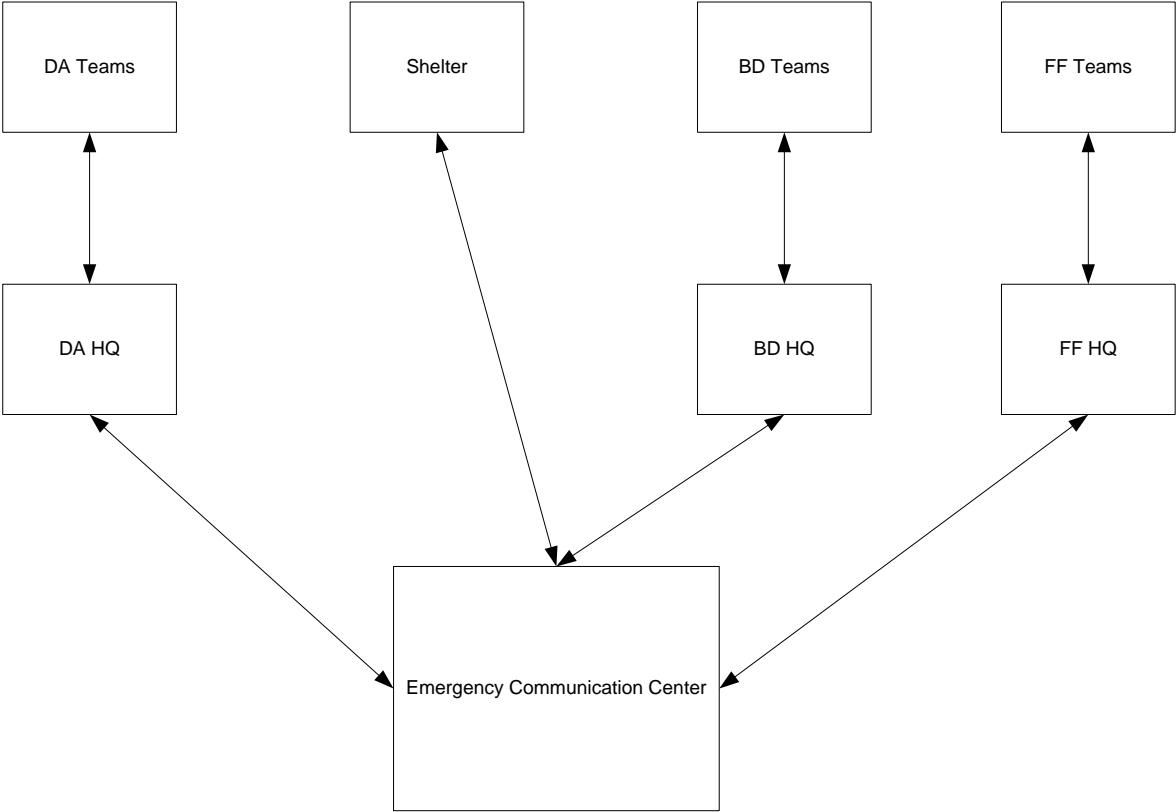


Red Cross Emergency Communications Flow:

Red Cross EC Flow



DRILL

American Red Cross

On-Site Detailed Damage Assessment Worksheet (Street Sheet)

| DR #: 123-14 | | DR Name: SPRING FLOODS - 14 | | | State: NJ | County: BARREN | City/Community: ELMWOOD PARK | | Date: | | | | |
|--------------------------|--------------|-----------------------------|-------|-------|-------------------------|----------------|-----------------------------------------------------------------------------------|--------------------------|-------------------------------------|----------------------------------|----------------------------|--------------------------------------|--------|
| Street Name: RIVER DRIVE | | | | | Geographical Reference: | | | | | | | | |
| House # | Apt. /Unit # | Damage Classification | | | | | # of Floors in dwelling or unit | Is there a Basement? Y/N | Water level in living area (inches) | Water level in basement (inches) | Is the electricity on? Y/N | Occupancy Type: Own? Rent? Seasonal? | OR 901 |
| | | Destroyed | Major | Minor | Affected | Inaccessible | | | | | | | |
| 333 | | S | M | A | S | M | A | 1 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 257 | | S | M | A | S | M | A | 2 | N | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 253 | | S | M | A | S | M | A | 1 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 249 | | S | M | A | S | M | A | 1 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 235 | | S | M | A | S | M | A | 2 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 229 | | S | M | A | S | M | A | 2 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 225 | | S | M | A | S | M | A | 2 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 191 | | S | M | A | S | M | A | 2 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| 181 | | S | M | A | S | M | A | 2 | Y | | | | |
| Description: | | | | | | | | | | | Name: | | |
| | | S | M | A | S | M | A | | | | | | |
| Description: | | | | | | | | | | | Name: | | |
| Total Single Family: | | 0 | 0 | 0 | 9 | 0 | Additional Information: SOME PUMPING - MOSTLY BASEMENT FLOODING FROM GROUND WATER | | | | | | |
| Total Mobile Home: | | 0 | 0 | 0 | 0 | 0 | | | | | | | |
| Total Apartment: | | 0 | 0 | 0 | 0 | 0 | Worker Completing Form: C STILLRS | | | | Supervisor: | | |

Street Name: RIVER DRIVE

111

American Red Cross

Area Assessment Worksheet

| | | | | | |
|-----------------|------------------------------|--------------|--------------------|--------------------------|-------|
| DR #: 123-14 | DR Name: SPRING FLOOD -14 | State: NJ | County: PASSAIC | City/Community: WAYNE | Date: |
|-----------------|------------------------------|--------------|--------------------|--------------------------|-------|

Geographic Reference: EAST OF PASSAIC RIVER / WEST OF WILLOWBROOK MALL

| | | | | | |
|---------------|---------------|------------------------------------------------------|--------------------------------|--|--|
| | | North Boundary | | | |
| | | ROUTE 46 | | | |
| West Boundary | PASSAIC RIVER | Approximate # of Dwellings/Units Impacted: <u>50</u> | General Information: | | |
| | | Destroyed: _____ % SFD: <u>100</u> % | <u>ACCESS ONLY FROM</u> | | |
| | | Major: _____ % MH: _____ % | <u>RT 46 E. ONTO</u> | | |
| | | Minor: <u>100</u> % Apt.: _____ % | <u>RIVERSIDE DRIVE</u> | | |
| | | Affected: _____ % | <u>DEAD END STREET</u> | | |
| | | Inaccessible: _____ % | Basements Prevalent? <u>NO</u> | | |
| | | PASSAIC RIVER | | | |
| | | South Boundary | | | |

WILLOWBROOK MALL

East Boundary

- Instructions:**
- Complete the top line with the appropriate information for the area you are reporting on.
 - **Geographic Reference:** Use this section to document the name of an area or a mobile home park or apartment complex name.
 - **Boundaries:** Provide the street names for each of the geographic boundaries that make up the area assessment. If there are more than four or less than four boundaries because of angled or curved streets, document that as well. Be creative and informative in your documentation.
 - **Approximate number of dwellings/units Impacted:** Document to the best of your ability the approximate number of dwellings or units within the area you are reporting on.
 - **Description of damage:** Provide a breakout of the degree of damage by percentage for the approximate number of dwellings/units impacted and provide a breakdown by dwelling type as well, if possible.
 - **Basements Prevalent?:** Document if basements are prevalent in this area with a Yes or No.

DRILL

American Red Cross

GROUP _____

STAFF REQUEST # 7

Affected chapters and DRO work units must complete and submit a Staff Request when additional staff/workers are needed and cannot be obtained from within the affected chapter area. Prior to the DRO infrastructure's establishment send all Staff Requests to disasterstaffingcenter@usa.redcross.org. After the DRO infrastructure is established all Staff Requests should be submitted electronically to the Staff Services Local Community Volunteers' Manager email address at the DRO headquarters.

| | | |
|--------------------|------------------|------------------------------|
| DR # <u>123-14</u> | DATE OF REQUEST: | DATE OF COMPLETION (FOR SS): |
|--------------------|------------------|------------------------------|

Requests for Individual Positions:

| ACT: | TASK(S) TO BE COMPLETED: | # Requested | Work Location | Supervising Staff? Y or N | DATES NEEDED From/To |
|--------------|--------------------------|-------------|------------------|---------------------------------------------------------------------|-------------------------|
| 1. <u>BD</u> | <u>WORKERS</u> | <u>6</u> | <u>FAIRFIELD</u> | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | / |
| 2. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |
| 3. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |
| 4. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |
| 5. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |
| 6. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |
| 7. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | / |

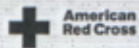
Requests for Teams:

| ACT: | Number of Teams Requested | Reporting Location | Work Location | Date Needed: |
|------|---------------------------|--------------------|---------------|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | | |
|---------------------------------------------------------|---------------------|-----------------------------------|
| <u>RON DENNIS</u> | | <u>RON. DENNIS @ REDCROSS.ORG</u> |
| Printed Name and Signature of Person Submitting Request | Date Requested | DRO E-Mail Address |
| <u>MC/BD/MG</u> | <u>973-555-3801</u> | <u>209 FAIRFIELD RD</u> |
| G/A/P of Requestor | Phone Number | Work Location |

FAIRFIELD, NJ 07004

| |
|--------------------------------------|
| Staff Services Only Comments: |
| |
| |
| |



Daily Shelter Report

DR # 123-14

Report Date _____

Report # 4**Staffing**

Shelter Facility Name LBJ HIGH SCHOOL City PATERSON State NT
 Shelter Manager Name HARRY SMITH Cell Phone # 201-555-3876
 Facility Coordinator Name JOSÉ RIVERA Cell Phone # 201-555-9867

| | Supervisor | Disaster Health Services | Disaster Mental Health | Facility Inspection Time |
|-----------|------------------|--------------------------|------------------------|--------------------------|
| 1st Shift | <u>H SMITH</u> | <u>NONE</u> | <u>NONE</u> | <u>8:20A</u> |
| 2nd Shift | <u>S COLEMAN</u> | <u>NONE</u> | <u>NONE</u> | <u>9:10P</u> |
| 3rd Shift | | | | |

Total # of Staff (including manager & supervisors): Shift 1 8 Shift 2 5 Shift 3

Shelter Population

National Shelter System (NSS) Contact Name _____ Phone # _____

| | Time Reported | Name of Reporter | Shelter Count |
|-----------------|---------------|------------------|---------------|
| Noon Report | <u>12:13P</u> | <u>H SMITH</u> | <u>42</u> |
| Midnight Report | <u>11:35P</u> | <u>S COLEMAN</u> | <u>73</u> |

5266 Daily Reporting

New Shelter Registrations Today 0

| | Breakfast | Lunch | Dinner | Total # Meals | Snacks | Water | Other Drinks | Total # Snacks & Drinks |
|--------------|-----------|-----------|-----------|---------------|------------|------------|--------------|-------------------------|
| Meals Served | <u>87</u> | <u>53</u> | <u>96</u> | <u>236</u> | <u>243</u> | <u>189</u> | <u>86</u> | <u>518</u> |

Comfort Kits Distributed 0 # Clean-Up Kits Distributed 0 # Other Bulk Items Distributed 0

Report 5266 #'s Daily To: Name SANDY Phone # 203-555-9254 By this time 3P

Supplies Inventory

| | Cots | Blankets | Comfort Kits | Clean-Up Kits | Other Items | Other Items Comment |
|---------------|-----------|-----------|--------------|---------------|-------------|---------------------|
| # of Supplies | <u>27</u> | <u>54</u> | <u>25</u> | <u>0</u> | <u>0</u> | <u> </u> |

Unusual Situations & Other Important Information (also record on the Shelter Log)

Prepared By (print name) HARRY SMITH Prepared By (signature) H Smith



Disaster Health Services Aggregate Morbidity Report Form

Part I: Site and Clients Demographic Information

| | | | |
|------------------------------------------------------------------------------------------------------------------------|------------------|------------|-----------|
| 1. Disaster Operation Relief Name & #: <u>SPRING FLOODS-14 123-14</u> | | Tally (IU) | Total (#) |
| 2. Reporting Date: | | Male | 2 |
| 3. Reporting Timeframe: <u>24 hours</u> | | Female | 4 |
| 4. Name of Site: <u>MORRIS ARMY</u> | | | |
| County: <u>Morris</u> | State: <u>NJ</u> | ≤ 2 | 1 |
| 5. Service Delivery Site: <input checked="" type="checkbox"/> Shelter <input type="checkbox"/> Outreach | | 3 to 18 | |
| <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Emergency Aid Station <input type="checkbox"/> Other | | 19 to 64 | 2 |
| 6. Total # of Clients Seen: | | ≥ 65 | 3 |

Part II: Reason for Visit (For each client visit, place a tick mark for all reason(s). Add up tallies & place # in the Total # column.)

| Categories | Tally (IU) | Total (#) | Categories | Tally (IU) | Total (#) |
|----------------------------------------|------------|-----------|---------------------------------------------------------------------|------------|-----------|
| Injury | | | Influenza-like-illness (ILI) | | 0 |
| Abrasion/laceration/cut | | | Skin (includes all skin conditions) | | 0 |
| Avulsion/amputation | | | OBGYN (includes all OBGYN) | | 0 |
| Bruise/contusion | | | Neurological | | 0 |
| Concussion | | | Behavior: agitated/disruptive | | 0 |
| Fracture | | | Anxiety/stress | | 0 |
| Sprain/strain | | | Depressed mood | | 0 |
| Mechanism of Injury | | | Psychotic symptoms | | 0 |
| Bite insect | | 0 | Suicidal/homicidal thoughts | | 0 |
| Bite snake | | 0 | Drug/alcohol intoxication | | 0 |
| Bite dog | | 0 | Other | | 0 |
| Bite human | | 0 | Follow-up Care | | |
| Burn (thermal or chemical) | | 0 | Blood pressure check | | 0 |
| Non-fatal drowning/submersion | | 0 | Blood sugar check | | 0 |
| Foreign body | | 0 | Dressing change/wound care | | 0 |
| Fall/slip/trip | 1 | 1 | Immunization/vaccination | | 0 |
| Hit by or against object | | 0 | Medication refill (please mark one tick for each medication refill) | | 0 |
| Carbon monoxide exposure | | 0 | Pregnancy check-up | | 0 |
| Ingestion of poison | | 0 | Other | | 0 |
| Motor vehicle crash | | 0 | Exacerbation of Chronic Illness | | |
| Use of machinery/tools/equipment | | 0 | Asthma | | 0 |
| Recreational/playing sports | | 0 | Cerebrovascular disease/stroke | | 0 |
| Assault | | 0 | Chronic joint pain | | 0 |
| Sexual assault/rape | | 0 | Congestive heart failure | | 0 |
| Other | | 0 | Coronary heart disease | | 0 |
| Acute Illness/Symptoms | | | Diabetes | | 0 |
| Fever (>100.4°F or 38°C) | | 0 | Epilepsy | | 0 |
| Conjunctivitis/pink eye/eye irritation | | 0 | Hypertension | | 0 |
| Extreme fatigue/overexertion | | 0 | Obstructive pulmonary disease | | 0 |
| Dehydration | | 0 | Previous mental health diagnosis | | 0 |
| Heat stress/heat exhaustion | | 0 | Other | | 0 |
| Cold-related conditions | | 0 | Disposition | | |
| Pain - not specified | 1 | 1 | Treated by Red Cross | | 0 |
| Pain - abdominal, stomach ache | | 0 | Not treated | | 0 |
| Pain - chest, angina, cardiac arrest | | 0 | Refused treatment | | 0 |
| Pain - ear pain or earache | | 0 | Referred to: | | |
| Pain - headache or migraine | 111 | 3 | Hospital/clinic | | 0 |
| Pain - muscle or joint | | 0 | Pharmacy | | 0 |
| Gastrointestinal - diarrhea | 1 | 1 | Physician | | 0 |
| Gastrointestinal - nausea/vomiting | | 0 | Other | | 0 |
| Respiratory (include all resp.) | | 0 | | | |

Complete one form per service location per 24 hrs. Email, fax or call completed form to DRO headquarters by 9 am.

Reported by: RITA RYAN
Disaster Health Services Aggregate Morbidity Report Form

Signature: [Signature]

DRILL

MASS CARE FEEDING UNIT DAILY ACTIVITY REPORT

Report all feeding activity using this form.

SHUTTER

Use this form to report the meals, snacks, and drinks served on an ERV, Fixed Kitchen Site, or in a Shelter.

Completed by: TREINKB Date: Location: MORRIS ARMORY DR #: 123-14

Count meals as served, if dropped to other agencies. Do NOT count meals dropped at ARC shelters; these are reported separately. Return this completed sheet to your supervisor daily, or as directed.

| FIRST MEAL | |
|----------------------------------------------|------------------------------------|
| County: | MORRIS |
| Manager/Driver: | TREINKB |
| Other staff | D ANDERSON D DEMPSEY H SMITH |
| A) # meals prepared by kitchen: | |
| ✓ | |
| Clamshell count before serving | 600 |
| Clamshell count after serving | 401 |
| B) Subtract to get meals served | 199 |
| Snack item count before serving | 480 |
| Snack item count after serving | 276 |
| C) Subtract to get snacks served | 204 |
| Cup count before serving | 1250 |
| Cup count after the serving | 1212 |
| D) Subtract to get drinks served | 38 |
| Canned/bottled drink count before serving | 288 |
| Canned/bottled drink count after serving | 67 |
| E) Subtract to get can/bottled drinks served | 221 |

| SECOND MEAL | |
|----------------------------------------------|-----------------------|
| County: | |
| Manager/Driver: | TREINKB |
| Other staff | C ANDERSON H SMITH |
| A) # meals prepared by kitchen: | |
| ✓ | |
| Clamshell count before serving | 401 |
| Clamshell count after serving | 118 |
| B) Subtract to get meals served | 283 |
| Snack item count before run | 525 |
| Snack item count after serving | 158 |
| C) Subtract to get snacks served | 367 |
| Cup count before serving | 1212 |
| Cup count after the serving | 1158 |
| D) Subtract to get drinks served | 54 |
| Canned/bottled drink count before serving | 432 |
| Canned/bottled drink count after serving | 135 |
| E) Subtract to get can/bottled drinks served | 297 |

| THIRD MEAL | |
|----------------------------------------------|--|
| County: | |
| Manager/Driver: | |
| Other staff | |
| A) # meals prepared by kitchen: | |
| | |
| Clamshell count before serving | |
| Clamshell count after serving | |
| B) Subtract to get meals served | |
| Snack item count before serving | |
| Snack item count after serving | |
| C) Subtract to get snacks served | |
| Cup count before serving | |
| Cup count after the serving | |
| D) Subtract to get drinks served | |
| Canned/bottled drink count before serving | |
| Canned/bottled drink count after serving | |
| E) Subtract to get can/bottled drinks served | |

Determine the number of meals that need to be prepared for the next day for each meal serving. In the boxes below, include comments explaining the reasoning for any changes made to the adjusted number of meals for next day. (i.e. power is back - expect an increase in meals for Saturday)

F) Adjust number of meals for next day 250

F) Adjust number of meals for next day 300

F) Adjust number of meals for next day ✓

| Radio or phone this information into your supervisor as soon as you are finished with the meal: | Consolidated Counts: | | | |
|-------------------------------------------------------------------------------------------------|----------------------|-----|-----|--------|
| | 1st | 2nd | 3rd | Totals |
| Snacks | 204 | 367 | - | 571 |
| Meals | 199 | 283 | - | 482 |

ICS-213 for General Messaging

The image shows a screenshot of the FLMSG 1.1.29 application window. The window title is "FLMSG: 1.1.29". The menu bar includes "File", "Form", "Template", "Config", "AutoSend", and "Help". The main area displays "ICS-213 report" and "file: new.213". Below this, there are tabs for "Originator" and "Responder". The form contains several input fields: "To" and "Pos." (position), "Fm" (from) and "Pos.", "Sub." (subject), "Date" (with a calendar icon), "Time" (with a clock icon), "Sig." (signature) and "Pos.", and a "Comp" (compression) checkbox. The "Comp" checkbox is checked, and the "base64" dropdown is selected. The "DOMX22" dropdown is also selected, and there is an asterisk "*" next to it. The "Message:" field is a large text area with a scrollbar on the right.

FLMSG: 1.1.29

File Form Template Config AutoSend Help

ICS-213 report file: new.213

Originator Responder

To Pos.

Fm Pos.

Sub.

Date Time

Message:

Sig. Pos.

Comp base64 DOMX22 *