PROCEDURES FOR APPLYING FOR RENEWAL OF SERVICE LINES FOR HOSPITALS OR OUTPATIENT DIAGNOSTIC CENTERS

1. Please complete the entire application responding to each applicable field. All applications must be signed by an authorized representative. Incomplete or unsigned applications will be returned which may delay the processing of the application.

2. All applications will need to be emailed to hfc.service@tn.gov . An email will be sent to the applicant within two (2) business days of receipt verifying that the application was received.

3. If the application involves MRI and/or PET, please review HFC's Medical Equipment Registry to ensure information submitted on the licensure application is consistent with previously submitted data.

4. Upon receipt of the application, HFC staff will review the application for completeness. Once determined to be complete, an invoice will be sent to the listed Billing contact. The requested license fee will need to be submitted to Health Facilities Commission, following the invoice instructions, by listed due date on the invoice.

   Licensing fee schedule is listed at the end of the application.

5. Once the license fees have been received, an approval letter will be sent to the listed CEO/Administrator.

   a. The renewal license certificate will then be created and mailed to the licensee. You should receive the physical license in ten (10) to fourteen (14) days.

All applicable laws, rules, policies, and guidelines 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.

Please note the licensure application does not take the place of the HFC Medical Equipment Registry. Medical Equipment Yearly submissions are still required.

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

RENEWAL APPLICATION FOR LICENSE OF SERVICES FOR HOSPITAL/OUTPATIENT DIAGNOSTIC CENTER

1. NAME AND PHYSICIAL ADDRESS OF FACILITY OF SERVICE

Provider Type (Check One): □ Hospital □ Outpatient Diagnostic Center (ODC)

Name

Address

City **State** **ZIP**

License Number:

2. CEO/ADMINISTRATOR OF PROVIDER

Name **Title**

Email Address

Company Name

Address

City **State** **ZIP**

Phone Number

3. BILLING INFORMATION FOR FACILITY

Name **Title**

Email Address

Company Name

Address

City **State** **ZIP**

Phone Number

On the following items, check all appropriate services to be licensed.

Have any of the following services been changed since the last occupancy approval or have had a Plans Review related to that service since the last approval? □ Yes □ No

If yes, what were the changes and date of changes?:

□ **RENEWAL OF A BURN UNIT:**

Physical Address of Service: _____

Number of Beds _____

What Age Group Will Be Served/Licensed?: □ Pediatric □ Adult □ Both

Will the Burn Unit be Verified by ABA?: □ Yes □ No (Please attach documentation of verification.)

If no, why:

□ **ESTABLISHING MRI UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: _____

Name Brand of Unit _____

Tesla _____

Type (i.e. Close, Short Bore, etc.) _____

Unit's Serial Number _____

Will the MRI Unit be Accredited?: □ Yes □ No

If MRI Unit will be Accredited, is it □ PENDING □ ACCREDITED

If ACCREDITED, What Organization? _____
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission. □ Yes □ No

□ **ESTABLISHING PET UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: _____

Name Brand of Unit _____

Type (i.e. PET Only, PET/CT, PET/MRI) _____

Unit's Serial Number _____

Will the PET Unit be Accredited?: □ Yes □ No

If PET Unit will be Accredited, is it □ PENDING □ ACCREDITED

If ACCREDITED, What Organization? _____
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission. □ Yes □ No

□ **RENEWAL NEONATAL INTENSIVE CARE UNIT (NICU):**

Physical Address of Service: _____

Choose Designation Type: □ **Designation at Different Level**

What is the Current License Level of Care? _____

□ **Renewal of NICU License**

□ **Ownership/Physical Location Change**

Number of Beds by Each Level

Level II _____
Level III _____
Level III with Surgery _____
Level IV _____

Have you been evaluated by AAP?: □ **Yes** □ **No**
If yes, please provide documentation.

Designate Expiration Date: _____

Neonatal Program Manager

_____
Name **Title**

_____
Email Address

_____
Phone Number

Neonatal Medical Director

_____
Name **Title**

_____
Email Address

_____
Phone Number

Pursuant to Tennessee Rule of Civil Procedure 72, I hereby declare under perjury that the information provided in this application is true and correct. Signee for this application certifies 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 services for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated §68-11-201 and Rules 0720-.14, 0720-36, and 0720-47 adopted by the Commission effective December 1, 2025. Signee also certifies 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.

Signature	**Date**

Printed Name

Non-Refundable Licensing Fees for Listed Licensed Services

An invoice will be sent to the contact for Billing for total payment of fees.

Burn Unit

Hospital: $1040

Neonatal Intensive Care Unit (NICU)

Hospital: $1040

MRI:

Hospital: $500 per MRI unit
Outpatient Diagnostic Center: Included with ODC License
Physician Office: $500 per MRI unit

PET:

Hospital: $500 per MRI unit
Outpatient Diagnostic Center: Included with ODC License
Physician Office: $500 per MRI unit

(as of December 1, 2025)