

 MINISTRY OF HEALTH	 BAHAMAS Hurricane Dorian Response, 2019	 PAHO <small>Pan American Health Organization</small> <small>World Health Organization</small>
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EMT Name	Name and Country		
EMT Type		Date and Time of Offer	dd / mm / yyyy HH:MM
EMT Global Classification Status	<input type="checkbox"/> No Account <input type="checkbox"/> Mentorship <input type="checkbox"/> Classified		

We agree to comply with EMT guiding principles and standards, available at

https://extranet.who.int/emt/featured#dfliip-df_manual2/1/

Internal Office Use Only			
Team Status:	<input type="checkbox"/> Approved	<input type="checkbox"/> Pending	Reason:
	<input type="checkbox"/> Tasked	<input type="checkbox"/> Declined	Reason:
Check:	<input type="checkbox"/> WHO Classified	<input type="checkbox"/> Airport	<input type="checkbox"/> Field Visit <input type="checkbox"/> Other:
Allocated Site:	<small>Location</small> <small>GPS Coordinates</small>		Allocation Date: dd / mm / yyyy
Other Comments:	<i>(e.g. reason for changing type vs the self-declaration from the team)</i>		

EMT INFORMATION	
ORGANIZATION	
ORGANIZATION TYPE: <input type="checkbox"/> NGO <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> MILITARY <input type="checkbox"/> OTHER:	
COUNTRY:	NUMBER OF EMTs: ## of ## (TOTAL EMT DEPLOYED)
TIME (HOURS/DAYS) OR ESTIMATED DATE OF ARRIVAL:	TIME (HOURS/DAYS) TO START OF SERVICES PROVISION:
ESTIMATED LENGTH OF STAY: ### days	
ORGANIZATION PRIMARY CONTACT (HQ)	
NAME:	POSITION:
ADDRESS:	
EMAIL:	PHONE: <small>+ country - area - phone number</small>
EMT TEAM LEADER	
NAME:	POSITION:
EMAIL:	EMAIL EMT:
LOCAL PHONE:	SATELLITE PHONE:

	EMT CAPABILITY	EMT NAME
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LOGISTIC SUPPORT
<p>Any logistical limitations or support required: <input type="checkbox"/> NO <input type="checkbox"/> YES Specify (e.g. transport should include total volume and weight).</p> <p><input type="checkbox"/> Self-sufficient</p>

<table border="1"> <tr><td>PHYSICIANS</td><td></td></tr> <tr><td>SURGEONS</td><td></td></tr> <tr><td>NURSES</td><td></td></tr> <tr><td>NURSES ASSISTANT/PARAMEDICS</td><td></td></tr> <tr><td>PSYCHOLOGISTS</td><td></td></tr> <tr><td>ALLIED HEALTH PERSONNEL</td><td></td></tr> <tr><td>MANAGEMENT</td><td></td></tr> <tr><td>LOGISTICS</td><td></td></tr> <tr><td>EPIDEMIOLOGISTS</td><td></td></tr> <tr><td>Other</td><td></td></tr> <tr><td>Other</td><td></td></tr> </table>	PHYSICIANS		SURGEONS		NURSES		NURSES ASSISTANT/PARAMEDICS		PSYCHOLOGISTS		ALLIED HEALTH PERSONNEL		MANAGEMENT		LOGISTICS		EPIDEMIOLOGISTS		Other		Other		<p>Other Capabilities (equipment):</p> <input type="checkbox"/> High Dependency Unit beds (light/field hospital style) <input type="checkbox"/> Oxygen Concentrator (2) <input type="checkbox"/> Nebulizer <input type="checkbox"/> ECG (2) <input type="checkbox"/> Laboratory (basic lab tests, electrolytes) <input type="checkbox"/> Limited Pharmacy for medium dependency care <input type="checkbox"/> Other (specify)
PHYSICIANS																							
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Other																							
Other																							

PREVIOUS DEPLOYMENT EXPERIENCE (ONLY LAST THREE)

YEAR	COUNTRY	EVENT	EMT(s) TYPE	DURATION (DAYS)

EXISTING OR PREVIOUS WORKING RELATIONSHIP IN BAHAMAS

ORGANIZATION	LOCATION	RELATIONSHIP

<p>DOCUMENTS REQUIRED</p> <input type="checkbox"/> Professional Practice License for each team member <input type="checkbox"/> List of staff including skill mix and designation <input type="checkbox"/> Copy of Passports <input type="checkbox"/> Visa documents, if applicable <input type="checkbox"/> Packing List (all equipment and drugs)	<p>NAME:</p> <p>Email:</p> <p>Signature:</p>
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END OF REGISTRATION FORM