

**OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT SERVICE
P.O. Box 268823
Oklahoma City, OK 73126-8823
Tel. (405) 271-6868 Fax. (405) 271-7360**

**CERTIFICATE OF NEED APPLICATION FOR EXEMPTION
FOR A LICENSED NURSING OR SPECIALIZED FACILITY
FACILITY REPLACEMENT OR RELOCATION**

I. Name and address of facility affected: _____

(Area Code) Telephone Number

(Area Code) Fax Number

II. Name and address of contact person: _____

(Area Code) Telephone Number

(Area Code) Fax Number

III. Submit ODH Forms 953-B, 953-C and 953-D to provide complete disclosure of all persons and entities involved in and affected by the transfer.

IV. Current number of licensed beds: _____ Number of licensed beds in new facility: _____

V. Straight-line distance from current site to new site: _____ miles. Attach a map that shows the current and new locations, and demonstrates that the sites are no more than three miles apart for rural areas, seven-and one-half miles apart for urban areas. The map must include a mileage scale.

VI. Attach a plan for the use of the facility to be replaced or relocated that ensures continuity of services. Will the existing facility be used as a licensed nursing facility after the new facility is licensed? []Yes []No

VII. This form must be accompanied by a \$100.00 filing fee. Make checks payable to the Oklahoma State Department of Health.

I certify that the foregoing is true and complete to the best of my knowledge and belief.

Typed or Printed Name of Person Signing for Applicant

Signature of Applicant

Name of Corporation, Partnership or Association

Official Title or Position

State of _____

County of _____

Signed and sworn to (or affirmed) before me on this _____ day of _____, 20____

Name(s) of person(s) making statement.

Signature of Notary Public

Seal or Stamp:

My Commission Expires: _____ / _____ / _____ My Commission Number is: _____