New Jersey Department of Human Services
Division of Developmental Disabilities

Provider Attestation for Visitation

Date: _____

To: Division of Developmental Disabilities

From: _____

Provider Name: _____

Contact Number: _____

I, of full age, hereby certify that I represent the aforementioned provider in the capacity listed and that I am duly authorized to the make the representations contained within this attestation on behalf of the provider and to bind the provider thereto. I attest that the provider has implemented all the requirements set forth in Guidance for Residential Providers on Visits with Family and Friends and Screening of Visitors and Staff in Residential Settings. I attest that no indoor visits will occur unless the setting has gone 14 days without newly COVID-19 positive residents or staff, does not have residents or staff who are currently displaying symptoms, and has a space for designated for visitation, sufficient staff, a mechanism for appointments and a plan to ensure sufficient PPE for visitation.

CEO or Designee Name	CEO or Designee Signature	Date
Witness Printed Name	Witness Signature	Date