GLENN COUNTY MHOAC PROGRAM
MED/HEALTH RESOURCE REQUEST

DATE:

INCIDENT NAME:

PRIORITY OF REQUEST: SUSTAINMENT

TYPE OF REQUEST: SUPPLIES/EQUIPMENT (MASKS, GLOVES, GOWNS, ETC)

REQUESTOR INFORMATION

LAST NAME, FIRST NAME:

EMAIL: PHONE:

TITLE: AGENCY/FACILITY:

ENTITY TYPE:

DELIVERY INFORMATION

RECIPIENT NAME:

EMAIL: PHONE:

* DELIVERY ADDRESS:

PRODUCT INFORMATION

PRODUCT NAME:

QUANTITY REQUESTED:

ITEM DESCRIPTION: ARE SUBSTITUTES OK? YES

PRODUCT NAME:

QUANTITY REQUESTED:

ITEM DESCRIPTION: ARE SUBSTITUTES OK? YES

TYPE OF PERSONNEL REQUESTED: NONE

(Be prepared to answer several additional questions if requesting personnel resources.)

DESCRIBE CURRENT SITUATION AND NEED FOR RESOURCES (All R/R must also be accompanied by a Situation Report):

ACTIONS TAKEN TO OBTAIN RESOURCES:

CLICK TO SUBMIT TO GLENN COUNTY MHOAC