IOWA DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF NEED
DELETION OF HEALTH SERVICE
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1. Name of Facility _____

2. Address_____
   Street City County Zip

3. Contact Person_____ (_____)_____
   Name Telephone

4. State the service to be deleted. The deletion of the service must be reported on the hospital's next annual report to the Department of Public. Section 135.63(2)"h", Iowa Code.

5. Attach an explanation why the service can be eliminated without creating a hardship for the facility or the individuals served.

6. Explain any other advantages or disadvantages to your patients or institution which may result from the deletion of the service.

7. **AUTHORIZATION:** Signatures of Administrator and Chairperson of the Board of Directors.

_____ _____
Administrator Board Chairperson

_____
Date

If this form is not completed and submitted at least thirty days before the deletion of a service, the facility is subject to review as a new or changed institutional health service under section 135.61(18)"f" and subject to sanctions under section 135.73.

588-1030 SERDEL (07/05)