

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

www.pnsystem.com 305.818.5940

CEMP submission **NOT INCLUDED OR PROVIDED**



Emergency Plan only \$ 184.99  
Federal addendums \$ 75.00 (Medicare Providers only)

email: [info@pnsystem.com](mailto:info@pnsystem.com)

Add electronic submission \$ 100.00

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

*\*please use proper capitalization*

**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: \_\_\_\_\_

*\*please use proper capitalization (all counties in your service area)*

*\* do not not print or scan the form please*

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

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

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

Work Phone Number: \_\_\_\_\_ *\*please use proper capitalization*

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

Home-Cell Phone Number: \_\_\_\_\_ alternate: \_\_\_\_\_

Local Police Information (Address/ph/fax/email):  
*---> can be a family member phone number*



*\*please use proper capitalization*

Alternate Resp. Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

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

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

Cell Phone Number: \_\_\_\_\_ Lease Landlord, or Association, Name/ phone: \_\_\_\_\_

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

Agency Owner(s): \_\_\_\_\_

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

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.) Other: \_\_\_\_\_

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

**4. DON:** *\*please use proper capitalization*

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)**

Backup Agency Name Phone Number

Submitted by (NAME): \_\_\_\_\_

*\*do not sign*

(Address)

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



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