APPLICATION FOR SITE SURVEY AND CERTIFICATION
OF OFFICE BASED SURGICAL SUITE – MD

All Application Fees Are Non-Refundable

NOTICE: A PHYSICIAN OFFICE AT WHICH LEVEL III SURGICAL PROCEDURES ARE PERFORMED IN AN OFFICE-BASED SURGICAL SUITE AS OF OCTOBER 1, 2007 MUST SUBMIT AN APPLICATION FOR A SITE SURVEY AND CERTIFICATION AND REMIT PAYMENT OF THE OFFICE-BASED SURGERY FEE TO THE DEPARTMENT OF HEALTH.

Level III surgical procedures require sedation which is defined as the use of a general anesthesia, deep sedation, or major conduction anesthesia and pre-operative sedation. This includes the use of: (a) General Anesthesia: loss of consciousness and loss of vital reflexes with probable requirement of external support of pulmonary or cardiac functions; and/or (b) Major Conduction Anesthesia (epidural, spinal, caudal); and/or (c) The use of nitrous oxide in conjunction with other types of sedatives.

APPLICATION INSTRUCTIONS

1. A physician office surgical suite is required to be certified by the Board in order to perform office-based surgery. The Responsible Physician (the physician in whose name the surgical suite certification will be issued for the office) must complete the Application for Site Survey and Certification of Office Based Surgical Suite. Attachments listed below as required must be included. Be sure that it has been signed and notarized.

   a) Written verification of hospital staff privileges from a hospital within an acceptable distance for the surgical suite where you have staff privileges to perform Level II surgeries.

   b) Copy of board specialty certification or a copy of the letter stating eligibility and the date to sit for the exam.

   c) Written verification of medical malpractice coverage.

   d) Architectural drawings for: 1) Life Safety Features; 2) Mechanical; and, 3) Electrical.

2. Please complete Attachment 1 for each physician that will be performing Level III procedures in the office-based surgery suite with attachments listed below as required.
a) Written verification of hospital staff privileges from a hospital within an acceptable
distance from the surgical suite where you have staff privileges to perform Level III
surgeries.
b) Copy of board specialty certification or a copy of the letter stating eligibility and the date
to sit for the exam.
c) Written verification of medical malpractice coverage.
d) Proof of ACLS Certification.

3. State law requires that no more than three (3) patients in a physician's office undergoing Level III
office-based surgery may be incapable of self-preservation at the same time. The board has
promulgated rules requiring physician offices that perform office-based surgery to adopt bylaws
that put in place a management system and documentation that will insure that no more than
three (3) patients that are in surgery or recovery are incapable of self-preservation at the same
time. Please attach your office based surgery suite's by-laws and documentation of the
management system with your application for surgical suite certification.

4. Send the completed application with a check or money order made payable to the TENNESSEE
DEPARTMENT OF HEALTH for the appropriate certification fee indicated on the front of the
application to:

   Board of Medical Examiners
   665 Mainstream Drive
   Nashville, Tennessee 37243

5. When the completed application is received and reviewed, the Board of Medical Examiners will
transmit it to the Department of Health, Division of Healthcare Facilities (HCF) for the purposes of
conducting the survey. After the survey is completed, HCF will transmit the results to the Board of
Medical Examiners who will make the final determination on the certification of the surgical suite
for office-based surgery.

6. The initial certification will be for one year. Annual renewal of the certification is required.
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A physician office surgical suite is required to be certified by the Board in order to perform Level III surgical procedures. Please provide the name and address of the facility to be certified and the name of the responsible physician in whose name the surgical suite certification can be issued for the office.

Name and address of the facility to be certified:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Telephone Number: (____) ____________________ Fax Number: (____) ____________________

Name of Responsible Physician: ___________________________ TN License Number: __________
First Middle Last

Address:_____________________________________________________________________________
Telephone Number: (____) ____________________ Fax Number: (____) ____________________

Please provide a list of all Level III Procedures you, the responsible physician plans on performing at this Office Based Surgical Suite.

Level III Procedures: ___________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Identify each hospital where you have privileges to perform the above identified procedures. Please provide written verification. At least one hospital where you have hospital staff privileges to perform Level III surgical procedures must be within an acceptable distance from the surgical suite.

________________________________________________________

________________________________________________________

Are you board certified? ______  _____ (Please provide copy of board certification or board eligibility)
Yes   No

Are you board eligible? ______  _____ If board eligible, date scheduled to take the exam: __________
Yes   No

Does he/she have medical malpractice coverage? ______  _____ (Please provide written verification)
Yes   No  of malpractice coverage)

Applicant: Fill out the following Affidavit in the Presence of a Notary Public

Affidavit and Release

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

________________________________________________________  __________________________
SIGNATURE                                             DATE

Sworn to before me this ______ day of ________________, ______.

________________________________________________________  Affix Seal Here
NOTARY PUBLIC

My Commission expires: ________________________________

__________________________________________  DATE
TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

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(Please fill out this Form for EACH Physician that will be performing
Level III surgical procedures in the Office-Based Surgical Suite)

For each physician performing Level III surgical procedures in this Office Based Surgical Suite, please provide the following:

Name of Physician: ______________________________ TN License Number: ___________________
                        First           Middle           Last

Please provide a list of all Level III Procedures you, the responsible physician plans on performing at this Office Based Surgical Suite.

Level III Procedures: ___________________________________________________________________
                        ____________________________________________________________________________
                        ____________________________________________________________________________
                        ____________________________________________________________________________

Identify each hospital where you have privileges to perform the above identified procedures. Please provide written verification. At least one hospital where you have hospital staff privileges to perform Level III surgical procedures must be within an acceptable distance from the surgical suite.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Are you board certified? ______   _____ (Please provide copy of board certification or board eligibility)
                        Yes            No
Are you board eligible? ______   _____ If board eligible, date scheduled to take the exam:__________
                         Yes            No
Does he/she have medical malpractice coverage? ______   _____ (Please provide written verification
                        Yes            No of malpractice coverage)