PEOPLES HEALTH

EVACUATION COMMUNICATION INFORMATION

In an effort to maintain communications with our physicians in the event of an evacuation, Peoples Health is gathering vital physician contact information. We will ask you to update this form periodically to ensure we have the most current contact information

The information provided on this document will not be publicized or shared with plan members. It is for restricted internal use only.

PROVIDER'S OFFICE INFORMATION (PLEASE PRINT)

Practice Name:

Office Address:

Office Main Phone: **Office Fax:**

PROVIDER'S PERSONAL INFORMATION (PLEASE PRINT)

Last Name: **First Name:**

Residential Address:

City: **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Other Phone:**

Personal E-mail: **Business E-mail:**

IF YOU ARE ASSIGNED TO A HOSPITAL IN THE EVENT OF AN EVACUATION

Hospital Name: **Phone:**

CONTACT INFORMATION FOR AUTHORIZED OFFICE REPRESENTATIVE (Practice Manager, Office Manager, Etc.)

Last Name: **First Name:** **Title:**

Home Phone: **Cell Phone:** **Other Phone:**

Personal E-mail: **Business E-mail:**

PROVIDER / AUTHORIZED REPRESENTATIVE SIGNATURE(S)

Physician Signature: **Date:**

Authorized Office Representative Signature: **Date:**

Printed Name: **Title:**

Provider Relations Representative: