Indiana Department of Health

~~Mike~~ Braun
Governor

Lindsay M. Weaver, MD, FACEP
State Health Commissioner

Design Professional's and Licensee's Attestation

Check Appropriate Facility Type:

- ☐ Hospital
- ☐ ASC
- ☐ Long-term Care Facility* (Residential or Comprehensive Care)
- ☐ DCS Licensed Child Caring Institution
- ☐ DMHA Licensed Private Mental Health Institutions

IDOH Assigned Project Number: ____-____-____

The undersigned **Architect or Engineer licensed in the State of Indiana ("Design Professional")** hereby certifies:

1.The Design Professional has created the project documents under the project number above (the "plans") regarding the architectural, mechanical, electrical and plumbing plans for the facility named below:

Facility's Licensed Name (or proposed name): _____
Address: _____
City/Town: _____ ZIP Code: _____

Project scope: _____
_____

2. The Design Professional has reviewed all submitted plans against the applicable regulations outlined in state rules (410 IAC 15-1.5-8, 410 IAC 16.2-3.1-19, 410 IAC 16.2-5-1.6, 410 IAC 15-2.5-7, 465 IAC 2-9 through -11, 440 IAC 1.5-3-8) and the applicable sections of the 2018 or 2022

Edition of the FGI *Guidelines for Design and Construction of Hospitals* and/or FGI *Guidelines for Design and Construction of Outpatient Facilities*, as appropriate to the facility type.
3. To the undersigned's knowledge, information and belief, all submitted plans meet the requirements of the above referenced codes and regulations in all material aspects, except for the non-conforming items for which waivers are requested (please list regulation numbers on an attached sheet and verify that a completed waiver request has been submitted for each item).

*If submitting for a Long-term Care Facility project fewer than 30,000 cubic feet, certification by a Design Professional is not required. Skip to Item 4.

Architectural or Engineering Firm Name: _____ Professional's Stamp

Architect/Engineer's Signature: _____
Printed Name: _____
Title: _____
Submission Date: _____
Revision Date (if applicable):_____

4. The undersigned **Licensee/Proposed Licensee** understands and agrees that notwithstanding a plan approval based upon this self-certification, the Health Care Engineering Division of the Indiana Department of Health (the "Division") shall have continuing authority to (1) review the plans submitted herewith and/or inspect the work with regard thereto, and (2) withdraw its approval thereto.

5. The facility named below shall have a continuing obligation to make any changes required by the Division to comply with the above-mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.

Facility Name: _____ Authorized Signature: _____

Address: _____ Name: _____
_____ Title: _____

Date: _____

Note: This Attestation must be stamped and signed, then scanned and submitted as a PDF document with the plan submittal package.