FORM C: Contact Person Information Form

Department of State Health Services
Medical Staffing for a Declared Emergency/Disaster Event Open Enrollment Application
OE No. HHS0014039

Legal Name of Respondent: ______________________________

This form provides information about the appropriate contacts in the respondent's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.

Contact: ____________ **Title:** ____________ **Phone:** ______ Ext. ______ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):** ____________
Contact: ____________ **Title:** ____________ **Phone:** ______ Ext. ______ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):** ____________
Contact: ____________ **Title:** ____________ **Phone:** ______ Ext. ______ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):** ____________
Contact: ____________ **Title:** ____________ **Phone:** ______ Ext. ______ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):** ____________
Contact: ____________ **Title:** ____________ **Phone:** ______ Ext. ______ **Fax:** ____________ **E-mail:** ____________	**Mailing Address (incl. street, city, county, state, & zip):** ____________