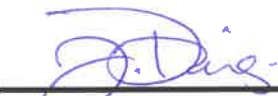
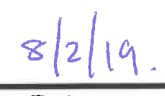


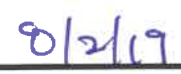
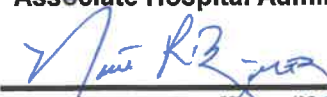
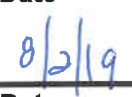
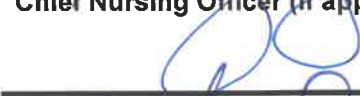

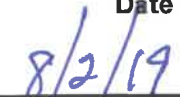




THIS IS TO CERTIFY THAT

**ARROWHEAD REGIONAL MEDICAL CENTER'S
PRIMARY CARE CENTERS**

**HAS BEEN REVIEWED AND UPDATED
AS NEEDED**

 _____ Department Manager	 _____ Date
 _____ Department Chair (if applicable)	_____ Date
 _____ Associate Hospital Administrator (if applicable)	 _____ Date
 _____ Chief Nursing Officer (if applicable)	 _____ Date
 _____ Chief Medical Officer (if applicable)	_____ Date
 _____ Chief Executive Officer	 _____ Date
_____ Chair, Board of Supervisors	_____ Date