**Certificate of Need Equipment Replacement Notification Form**

Pursuant to 19a-638(b)(18), existing imaging equipment may be replaced, if such equipment was acquired through Certificate of Need (“CON”) approval or a certificate of need determination, provided a health care facility, provider physician or a person notifies the Office of Health Strategy (“OHS”) using this form, of the date on which the equipment is replaced and the disposition of the replaced equipment.

The completed form ***must be filed electronically*** through the OHS’ single point of access, its [CON Web Portal](http://dphconwebportal.ct.gov).

***First time Portal users must register prior to submitting any documents.***To register, click here: [Certificate of Need Web Portal](http://dphconwebportal.ct.gov/)

For any questions, please email [HSP@ct.gov](mailto:HSP@ct.gov) or call (860) 418-7001.

**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