



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**Certificate of Need Equipment Replacement Notification Form**

Pursuant to 19a-638(b)(18), an existing imaging equipment may be replaced, if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider physician or a person notifies OHCA of the date on which the equipment is replaced and the disposition of the replaced equipment.

**Please complete the following:**

Provider Name & Address:	
Name and description of the equipment to be replaced:	
Docket or Report number of the CON authorization of the existing imaging equipment being replaced:	
Address of the existing imaging equipment:	
Name and description of the replacement equipment:	
Location where replacement equipment will be operated:	
The date the replaced equipment was replaced:	
The disposition of the replaced equipment	

Person Completing the form: \_\_\_\_\_, \_\_\_\_\_  
Name Title  
\_\_\_\_\_, \_\_\_\_\_  
Signature Date