



Capital Area Public Health Network Facility Registration*

Facility Name & Address		
Name:		
Street:		
City:	Zip:	County:

Primary Contact Name:	Title:
Phone:	After Hours Phone/Pager:

Secondary Contact Name:	Title:
Phone:	After Hours Phone/Pager:

Clinical Director Contact Name:	Title:
Phone:	After Hours Phone/Pager:

Security/ Physical Plant Contact Name:	Title:
Phone:	After Hours Phone/Pager:

Persons/Positions authorized to sign Pickup Authorization Form:		
1. Name:	Title:	Phone:
2. Name:	Title:	Phone:
3. Name:	Title:	Phone:

Number of Residents, Employees and Household Members			
Residents:	Employees:	Household Members:	Other:

List Additional Facilities:
Languages of employees and residents:

Completed by:	Title:
Signature:	Date:

***To be completed by the facility in advance and forwarded to CAPHN**