Health Care Facility Exercise Registration Form

Facility Name: _____

Address: _____

Phone:_____

Type of Facility:

□hospital	□dialysis center	□nursing home/long-term care
□rehab center	□home health care	□surgical/ambulatory care
□hospice	□other:_____	

Emergency Management
Director/Coordinator:_____

Email:_____

Phone:_____

Facility 24/7 Hour number:_____

Does your facility have an Emergency Operations Plan? □Yes □No

Does your facility have an EM Resource account from the North Central Texas Trauma Regional Advisory Committee (NCTTRAC)? □Yes □No

Please complete and send back to lourdes.rodriguezlugo@fortworthtexas.gov