

CERTIFICATION OF GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM

AGENCY FOR HEALTH CARE ADMINISTRATION

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FROM:

(NAME OF HOSPITAL)

(MEDICAID ID)

(STREET ADDRESS)

(CITY)

(ZIP CODE)

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM INPUT FORM AS PART OF THE STATEWIDE MEDICAID RESIDENCY PROGRAM, IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF SECTION 409.909, F.S. TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION CONTAINED IN THE REPORT SUBMITTED IS TRUE, ACCURATE, AND COMPLETE AND HAS BEEN PREPARED FROM THE HOSPITAL'S BOOKS AND RECORDS, EXCEPT AS NOTED:

CHIEF EXECUTIVE OFFICER

(TYPE OR PRINT)

(SIGNATURE)

(DATE)