

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001

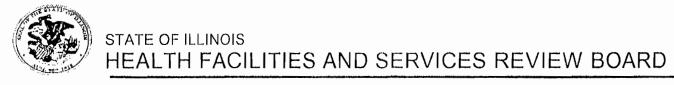
| IDENTIFICATION Name (Please Print) _ | MARNI | JANK | MANZKE |
|---------------------------------------|---------------------------------|--------------------------|--|
| city (REAM) | PARK | State / | zip 601.63 |
| Signature 1 | Jan Jan | 2. Ma | als |
| | e.g.c. | | |
| REPRESENTATION (7 entity.) | This section is ta be filled if | the witness is appearing | on behalf of any graup, organization or othe |
| Entity, Organization Health Care) | , etc. represented i | n this appearance | (i.e., ABC Concerned Citizens for |
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| POSITION (<i>Circle ap</i> | propriate position | | |
| | | | |
| Support | Op | pose | Neutral |



Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001

| I. | Name (Please Print) COLPEN STOEFF |
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| | City MOKENA State IL Zip 60445 |
| | City MOKENA State 11 zip 60495' Signature College Stuff |
| Н. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
| | entity.) |
| | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for |
| | Health Care) SAVE PHFC |
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| | |
| III. | POSITION (Circle appropriate position) |
| | Support Oppose Neutral |



Public Hearing Appearance Only Registration Form

I. IDENTIFICATION

Name (Please Print)

City

Orland lank

State

Ti

Signature

REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other

REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

III. POSITION (Circle appropriate position)

Support

Project Number: 16-001

Oppose

Neutral

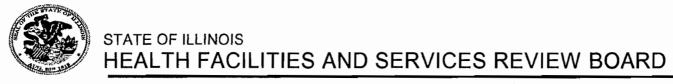


HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Appearance Only Registration Form

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 I. **IDENTIFICATION** Name (Please Print) II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) HI. POSITION (Circle appropriate position) Support Oppose Neutral



| Project N | Number: 16-001 |
|-----------|--|
| l. | Name (Please Print) ROBERTA CONCANNON |
| | City TINLEY PARKState IL zip 604/87 |
| | Signature John Loucaru |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
| | entity.) |
| | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for |
| | Health Care) Palos H+FC members |
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| 111. | POSITION (Circle appropriate position) |
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| | (Support Oppose Neutral |



STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

| Facility | Name: Palos Community Hospital – Orland Park |
|----------|---|
| Project | Number: 16-001 |
| I. | Name (Please Print) 105 Emal VISEMEL |
| | City (D. P. State 7/ zip 60462 |
| | Signature Alexand |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
| | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
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| III. | POSITION (Circle appropriate position) |
| | Support Oppose Neutral |
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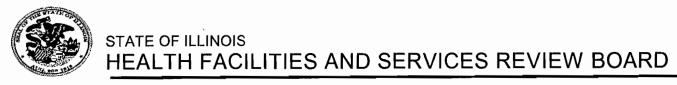


| roject | t Number: 16-001 |
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| I. | Name (Please Print) State Dobroff City Homor Glan State Zip 604 Signature State Table To State Zip 604 |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
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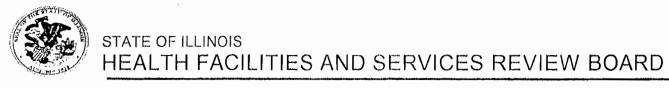
Facility Name: Palos Community Hospital – Orland Park

Project Number: 16-001

| IDENTIFICATION Name (Please Print) | LYONS | | |
|--|-------------------------------|------------------------|----------------------------------|
| City ORLAND PK. | State | , <u>L.</u> | zip 60462 |
| Signature Short 7 | you a | | |
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| Entity, Organization, etc. repre Health Care) | esented in this appe | earance (i.e., ABC | Concerned Citizens for |
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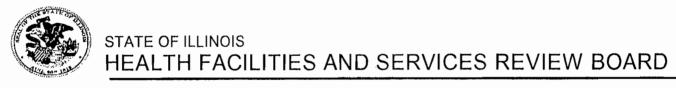


| Project | Number: 16-001 | | | |
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| 1. | IDENTIFICATION Name (Please Print) | ILEEN | DUHIG-1 | -Yous |
| | City DRLAND | PKsta | ate _ <i>i L</i> . | zip_ 60462 |
| | Signature <u>Eile</u> | n Lik | j - Lyons | |
| II. | entity.) | | | alf of any group, organization or other ABC Concerned Citizens for |
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| 111 | DOSITION (Circle general) | viete position! | | |
| III. | POSITION (Circle appropr | rate position) | | |
| | Support | Oppo | se | Neutral |



Project Number: 16-001

| I. | Name (Please Print) CAILL JANKOWSKI' |
|-----|--|
| | City Traley PK State IL Zip 60477 |
| | Signature Carol In Jonhowsh |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
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| Ш. | POSITION (Circle appropriate position) |
| (| Support Oppose Neutral |



| ojecti | Number. 10-001 |
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| 1. | Name (Please Print) Robert S. StRAZ |
| | City PAlos Hts State Ic zip6. VIZ |
| | Signature |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
| | entity.) |
| | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for |
| | Health Care) Health Care) |
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| III. | POSITION (Circle appropriate position) |
| | Support Oppose Neutral |



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|------------|---|
| Project N | Number: 16-001 |
| I. | Name (Please Print) Kara Fredman City Highland Park State L zip 60035 Signature Wara Freelman |
| II. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
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| III. | POSITION (Circle appropriate position) |
| | Support Oppose Neutral |



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| IDENTIFICATION Name (Please Print) | DRRY HUN | τ | | |
| City ORLAND PA | State | - 1L | | |
| Signature Signature | • | | | |
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| entity.) | | | | |
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| Health Care) | | | | |
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