



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