

First In Home Care Since 1885



SITE INFORMATION FORM

3653 Central Avenue, Ft. Myers, FL 33901
239-337-4848 fax: 239-337-2132

Site: _____

Site address: _____

City: _____ Zip _____

Contact Person: _____ Phone Number: _____

Address: _____ City: _____ Zip: _____

Would you like to be contacted via e-mail: Yes No E-Mail Address: _____

Is clinic site open to the public? _____ Yes _____ No
 Is clinic site private for residents/members? _____ Yes _____ No
 Is clinic site for staff only? _____ Yes _____ No
 Is clinic site direct-billed to the company? _____ Yes* _____ No

*if yes, please provide the billing information below:

Company billing information (if applicable) Company Name _____
 Address _____
 City _____ State _____ Zip _____
 Contact Name: _____ Phone _____

Number choices 1, 2, and 3 in order of preference. (If there is any day of the week or time that would absolutely not work, let us know that as well. We will make every effort to give you your preferred days and times)

Preferred

day: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Preferred

Time: Morning _____ Afternoon _____ **Preferred Month:** Sep _____ Oct _____ Nov _____ Dec _____

If you, as the contact person, are a seasonal resident, you must provide a local contact that is available to receive phone calls and mail during your absence.

My absence will be during: _____

In my absence, please contact: Name _____

Address _____

City _____ Zip _____ Phone _____