HOSPITAL
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 _____Total Number of Licensed Beds_____

Administrator _____

List number of following types of beds:

_____Swing Beds_____NICU Beds_____Psychiatric Beds_____Alcohol and Drug Beds_____Rehab Beds

Type of Hospital (please check one):

_____General_____CAH_____Chronic Disease_____Orthopedic_____Pediatric_____Eye, Ear, Nose Throat and Rehab

____ Rural Emergency Hospital (REH)

_____Trauma Care Level (**circle one**) I II III or IV

Pediatric Emergency Care Facility Designation (please check one):

_____Basic_____CRPC_____General_____Primary

1. a. Do you have a ST-Elevation Myocardial Infarction (STEMI) designation? Yes_____No_____

   b. If yes, provide proof of designation, and please check one:

   _____Receiving Center _____Referring Center _____N/A

2. a. Do you have a Stroke related designation? Yes_____No_____

   b. If yes, provide proof of designation, and please check one:

_____Comprehensive Stroke Center_____Primary Stroke Center_____Acute Stroke-Ready Hospital

_____Other_____N/A

Mailing address if different from the Facility location address:

Name_____

Street_____

City_____State_____Zip _____

Ownership of Building:

Name_____Phone Number (_____)_____

Street_____

City_____State_____Zip _____

Satellite Hospitals:

1. Number of satellite hospitals: _____

Provide the name, address, phone number and number of beds of each satellite hospital:

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

_____

_____

_____

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 Code

_____

Name Address City, State, Zip Code

_____

Name Address City, State, Zip Code

(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 deemed by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.?

Yes_____ No_____ Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body including but not limited JCAHO, CARF, etc.?

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? Yes_____No _____

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

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 _____

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