IOWA DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF NEED DELETION OF HEALTH SERVICE

_____ Name of Facility _____ 1. 2. Address Street City County Zip Contact Person____ 3. Name Email _____ Date of deletion _____ 4. State the service to be deleted. The deletion of service must be reported on the hospital's next annual 5. report to the Department of Public Health. Section 135.63(2)h, Iowa Code. Explain why service can be eliminated without creating a hardship for the facility or the 6. individuals served.

AUTHORIZATION: Signatur	res of Administrator and Chairperson of the Board of Director

If this form is not completed and submitted at least thirty days before the reduction, 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.