



Please Fill OUT The following Information for your Emergency PLAN:

Basic Information about the Agency

Agency Name: _____

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: _____

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: _____