



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: _____

Pager Number: N/A _____

Cell Phone Number: _____

Alternate Name/Title: _____

Home Phone Number: _____

Work Phone Number: _____

Pager Number: N/A _____

Cell Phone Number: _____

3. Agency Owner(s)

Name/Title: _____

Address: _____

Work Phone Number: _____

Home Phone Number: _____

Pager Number: N/A _____

Cell Phone Number: _____

4. DON:

Name/Title: _____

Home Address: _____

Work Phone Number: _____

Home Phone Number: _____

Administrator: _____

Name

Nursing Supervisor: _____

Name

Education Coordinator: _____

Name

Medical Records: _____

Name

Submitted by: _____

Signature: _____

Date: _____