



Certificate of Need Program


REPRESENTATIVE REGISTRATION

| | |
|---|--|
| (A registration form must be completed for each project presented.) | |
| Project Name Mercy Hospital St. Francis | Number 6204 HS |
| (Please type or print legibly.) | |
| Name of Representative Valerie Davis | Title Administrator |
| Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other) Mercy Hospital St. Francis | Telephone Number 417-678-7830 |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | |
| Who's interests are being represented? (If more than one, submit a separate Representative Registration Form for each.) | |
| Name of Individual/Agency/Corporation/Organization being Represented Mercy Hospital St. Francis | Telephone Number 417-934-7000 |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | |
| Check one. Do you: <input checked="" type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Neutral | Relationship to Project: <input type="checkbox"/> None <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Legal Counsel <input type="checkbox"/> Consultant <input type="checkbox"/> Lobbyist <input type="checkbox"/> Other (explain): |
| Other Information: _____ _____ | _____ _____ |
| I attest that to the best of my belief and knowledge the testimony and information presented by me is truthful, represents factual information, and is in compliance with §197.326.1 RSMo which says: <i>Any person who is paid either as part of his normal employment or as a lobbyist to support or oppose any project before the health facilities review committee shall register as a lobbyist pursuant to chapter 105 RSMo, and shall also register with the staff of the health facilities review committee for every project in which such person has an interest and indicate whether such person supports or opposes the named project. The registration shall also include the names and addresses of any person, firm, corporation or association that the person registering represents in relation to the named project. Any person violating the provisions of this subsection shall be subject to the penalties specified in §105.478, RSMo.</i> | |
| Original Signature <i>Valerie Davis</i> | Date 07/07/2025 |



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|--|--|--|--------------------|--------------------------|---|-------------------------------|---------------------------------|--|----------------------------------|--|--|-------------------------------------|--|-----------------------------------|--|---|--------------------|--|-------|--|-------|--|
| Project Name Mercy Hospital St. Francis | | Number 6204 HS | | | | | | | | | | | | | | | | | | | | |
| <i>(Please type or print legibly.)</i> | | | | | | | | | | | | | | | | | | | | | | |
| Name of Representative Roger Strosnider | | Title Sr Mgr-Facilities Maint & Ops | | | | | | | | | | | | | | | | | | | | |
| Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other) Mercy Hospital St. Francis | | Telephone Number 417-934-7007 | | | | | | | | | | | | | | | | | | | | |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | | | | | | | | | | | | | | | | | | | | | | |
| Who's interests are being represented? <i>(If more than one, submit a separate Representative Registration Form for each.)</i> | | | | | | | | | | | | | | | | | | | | | | |
| Name of Individual/Agency/Corporation/Organization being Represented Mercy Hospital St. Francis | | Telephone Number 417-934-7000 | | | | | | | | | | | | | | | | | | | | |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"><tr><td>Check one. Do you:</td><td>Relationship to Project:</td></tr><tr><td><input checked="" type="checkbox"/> Support</td><td><input type="checkbox"/> None</td></tr><tr><td><input type="checkbox"/> Oppose</td><td><input checked="" type="checkbox"/> Employee</td></tr><tr><td><input type="checkbox"/> Neutral</td><td><input type="checkbox"/> Legal Counsel</td></tr><tr><td></td><td><input type="checkbox"/> Consultant</td></tr><tr><td></td><td><input type="checkbox"/> Lobbyist</td></tr><tr><td></td><td><input type="checkbox"/> Other (explain):</td></tr><tr><td colspan="2">Other Information:</td></tr><tr><td colspan="2"><hr/></td></tr><tr><td colspan="2"><hr/></td></tr></table> | | | Check one. Do you: | Relationship to Project: | <input checked="" type="checkbox"/> Support | <input type="checkbox"/> None | <input type="checkbox"/> Oppose | <input checked="" type="checkbox"/> Employee | <input type="checkbox"/> Neutral | <input type="checkbox"/> Legal Counsel | | <input type="checkbox"/> Consultant | | <input type="checkbox"/> Lobbyist | | <input type="checkbox"/> Other (explain): | Other Information: | | <hr/> | | <hr/> | |
| Check one. Do you: | Relationship to Project: | | | | | | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> Support | <input type="checkbox"/> None | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Oppose | <input checked="" type="checkbox"/> Employee | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Neutral | <input type="checkbox"/> Legal Counsel | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Consultant | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Lobbyist | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Other (explain): | | | | | | | | | | | | | | | | | | | | | |
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| Original Signature  | | Date 7/8/2025 | | | | | | | | | | | | | | | | | | | | |



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| (A registration form must be completed for each project presented.) | |
|---|--|
| Project Name Mercy Hospital St. Francis | Number 6204 HS |
| (Please type or print legibly.) | |
| Name of Representative Trish Rees | Title Manager-Radiology Services |
| Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other) Mercy Hospital St. Francis | Telephone Number 417-934-7175 |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | |
| Who's interests are being represented? (If more than one, submit a separate Representative Registration Form for each.) | |
| Name of Individual/Agency/Corporation/Organization being Represented Mercy Hospital St. Francis | Telephone Number 417-934-7000 |
| Address (Street/City/State/Zip Code) 100 US-60 Mountain View, MO 65548 | |
| Check one. Do you: <input checked="" type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Neutral | Relationship to Project: <input type="checkbox"/> None <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Legal Counsel <input type="checkbox"/> Consultant <input type="checkbox"/> Lobbyist <input type="checkbox"/> Other (explain): |
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| Original Signature | Date 7/2/2025 |