CON - Form 4
Revised (12/2020)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED

Witness List

RE: Health Facility Name: _____
CON #: _____
CASE #: _____

Hearing date & time: _____

Please take notice that _____
(Name of Person or Party)

Intends to call the following persons to testify at the hearing scheduled in the above-referenced matter.

WITNESS	SUMMARY OF TESTIMONY
1.	
2.	
3.	
4.	
5.	

_____
(Signature) (Date)

(TO BE FILED WITH THE OFFICE OF INSPECTOR GENERAL, DIVISION OF CERTIFICATE OF NEED, AND SERVED ON ALL KNOWN AFFECTED PARTIES FIVE (5) CALENDAR DAYS PRIOR TO THE DATE OF THE HEARING FOR NONSUBSTANTIVE REVIEW AND SEVEN (7) CALENDAR DAYS PRIOR TO THE DATE OF THE HEARING FOR FORMAL REVIEW AND OTHER CERTIFICATE OF NEED HEARINGS)

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