LOGO

Letterhead of the referral facility

**CERTIFICATION OF SERVICE DELIVERY SUPPORT**

 **(Level 2 or Level 3 hospital)**

This is to certify that our institution is a DOH licensed and PhilHealth accredited level \_\_ hospital and is the referral facility of **(Name of referring facility/ CIU)** for its COVID 19 patients needing further management. As a service delivery partner, we shall provide the necessary services for patients in accordance with the applicable guidelines set forth by the DOH.

This certification is being issued for PhilHealth accreditation and monitoring purposes.

CERTIFIED BY: CONCURRED BY:

**Referral Facility Referring Facility**

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Medical Director/Administrative Officer Medical Director/Administrative Officer

Signature over printed name and designation Signature over printed name and designation

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