

# SAMPLE

## FACILITY LETTERHEAD

DATE

Texas Department of State Health Services  
Office of EMS/Trauma Systems, MC 1876  
Neonatal Designation Program  
P.O. Box 149347  
Austin, TX 78714-9347

I, (name of authorized facility CEO or hospital administrator), hereby acknowledge that I have reviewed (facility name) "Neonatal Facility Designation Application" for the purpose of Level I designation along with the completed "Level I (Well-Nursery) Self-Audit". I hereby attest that the information provided is true and accurate to the best of my knowledge.

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(typed name and title of authorized signer with signature above)