WKC ARES MEDICAL
FACILITY DAMAGE ASSESSMENT

MEDICAL FACILITY NAME:_____ **Date:** _____ **Time:** _____

Name of person in charge: _____ **Phone:** _____

To be used to report to the Net Control and NOT USED for building safety.

0	1	2	3		**STRUCTURAL**
				a	External walls
				b	Internal Walls
				c	Roof
				d	Floors
				e	Stairs/fire exits
				f	Heliports
				g	Access Roads

Comments:

Key
0 = None
1 = Minor
2 = Major
3 = Destroyed

0	1	2	3		**NON- STRUCTURAL**
				h	Food Service
				i	Generators
				j	Mechanical Equipment
				k	Elevators
				l	Other Equipment

Comments:

Y	N	L		**RESOURCES**
			m	Power from the grid
			n	Generator(s)
			o	Generator Fuel (based on 8 hour max load)
			p	Water
			q	Heating Systems
			r	Air Conditioning Systems
			s	Telephones
			t	Radios - inter facility
			u	Radios - EMS
			v	Medical Supplies
			w	Other

Commenrts:

Key
Y = Yes
N = No
L = Limited

P	N		**STAFFING**
		x	Medical Staff
		y	Nursing / Paramedical
		z	Ancillary Support
			Communications Support
			Other specialty staff

Comments:

Key
P = Presently here
N = Need

When completed fax or transmit via radio to Net Control

Completed By:_____ Call Sign: _____ Date:_____ Time:_____