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| **I. PURPOSE** |
| The purpose of this plan is to protect the health and well-being of patients, employees and clients of Click here to enter text. during times of disaster. In addition, this plan is designed to provide for the continuity of operations during the post-disaster period. |

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| **II. SITUATION AND ASSUMPTIONS** |
| *A. Meeting Locations* |
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| --- | --- | --- | --- |
| Location and type | Contact Person | Address and coordinates | Telephone Number |
| Neighborhood meeting place(employees): | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Local Patient Evacuation Location: | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Local Patient Evacuation Location: | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Regional Patient Evacuation Location: | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Regional Patient Evacuation Location: | Click here to enter text. | Click here to enter text. | Click here to enter text. |

 |
| *B. Employee Information* |
|

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| --- | --- |
| Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No | Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No |
| Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No | Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No |
| Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No | Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No |
| Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No | Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No |
| Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No | Name: Click here to enter text.Position: Click here to enter text.Contact Info: Click here to enter text.Personal Plan: [ ]  Yes [ ]  No |

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| *C. Hospitalized Animals* |
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| --- | --- | --- | --- |
| Patient ID | Owner Name | Owner Contact Information | Group (ICU, boarding, etc) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| *D. Other Important Numbers* |
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| **Description and Name** | **Telephone Numbers** |
| Sheriff | Click here to enter text. |
| Local Animal Control | Click here to enter text. |
| Gas Provider | Click here to enter text. |
| Electrical Provider | Click here to enter text. |
| Alarm Company | Click here to enter text. |
| Emergency Management Coordinator | Click here to enter text. |
| Emergency Animal Hospital | Click here to enter text. |
| Building Contractor | Click here to enter text. |
| Telephone/Internet Provider | Click here to enter text. |
| Pharmaceutical Supplier | Click here to enter text. |
| Texas State Board of Veterinary Examiners | Click here to enter text. |

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| **III. CONCEPT OF OPERATIONS** |
| *A. Operational Timeline* |
| Click here to enter text. |
| *B. Patient/Animal Discharge Procedures* |
| Click here to enter text. |

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| *C. Employee Notification* |
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| --- | --- | --- | --- |
| Name | Position | Contact Information | Responsible for calling |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| *D. Patient Relocation* |
| Click here to enter text. |
| *E. Patient Identification* |
| Click here to enter text. |
| *F. Medical Records* |
| Click here to enter text. |
| *G. Inventory* |
| Click here to enter text. |
| *H. Cash, Financial Instruments, and Financial Transactions* |
| Click here to enter text. |

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| *I. Insurance* |
| Click here to enter text. |
| *J. Continuity of Operations (Your facility with limited infrastructure)* |
| Click here to enter text. |
| *K. Continuity of Operations (Local facility other than your practice)* |
| Click here to enter text. |
| *L. Continuity of Operations (Regional facility other than your practice)* |
| Click here to enter text. |
| *M. Security (to include fire protection and hazardous material security)* |
| Click here to enter text. |

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| **IV. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES** |
| Click here to enter text. |

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| **V. ADMINISTRATION AND LOGISTICS** |
| *A. Financial Tracking and Documentation* |
| Click here to enter text. |
| *B. Nutritional Support (patients and employees)* |
| Click here to enter text. |
| *C. Housing and Sanitation (patients and employees)* |
| Click here to enter text. |
| *D. Pharmaceuticals and Medical Supplies* |
| Click here to enter text. |

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| **VII. PLAN MAINTENANCE** |
| Click here to enter text. |