SAMPLE

FACILITY LETTERHEAD

DATE

Texas Department of State Health Services
Office of EMS/Trauma Systems, MC 1876
Maternal 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 (your facility's name)'s "Maternal Facility Designation Application" for the purpose of Level I designation along with the completed "Level I (Basic Care) Self-Survey Report". 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)