Stroke Center Affidavit

Name, address and contact information of hospital attesting by affidavit that the hospital meets the criteria to be a primary/comprehensive stroke center as specified in 59A-3.2085(15), Florida Administrative Code (F.A.C.).

Name of Hospital: _____

Address: _____

City/State/Zip: _____

Phone: _____

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital meets the said criteria for a state recognized stroke center. Check applicable item(s) below:

❑ This facility has been certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a primary stroke center, and a copy of our certification letter from JCAHO is attached.

❑ This facility meets all of the criteria for a **primary stroke center** as specified in 59A-3.2085(15)(a), Florida Administrative Code.

❑ This facility meets all of the criteria for a **comprehensive stroke center** as specified in 59A-3.2085(15)(b), Florida Administrative Code.

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Hospital Chief Executive Officer (CEO)

Print Name: _____, who is a resident of

_____ County, State of _____,

Dated this _____ day of _____(month), _____(year)

Signature: _____

Hospital Chief Executive Officer (CEO)

Sworn to and subscribed before me, this _____day of _____.
(Month/Year)

This individual is personally known to me or produced the following identification:

_____

_____
Notary Public (Type or Print Name)

_____
Notary Public (Signature)

_____
My Commission Expires

Notary State Seal:

Return form to:
Agency for Health Care Administration
Hospital and Outpatient Services Unit
MS # 31
2727 Mahan Drive
Tallahassee, FL 32308