

**Health Care Partner Contribution Certification Form**

**Linking Industry to Nursing Education (LINE) Fund**

Enclosed is the certification form, required for the application of the Linking Industry to Nursing Education (LINE) Fund, which is intended to meet local, regional, and state workforce demand by recruiting faculty and clinical preceptors, increasing the capacity of high-quality nursing education programs, and increasing the number of nursing education program graduates who are prepared to enter the workforce.

To apply for the LINE Fund, this certification form must be completed and signed by an authorized official of both the health care partner and the recipient agency and included in the application. Applicants are allowed to have more than one health care partner when applying for the LINE Fund. If an applicant has more than one health care partner, the applicant should submit one application with all health care partners with the total funds contributed detailed. Additionally, the applicant should submit this form for each health care provider.

**Part I (to be completed by the health care partner)**

*Please print or type*

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| --- |
|  Health Care Provider Name:  |
|  Recipient Agency Name:  |
|  Confirmation that health care partner meets eligibility criteria under section 768.38(2), Florida Statutes, (\*see note below) and is located and licensed to operate in the State of Florida. (Mark with X)  \_\_ Meets criteria  \_\_ Does not meet criteria   |
|  Mailing Address:   |  Fund, Foundation, Assn. Name *(if applicable):*  |
|  City:  | State:  | Zip Code:  |  Total cash contribution:  $  |
|  Name of Authorized Officer:  |  Title of Authorized Officer:   |
|  Phone Number of Authorized Officer:  |  Email Address of Authorized Officer:   |
| I certify that the information submitted is correct and represents the health care partner’s intent to make a cash contribution under the provisions of the LINE Fund. It is understood that if the educational institution is awarded a LINE Fund award, the institution will not receive the matching funds until the health care partner’s contribution is received by the institution.   Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                      Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

**Part II (to be completed by the recipient agency)**

*Please print or type*

|  |  |
| --- | --- |
|  Agency Name:   |  Agency Type: (Mark with X)   \_\_ School district   \_\_ Florida College System institution    \_\_ Independent Colleges and Universities of Florida member    \_\_ Commission for Independent Education member   |
|  Mailing Address:   |
|  City:  |  State:   |  Zip Code:   |
|  Name of Authorized Officer:   |  Title of Authorized Officer:    |
|  Phone Number of Authorized Officer:   |  Email Address of Authorized Officer:    |

*\*Note:* Pursuant to Section 768.38(2), a “healthcare provider” is defined as:

* A provider as defined in s. 408.803, F.S.
* A clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.
* A federally qualified health center as defined in 42 U.S.C. s. 1396d(l)(2)(B), as that definition exists on the effective date of this act.
* Any site providing health care services which was established for the purpose of responding to the COVID-19 pandemic pursuant to any federal or state order, declaration, or waiver.
* A health care practitioner as defined in s. 456.001, F.S.
* A health care professional licensed under part IV of chapter 468.
* A home health aide as defined in s. 400.462(15), F.S.
* A provider licensed under chapter 394 or chapter 397 and its clinical and nonclinical staff providing inpatient or outpatient services.
* A continuing care facility licensed under chapter 651.
* A pharmacy permitted under chapter 465.