HOSPITAL AFFIDAVIT FOR STATEWIDE WAGE INDEX RECLASSIFICATION

Stat	e of
Cou	nty or parish of
I,	g duly sworn, depose and say as follows: (type or print name),
DCIII	g dary sworm, depose and say as ronows.
(1)	I certify that
(2)	I understand that all prospective payment system hospitals in the state must apply as a group for reclassification to a statewide wage index through a signed single application.
(3)	I understand that all prospective payment system hospitals in the state must agree to the reclassification to a statewide wage index through a signed affidavit on the application.
(4)	I understand that all prospective payment system hospitals in the state must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.
(5)	I understand that the hospital waives its rights to any wage index classification that it would otherwise receive absent the statewide wage index classification, including a wage index that it might have received through individual geographic reclassification.
(6)	I certify that I am an officer of the hospital or a corporate officer of the hospital's parent corporation with authority to sign this affidavit for the hospital's inclusion in the statewide wage index reclassification request.
	Signature:
	Title:
	Phone number:
	E-mail address:
Sub	scribed and sworn to before me
This	day of, 20
Nota	ary Public
Мус	commission expires: