Central and West Central Minnesota Healthcare Preparedness Coalition
Healthcare Facility Membership Signature Form

(this form is for hospitals, long term care, assisted living, hospice, clinics, and Community Health Boards/Local Public Health use only)

Healthcare Facility/Agency Information

Legal Facility Name: _____

List of other facilities that fall under this facility – i.e. LTC/Clinics:

_____

_____

Facility Phone number: _____

Command Center Phone #: _____ Command Center Email: _____

Address: _____

Facility/Agency Administrator Contact Information

☐ The Facility Administrator contact information is accurate and there are no changes.

Name: _____ Position Title: _____

Primary Phone: _____ Email: _____

Primary Facility/Agency Emergency Preparedness Representative

☐ The Emergency Preparedness Representative contact information is accurate and there are no changes.

Name: _____ Position Title: _____

Primary Phone: _____ Email: _____

Alternate 1 Facility/Agency Emergency Preparedness Representative

☐ The Alternate 1 contact information is accurate and there are no changes.

Name: _____ Position Title: _____

Primary Phone: _____ Email: _____

Alternate 2 Facility/Agency Emergency Preparedness Representative (only complete if applicable)

☐ The Alternate 2 contact information is accurate and there are no changes.

Name: _____ Position Title: _____

Primary Phone: _____ Email: _____

DATE COMPLETED/UPDATED: _____

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By signing this document, _____, will participate in the Central or West Central Minnesota Healthcare Preparedness Coalition (based upon geographic location) in the following ways (check all that apply):

Facility Contact Information (see page 1)

☐ I have reviewed the facility contact information on page one and acknowledge that the information provided is up to date and/or have made the appropriate revisions. I agree to provide the coalition staff any updated information if changes to page one are necessary prior to the end of the year reporting.

Bylaws

☐ I have reviewed the bylaws which are posted in the coalition website (link below) and by checking this box, I agree to be member of the coalition as described in the bylaws.

Memorandum of Understanding (MOU)

☐ I have reviewed the MOU which is posted in the coalition website (link below) and by checking this box, I agree to collaborate and assist other healthcare facilities/agencies as resources allow during times of disaster, as described in the MOU.

Funding Agreement

☐ I understand my health care facility/agency may be eligible for reimbursement from the Hospital Preparedness Program (HPP) grant, for projects and programs related to coalition development as described in the budget.

☐ I will not use reimbursed Federal funds to influence Federal agencies.

☐ I have provided coalition staff with a copy of my facilities IRS W-9 form and understand this document needs to be completed prior to receiving reimbursement. The W-9 form can be found at: **
All documents can be found on the coalition website: www.cwchealthcarecoalitions.org

This document will be held by the coalition in perpetuum. The members are requested that if there are changes to the points of contact - these changes are sent to the Regional Coordinator.

Name Printed:

Title:

Signature:

_____ Date: