

**DHHS FACILITY CONSTRUCTION
Completion Certificate**

All applicable items checked below have been completed, properly installed, cleaned, tested, and approved to be used for treatment and care of the occupants within the following health care facility:

Facility Name:

Address / City:

Project / Phase Name:

Date:

Occupancy Approvals from Authorities: (Printed name, signature, date, & phone number, if attachment not included)

- State Fire Marshal or Delegated Authority –MUST ATTACH CERTIFICATE of OCCUPANCY or OCCUPANCY APPROVAL DOCUMENT from SFM or Delegated Authority ONLY to verify approval for health occupancy.
- Building Official (Qualified Inspector or Other).....by
- Plumbing Inspector (Qualified Inspector or Other).....by
- State Electrical Inspector (Delegated Authority).....by
- Elevator Inspector (State or Other)by
- Boiler Inspector (State or Other)by
- _____by

Completion Certifications from Engineers, Installers, or Others: (Complete and attach applicable certifications)

- Food Service (hoods, equipment, housekeeping, dishwasher hot water _____ degrees or chemical).....
- Food Storage (freezer _____ degrees, cooler _____ degrees, and stored _____+ inches above floor).....
- Laundry (personal, divided bulk, soak/hand sink, housekeeping, hot water _____ degrees or other)....
- Equipment installed and approved for use (care, treatment, diagnostic, sterilizing, and medical)
- Sanitation (clean utility, soiled utility waste disposal, housekeeping, and scrub/hand sink accessories).....
- Protective Shielding (radiation, magnetic, radio frequency, electronic, and sound transmission)
- Safety Equipment (handrails, grab bars, guard rails, hardware, and other _____)
- Room finishes (scrubable, washable, food code, joints/fixture sealed, base, and other finishes).....
- Privacy curtains are installed (nursing care beds, care and treatment cubicles, bathing, and windows)
- Water Quality (public water, private well samples, back-flow, air gap, and indirect connections)
- Hot water Temperatures (bathing _____ degrees, and handwashing _____ degrees maximums at fixture).....
- Heating and Cooling System (temperature _____ to _____, surgery _____ to _____ degrees)
- Ventilation System (_____ pre-filter, _____ final filter efficiencies, and air flow from clean to soiled locations)
- Exhaust System (_____ air changes/hour in janitor, toilets/baths, soiled, waste, and laundry)
- Electrical System (isolated power, equipotential grounding, redundant grounding, and GFIC protected)
- Illumination (5 fc general, 10 fc corridors, 20 fc personal care/dining, 30 fc reading/activity, 40 fc food service, 50 fc hazardous, 70 fc care/treatment, 100 fc exam, 200 fc procedure, and 1000 fc surgery)
- Reduced night lighting (nursing care rooms, corridors, toilet, bathrooms, and central toilets/bathing)
- Emergency Generator (Life Safety, distinctively marked outlets, and _____ hour minimum on-site fuel supply)
- Emergency Power (nurse call, critical/life support equipment, medical gas, and essential lighting)
- Nurse Call System (care/treatment, beds, toilets, bathing, and central toilets/bathing)
- Medical Gas system or equipment installed and tested -- NFPA (O₂, V, A, N₂O, and _____)
- _____.....
- _____.....

I am a licensed Nebraska Architect or Engineer and have inspected the above facility (project) for compliance with approved construction plans, have attached schematic floor plan(s) and other approval documents and to the best of my knowledge, this project complies with applicable health care facility licensure regulations. This project is complete and has been approved for use at this time.

NAME: (print & sign)

LICENSE NUMBER:

DATE: