

1/8" = 1'-0"

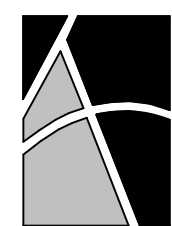
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healthcare facilities solutions

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I hereby certify that this plan, specification or report was prepared by me or under my direct supervision and that I am a duly licensed Architect under the laws of the State of Minnesota.

Signature _____
Registration No. _____
Date _____

APPROVED SERVICE LINE DIRECTOR	DATE	APPROVED INFECTION CONTROL NURSE	DATE
APPROVED GENM COORDINATOR	DATE	APPROVED PATIENT SAFETY	DATE
APPROVED PROJECTS SECTION MANAGER	DATE	APPROVED CHIEF OF POLICE	DATE
APPROVED DIRECTOR FMS	DATE	APPROVED SAFETY MANAGER	DATE

DRAWING TITLE	DATE
ATTIC PLAN	12/16/2011
APPROVED CHIEF OF STAFF	DATE
APPROVED MEDICAL CENTER DIRECTOR	DATE

PROJECT TITLE	DATE
LONG TERM / INTERMEDIATE PSYCHIATRIC UNIT	12/16/2011
BUILDING No.	CHECKED BY
4801 VETERANS DRIVE, ST CLOUD MN	Author

PROJECT NO.	DATE
1002.001.00	12/16/2011
DRAWING NO.	DATE
AS103	12/16/2011

