

**STATEMENT OF INTENT**  
For Hospitals/ASC/FSDC

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

Name of Hospital/ASC/ FSDC: \_\_\_\_\_

Address: \_\_\_\_\_

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

**1. For Initial/Re-accreditation**

- a. I agree that, in case the pre-accreditation survey is conducted in my hospital/ASC/FSDC on or before April 30 of the current year, and the application is approved before May 1 of the accreditation year, the start of my accreditation will be prior to May 1 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 after May 1 and/or the application is approved after May 1, the start date of my accreditation shall be on the date when it has complied with all the standards and requirements of accreditation.

\_\_\_\_\_  
Signature over Printed Name of the  
Authorized Person

- b. I agree that, in case the pre-accreditation survey is conducted in my hospital/ASC/FSDC on or before April 30, and the application is approved before May 1 of the accreditation year, the start of my accreditation will be on May 1 (Option B).

\_\_\_\_\_  
Signature over Printed Name of the  
Authorized Person

**2. Downgrading of Accreditation Award (for hospitals only)**

I agree that, in case my hospital does not qualify for the accreditation award it has applied for, the hospital be granted the Accreditation Award it is compliant with.

\_\_\_\_\_  
Signature over Printed Name of the  
Authorized Person