**NAME OF PERSON COMPLETING FORM**:

**PHONE NUMBER**:

**[ ]  PROVIDER HAS NO LOCATIONS TO REPORT.**

**\*\*Provider-Based Off-Site Locations share the same CMS provider number as the hospital\*\***

**\*\*Please return form even if there are no locations to report\*\***

|  |
| --- |
| Provider-based off-site location |
| Main Hospital Name:       | CMS Provider #:       |
| Name of Off-Site Location:       |
| Off-Site Street Address:       |
| City:       | State:       | ZIP Code:       |
| County:       |
| Services Provided:       |
| Sprinklered Status |
| [ ]  Totally Sprinklered[ ]  Partially Sprinklered[ ]  Not Sprinklered |

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| Provider-based off-site location |
| Main Hospital Name:       | CMS Provider #:       |
| Name of Off-Site Location:       |
| Off-Site Street Address:       |
| City:       | State:       | ZIP Code:       |
| County:       |
| Services Provided:       |
| Sprinklered Status |
| [ ]  Totally Sprinklered[ ]  Partially Sprinklered[ ]  Not Sprinklered |

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| --- |
| Provider-based off-site location |
| Main Hospital Name:       | CMS Provider #:       |
| Name of Off-Site Location:       |
| Off-Site Street Address:       |
| City:       | State:       | ZIP Code:       |
| County:       |
| Services Provided:       |
| Sprinklered Status |
| [ ]  Totally Sprinklered[ ]  Partially Sprinklered[ ]  Not Sprinklered |