



FAX THIS REPORT OR EMAIL TO:

Office of Health Facility Licensure & Certification
Attention: Behavioral Health Program
Fax: (304) 558-2515
Email: DHHROHFLACRightFax@wv.gov

LOG NUMBER _____
DATE _____

OFFICIAL USE ONLY

NOTE: This form is to be completed for all licensed sites affected.

FACILITY/CENTER INFORMATION

Name: _____
Type: _____
Address: _____
Street Address *Apartment / Unit #*

City *State* *ZIP Code*

SYSTEM FAILURE DETAILS

Date of interruption of services: _____ Time of interruption of services: _____
Estimated time of resumption of services: _____
Was a fire watch implemented? Yes No If yes, time started: _____ Time ended: _____
If a system failure is being reported, circle all systems that apply:
 Water Gas/Propane Electricity Phone Fire alarm/suppression
How will consumer/client medications be stored? _____

Names of consumers/clients affected: _____

EVACUATION SITE

Address: _____
Street Address *Apartment / Unit #*

City *State* *ZIP Code*

Description: _____

Number of Male consumers/clients evacuated: _____ Number of Female consumers/clients evacuated: _____

Describe the number of consumers/clients by gender housed in each room and staff to consumer/client ratios for each room:

Please contact the Behavioral Health Program when consumers/clients are returned to their residential unit.