

Health Care Providers Universal Service Program

Services Ordered and Certification

Estimated Average Burden Hours Per Response: 1.5 hours

Please read instructions before completing. (To be completed by Health Care Provider seeking Universal Service funding.)

Block 1: Subscriber Information

1. Name of Applicant	2. Federal EIN	3. Universal Service Control Number	4. Customer ID Number	5. Funding Year	
6. Type of Institution <i>(Check only one)</i> : <input type="checkbox"/> rural health care provider <input type="checkbox"/> non-rural health care provider <input type="checkbox"/> consortium of health care providers and/or other entities					
7. Complete Mailing Address of Applicant					
Street	County	City	State	Zip Code	Telephone number
8. Contact Person's Name					
9. Mailing Address <i>(if different from Item 5)</i>					
Street	County	City	State	Zip Code	Telephone number
FAX number		E-mail address			

Block 2: Services Contracted

10. a. Name of telecommunications service provider *(List only one per form. Submit additional FCC Form 466 for additional service provider.)*

b. List the service(s) for which the applicant has signed a contract. *(Attach additional sheets if necessary. Attach a copy of the service contract.)*

Federal EIN Number	Name of Entity	Services Ordered	Contract Expiration Date	Date Service Scheduled to Commence	Rate for Contracted Services

c. Provide the total estimated discount for the services the applicant intends to contract for during next year's application process. \$ _____.

Block 3: Certification

11. I certify that the above-named institution has considered all bids received and selected the most cost effective method of providing the requested service or services, where the most cost effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care facility deems relevant to choosing a method of providing the required health care services.
12. I certify that I am authorized to submit this request on behalf of the above-named institution or institutions , that I have examined this request, and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.

13. Signature

14. Date

15. Printed name of authorized person

16. Title or position of authorized person

Persons willfully making false statements on this form can be punished by fine or forfeiture, under the Communications Act, 47 U.S.C. Secs. 502,503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C., Sec. 1001.

Return Form to: Administrator
Health Care Corporation
100 South Jefferson Road
Whippany, New Jersey 07981