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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02741 (06/2023) | | | | **STATE OF WISCONSIN**  Office of Preparedness and Emergency Health Care | | | | | | |
| WISCONSIN EMERGENCY ASSISTANCE VOLUNTEER REGISTRY (WEAVR)STAFFING REQUEST | | | | | | | | | | |
| Date of Request | Time of Request | | | Email Reply to (fax or phone if necessary) | | | | | | |
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| **Directions for Requesting Organization**  Prior to submitting this form, please contact your Local or Tribal Health Department to inform them of the situation and request a local WEAVR request.  Please complete the request form and send it to: [DHSWEAVRMail@wisconsin.gov](mailto:DHSWEAVRMail@wisconsin.gov). Forms will be reviewed Monday through Friday, 8:00 a.m. to 4:00 p.m. A request for volunteers will be sent to the WEAVR registrants, and after 24 hours an email will be sent to the requester with the names and contact information of those who volunteered. WEAVR can’t guarantee that it will be able to source staff for your facility The requesting organization should be prepared to answer questions from the volunteers, including rate of pay if applicable, reimbursement of expenses, location, and duration, along with others. A requirement to submit a WEAVR request is to exhaust all local resources. Examples of this include:   * Have you conducted a WEAVR request with your Local or Tribal Health Agency? * Have you implemented a surge plan or emergency response plan at your facility? * Have you contacted staffing agencies? * Has your facility been working with the Division of Quality Assurance? | | | | | | | | | | |
| **Requesting Organization** | | | | | | | | | | |
| Organization Name | | | | Name and Title of Contact Submitting Request | | | | | | |
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| Physical Address of Response Site | | | | Phone Numbers | | | | Email or Fax | | |
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| Description of Volunteer Opportunity (Be specific and include information such as the type of facility, what the situation at the facility is, and what work people will be doing.) | | | | | | | | | | |
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| **Staffing Resources Requested** | | | | | | | | | | |
| Resource Description (use occupation names [RN, CNA, LPN, etc.]) | | | | | Quantity | | Time and Date Needed by | | | Duration |
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| Additional considerations or requests (Include information such as if volunteers will be paid or reimbursed for expenses, is liability coverage provided, is lodging provided.) | | | | | | | | | | |
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| What shifts are needed? Can your facility offer shift flexibility? | | | | | | | | | | |
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| Who are the 24/7 contact people for this request from your organization? | | | | | | | | | | |
| Name | | Phone | Secondary Phone | | | Email | | | Fax | |
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