CERTIFICATION OF AMBULATORY PATIENT DATA
To
STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION
Office of Data Collection and Quality Assurance
2727 Mahan Drive, Mail Stop 16
Tallahassee, Florida 32308-5403

(Name of Provider)	**(AHCA Number)**
(Street Address)	**(Telephone Number)**
(City and Zip Code)	**(Fax Number)**

I have examined the ambulatory patient data report and, to the best of my knowledge and belief, the information contained in this report is true, accurate, and complete, and has been prepared from the books and records of this ambulatory center, except as noted.

Report period of worksheets: _____ **TO** _____

NAME OF EXECUTIVE OFFICER: _____

OFFICIAL TITLE: _____

SIGNATURE: _____

DATE: _____

"Executive Officer" as defined in 59B-9.031(6)
chief executive officer, chief financial officer, chief operating officer, president, vice president in charge of a principal business unit, division or function