CERTIFICATION FORM
FOR NNSA DIRECTIVES

NNSA Directive Number: _____

NNSA Directive Title: _____

Certification Date: _____

Office of Primary Interest: _____

Point of Contact: _____

E-Mail Address: _____

Telephone Number: _____

Date: _____

Recommendation: (Initial one of the options below.)

_____ This NNSA Directive is accurate and relevant in its current form.
_____ Incorporate into existing NNSA Directive (SD/NAP) _____
_____ Develop new NNSA Directive
_____ This NNSA Directive is no longer needed

Comments:

_____

_____

Authorizing Signature:

_____Date: _____

Print Name and Title:

_____