



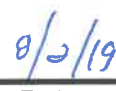
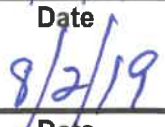
THIS IS TO CERTIFY THAT

ARROWHEAD REGIONAL MEDICAL CENTER'S

Administrative Operations Manual

HAS BEEN REVIEWED AND UPDATED

AS NEEDED

 _____ Chief Nursing Officer	 _____ Date
 _____ Chief Medical Officer (if applicable)	 _____ Date
 _____ Chief Executive Officer	 _____ Date
_____ Chair, Board of Supervisors	_____ Date