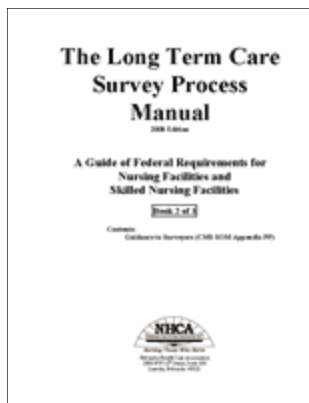


Order Form
Nebraska Health Care Association
 Mail: 3900 NW 12th St Ste 100, Lincoln NE 68521-3037
 Fax: (402) 475-6289 Phone: (402) 435-3551

Long Term Care Survey Process Manual
September 30, 2009 Update!

**Revisions to Appendix PP –
 “Interpretive Guidelines for
 Long-Term Care Facilities,”
 Tag F441”**

**SUMMARY OF
 CHANGES:** This instruction
 combines F Tags 441, 442,
 443, 444 and 445, and
 incorporates the guidance into
 F441. This was done to bring
 everything that relates to
 infection control into one
 location to best utilize the
 surveyors time and resources.



| <u>Long Term Care Survey Process Manual</u> | | |
|--|---------------|-------------------|
| Qty | <u>Member</u> | <u>Non-Member</u> |
| ___ Sept 30, 2009 Update | \$10.00 | \$15.00 |
| Sales Total = \$ _____ | | |
| S&H (15% of Total) (Minimum \$5.00) + | | |
| (Maximum \$40) = \$ _____ | | |
| Taxable Amount = \$ _____ | | |
| Sales Tax (your city plus 5.5%) = \$ _____ | | |
| TOTAL DUE = \$ _____ | | |
| Please Note: <i>Personal Associate, Student, Business Members, and Non-Members are REQUIRED TO PRE-PAY on all orders.</i> | | |
| My billing address is: | | |
| Facility/Company: _____ | | |
| Address: _____ | | |
| City, St, Zip: _____ | | |
| Phone: _____ | | |
| Company Contact: _____ | | |

Billing Information: Check Enclosed Cash
 Credit Card Bill

| |
|---|
| Cardholder's Name (PRINT): _____ |
| Credit Card #: _____ |
| Expiration Date: _____ |
| Cardholder's Billing Address, City, State, Zip: _____ |
| Signature: _____ |
| Your signature on the line above will authorize this transaction. ↑ |

