# Supplemental Staffing Request Information

| Requestor Details | |
|---|---|
| Date of Request: | |
| Request Point of Contact: | |
| Requestor Email: | |
| Requestor Address: | |
| Requested Phone: | |

| Requesting Facility Details | |
|---|---|
| Facility Name: | |
| Facility Type: | |
| County: | |
| Total Facility Capacity: | |
| Number of Free, Patient-Ready Beds: | |
| Does the Facility Currently Have COVID-19 Positive Patients (yes/no): | |

| Deployment Details | |
|---|---|
| Requested **Start Date**: | |
| Requested **End Date**: | |
| **Requested kind of staff and number of each:** | |
| Staff classification (eg. RN, LVN, CNA) | Number |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Total Number of Staff Requested: | |

| Requested Coverage | | | | | | |
|---|---|---|---|---|---|---|
| **Shift Days of the Week (check all that apply)** | | | | | | |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| | | | | | | |
| **Shift Duration (in hours):** | | | | | | |
| **AM Shift Hours** | | | | | | |
| From: | | To: | | | | |
| Kind of Staff Requested for AM Shift | | | | | | Number of Staff Requested for Shift |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **PM Shift Hours** | | | | | | |
| From: | | To: | | | | |
| Kind of Staff Requested for PM Shift | | | | | | Number of Staff Requested for Shift |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **NOC Shift Hours** | | | | | | |
| From: | | To: | | | | |
| Kind of Staff Requested for PM Shift | | | | | | Number of Staff Requested for Shift |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Instructions For Arrival

(eg. instructions for accessing the facility, parking, security, point of contact):

## Additional Information

Information not captured in this form or the corresponding Resource Request