| **(NAME) HEALTH DEPARTMENT** | | | | | |
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| **POLICY TITLE:** | | | **PROGRAM AREA:** | | |
| **PURPOSE STATEMENT:** (Type the “why.”) | | | | | |
| **SCOPE (PERSONS AFFECTED / RESPONSIBLE):** (Type “who” is responsible for “what.”) | | | | | |
| **PUBLIC HEALTH ESSENTIAL SERVICE:** | | | | | |
| **DEFINITIONS:** (Type clarification/standardization of terms, as appropriate.) | | | | | |
| **POLICY:** (Type “what” shall be done.) | | | | | |
| **REFERENCES:** (Type a list of other policies, plans, manuals or guidelines that may be relevant to this policy.) | | | | | |
| **LEGAL AUTHORITY:** (Type the legal basis for the policy, e.g., statute, rule, ordinance, as appropriate.) | | | | | |
| **RELATED PROCEDURE(S):** (Type a list of procedures that may be relevant to this policy.) | | | | | |
| **Prepared by:** | | | | | |
| **Approved by**: | | | | | |
|  | |  | |  | |
| Health Director Date | |  | | Program Director Date | |
|  | |  | |  | |
| Medical Director Date | |  | | Program Manager/Supervisor Date | |
| **Original Effective Date:** | | | **Review Periodicity:** | | |
|  | | | | | |
| **Date reviewed/updated:** | **Changes made:** | | | | **Reviewed by:** |
|  |  | | | |  |
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| **PROCEDURE TITLE:** | | | **PROGRAM AREA:** | | |
| **PURPOSE STATEMENT:** (Type the “why.”) | | | | | |
| **SCOPE (PERSONS AFFECTED / RESPONSIBLE):** (Type “who” is responsible for “what.”) | | | | | |
| **LIST OF SUPPLIES/EQUIPMENT:** | | | | | |
| **STEPS INVOLVED IN ACTIVITY:** (Type outline/specific steps of “what” shall be done.) | | | | | |
| **REFERENCES:** (Type a list of plans, manuals or guidelines that may be relevant to this procedure.) | | | | | |
| **LEGAL AUTHORITY:** (Type the legal basis for the policy, e.g., statute, rule, ordinance, as appropriate.) | | | | | |
| **RELATED POLICY(IES):** (Type a list of policies that may be relevant to this procedure.) | | | | | |
| **Prepared by:** | | | | | |
| **Approved by**: | | | | | |
|  | |  | |  | |
| Health Director Date | |  | | Program Director Date | |
|  | |  | |  | |
| Medical Director Date | |  | | Program Manager/Supervisor Date | |
| **Original Effective Date:** | | | **Review Periodicity:** | | |
|  | | | | | |
| **Date reviewed/updated:** | **Changes made:** | | | | **Reviewed by:** |
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