



## AMBULATORY SURGICAL TREATMENT CENTER RENEWAL APPLICATION

All applicable laws, 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: \_\_\_\_\_  
 \_\_\_\_\_

**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
_____	_____	_____
_____	_____	_____

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

Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date \_\_\_\_\_

3. 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 \_\_\_\_\_

4. 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 \_\_\_\_\_

5. 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. 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 \_\_\_\_\_

7. 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.**

**VERIFICATION BY APPLICANT:**

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 TCA §71-6-103 to report incidents of abuse or neglect.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Title or Position

\_\_\_\_\_  
Date