AFFIDAVIT

I hereby certify that all offices in which I administer anesthesia services to my patients meet the same guidelines as those found in my primary office.

Primary office inspected on _____, 20_____.

_____
Street Address, City, State, Zip Code

Other office locations where I administer anesthesia:

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____ _____
Signature Date

_____
Typed or Printed Name