

North Carolina 2016 State Medical Facilities Plan Order Form

Name: _____
(Required)

Organization: _____
(Optional)

Mailing Address: _____
(Required)

E-Mail: _____
(Optional)

Phone Number: _____
(Required)

If your zipcode is inside N.C.
and does not begin with
287, 288 or 289:

\$ 15.90 NC 2016 SMFP
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If your zipcode begins with
287, 288, 289 or outside of NC:

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Number of copies _____ x \$ = \$ _____
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Check enclosed in amount of: \$ _____
Same as Total Due

Checks should be made to: North Carolina Division of Health Service Regulation

Return completed form to: Division of Health Service Regulation
Healthcare Planning & Certificate of Need Section
2704 Mail Service Center
Raleigh, N.C. 27699-2704