NOTICE OF TERMINATION OR REDUCTION OF A HEALTH SERVICE
OR REDUCTION OF BED CAPACITY

Pursuant to 900 KAR 6:110, Section 3, a health facility shall notify this office within thirty (30) days prior to termination or reduction of a health service, or reduction of bed capacity.

1. Name of Health Facility _______________________________________________________
   License Number ____________________________________________________________
   Address of Facility __________________________________________________________

   (City) (State) (Zip) (County)

2. Health service that will be terminated or reduced: ______________________________

3. Date that health service will be terminated or reduced: _________________________

4. Type and number of beds that will be reduced, and bed capacity after reduction:

5. Date that bed capacity will be reduced: ______________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(PRIITED NAME) (TITLE)

(EMAIL ADDRESS) (AREA CODE-TELEPHONE NO-EXT)

(Signature of Authorized Representative) (Date)

COMPLETE AND RETURN TO:

OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED
275 EAST MAIN STREET 5EA
FRANKFORT, KY 40621
Phone: (502) 564-9592
Email: CON@ky.gov
Fax: (502) 564-6546