

Health Care Providers Universal Service Program

Telecommunications Service Providers Support

Estimated Average Burden Hours Per Response: 1.5 hours

Please read instructions before completing.

(To be completed by Telecommunications Carriers.)

Block 1: Applicant Information

1. Name of Health Care Facility to be served		2. Customer ID Number		3. Federal EIN		4. Application Control Number		5. Funding Year			
6. Selected Service Provider's Name											
7. Complete Mailing Address of Applicant											
Street			County		City		State		Zip Code		Telephone number
8. Contact Person's Name:											
9. Telephone number				10. FAX number			11. E-mail address				

Block 2: Calculation of Rates:

12. Applicable rural rate(s) (Show how rate is calculated.*)	
13. Applicable urban rate(s) (Show how rate is calculated.*)	
14. Applicable discount *	
* (You may attach Discount Worksheet, Form XXX, to show calculations.)	

Block 3: Certification Statement

15. I hereby certify that the service provider is an eligible telecommunications provide under section 254(e) of the act and has been designated eligible by its state commission to provide supported telecommunications services to health care facilities (unless providing only toll-free or local dial-up access to the Internet Service Provider). I also certify that:

- a. Adequate records of use are maintained by the telecommunications provider in cases where the health care facility is a member of a consortium that share facilities. Such records are subject to audit or examination by the Administrator or other state of federal agency with jurisdiction.
- b. Adequate records of use are maintained by the telecommunications provider in cases where the health care facility use their facilities for multi-purposes. Such records are subject to audit or examination by the Administrator or other state of federal agency with jurisdiction.

16 I hereby certify that the services listed above have been or are being provided to the above-named institution. I certify that I am authorized to submit this request on behalf of the above-named institution and 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.

17. Signature		18. Date	
19. Printed name of authorized person			
20. 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.

The Health Care Providers *Services Ordered and Certification Form* (FCC Form 466) will not be processed by the Administrator without this Form.

Return this worksheet to the Health Care Provider to be attached to its *Services Ordered and Certification Form* (FCC Form 466) and submitted to the RHC Fund Administrator.