

Health Care Providers Universal Service Program

Receipt of Service Confirmation

Estimated Average Burden Hours Per Response: 1.5 hours

Please read instructions before completing. (To be completed by Health Care Provider seeking Universal Service funding.)

Block 1: Subscriber Information

1. Name of Applicant:	2. Federal EIN	3. Universal Service Control Number	4. Customer ID Number	5. Funding Year	
6. Type of Institution (<i>Check only one</i>): <input type="checkbox"/> rural health care provider <input type="checkbox"/> non-rural health care provider <input type="checkbox"/> consortium of health care providers and/or other private entities					
7. Complete Mailing Address of Applicant					
Street	County	City	State	Zip Code	Telephone number
8. Contact Person's Name:					
9. Mailing Address (if different from Item 5)					
Street	County	City	State	Zip Code	Telephone number
FAX number		E-mail address			

Block 2: Services

10. Provide the following information about the services the applicant is receiving.

Service Provider	Services	Date Service Commenced	Contract Total Amount

Block 3: Certification

11 I certify that the services listed above have been or are being provided to the above-named institution or consortium of institutions. 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.	
12. Signature	13. Date
14. Printed name of authorized person	
15. 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.

Return Form to:
Administrator
Health Care Corporation
100 South Jefferson Road
Whippany, New Jersey 07981