NORTH DAKOTA FACILITY SPECIAL NEEDS REGISTRY

NORTH DAKOTA DEPARTMENT OF EMERGENCY SERVICES
HOMELAND SECURITY
SFN 58995 (4-2013)

FACILITY INFORMATION

Facility Name		Facility Type	
Address	City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Fax Number	
E-Mail Address		Average Occupancy	
Does your facility have an emergency disaster plan? ☐ Yes ☐ No			

24-HOUR CONTACT INFORMATION

Contact Name		Position	
Address	City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Fax Number	
Contact Name		Position	
Address	City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Fax Number	
Contact Name		Position	
Address	City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Fax Number	

GENERAL INFORMATION

Enter the approximate number of residents with the following functional needs.

Life-sustaining Medication		Life-sustaining Equipment	
Vision Impairment/Blind		Mobility Impairment	
Hearing Impairment		Homecare Assistance	
Deaf		Mental/Cognitive Condition	
Speech Impairment		Service Animal	
Ventilator Required		Interpreter (Type of Language/Sign Language)	
Supplemental Oxygen Required		Assistive Technology (i.e. Power Chair, Communication Device, Hearing Aids)	

PRIMARY PHYSICIAN INFORMATION (OPTIONAL)

Name	Telephone Number

OTHER

Additional Information About Your Facility That Would Assist in the Planning Process:

Disclaimer:
In the event of an actual emergency, evacuation, or any type of disaster, response agencies will attempt to provide necessary assistance, but the N.D. Department of Emergency Services (NDDES) and other response agencies cannot guarantee you will receive help. NDDES strongly recommends and urges the facility to take all necessary precautions to protect your residents, staff, and property prior to and during an emergency, evacuation, or disaster.

Notice of Responsibility:
I understand that any assistance rendered will only be for the duration of the emergency. I understand the occurrence of an emergency or disaster does not eliminate any responsibility the facility may have for charges and costs associated with hospitalization, care at residential facilities, medical evacuation, or medical transportation. I understand that it is my responsibility to promptly notify 2-1-1 to ensure the accuracy of the facility's information.

Release of Information and Consent:
I authorize emergency response personnel to enter the facility during search and rescue operations following a disaster, if necessary to assure the safety and welfare of the facility's residents and staff.

I understand that information provided is strictly confidential and will be used only for emergency planning and response purposes. The facility agrees information may be disclosed and used to assist emergency services personnel, medical providers, transportation agencies, and others as necessary to provide care and respond to the facility's needs during an emergency, evacuation, or disaster.

I have read and understand the above statements. I certify that the information contained in the facility's registration is true and correct to the best of my knowledge.

Facility's Representative Signature	Date

If you are submitting by email, type your name in lieu of a written signature.