HiFlex Physio

Contingency Plan

Name:

Title:

Main Business Address:

Postal Address:

ABN:

ACN:

Date:

Review Date:

1. Emergency Contact Persons

2. Business Policy

3. Business Description

4. Office Locations

5. Alternative Physical Location(s) of Employees

6. Customers’ Access

7. Date Back-Up and Recovery (Hard Copy and Electronic)

8. Financial and Operational Assessments

9. Critical Operational Systems

10. Alternate Communications between the Business and Customers, Employees, and Regulators

11. Critical Personnel and Stakeholders

12. Regulatory Reporting

13. Updates and Annual Review

14. Senior Manager Approval

Signed: _____

Title: _____

Date: _____