

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

**Certificate of Need Equipment Replacement Notification Form**

Pursuant to 19a-638(b)(18), an existing imaging equipment may be replaced, if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider physician or a person notifies OHCA of the date on which the equipment is replaced and the disposition of the replaced equipment.

**Please complete the following:**

|  |  |
| --- | --- |
| Provider Name & Address: |  |
| Name and description of the equipment to be replaced: |  |
| Docket or Report number of the CON authorization of the existing imaging equipment being replaced: |  |
| Address of the existing imaging equipment: |  |
| Name and description of the replacement equipment: |  |
| Location where replacement equipment will be operated: |  |
| The date the replaced equipment was replaced: |  |
| The disposition of the replaced equipment |  |

Person Completing the form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date