TRAINING, EDUCATION, and CLINICALS IN HEALTH (TEACH) FUNDING PROGRAM
CERTIFICATION

TO: AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive
Fort Knox Building 3 MS #23
Tallahassee, Florida 32308

FROM:

_____ _____
(NAME OF QUALIFIED FACILITY) (MEDICAID ID)

_____ _____
(STREET ADDRESS) (TYPE)

_____ _____
(CITY) (ZIP CODE)

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING TEACH QUARTERLY REPORTING FORM DATED_____, IN ACCORDANCE WITH, AND SUBJECT TO, THE PROVISIONS OF SECTION 409.91256, F.S.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION CONTAINED IN THE TEACH QUARTERLY REPORTING FORM DATED_____, AS SUBMITTED, IS TRUE, ACCURATE, AND COMPLETE AND HAS BEEN PREPARED FROM THE QUALIFYING FACILITY'S BOOKS AND RECORDS, EXCEPT AS NOTED:

_____

_____

_____

_____

CHIEF EXECUTIVE OFFICER _____
(TYPE OR PRINT)

_____
(SIGNATURE)

_____
(DATE)