

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.**

CCN = Centers for Medicare & Medicaid Services Certified Number; EQRS = End Stage Renal Disease (ESRD) Quality Reporting System

Job Title*	Name*	Credentials	Email Address*
Facility Administrator/ Clinical Manager			
Clinical Coordinator/ Charge Nurse			
Social Worker			
Social Worker			
CROWNWeb/ EQRS Contact			
CROWNWeb/ EQRS Contact			
Regional Operations Manager			
Regional Clinical Manager			
Medical Director			
Home Program Manager			
Dietitian			

This form is for Network contact purposes only. User accounts required by other systems (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.

PHI = Personal Health Information; PII = Personally Identifiable Information; DOB = date of birth; SSN = Social Security Number; CMS = Centers for Medicare & Medicaid Services