AMBULATORY SURGICAL TREATMENT CENTER RENEWAL APPLICATION

All applicable law, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html. Please check this website periodically for updates.

Name of the Facility/Agency ______________________________

Facility License Number ______________________________

Location of the Facility:

Street ______________________ City ______________________

County ______________ State ______________ Zip ______________

Phone Number (______) ______________ Fax Number (______) ______________

Twenty-four (24) Hour Emergency Phone Number (_______) ______________

E-Mail Address ______________________________

Administrator Information:

Administrator ______________________________

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, or fraud)? Yes_______ No_______

If yes, what charge(s)? ______________________________

Location of Conviction ______________________ Date ______________
(City) (County) (State)

Mailing address if different from the Facility location address:

Name ______________________________

Street ______________________________

City ______________ State ______________ Zip ______________

Ownership of Building:

Name ______________________ Phone Number (______) ______________

Street ______________________________

City ______________ State ______________ Zip ______________

1. Check classification of institution for which application is made:

General Surgical Clinic______	Maternity Clinic ______	Gynecological Clinic______	Other (specify)________
Abortion Clinic______	Plastic Surgery______	Ophthalmological Clinic______	
EENT Clinic ______	Urological Clinic______	Gastroenterology Clinic______	
Dental Clinic______	Acupuncture Clinic______	Cancer Treatment Clinic ______	

2. Briefly state the overall objective of the surgical treatment center: ____

____

3. a. List the number of Magnetic Resonance Imaging (MRI) machines & Positron Emission Tomography (PET) units utilized in your facility.

MRI machines ______ PET units _____

b. If MRI &/or PET machines/units are utilized, does your facility hold accreditation by a nationally recognized & CMS approved accrediting organization per machine, unit, and/or diagnostic type? **If so, provide proof of accreditation.**

Yes______ No_______ Expiration Date____________________________________

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual ______ Partnership ______ Corporation ______ Limited Liability Company_______

Church Related ______ Government/County ______ Other________

b. Check one: For Profit ______ Non-profit ______

c. Legal Entity checked in 1.a:

Name____ Phone Number (______)_____________________

Street ____

City____State_____________________________Zip_____________

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

____

Name Address City, State, Zip

____

Name Address City, State, Zip

(If additional space is needed, please use a separate sheet)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes ______ No ______

f. If no to e., who has said authority? ____

2. a. Is the ambulatory surgical treatment center a hospital-based ambulatory surgical treatment center? Yes ______ No ______

b. Is the ambulatory surgical treatment center a non-hospital ambulatory surgical treatment center?

Yes________No______

3. a. Is this facility/organization accredited by a **federal approved** accrediting body (i.e., JCAHO, CARF, etc.)? **Provide proof of current accreditation.**

Yes_______ No______ Expiration Date______________________________

4. a. Is this facility chain affiliated? Yes______ No______

b. If yes, list name, address, and phone number of the parent company:

Name______________________________Phone Number (_____)________________

Street____

City____________________State_______________Zip______________

5. a. If a corporation, is there a holding company/parent corporation? Yes______ No ______

b. If yes, list the name, address, and phone number of the holding company/parent corporation.

Name______________________________Phone Number (______)________________

Street____

City____________________State_______________Zip______________

6. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes______ No ______

b. If yes, list names and addresses of all such facilities:

____

____

____

7. a. Do you have a contract with a management firm to operate this facility? Yes______ No ______

If yes, specify dates: From________________________ To ____________________

b. If yes, specify name of firm:______________________________________

Street______________________________ Phone number (_________)________________

City____________________State_______________Zip______________

8. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other states? Yes________ No________

b. If yes, where?______________________________When?____________________

c. For what reason?____

FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION. FEES ARE NON-REFUNDABLE.

<u>VERIFICATION BY APPLICANT:</u>

Signee for application verifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also verifies that a policy has been implemented to inform all employees of their obligation under T.C.A. §71-6-103 to report incidents of abuse or neglect.

______________________________	______________________	____________
Applicant Signature	Title or Position	Date