as at your local emergency operations center
- Public health as well as local, state, and tribal governments
- Private sector and nongovernmental organizations

The National Incident Management System

NIMS is flexible and scalable for all types of hazards, including disasters that may have multiple incidents occurring at the same time. NIMS employs standardized communication terms that responders across all agencies can understand, allowing for unified area command.

Objectives

NIMS implementation objectives for healthcare organizations released in June 2008 include the following categories:[7]

1. **Adoption, including:**
    - A formal CEO-signed statement of NIMS adoption (see Figure 1.1 at the end of this chapter for a sample statement)
    - Federal preparedness awards:
        - Hospitals need to comply with NIMS objectives if they receive federal preparedness and response grants, contracts, or cooperative agreement funds

2. **Preparedness planning, including:**

   - Revising and updating plans:
     - Chapter 3 of this handbook discusses components for planning
   - Mutual aid agreements:
     - Agreements need to be updated regularly, including supply vendor agreements, hospital coalition agreements that include sharing of resources and assets during disasters, and interhospital agreements that include accommodations for space to support patient evacuation, staff relocation, and supplies

3. **Preparedness training and exercises, including:**

   - IS-700 (NIMS: An Introduction), ICS-100, and ICS-200 certification:
     - These foundation courses are mandatory for all Hospital Incident Command System (HICS)–designated and alternate positions, nursing supervisors/administrative coordinators, and staff members who support hospital emergency response
   - IS-800B NRF:
     - Healthcare staff members who have already completed IS-800A (National Response Plan) are not required to take IS-800B; however, it is recommended
     - This is another foundation course that is mandatory for all HICS–designated and alternate positions, nursing supervisors/administrative coordinators, and staff members who support hospital emergency response
   - Homeland Security Exercise and Evaluation Program (HSEEP)
     - This is a standardized method to plan and evaluate exercises, as well as to identify performance improvement measures, corrective actions, and evaluation of those actions
     - HSEEP is the standard for all communitywide and regional exercises and is a good structure to use for hospital internal training, competencies, tabletop exercises, and drills

4. **Communication and information management, including:**

   - Interoperability incorporated into acquisition programs:
     - Includes purchase of equipment; programming; and emergency notification, surveillance, and management software systems
   - Standard and consistent terminology
   - Collection and distribution of information

5. **Command and management, including:**

   - Incident command system (ICS):
     - The HICS structure is an accepted methodology for hospitals to use in emergencies and disasters and is consistent with the principles of NIMS in terms of command practices, language and communication terms, supporting documentation for job actions, an all-hazards approach, and training expectations[8]
   - Incident action planning and common communication plans:
     - There are common forms that all response agencies use, including hospitals[9]
   - Adoption of public information principles:
     - Hospital public information officers need to coordinate public information with the joint information center of their local, county, or regional emergency operations center
   - Gathering, verification, coordination, and dissemination of public information

Preparing Your Facility

Hospitals and other emergency response agencies need to prepare for an assortment of threats, including events that could be broad in scope and potentially catastrophic. Fifteen DHS national planning scenarios are listed within the National Preparedness Guidelines that include terrorist attacks, major disasters, and other emergencies.[10] Fourteen of these scenarios apply to hospitals in terms of the potential for receiving a surge of casualties, and these same scenarios are those recommended for HICS planning and preparedness activities.

The following is a list of the 14 national planning scenarios that apply to hospitals:

1. Improvised nuclear device
2. Aerosol anthrax
3. Pandemic influenza
4. Plague
5. Blister agent
6. Toxic industrial chemicals
7. Nerve agent
8. Chlorine tank explosion
9. Major earthquake
10. Major hurricane
11. Radiological dispersal device
12. Improvised explosive device
13. Food contamination
14. Cyber attack

DHS has developed a "target capabilities" list with a corresponding "universal task list" to serve as a master guide for all emergency response agencies to advance capabilities to manage all types of hazards.[11] Hospitals will need to focus on issues such as medical surge and responder health and safety; however, other capabilities will need to be explored as well, including fatality management, community surge, and others that involve working with community emergency response partners. For example, one of the target capabilities applicable to hospitals is the ability to rapidly expand capacity to manage a medical surge. There are two outcomes for this target capability:

- Rapid and appropriate care for the injured or ill
- Maintenance of the continuity of care for non-incident-related illness or injury

Internal and external factors

Hospitals should not be preparing their organizations in isolation, but rather in coordination with other hospitals; community emergency response agencies; public health; and their local, county, or regional emergency management and emergency operations centers.

In a major disaster or catastrophic event, there is potential for a wide impact area. HICS team members must know the chain of communication and pathways for emergency response. The field has developed and established proven methods for information-sharing and response, and the expectation is for hospitals to use the same processes. Hospitals can serve as host or receiving hospitals to receive patients and staff members from hospitals within an impact area that has suffered major or catastrophic damage. Your staff will need to understand the major concerns facing the survivors and be prepared for such an occurrence. Exercise your hospital through a catastrophic scenario as a hospital within an impact area and, alternatively, as a receiving hospital.

On a local level, your hospital organization is a stakeholder within your state's planning as part of a unified national response. Your hospital plans need to align with your county, regional, and state plans, just as state plans are aligning with federal planning. This remains a work in progress; however, it is underway, and your state already lists your hospital among your state's assets as critical infrastructure. Be proactive by volunteering as a hospital representative to your state's work groups associated with hospital emergency preparedness and disaster capabilities planning. It is now a requirement for receiving grant funding that your hospital will be in compliance with state and federal emergency management standards.

Needless to say, there is already established guidance for hospitals to advance their planning. Organizations are leaning on their EMCs now more than ever to prepare their facilities!

Endnotes

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Figure 1.1 Sample NIMS Resolution

A resolution affirming the commitment of **[insert name of your hospital]** to authorize the adoption of the National Incident Management System (NIMS) as the basis for all incident management as required by homeland security presidential directive (HSPD)-5.

WHEREAS, the President of the United States of America in his HSPD-5 directed the secretary of the Department of Homeland Security to develop and administer a National Incident Management System (NIMS), which would provide a consistent nationwide approach for federal, state, local, and tribal governments to work more efficiently, and effectively to prevent, prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity; and

WHEREAS, the NIMS establishes a single, comprehensive approach to disaster incident management to ensure that all levels of government and responding agencies across the nation have the capacity to work efficiently and effectively together using a national approach to disaster incident management;

WHEREAS, it is necessary and desirable that all federal, state, local, and tribal homeland security partner agencies and personnel coordinate their efforts to effectively and efficiently provide the highest levels of incident management;

WHEREAS, NIMS provides a core set of concepts, principles, terminology, and technology for the most efficient and effective incident management between federal, state, local, and tribal organizations and responding agencies;

WHEREAS, the NIMS standardized procedures for managing personnel, communications, facilities, and resources will improve the hospital's ability to utilize federal funding to enhance agency readiness, maintain personnel safety, and streamline incident management processes;

WHEREAS, the incident command system components of NIMS are already an integral part of various incident management activities throughout the hospital, including current emergency management training programs; and

Now, therefore, be it resolved by the senior executive administration of **[insert name of your hospital]** that:

1. **[Insert name of your hospital]** adopts the National Incident Management System (NIMS) as its system for preparing and responding to disaster or emergency incident(s).

2. Employees of **[insert name of your hospital]** with specific command and control responsibilities will complete the required NIMS training appropriate to their level of assigned responsibilities, and maintain that level of training by certification within the time frames established by the federal requirements for NIMS.

Passed, adopted, and approved, this _____ day of _____, **[insert year]**.

Senior executive for **[insert name of your hospital]**

By: _____
[Insert title: CEO, COO, other]

Source: Mary Russell, adapted for hospital use from FEMA's *Sample Executive Orders, Implementation Plan Templates*

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