

**Return Form to:** dhss06sg\_shoc\_operations@delaware.gov

Date Sent:	Time:	Priority: <input type="checkbox"/> Low <input type="checkbox"/> Routine <input type="checkbox"/> High
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**REQUESTOR INFORMATION**

Person Making Request:	Title:
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Requestor's Organization:

DIRECT Phone #:	Mobile #:	Fax #:
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Email Address:

Type Organization:

<b>State Agency</b> <input type="checkbox"/> DPH <input type="checkbox"/> DEMA <input type="checkbox"/> DDDS <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>Schools</b> <input type="checkbox"/> K-12 <input type="checkbox"/> Day Care <input type="checkbox"/> Camps <input type="checkbox"/> IHE <input type="checkbox"/> _____	<b>Healthcare Provider</b> <input type="checkbox"/> Private Provider <input type="checkbox"/> Pharmacy <input type="checkbox"/> Hospital <input type="checkbox"/> _____	<b>Congregate Setting</b> <input type="checkbox"/> Long Term Care Facility Federally Funded <input type="checkbox"/> Department of Corrections <input type="checkbox"/> _____
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**FACILITY/PRACTICE INFORMATION**

Population Served:  K-12  Age >65  Other:

Who are you testing?  Staff  Public  Congregate Care Residents  Other:

Number of tests conducted **PER** week:

Other testing options tried?  YES  NO If NO, explain:

**REQUESTED RESOURCES** Description of Requested Assistance/Resources Required

<input type="checkbox"/> Rapid Antigen Test- <b>SEE BELOW</b> <input type="checkbox"/> BinaxNOW (40/box) <input type="checkbox"/> BD Veritor <input type="checkbox"/> Abbott ID	<input type="checkbox"/> PCR <input type="checkbox"/> Alinity (Curative) <input type="checkbox"/> NP/OP (Kits) <input type="checkbox"/> NP/OP (Bulk - Assemble )	Who is processing PCR tests? <input type="checkbox"/> State Lab <input type="checkbox"/> Curative <input type="checkbox"/> Other:	<b>IN OUTBREAK?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
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Quantity:	Ea/Box	Detailed Resource Requested (include resource Type/Kind):

**\*REQUIRED FOR RAPID ANTIGEN TEST KITS**

Does facility or practice hold a CLIA waiver or certificate?  YES  NO

Practitioner Name:	Practitioner NPI:
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Practitioner Phone Number:	Practitioner Email:
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Does facility or practice have an analyzer?  YES  NO If yes, model:

**DELIVERY/PICKUP/POINT OF CONTACT INFORMATION**

Delivery Address:

Delivery Site Point of Contact:	Phone #:
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**COMMENTS**

Return Form to:

<b>HCSB ACTION</b>		
Received By:	Date:	Time:
<input type="checkbox"/> Filled request in entirety <input type="checkbox"/> Partially filled <input type="checkbox"/> Request denied <input type="checkbox"/> Other:		
Justification:		
Signature:		
<b>SHOC ACTION</b>		
Received By:	Date:	Time:
<input type="checkbox"/> Attestation Form on file <input type="checkbox"/> Conservation Letter on File	Previous Requests:	
Approved Request sent to: <input type="checkbox"/> Logistics <input type="checkbox"/> Planning <input type="checkbox"/> Finance and Admin <input type="checkbox"/> Other:		
Task Completed: <i>(signature, date &amp; time)</i>		
<input type="checkbox"/> Copy of form to Operations		<input type="checkbox"/> Copy of form to Finance and Admin