



Georgia Certificate of Need Request for Determination (Equipment Below Threshold)

FOR OFFICE OF HEALTH PLANNING USE ONLY	
<p style="text-align: center; margin: 0;">REQUEST NUMBER</p> <p style="font-size: 24px; margin: 0;">DET-EQT</p>	<p style="text-align: center; margin: 0;"><i>DATE STAMP</i></p>
Signed Original and 1 Copy _____ Fee Verified _____	

GENERAL INFORMATION:

This DET-EQT Request form is the required document that the Department reviews in the analysis and evaluation of the proposed acquisition of diagnostic, therapeutic, or other imaging equipment at a value or expenditure below the equipment threshold in accordance with O.C.G.A. § 31-6-47(a)(28) and Ga. Comp. R. & Regs. r. 111-2-2-.10(3).

1. Requesting Parties must submit this request form electronically via the Department's web portal located at: <https://dch.georgia.gov/office-health-planning-applications-and-requests-forms-0>
2. The filing fee of \$250.00 shall be made payable to the "Department of Community Health" and shall be remitted by Certified Check or Money Order. **A copy of the Certified Check or Money Order must be included with your web portal submission.**
3. Failure to submit the required fee on the original form will result in non-acceptance of the request.
4. In addition to this form, Requesting Parties may submit a letter detailing and providing an overview of the proposed acquisition of equipment. If such a letter is submitted with this DET-EQT Request form, it should be attached to this form as **Exhibit 1**.
5. The Department will make every attempt to review the information submitted and issue a determination within 60 days of acceptance.

PLEASE COMPLETE THE FOLLOWING TABLE TO VERIFY PROPER SUBMISSION OF YOUR REQUEST	
Requesting Party Name:	
1. Did you submit this form via the Department's web portal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you remitted a \$250.00 Certified Check or Money Order payable to "Department of Community Health" along with a copy of the web portal submission confirmation form ?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Instructions

1. Please read all instructions and review this DET-EQT Request form in its entirety before attempting to complete and submit it.
2. A requesting party may submit additional information, such as a general overview of the project as **Exhibit 1**. This information may be in the form of a letter on 8 ½ x11-inch paper. These sheets may be on letterhead. Note, however, that **Exhibit 1** is not required.
3. In completing the DET-EQT Request form, if a particular rule or consideration requires substantiating documents such as purchase orders as an exhibit, the requested documents must be placed with the noted Exhibit without exception and must conform to the Instructions for Organization of Exhibits on the next page of these instructions.
4. This DET-EQT Request form must be typewritten or completed and printed in this MS Word format. Handwritten responses must not be submitted and will not be accepted.
5. Throughout this DET-EQT Request form, the following symbols are utilized for emphasis:

 Emphasizes instances where supporting documentation is requested and required to be attached as an Exhibit; and

 Emphasizes important instructions or notes that should be adhered to.

6. Please remit the following items to the address below: a copy of the web portal submission confirmation form; and, the \$250.00 filing fee in the form of a Certified Check or Money Order made payable to "Department of Community Health".

Department of Community Health
Office of Health Planning
DET-EQT Request
2 Peachtree Street, NW, 5th Floor
Atlanta, GA 30303

7. Faxed copies of documents and information are not official. All submissions must be via the Department's web portal.

Instructions for Organization of Exhibits

The organization of exhibits is mandated by this DET-EQT Request form and the Table of Exhibits that follows:

1. REQUESTING PARTIES MUST **NOT** VARY FROM THIS ORGANIZATIONAL STRUCTURE.
2. Exhibits must be separated by numbered pages.
3. In the event that there are no applicable documents pertaining to a specified Exhibit, indicate that the Exhibit is not applicable in the table below. There is no reason to submit pages for exhibits that are not applicable.
4. Each Exhibit may have more than one document.

TABLE OF EXHIBITS			
Number	Exhibit Name	Check if Included	Check if N/A
Exhibit 1	Letter providing information and overview of the project		
Exhibit 2	Purchase Orders, Quotes, Invoices, Fair Market Valuation for Equipment Item #1		
Exhibit 3	Shielding Invoices for Equipment Item #1		
Exhibit 4	Additional Mobile Sites		
Exhibit 5	Purchase Orders, Quotes, Invoices, Fair Market Valuation for Equipment Item #2		
Exhibit 6	Shielding Invoices for Equipment Item #2		
Exhibit 7	Purchase Orders, Quotes, Invoices, Fair Market Valuation for Equipment Item #3		
Exhibit 8	Shielding Invoices for Equipment Item #3		

Section 1 – Requesting Party Identification

1. Please complete the following information identifying the party requesting this DET-EQT. This should be the same party that is acquiring the equipment. The Contact Person should be an individual directly affiliated with the Requesting Party and not a consultant or attorney.

REQUESTING PARTY		
Legal Entity or Person:		
Address 1:		
Address 2:		
City:	State:	Zip:
County:		
CONTACT PERSON		
Name:	Title:	
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		

2. Indicate the type of facility that will use and operate the equipment that is the subject of this DET-EQT Request.

FACILITY TYPE	
<input type="checkbox"/> Hospital	
<input type="checkbox"/> Single Physician Private Office	
<input type="checkbox"/> Single Group Physician Practice Private Offices	

3. Does the Requesting Party have Legal Counsel to whom legal questions regarding this request may be addressed?

YES NO

If **YES** → Identify the lead attorney on the next page.

If **NO** → Continue to the next question.

LEGAL COUNSEL		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		

4. Did a Consultant prepare and/or provide information in this DET-EQT request? YES NO

If **YES** → Identify the Consultant below.

If **NO** → Continue to the next question.

CONSULTANT		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		

5. Does the Requesting Party wish to designate and authorize an individual other than the Requesting Party Contact listed in response to Question 1 to act as the representative of the Requesting Party for purposes of this request?

YES NO

If **YES** → Please complete the information in the following table. By doing so, the Requesting Party authorizes the representative to submit this DET-EQT request; to provide the Department of Community Health with all information necessary for a determination on this request; to enter into agreements with the Department of Community Health in connection with this request; and to receive and respond, if applicable, to notices in matters relating to this request.

If **NO** → Continue to the next question.

AUTHORIZED REPRESENTATIVE		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

 **NOTE:** The authorization provided on the previous page will remain in effect for this request until written notice of termination is sent to the Department of Community Health that references the specific request number. Any such termination must identify a new authorized representative. Also, if the authorized representative's contact information changes at any time, the Requesting Party must immediately notify the Department of Community Health of any such change.

6. Does the Requesting Party have any lobbyist employed, retained, or affiliated with the Requesting Party directly or through its contact person or authorized representative?

YES NO

If **YES** → Please complete the information in the table below for each lobbyist employed, retained, or affiliated with the Requesting Party. Be sure to check the box indicating that the Lobbyist has been registered with the State Ethics Commission. Executive Order 10.01.03.01 and Rule 111-1-2-.03(2) require such registration.

If **NO** → Continue to the next question.

LOBBYIST DISCLOSURE STATEMENT		
Name of Lobbyist	Affiliation with Requesting Party	Registered with State Ethics Commission?
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employed <input type="checkbox"/> Other Affiliation	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 3 – Equipment Valuation

8. Please complete the following line item valuation sheet for the equipment that is the subject of this DET-EQT Request.

EQUIPMENT LINE ITEM VALUATION SHEET # 1		
Manufacturer:		Model:
Select one of the following: <input type="checkbox"/> Mobile <input type="checkbox"/> Fixed		
Type of Equipment: <input type="checkbox"/> MRI <input type="checkbox"/> CT Scanner <input type="checkbox"/> Other:		
Means of Acquisition: <input type="checkbox"/> Purchase <input type="checkbox"/> Operational Lease <input type="checkbox"/> Capital Lease <input type="checkbox"/> Gift <input type="checkbox"/> Other:		
ITEM	EXPENDITURE/ FAIR MARKET VALUE	
(1) Unit Base Price		\$
(2) 1 st Year Warranty	<input type="checkbox"/> Check if Included in Base Price	\$
(3) Operator Training	<input type="checkbox"/> Check if Included in Base Price	\$
(4) Installation and Equipment Assembly	<input type="checkbox"/> Check if Included in Base Price	\$
(5) Transportation and Insurance	<input type="checkbox"/> Check if Included in Base Price	\$
(6) Functionally Related Equipment <i>(Check all that Apply)</i>	<input type="checkbox"/> Water Chiller	\$
	<input type="checkbox"/> Laser Camera	\$
	<input type="checkbox"/> Workstation	\$
	<input type="checkbox"/> Surge Protection	\$
	<input type="checkbox"/> Computer Hardware	\$
<input type="checkbox"/> Other:		\$
(7) Options, Software, Extra Packages or Accessories	<input type="checkbox"/> Check if Included in Base Price	\$
(8) RF or Other Protective Shielding	<input type="checkbox"/> Check if Included in Base Price	\$
(9) Service Contract- Year 1-5	<input type="checkbox"/> Check if Included in Base Price	\$
(10) Volume or Bulk Purchase Discount	<input type="checkbox"/> Check if Included in Base Price	\$
(11) Mobile Coach, Trailer, Van, Tractor	<input type="checkbox"/> Check if Included in Base Price	\$
(12) TOTAL (Sum of All of the Above)		\$

☞ Attach as **Exhibit 2** the purchase order(s), invoices, etc. for any equipment listed above with a purchase price or fair market value over \$10,000. For example, if an MRI valued at \$300,000, a water chiller valued at \$10,500, and a laser camera valued at \$8,000 is indicated above, attach purchase orders, invoices, price quotes, etc., as **Exhibit 2** for the water chiller and the MRI. If the equipment is already owned (for example, the legal entity owns the equipment, but has been using it in another State) or is being leased, please attach as **Exhibit 2** an affidavit from a reputable vendor of the type of equipment reporting the fair market value of said equipment for each piece of equipment with a value over \$10,000.

☞ Attach as **Exhibit 3** any invoices or price quotes for R/F, lead, or other protective shielding, if necessary (i.e. expenditures for such shielding exceed \$10,000.)

9. Is more than one piece of diagnostic or therapeutic equipment being acquired simultaneously?

 **NOTE:** Only indicate **YES** if multiple pieces of equipment are being acquired simultaneously. For purposes of this form, you should consider simultaneously to mean that an additional piece of equipment would be acquired within 6 months before or after the installation and first use of another piece of diagnostic or therapeutic equipment.

YES **NO**

If **YES** → Continue to Question 10.

If **NO** → Skip Question 10, and Continue to Question 11.

10. If you have answered **YES** to question 9, above, is each piece of simultaneously acquired equipment associated? Read this Question carefully and in its entirety before responding.

 **NOTE:** Multiple pieces of diagnostic, therapeutic, or other imaging equipment are considered associated if they share a relationship or association based on law, regulation, definition, function, procedure, or process. For example, diagnostic imaging equipment is considered to be associated if the pieces are for use in the same location for diagnostic imaging services. For example, if a CT scanner and MRI are being acquired simultaneously, they should be reported on individual line item valuation sheets.

YES **NO**

If **YES** → Complete additional Equipment Line Item Valuation Sheets on pages 6.1 and 6.2, one for each piece of additional associated equipment being acquired simultaneously. There are two additional equipment valuation sheets after this page, one on each page. Only complete the number of sheets needed. If you need only one additional sheet, once printed, discard the sheet not needed, i.e. Page 6.2

If **NO** → Explain in the space below why such simultaneously acquired equipment should not be associated. Do not exceed the allotted space for your response. Continue to Question 11 on page 6.3. Once this form is completed and printed, discard pages 6.1 and 6.2.

 **NOTE:** Only fill out this table if you are simultaneously acquiring additional associated equipment, i.e. you have answered **YES** to both Questions 9 and 10! **BEFORE SUBMITTING, DISCARD THIS SHEET IF YOU ARE ACQUIRING ONLY ONE PIECE OF EQUIPMENT.**

EQUIPMENT LINE ITEM VALUATION SHEET # 2		
Manufacturer:	Model:	
Select one of the following: <input type="checkbox"/> Mobile <input type="checkbox"/> Fixed		
Type of Equipment: <input type="checkbox"/> MRI <input type="checkbox"/> CT Scanner <input type="checkbox"/> Other:		
Means of Acquisition: <input type="checkbox"/> Purchase <input type="checkbox"/> Operational Lease <input type="checkbox"/> Capital Lease <input type="checkbox"/> Gift <input type="checkbox"/> Other:		
ITEM	EXPENDITURE/ FAIR MARKET VALUE	
(1) Unit Base Price		\$
(2) 1st Year Warranty	<input type="checkbox"/> Check if Included in Base Price	\$
(3) Operator Training	<input type="checkbox"/> Check if Included in Base Price	\$
(4) Installation and Equipment Assembly	<input type="checkbox"/> Check if Included in Base Price	\$
(5) Transportation and Insurance	<input type="checkbox"/> Check if Included in Base Price	\$
(6) Functionally Related Equipment <i>(Check all that Apply)</i>	<input type="checkbox"/> Water Chiller	\$
	<input type="checkbox"/> Laser Camera	\$
	<input type="checkbox"/> Workstation	\$
	<input type="checkbox"/> Surge Protection	\$
	<input type="checkbox"/> Computer Hardware	\$
<input type="checkbox"/> Other:		\$
(7) Options, Software, Extra Packages or Accessories	<input type="checkbox"/> Check if Included in Base Price	\$
(8) RF or Other Protective Shielding	<input type="checkbox"/> Check if Included in Base Price	\$
(9) Service Contract - Year 1-5	<input type="checkbox"/> Check if Included in Base Price	\$
(10) Volume or Bulk Purchase Discount	<input type="checkbox"/> Check if Included in Base Price	\$
(11) Mobile Coach, Trailer, Van, Tractor	<input type="checkbox"/> Check if Included in Base Price	\$
(12) TOTAL (Sum of All of the Above)		\$

 Attach as **Exhibit 5**, the purchase order(s), invoices, etc. for any equipment listed above with a purchase price or fair market value over \$10,000. For example, if an MRI valued at \$300,000, a water chiller valued at \$10,500, and a laser camera valued at \$8,000 is indicated above, attach purchase orders, invoices, price quotes, etc., as **Exhibit 5** for the water chiller and the MRI. If the equipment is already owned (for example, the legal entity owns the equipment, but has been using it in another State) or is being leased, please attach as **Exhibit 5** an affidavit from a reputable vendor of the type of equipment reporting the fair market value of said equipment for each piece of equipment with a value over \$10,000.

 Attach as **Exhibit 6** any invoices or price quotes for R/F, lead, or other protective shielding, if necessary (i.e. expenditures for such shielding exceed \$10,000.)

 **NOTE:** Only fill out this table if you are simultaneously acquiring two pieces of additional associated equipment, i.e. you have answered **YES** to both Questions 9 and 10! **BEFORE SUBMITTING, DISCARD THIS SHEET IF YOU ARE ACQUIRING ONLY ONE OR TWO PIECES OF EQUIPMENT.**

EQUIPMENT LINE ITEM VALUATION SHEET # 3		
Manufacturer:	Model:	
Select one of the following: <input type="checkbox"/> Mobile <input type="checkbox"/> Fixed		
Type of Equipment: <input type="checkbox"/> MRI <input type="checkbox"/> CT Scanner <input type="checkbox"/> Other:		
Means of Acquisition: <input type="checkbox"/> Purchase <input type="checkbox"/> Operational Lease <input type="checkbox"/> Capital Lease <input type="checkbox"/> Gift <input type="checkbox"/> Other:		
ITEM	EXPENDITURE/ FAIR MARKET VALUE	
(1) Unit Base Price		\$
(2) 1st Year Warranty	<input type="checkbox"/> Check if Included in Base Price	\$
(3) Operator Training	<input type="checkbox"/> Check if Included in Base Price	\$
(4) Installation and Equipment Assembly	<input type="checkbox"/> Check if Included in Base Price	\$
(5) Transportation and Insurance	<input type="checkbox"/> Check if Included in Base Price	\$
(6) Functionally Related Equipment <i>(Check all that Apply)</i>	<input type="checkbox"/> Water Chiller	\$
	<input type="checkbox"/> Laser Camera	\$
	<input type="checkbox"/> Workstation	\$
	<input type="checkbox"/> Surge Protection	\$
	<input type="checkbox"/> Computer Hardware	\$
<input type="checkbox"/> Other:		\$
(7) Options, Software, Extra Packages or Accessories	<input type="checkbox"/> Check if Included in Base Price	\$
(8) RF or Other Protective Shielding	<input type="checkbox"/> Check if Included in Base Price	\$
(9) Service Contract - Year 1-5	<input type="checkbox"/> Check if Included in Base Price	\$
(10) Volume or Bulk Purchase Discount	<input type="checkbox"/> Check if Included in Base Price	\$
(11) Mobile Coach, Trailer, Van, Tractor	<input type="checkbox"/> Check if Included in Base Price	\$
(12) TOTAL (Sum of All of the Above)		\$

 Attach as **Exhibit 7**, the purchase order(s), invoices, etc. for any equipment listed above with a purchase price or fair market value over \$10,000. For example, if an MRI valued at \$300,000, a water chiller valued at \$10,500, and a laser camera valued at \$8,000 is indicated above, attach purchase orders, invoices, price quotes, etc., as **Exhibit 7** for the water chiller and the MRI. If the equipment is already owned (for example, the legal entity owns the equipment, but has been using it in another State) or is being leased, please attach as **Exhibit 7** an affidavit from a reputable vendor of the type of equipment reporting the fair market value of said equipment for each piece of equipment with a value over \$10,000.

 Attach as **Exhibit 8** any invoices or price quotes for R/F, lead, or other protective shielding, if necessary (i.e. expenditures for such shielding exceed \$10,000.)

11. Complete the following table to summarize all Equipment Line Item Valuations. Enter the Total, Line 12, from the table on Page 5 on Line 1 below. On Line 2 below, enter the sum of all Total, Line 12, from each additional Equipment Line Item Valuation Sheet attached as Page 6.1, etc. If you are acquiring only one piece of equipment, or other equipment being simultaneously acquired is not associated, enter "0" on Line 2. On Line 3, enter the sum of Lines 1 and 2.

TOTAL EQUIPMENT LINE ITEM VALUATION	
(1) Equipment Line Item Valuation Sheet # 1 <i>(page 5)</i>	\$
(2) Total of Additional Equipment Line Item Valuation Sheets <i>(page 6.1, etc.)</i>	\$
(3) TOTAL EQUIPMENT VALUATION	\$

12. Is the amount of Question 11, Line 3 less than the current threshold for diagnostic or therapeutic or other imaging equipment?

YES NO

If NO → **Your project will require prior CON review and approval. In lieu of this form, you should submit an application for a certificate of need via the Department's online portal.**

The Remainder of this Page Left Blank

Section 4 – Requesting Party Affidavit

13. Read the following affidavit carefully; complete the required fields, sign and date, and have the original notarized.

I, _____ (Enter Name , Enter Title) of

(Enter Entity) being duly sworn, depose

and state the following:

1. I am over the age of eighteen, suffer no legal disability, and am competent to give this Affidavit. The information provided in this Request for Letter of Determination and in this Affidavit is true and accurate to the best of my knowledge;
2. This Affidavit is given in connection with the request for the issuance of a Letter of Determination by the Department of Community Health (the "Department");
3. I am seeking to acquire the equipment disclosed in this Request for Letter of Determination;
4. The undersigned is capable of making a binding commitment on behalf of said entity;
5. I certify that no acquisition of additional items not listed on the Line Item Valuation Sheets, to be added to or used with the operational configuration of the particular diagnostic, therapeutic or other imaging equipment at issue to include functionally related equipment, will be made or will take place for a period of six (6) months from the date of installation and first use of the equipment that would put the total expenditure incurred on the diagnostic, therapeutic or other imaging equipment, or its operational configuration over the Department's equipment threshold;
6. I further certify that no acquisition of additional equipment reasonably related to or associated with the general type of service provided by the equipment to be acquired not listed on a Line Item Valuation Sheet will occur within a period of six (6) months from the date of installation and first use of said equipment, that is that such expenditure for associated, but not functionally related equipment, regardless of modality, shall occur simultaneously;
7. I further certify that the Line Item Valuation Sheets included in the request are accurate, reflect all of the expenses required by Ga. Comp. R. & Regs. r. 111-2-2-.10(3), and reflect the true cost of acquiring the exact same equipment and any and all associated and simultaneous items and activities; and the price shown on the price quotation(s) or purchase order(s) reflects the exact amount of the total expense that will be incurred and paid to the manufacturer or vendor for the exact same equipment listed on the price quotation or purchase order. If such equipment, is obtained by lease or other use, I certify that the amount reflected on the Line Item Valuation Sheets reflect the fair market values, as applicable, and that such value reflects the total dollar amount that would have been expended had the equipment been purchased.

Signature

Date

Subscribed and sworn to before me on
this _____ day of _____, 20_____

(Notary Seal)

Notary Public

My commission expires: _____

Section 5 – Certification

By signing below,

- a) I hereby certify that the contained statements and all addenda, appendices, exhibits, or attachments hereto are true and complete to the best of my knowledge and belief and that I possess the authority to submit this request and bind the Requesting Party to promises made herein;
- b) I understand that a representative of the Office of Health Planning may make a direct request of me for additional information in order to issue a Letter of Determination; and
- c) I further understand that if issued a Letter of Determination, the Requesting Party is bound to any representations that have been made within this DET-EQT Request and any and all supplemental information.

REQUESTING PARTY CERTIFICATION	
Signature of Authorized Signatory (BLUE INK ONLY):	
<i>Name:</i>	
<i>Title:</i>	<i>Date:</i>

Section 6 – Vendor/Manufacturer Affidavit

INSTRUCTIONS: Provide the following affidavit for completion by the vendor or manufacturer of the equipment that is the subject of this DET-EQT Request. If you are leasing the equipment, or if you already own the equipment but it has not been used in Georgia, a reputable vendor of equipment who can attest to the fair market value of said equipment should fill out this affidavit.

If you have answered **YES** to Question 9 and 10 on page 6, you have indicated that you are acquiring more than one piece of associated equipment simultaneously. If this is the case, copy this Affidavit for completion by each Vendor/Manufacturer of each piece of equipment and include such copies following this page.

AFFIDAVIT

My name is _____.

The Requesting Party for this DET-EQT is _____.

I am an adult suffering from no known legal disabilities and I am competent to testify regarding the matters set forth herein based upon my personal knowledge. I am freely making this Affidavit in connection with the request for a Letter of Determination with respect to the acquisition of diagnostic, therapeutic equipment or other imaging equipment.

I am _____ of _____,
(Enter Title or Position) (Enter Name of Company)

the manufacturer, or a vendor of the _____
(Enter Equipment Model and Year)

that is the subject of this DET-EQT Request. I am capable of making a binding commitment on behalf of said manufacturer or vendor.

Please check one of the following:

I hereby certify that the price shown on the purchase order or price quotation is the total expense that the Requesting Party is incurring for the equipment shown and the total dollar amount that the manufacturer or vendor is receiving for the exact unit shown on the purchase order or price quotation.

The equipment that is the subject of this affidavit is being leased or acquired through a means other than purchase. I have been asked by the Requesting Party to provide a fair market value quotation. I hereby certify that the value reported in this DET-EQT Request is the fair market value for the equipment listed above. Had the Requesting Party purchased said equipment, this value would have been a reasonable amount that it the Requesting Party would have incurred for obtaining the equipment.

Signature

Date

Subscribed and sworn to before me on
this _____ day of _____, 20____

(Notary Seal)

Notary Public

My commission expires: _____