EXIGENT CIRCUMSTANCES (EC) REPORTING FORM

**This form is to be both completed and transmitted as an e-mail attachment only by the Facility Administrator.**

**This form is due at the Division of Health Care Quality, Office of Long Term Care Residents Protection within 24 hours of the EC.**

**Please, One (1) form per day.**

**FACILITY NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF (EC): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Day shift CNA(s) \_\_\_\_\_\_ Nurse(s) \_\_\_\_\_\_\_\_\_**

**Evening shift CNA(s) \_\_\_\_\_\_ Nurse(s) \_\_\_\_\_\_\_\_\_**

**Night shift** **CNA(s) \_\_\_\_\_\_ Nurse(s) \_\_\_\_\_\_\_\_\_**

**Reason:**

**Replacement staff unavailable \_\_\_\_\_\_**

**Last minute callout \_\_\_\_\_\_**

**Increased census \_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Management Personnel assuming Direct Care Responsibilities if applicable:**

**Nursing Director \_\_\_\_\_\_**

**Assistant Nursing Director \_\_\_\_\_\_**

**Other (Title) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Administrator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PLEASE PRINT**

**Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Submission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

E-mail to Robert.Smith@delaware.gov