COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL DIVISION OF CERTIFICATE OF NEED

Witness List

RE: Health Facility Name: CON #:

# CASE #:

CON - Form 4 Revised (12/2020)

Hearing date & time:

Please take notice that

(Name of Person or Party)

Intends to call the following persons to testify at the hearing scheduled in the above-referenced matter.

# WITNESS SUMMARY OF TESTIMONY

1.

2.

3.

4.

5.

(Signature) (Date)

# (TO BE FILED WITH THE OFFICE OF INSPECTOR GENERAL, DIVISION OF CERTIFICATE OF NEED, AND SERVED ON ALL KNOWN AFFECTED PARTIES FIVE (5) CALENDAR DAYS PRIOR TO THE DATE OF THE HEARING FOR NONSUBSTANTIVE REVIEW AND SEVEN (7) CALENDAR DAYS PRIOR TO THE DATE OF THE HEARING FOR FORMAL REVIEW AND OTHER CERTIFICATE OF NEED HEARINGS)

**COMPLETE AND RETURN TO**:

# OFFICE OF INSPECTOR GENERAL DIVISION OF CERTIFICATE OF NEED 275 EAST MAIN STREET 5EA FRANKFORT, KY 40621

Phone: (502) 564-9592

Email: CON@ky.gov Fax: (502) 564-6546