HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

Facility Personnel Change Form

Network:	CCN #:	Facility Name:

Printed Name of Person Completing this Form:	Role:
Email:	Date:

Instructions: Please complete all **required (*)** fields when key personnel or their contact information has changed. Use blank rows if you want to notify the Network of additional staff. **Leave blank if positions have not changed.**

Job Title*	Name*	Credentials	E-mail Address*
Facility Administrator/ Clinical Manager			
Clinical Coordinator/ Charge Nurse			
Social Worker			
Social Worker			
Crown Web/ EQRS Contact			
Crown Web/ EQRS Contact			
Regional Manager			
Medical Director			
Home Program Manager			
Dietitian			

EMERGENCY CONTACTS (2) REQUIRED

The contact person(s) for the Network in case of a disaster. Each facility needs one primary and one backup contact on file with the Network.

	Emergency Contact Name*	Office Phone & Ext*	Cell Phone (required)*	E-mail Address*
1*				
2*				

This form is for Network contact purposes only. User accounts required by other systems (QIP POC/Viewer, EQRS/CROWNWeb) need to be created separately, using the methods designated by those systems.

Submit this form to the Network by email to mreiland@hsag.com or by fax to:
Network 7 813.354.1514 | Network 13 405.942.6884
Network 15 303.860.8392 | Network 17 415.897.2422
Network 18 818.696.7041

Do NOT email PHI/PII (Name, DOB, SSN, Medicare #, etc.) to the Network. All Security violations are reported to CMS.

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