MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG TERM CARE REGULATION

CERTIFICATION OF ELECTRIC WIRING

FACILITY ID NUMBER	

FACILITY NAME	FACILITY TYPE ☐ RCF I ☐ RCF* (II) ☐ ALF ☐ ALF** ☐ ICF ☐ SNF

ADDRESS (STREET, CITY, ZIP CODE)

OWNER	ADMINISTRATOR

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, HAVE MADE AN INSPECTION OF THE ELECTRIC WIRING IN THE ABOVE-NAMED ESTABLISHMENT, AND FIND THAT THE ELECTRICAL INSTALLATION ☐ **IS** ☐ **IS NOT** ESSENTIALLY IN COMPLIANCE WITH THE REQUIREMENTS OF THE NATIONAL ELECTRICAL CODE INSOFAR AS THE INSTALLATION IS CONCERNED, AND IS IN SAFE OPERATING CONDITION.

REMARKS

SIGNATURE	PRINT NAME	TITLE

NAME OF COMPANY	TELEPHONE NUMBER	DATE

ADDRESS (STREET, CITY, ZIP CODE)

RETURN TO:	**MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES** **DIVISION OF REGULATION AND LICENSURE** **SECTION FOR LONG TERM CARE REGULATION** **REGION**
	ADDRESS
	CITY, STATE, ZIP CODE