**State of Tennessee**
**Health Facilities Commission**
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
**www.tn.gov/hfc** Phone: 615-741-2364 hsda.staff@tn.gov

# INITIAL NOTIFICATION OF EXEMPTION OF CERTIFICATE OF NEED ACTIVITY IN COUNTY WITHOUT A LICENSED HOSPITAL

**Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a Certificate of Need service within a county that contains no actively licensed hospital under Public Chapter 985 effective July 1, 2025. This form must be emailed to hsda.staff@tn.gov.**

1. **REPORTING DATE:** _____

2. **NAME AND ADDRESS OF PROPOSED PROJECT**

_____
**Name**

_____
**Address**

_____
**City** **State** **Zip**

3. **NAME AND ADDRESS OF OWNER OF PROJECT**

_____
**Name**

_____
**Address**

_____
**City** **State** **Zip**

**Will the project be a satellite? If so, with whom?** _____

## 4. CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION

**Name** **Title**

**Email Address**

**Company Name**

**Address**

**City** **State** **Zip**

**Phone Number** **Fax Number**

## 5. CHECK THE COUNTY WHERE EXEMPTION ACTIVITY TAKES PLACE:

| | | | |
|---|---|---|---|
| ____ Chester | ____ Grundy | ____ Moore | ____ Stewart |
| ____ Crockett | ____ Jackson | ____ Morgan | ____ Union |
| ____ Decatur | ____ Lake | ____ Perry | ____ Van Buren |
| ____ Fayette | ____ Lewis | ____ Pickett | |
| ____ Fentress | ____ McNairy | ____ Polk | |
| ____ Grainger | ____ Meigs | ____ Sequatchie | |

**6. CHECK THE CON PROJECT TYPE REQUESTING EXEMPTION:**
*Check all that are appropriate*

_____ **Ambulatory Surgical Treatment Center – Single Specialty**

_____ **Ambulatory Surgical Treatment Center – Multi-Specialty**

_____ **Cardiac Catheterization – Diagnostic**

_____ **Cardiac Catheterization – Therapeutic**

_____ **Cardiac Catheterization – Both Diagnostic and Therapeutic**

_____ **Comprehensive Inpatient Rehabilitation Services**

_____ **Acute Care Hospital**

_____ **Long-Term Hospital**

_____ **Outpatient Diagnostic Center**

_____ **Positron Emission Tomography (PET)**

_____ **Intellectual Disability Institutional Habilitation Facility – ICF/IID**

_____ **Magnetic Resonance Imaging (MRI)**

_____ **Relocation of existing Certificate of Need within exempted county.**

_____ **Freestanding Emergency Department**
*(Must be at least 10 miles from any actively licensed acute care hospital or FSED in another county.)*
*Provide proof of compliance using Google Maps.*

**7. DESCRIPTION OF REQUESTED CON EXEMPTED PROJECT:**

| |
|---|
| |

8. **IF THE PROJECT IS RELOCATING AN APPROVED CON, INDICATE PROJECT AND CON NUMBER:**

| |
|---|
| |

9. **ACCREDITATION – WILL THE PROJECT BE ACCREDITED? If so, with whom.**

**Please Check**

_____ **(AAAASF – American Association for Accreditation Ambulatory Surgery Facilities**

_____ **(ACHC) – Accreditation Commission for Health Care**

_____ **(ACR) – American College of Radiology**

_____ **(ACRO) – American College of Radiation Oncology**

_____ **(ASTRO) – American Society for Radiation Oncology**

_____ **(CARF) – Commission on Accreditation of Rehabilitation Facilities**

_____ **(CCAC) – Continuing Care Accreditation Commission**

_____ **(CHAP) – Community Health Accreditation Partner**

_____ **(DNV) – Det Norske Veritas Healthcare's National Integrated Accreditation for Healthcare Organizations**

_____ **(HFAP) – Health Facilities Accreditation Program**

_____ **(NCQA) – National Committee for Quality Assurance**

_____ **(TJC) – The Joint Commission**

_____ **(URAC) – Utilization Review Accreditation Commission**

_____ **Other – Specify:** _____

10. **IF NOT PLANNING TO BE ACCREDITED, PLEASE EXPLAIN BELOW:**

| |
|---|
| |

11. **TARGET DATE FOR COMPLETION:** _____

**(INSERT STATEMENT/ATTESTATION FOR SIGNATURE HERE)**

| | |
|---|---|
| **Signature** | **Date** |
| **Printed Name** | |