(OAR 333-580-0080)

FOR HEALTH DIVISION USE ONLY	
APPN. NO.	
DATE RECEIVED	
DATE COMPLETE	
FEE	

STATE OF OREGON
CERTIFICATE OF NEED APPLICATION FORM

Facility Name: _____

Street Address: _____ City/Zip: _____

Applicant/ Licensee: _____

Licensee Address (if different): _____

Facility Administrator: _____ Phone: _____

Medicare Provider No.: _____ Medicaid Provider No.: _____

PERSON AUTHORIZED TO ANSWER QUESTIONS, ACT AND RECEIVE SERVICE ON BEHALF OF THE APPLICANT (if other than the facility administrator)

Name: _____ Phone: _____

Title: _____

Firm: _____

Address: _____ City/Zip: _____

Have you previously submitted an application for this or a similar project? YES ☐ NO ☐

If yes, date submitted: _____ Application ID No. _____

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content of information contained in this application. I therefore declare under penalty of perjury, that the project described and each statement, amount and supporting documents included are true and correct to the best of my knowledge and belief.

Name: _____ Title: _____

Signature: _____ Date: _____