Facility Information Sheet (New or Updates)

Action Requested:	☐ Add New Facility ☐ Update Existing Information ☐ Close Facility
Facility Name:	
Tier:	
Facility Type:	
Region:	
Parish:	
Operating Status *(If closed provide date)*:	
Business Status *(If closed provide date)*:	
AHA ID:	
License Number:	
State ID:	
Medicare/CCN:	
Ownership:	
Sector ID:	
Hosting Capacity:	
Staff Count:	
License Beds:	
NHSN Org ID:	
Offsite Facility:	
Ventilators:	
Facility Group:	
Admin First Name:	
Admin Middle Name:	
Admin Last Name:	
Phone:	
Email Address:	
Fax:	
Satellite Phone:	
Street:	
Optional Line:	
City:	
State:	

Please return to ESF8Help@la.gov or upload to the Documents Portal for processing.

Zip:	
Longitude:	
Latitude:	
Helipad Longitude:	
Helipad Latitude:	
Helipad Max Weight:	
Helipad Description:	
Has Child Facility:	
Child Facility Name, if yes:	
Facility Point of Contact:	Name: Email: Office: ( ) Cell: ( )
Emergency Preparedness Contact:	☐ Same as above *(If not provide name, email and cell)* Name: Email: Office: ( ) Cell: ( )