APPLICATION FOR A GENERAL HOSPITAL CERTIFICATE OF NEED
Except for Transfer of a Certificate of Need

LEGAL NAME OF APPLICANT

AUTHORIZED REPRESENTATIVE/CONTACT PERSON

MAILING ADDRESS

CITY, STATE, AND ZIP CODE

TELEPHONE (AREA CODE AND NUMBER)

E-MAIL ADDRESS

FACILITY/PROJECT NAME

CHIEF EXECUTIVE OFFICER

STREET ADDRESS/SITE LOCATION

CITY

DISTRICT/SUBDISTRICT (IF APPLICABLE)

COUNTY:

- 1. Alachua
- 2. Baker
- 3. Bay
- 4. Bradford
- 5. Brevard
- 6. Broward
- 7. Calhoun
- 8. Charlotte
- 9. Citrus
- 10. Clay
- 11. Collier
- 12. Columbia
- 13. DeSoto
- 14. Dixie
- 15. Duval
- 16. Escambia
- 17. Flagler
- 18. Franklin
- 19. Gadsden
- 20. Gilchrist
- 21. Glades
- 22. Gulf
- 23. Hamilton
- 24. Hardee
- 25. Hendry
- 26. Hernando
- 27. Highlands
- 28. Hillsborough
- 29. Holmes
- 30. Indian River
- 31. Jackson
- 32. Jefferson
- 33. Lafayette
- 34. Lake
- 35. Lee
- 36. Leon
- 37. Levy
- 38. Liberty
- 39. Madison
- 40. Manatee
- 41. Marion
- 42. Martin
- 43. Miami/Dade
- 44. Monroe
- 45. Nassau
- 46. Okaloosa
- 47. Okeechobee
- 48. Orange
- 49. Osceola
- 50. Palm Beach
- 51. Pasco
- 52. Pinellas
- 53. Polk
- 54. Putnam
- 55. Saint Johns
- 56. Saint Lucie
- 57. Santa Rosa
- 58. Sarasota
- 59. Seminole
- 60. Sumter
- 61. Suwannee
- 62. Taylor
- 63. Union
- 64. Volusia
- 65. Wakulla
- 66. Walton
- 67. Washington

OWNERSHIP TYPE:

- 1. Private for profit hospital
- 2. Proprietary hospital system
- 3. Non profit hospital
- 4. Non-profit hospital system
- 5. Local government hospital
- 6. State hospital

PROJECT/SERVICE TYPE:

- 1. New facility
- 2. Replacement facility
- 3. Satellite facility

PREVIOUS CON NUMBERS:

__________ __________ __________

CON TRANSFERS:

__________ __________ __________

PROJECT COSTS:

Capital Expenditures __________________

Operating Costs __________________

NUMBER OF NEW/AFFECTED BEDS (+/-):

______ General Acute Care

ADDITIONAL PROJECT DETAILS/REMARKS:

AHCA Use Only:

CON Number ____________

Date Received ____________

Fee Received ____________

LOI Date ____________