

Password Agreement

PLEASE NOTE

The CEO appointed by the Governing Body must complete the password agreement. The e-mail address provided to the Department must be the e-mail address of the person to receive licensure notification as appointed by the Governing Body.

Name of Facility _____

Facility ID Number _____

Address of Facility _____

Telephone Number _____ Fax Number _____

Facility Emergency Contact Info: Name: _____

Telephone: _____ Email: _____

I, _____, hereby certify that I am the Administrator/Director/Chief Executive Officer (**please circle**) as appointed by the Governing Body of _____

Facility Name

and that I am responsible for submitting a Plan of Correction in response to deficiencies cited by the Pennsylvania Department of Health on the Statement of Deficiencies.

1. I acknowledge that I will be the recipient of the facility login identification number and my individual password from the Pennsylvania Department of Health.
2. I agree to maintain the confidentiality of both the facility login identification number and my password.
3. I recognize and acknowledge that the use of my password to electronically submit a Plan of Correction in response to deficiencies cited in the Statement of Deficiencies identifies me as the signer of the Plan of Correction.
4. I further recognize and acknowledge that the use of my password, in conjunction with the submission of a Plan of Correction, authorizes the Pennsylvania Department of Health to conclusively accept that electronic Plan of Correction as my authorized submission.

I have had the opportunity to review this Agreement and hereby agree to the above statements.

Administrator/CEO/Director

Witness

Effective Date of Change

E-Mail Address

NOTE: Please return this form to:
Department of Health - Division of Acute and Ambulatory Care
625 Forster Street
Room 532, Health & Welfare Building
Harrisburg, PA 17120
Fax Number: 717-705-6663