Oklahoma State Department of Health
Health Facility Systems
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Oklahoma City, Ok 73102-6406
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CERTIFICATE OF NEED APPLICATION
FOR LONG TERM CARE FACILITY ACQUISITION

MANAGEMENT'S WRITTEN STATEMENTS
[OAC 310:620-3-2] [OAC 310:620-3-3(2)]

Facility Name: _____

Applicant's Name: _____

License #: _____

I intend to contract or accept employment with the Facility (or continue to contract or accept employment with the Facility, as applicable) after the change of ownership is completed. The undersigned anticipates spending as much time as is necessary working at the Facility to meet the varying needs of the Facility and its residents (anticipated to be on average a minimum of ____ to ____ hours per Month).

_____
Signature

_____
Official Title or Position

Signed _____ day of _____20___.