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

   _____

   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 your facility/organization accredited by a **federally 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.

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