Insert Facility Name/Logo

**Date:**

**From:**

**Re:** Attestation to provision of Medications for Opioid Use Disorder

**To:** National Health Service Corps

[Insert brief overview of site (and organization if applicable) as services provided and patient population]. This letter is to certify that FACILITY NAME located at FACILITY ADDRESS provides Medications for Opioid Use Disorder (MOUD) in an outpatient clinical setting. Medications For Opioid Use Disorder services are available to patients [Insert days and hours of operation for medications for Opioid Use Disorder]. At this clinical service site, the Medications for Opioid Use Disorder patient panel for the six-month period beginning START DATE and ending END DATE included [Number of patients receiving medications for opioid use disorder].

Signature of CEO and/or Medical Director

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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