[Schedule **20**]

Certificate of Need Application

For Establishment/Construction Requiring Full Review *****

Personal Qualifying Information

NAME		BUSINESS OR PROFESSION
FULL STREET ADDRESS	TITLE	DATE AND LOCATION OF BIRTH
CITY STATE ZIP		TELEPHONE NO.

I - Licenses Held

NAME OF PROFESSION	LICENSE #	NAME OF PROFESSION	LICENSE NO.
GRANTED BY (AGENCY)	CITY & STATE	GRANTED BY (AGENCY)	CITY & STATE
SPECIALTY	DATE LICENSE ISSUED	SPECIALTY	DATE LICENSE ISSUED
LICENSED FROM	LICENSED TO	LICENSED FROM	LICENSED TO

II- Formal Education

FROM	**TO**	**NAME**	**LOCATION**	**DEGREE**
		HIGH SCHOOL		
		COLLEGE		

Personal Qualifying Information*

III- EMPLOYMENT HISTORY FOR THE PAST 10 YEARS

(A)

From	To	Firm Name	Firm Address	Position Held

(B) **Offices Held in Health Facilities/Organizations**

Enter below each officership and/or directorship held now or previously (within the last 10 years) in any health care, adult care or mental health facility, program or organization requiring licensure or certification in New York State. Officerships and directorships in similar facilities or agencies outside of New York State must also be disclosed. Include facilities for which applications were previously disapproved or withdrawn.

From	To	Name of Facility	Address of Facility	Office Held

(C) **For individuals who have not previously served as a director/officer nor have had managerial experience with a health facility/organization, please attach an affirmative statement explaining why you are qualified to operate a health care facility. This statement should include, but not be limited to, any relevant community/volunteer background and experience.**

Personal Qualifying Information*

IV- Record of Legal Actions

A. Except for minor traffic violations, have you ever been convicted of a crime?
Yes____ No____

B. Have you ever been the subject of an administrative action related to the ownership or operation of a hospital, facility, home, or other institution providing care to persons?
Yes____ No____

C. Are there any criminal actions pending against you?
Yes____ No____

D. Are there now or have there been any civil or administrative actions pending against you involving the Medicare or Medicaid programs?
Yes____ No____

If the answer to any of the above questions is "Yes," complete the section below for each such action (attach a separate sheet if necessary).

DATE OF ACTION Month / Day / Year	TYPE OF ACTION	LOCATION OF ACTION

PERSONS AND/OR FACILITIES INVOLVED

GIVE FURTHER DETAILS DESCRIBING THE NATURE OF THE ACTIONS AND THE DISPOSITION, IF ANY.

V- Certification

The undersigned hereby certifies under penalty of perjury, that the information contained herein and attached hereto is accurate, true and complete in all material respects.

SIGNATURE DATE

NOTARIZE