pennsylvania
DEPARTMENT OF HEALTH

Date sent: _____

Password Agreement

PLEASE NOTE: The "Password Agreement" must be returned within 30 days from the above date. Failure to return the "Password Agreement" will result in the facility being cited.

The CEO/administrator appointed by the governing body must sign the "Password Agreement". The email address provided to the Department must be the email address of the person who has been appointed by the governing body or its representative to receive licensure notifications.

Name of Facility _____ **Facility ID number** _____

Address of Facility_____

Telephone number _____ **Fax number** _____

Designated Password Agreement Holder (Point of Contact)

Name	Telephone	Email Address

I, _____, hereby certify that: I am the Administrator/Chief Executive Officer/ Director (**please circle position**) appointed by the governing body; the email address provided above will be the point of communication with the Department; I am responsible for ensuring that the facility license/registration is renewed timely; and I am responsible for ensuring that a Plan of Correction is submitted in a timely fashion in response to deficiencies cited by the Pennsylvania Department of Health (Department) on any Statement of Deficiencies.

1. I acknowledge that the email address on this "Password Agreement" will be used as the Department's primary method of communication with the facility.
2. I acknowledge that the individual named above will receive the facility login identification number and the individual password provided by the Pennsylvania Department of Health.
3. I agree to ensure the confidentiality of both the facility login identification number and the password.
4. I recognize and acknowledge that the use of the 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.
5. I recognize and acknowledge that the use of the password to electronically submit the license/registration renewal application obligates me to ensure the complete and timely submittal of the application.
6. I further recognize and acknowledge that the use of the password, in conjunction with the submission of a Plan of Correction and license/registration renewal application, authorizes the Pennsylvania Department of Health to conclusively accept an electronic license/registration renewal application or Plan of Correction as my authorized submission.

Emergency/Secondary Contact Person

Name	Email Address

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

_____ _____
Administrator/CEO/Director Witness

_____ _____
Effective Date of Change Administrator/CEO/Director Email 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: 717-705-6663

OR **Email the form to:**
RA-DAAC@pa.gov