

	LOCAL HEALTH DEPARTMENT CONFIRMATION OF GATING CRITERIA SATISFACTION	
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I confirm for _____ as follows:
Specify county or counties

1. a. There is a downward trajectory of documented COVID-19 cases within at least a 14 28 42 day period.

OR

b. There is a downward trajectory of positive COVID-19 tests as a percent of total COVID-19 tests within at least a 14 28 42 day period (flat or increasing volume of tests).

2. Regional health care facilities are able to treat all patients without crisis care.

Date

Signature of health department representative

Print name

Title

Health department address

City, state, zip

Telephone no.