STATEMENT OF INTENT
For OPB, MCP, DOTS Providers

Date: _____

Name of OPB/MCP/DOTS Provider:_____

Address: _____

Sign the applicable items if you agree to the statements below:

For Initial/Re-accreditation

a. I agree that, in case the pre-accreditation survey is conducted in my health facility on or before December 31 of the current year, and the application is approved before January 1 of the succeeding year, the start of my accreditation will be prior to January 1 of the succeeding year and I will file my application for renewal of accreditation within thirty (30) days from receipt of notice of approval of accreditation (Option A).

However, if the pre-accreditation survey is conducted in my health facility and the application is approved after January 1, the start date of my accreditation shall be on the date of survey.

_____
Signature over Printed Name of the
Authorized Person

b. I agree that, in case the pre-accreditation survey is conducted in my health facility on or before December 31 of the current year, and the application is approves before January 1 of the succeeding year, the start of my accreditation will be on January 1 of the succeeding year (Option B).

_____
Signature over Printed Name of the
Authorized Person