



**Please Fill OUT The following Information for your Emergency PLAN:**

**Basic Information about the Agency**

Agency Name: \_\_\_\_\_ License #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (This number will be answered at all times)

Fax Number: \_\_\_\_\_

County (ies) Licensed in: \_\_\_\_\_ email: \_\_\_\_\_

**Person in Charge during Emergency (Key Staff)**

**Primary** Name/Title: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

email: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Local Police Information (Address/ph/fax/email):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Alternate** Name/Title: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

email: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Lease Landlord, or Owner Association:

\_\_\_\_\_

**3. Agency Owner(s)**

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

email: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Agency population, service provided: Skilled Services (Nursing & Therapy)

Non Skilled Services (Aide, Personal Care, etc.) Other: \_\_\_\_\_

Elderly persons Minors Any ages patients Other: \_\_\_\_\_

**4. DON:**

Name/Title: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ email: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Administrator: \_\_\_\_\_ email: \_\_\_\_\_

Nursing Supervisor: \_\_\_\_\_ email: \_\_\_\_\_

Name

Education Coordinator: \_\_\_\_\_ email: \_\_\_\_\_

Medical Records: \_\_\_\_\_ email: \_\_\_\_\_

Submitted by: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_