COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL DIVISION OF CERTIFICATE OF NEED

CON-Form 10B

Revised (12/2020)

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)

1. Health service that will be terminated or reduced:
2. Date that health service will be terminated or reduced:
3. Type and number of beds that will be reduced, and bed capacity after reduction:
4. Date that bed capacity will be reduced:

(PRINTED 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