DEPARTMENT OF HEALTH
AND HOSPITALS

Health Standards Section

Attestation for Compliance with Plan Review Directives

Plan Review Tracking Number:	
Project Being Attest To:	
Project Location Being Attested To:	
Purpose of the Plan Review Being Attested To:	
Hospital's License Number or DBA Name:	
Administrator:	**Designated Contact Person:**
Administrator Phone:	**Designated Contact Person Phone#:**

This attestation form must be signed by the Administrator/Designee of the Facility. You must return this form as part of your DHH Licensing Application.

Attention: Read the Following Carefully Before Signing.

Statements of Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001).

I certify that I have reviewed the directives issued by the Plan Review Department relative to Plan Review Number P_____. Based upon my personal knowledge and belief, I attest that this facility has made all corrections (see next page) and met all directives on the letter issued for the date of _____. I attest that this facility meets and will continue to meet the applicable requirements set forth in the State of Louisiana Rules, Regulations and Minimum Standards, Standards of payment, all applicable Conditions of Participation/Conditions of Coverage found in the Code of Federal Regulations, and the current applicable Guidelines for Design and Construction of Health Care Facilities. I agree that if the facility fails to meet any of these requirements, I will notify the Health Standards Section of DHH of the changes immediately in order to permit a valid determination of the facility's compliance to the regulations. I understand that the Health Standards Section of DHH, Centers for Medicare and Medicaid Services (CMS), or its representatives, has the right to conduct an on-site survey at any time to validate whether the information provided is true.

Administrator/Designee Signature: _____ Date: _____
Architect Signature (mandatory): _____ Date: _____

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Plan Review Comments Listed on the "DHH FACILITY LICENSING RECOMMENDATION"
(Please also include comments from any amendment pages)

Item # on Plan Review Letter	FGI #	Explanation of how the hospital corrected/complied with this requirement
Example: #3	**2.2-3.4.1.3 documentation from certified physicist detailing radiation protection within new CT scan room and X-ray room.**	**The physicist report is attached showing compliance with this requirement.**

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