

TRI CITY HOSPICE INC.  
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**EMERGENCY PLAN ACKNOWLEDGEMENT**

**Patient Name:** \_\_\_\_\_ **MRN:** \_\_\_\_\_ **Date** \_\_\_\_\_

I hereby acknowledge that I have received information regarding TRI CITY HOSPICE INC's. management plan during the initial visit. I have been notified to provide TRI CITY HOSPICE INC. with my emergency plan for the home and special needs.

(Return to Office)

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**HOSPICE REPRESENTATIVE:** \_\_\_\_\_