Type of Agency: ☐ Medicare Provider ☐ Private Duty ☐ Non Skilled ☐ Nurse Registry

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*"Serving Home Health Agencies Since 1992!"*

# PN SYSTEM

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COMPANY NAME: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ FAX #: _____

AHCA LICENSE # (if applicable): HHA29999 _____ COUNTY: _____

HOURS OF OPERATION: _____ AM - _____ PM ACCREDITATION Company: _____

CONTACT NAME: _____

CONTACT PHONE # (other than company phone): _____

PERSONAL/COMPANY E-MAIL: _____

REFERRED TO OUR COMPANY BY (Name): _____

Certification: ☐ Medicare ☐ Medicaid ☐ Other:

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***PLEASE FILL OUT A e-check, CREDIT CARD INFORMATION, FOR PAYMENT OF YOUR ORDERS.***

**e-Check: Bank routing #:** _____

**Checking Account #:** _____

CREDIT CARD TYPE: _____ ☐ (YOU CAN PAY USING Zelle number 786-514-9352) * preferred
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