Clinic Minimum Wage Waiver Program Declaration Form

Declaration:

The undersigned representative of the Applicant hereby declares that they are an authorized executive officer of the covered health care facility and all documents and information provided to the Department of Health Care Access and Information in conjunction with this waiver request and Application form are true, correct, and represent the scope of business conducted by the Applicant.

_____ _____

Signature Date

_____

Executive Name and Title

_____

Name of Organization