

Michigan Department of Community Health  
Bureau of Health Systems  
**Division of Nursing Home Monitoring**

**CERTIFICATE OF APPOINTMENT FOR AUTHORIZED REPRESENTATIVE**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Notice is hereby given to the Michigan Department of Community Health in accordance with a provision of Rules for Nursing Homes that \_\_\_\_\_ has appointed  
(Owner of facility requesting license and/or certification)

\_\_\_\_\_ as its authorized representative to:  
(Name)

- a. Submit applications and make amendments thereto.
- b. Provide the Department with all information necessary for a determination with respect to applications.
- c. Enter into agreements with the Department in connection with licensure or certification.
- d. Receive notice and service of process in matters relating to licensure or certification.

This action taken on \_\_\_\_\_ and is effective immediately.  
(Date)

This appointment will remain in effect until written notice of termination is sent to the Director, Division of Nursing Home Monitoring.

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Title

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Please remit to:

Department of Community Health  
Bureau of Health Systems  
Division of Nursing Home Monitoring  
P.O. Box 30664  
Lansing, MI 48909