

## SKILLED AGENCIES \* do not not print or scan the form please

\* Please save the document in your computer, using Adobe Reader type the info, and then email to us.

www.pnsystem.com 305.818.5940 email: info@pnsystem.com

☐ Emergency Plan cost  
\$ 295.00

☐ Federal addendum  
\$ 85.00 (Medicare Providers  
only Agencies)



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

\*please use proper capitalization, means Use Capital Letter at beginning of Names, Street, City, then lower case.

### Basic Information about the Agency

Agency: License #: User: Password:

Address:

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

Fax Number:

County (ies) Licensed in: (All counties in your service area) Email:

\*please use proper capitalization

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

**Administrator** Name/Title:

Home Address:

Work Phone Number: \*please use proper capitalization

Personal email: (alternate number can be a family member phone number)

Home-Cell Phone Number: alternate: Local Police Information (Address/ph/fax/email).

\*please use proper capitalization

**Alternate** Resp. Name: Title:

Home Phone Number:

Work Phone Number:

Personal email: Lease Landlord, or Association, Name / phone:

Cell Phone Number:

**Agency Owner(s)** \*please use proper capitalization

Name/Title: Title: Agency Owner 2 (if applicable) Title:

Home Address:

Home Address:

Work Phone Number:

Home Phone Number:

Personal email:

Cell Phone Number: alternate: alternate:

(alternate number can be a family member phone number)

Agency population, service provided: ☐ Skilled Services (Nursing & Therapy) ☐ Non Skilled Services (Aide, Personal Care, etc.) ☐ Elderly persons ☐ Minors  
☐ Any ages patients ☐ Other: Other:

**4. DON:** \*please use proper capitalization, means Use Capital Letter at beginning of Names, Street, City, then lower case

Name/Title:

Home Address:

Work Phone Number: Email:

Cell Phone Number:

**(Alternate DON Name)**

Nursing Supervisor: Email:

Education Coordinator: Email:

Medical Records: Email:

**(Resp. for filling)**

Submitted by (NAME):

\*do not sign

Date:

\* Please save the document in your computer, using Adobe Reader type the info, and then email to us.



**CHAP**  
Certified Consultant

