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 APPLICATION FOR LICENSE OF SERVICES FOR HOSPITAL OR OUTPATIENT DIAGNOSTIC CENTER

1. NAME AND PHYSICIAL ADDRESS OF FACILITY OF SERVICE

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

Baptist Hospital Collierville
Name

1500 West Poplar Ave
Address

Collierville	**TN**	**38017**
City	**State**	**ZIP**

00000000104
License Number:

2. CEO/ADMINISTRATOR OF PROVIDER

Lindsay Stencel	**CEO**
Name	**Title**

Linsey.stencel@bmhcc.org
Email Address

Baptist Hospital Collierville
Company Name
1500 West Poplar Ave
Address

Collierville	**TN**	**38017**
City	**State**	**ZIP**

901-861-9411
Phone Number

3. **BILLING INFORMATION FOR FACILITY**

Patricia Conrad	Accounts Payable	
Name	Title	
Patricia.conrad@bmhcc.org		
Email Address		
Baptist Memorial Corp		
Company Name		
350 Humphries Blvd		
Address		
Memphis	TN	38120
City	State	ZIP
901-227-7742		
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 x No

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

□ **ESTABLISHMENT 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: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Magnetom Altea

Tesla 1.5

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

Unit's Serial Number 18962

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

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

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

If no, why:

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

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

Physical Address of Service: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Biograph Trinion

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

Unit's Serial Number 28468

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

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

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

If no, why:

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

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

Physical Address of Service: _____

Choose Designation Type: □ **First Time Self Designation/Initial NICU License**

□ **Designation at Different Level**

What is the Current License Level of Care? _____

What is the Requested Level? _____

□ **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.

Tracy Vest 12/1/2025

Signature **Date**

Tracy Vest

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)

Distribution List:
Purchaser
Assembler
State Radiation Health Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION
REPORT OF ASSEMBLY OF A DIAGNOSTIC X-RAY SYSTEM

Form Approved: OMB No. 0910-0025
Expiration Date: February 28,2026
See Reverse for PRA Statement

Assembler/Purchaser Control Number
904196 06-25-2025

1. EQUIPMENT LOCATION

a. NAME OF HOSPITAL, DOCTOR OR OFFICE WHERE INSTALLED: **Akumin / Alliance Healthcare Services**

b. STREET ADDRESS: **18201 Von Karman- Suite 600**

c. CITY: **Irvine** | d. STATE: **CA**

e. ZIPCODE: **92612** | f. TELEPHONE NUMBER: **502-706-9290**

2. ASSEMBLER INFORMATION

a. COMPANY NAME: **Siemens Medical Solutions USA, Inc.**

b. STREET ADDRESS: **221 Gregson Drive**

c. CITY: **Cary** | d. STATE: **NC**

e. ZIPCODE: **27511** | f. TELEPHONE NUMBER: **919-804-8395**

3. GENERAL INFORMATION

a. THIS REPORT IS FOR ASSEMBLY OF CERTIFIED COMPONENTS WHICH ARE (Check appropriate box(es))

- ☒ NEW ASSEMBLY- FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY-FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY-MIXED SYSTEM (Both certified and non-certified components)
- ☐ REPLACEMENT COMPONENTS IN AN EXISTING SYSTEM
- ☐ AN ADDITION TO AN EXISTING SYSTEM

b. INTENDED USE(S) (Check appropriate box(es))

☐ GENERAL PURPOSE RADIOGRAPHY	☐ UROLOGY	☒ CT WHOLE BODY SCANNER	☐ RADIATION THERAPY SIMULATOR	☐ OTHER (Specify in comments)
☐ GENERAL PURPOSE FLUOROSCOPY	☐ MAMMOGRAPHY	☐ HEAD-NECK (Medical)	☐ C-ARM FLUOROSCOPIC	
☐ TOMOGRAPHY (Other than CT)	☐ CHEST	☐ DENTAL-INTRAORAL	☒ DIGITAL	
☐ ANGIOGRAPHY	☐ CHIROPRACTIC	☐ DENTAL-CEPHALOMETRIC	☐ BONE MINERAL ANALYSIS	
☐ PODIATRY	☒ CT HEADSCANNER	☐ DENTAL-PANORAMIC	☐ DENTAL-CT	

c. THE X-RAY SYSTEM IS (Check one)
- ☒ STATIONARY
- ☐ MOBILE

d. THE MASTER CONTROL IS IN ROOM: **Mobile Control room**

e. DATE OF ASSEMBLY: **06/25/2025** (mm) (dd) (yyyy)

4.COMPONENT INFORMATION *(If additional space is needed for the section use another form, replacing the preprinted number with this Form Number, and complete Items 1, 4, and 5 only)*

a. THE MASTER CONTROL IS
- ☒ NEW INSTALLATION
- ☐ EXISTING (Certified)
- ☐ EXISTING (Non-certified)

b. CONTROL MANUFACTURER: **Siemens AG**

d. CONTROL SERIAL NUMBER: **28468**

e. DATE MANUFACTURED: **03/2025**

c. CONTROL MODEL NUMBER: **11061357**

f. SYSTEM MODEL NAME (CT Systems Only): **Biograph Trinion**

Complete the following information for the certified components listed below which you installed. For beam limiting devices, tables and CT gantries enter the manufacturer and Model number in the indicated spaces. For other certified components, enter in the appropriate blocks how many of each you installed in the system.

g. SELECTED COMPONENTS

	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	Siemens AG	11061232	04/2025
	Siemens AG	10755469	04/2025
	Siemens AG	11664100	04/2025

h. OTHER CERTIFIED COMPONENTS (Enter number of each installed in appropriate blocks)

1	X-RAY CONTROL	0	CRADLE
1	HIGH VOLTAGE GENERATOR	0	FILM CHANGER
0	VERTICAL CASSETTE HOLDER	0	IMAGE INTENSIFIER
1	TUBE HOUSING ASSEMBLY	0	SPOT FILM DEVICE
0	DENTAL TUBE HEAD	0	FLUOROSCOPIC IMAGING ASSEMBLY
0	CEPHALOMETRIC DEVICE	0	IMAGE RECEPTOR
0	IMAGE RECEPTOR SUPPORT DEVICE	0	FLUOROSCOPIC AIR KERMA DISPLAY DEVICE
0	OTHER		

5.ASSEMBLER CERTIFICATION

I affirm that all certified components assembled or installed by me, for which this report is being made, were adjusted and tested by me according to the instructions provided by the manufacture(s), were of the type required by the manufacturer(s), were of the type required by the diagnostic x-ray performance standard (21 CFR Part 1020), were not modified to adversely affect performance, and were installed in accordance with provisions of 21 CFR Part 1020. I also affirm that all instruction manuals and other information required by 21 CFR Part 1020 for this assembly have been furnished to the purchaser and, within 15 days following completion of the assembly, a copy of this form will be submitted to the purchaser and, where applicable, to the State agency responsible for radiation protection.

a. PRINTED NAME: **Headrick,Steve**

b. SIGNATURE

Signature: Sandi G. Christianson *Electronically signed by: Sandi Christianson Reason: I have reviewed this document Date: Jun 26, 2025 11:19 EDT*

Email: sandi.christianson@siemens-healthineers.com

Signed for: Headrick,Steve 6/25/2025

6.COMMENTS

New Install:Biograph Trinion FL:400-904196

FORM FDA 2579 (02/23) PREVIOUS EDITIONS MAY BE USED

Contact Information for State Radiation Health Offices is available on the website of the Conference of Radiation Control Program Directors (CRCPD), https://www.crcpd.org/mpage/Map
Form may be downloaded at: https://www.fda.gov/media/144454/download

Contact Information for State Radiation Health Offices is available on the website of the Conference of Radiation Control Program Directors (CRCPD), https://www.crcpd.org/mpage/Map

Form may be downloaded at: https://www.fda.gov/media/144454/download

This section applies only to requirements of the Paperwork Reduction Act of 1995

DO NOT SEND YOUR COMPLETED FORM TO THE PRA STAFF EMAIL ADDRESS BELOW.

The burden time for this collection of information is estimated to average 18 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden, to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."

Baptist Memorial Hospital - Collierville - MRI

1500 West Poplar Ave.
Collierville, Tennessee 38017

was surveyed by the
ACR Committee on MRI Accreditation
of the Commission on Quality and Safety

The following magnet was approved

Siemens Medical Systems MAGNETOM Altea 2021

For

Body, Head, MRA, MSK, Spine

Accredited from:

December 07, 2023 through March 29, 2027

CHAIR, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 02821-04

ATTACHMENT - A

MEDICAL EQUIPMENT INFORMATION

Equipment Type (i.e. MRI or PET)	Physical Address of Service	Brand Name	Type (i.e. Tesla/Short Bore; PET/CT)	Serial Number	Accredited (Yes/No/Pending)	Accreditation Organization	Unit Registered with HFC (Yes/No)
PET/CT	1500 West Poplar Ave Collierville TN 38107	Siemens Biograph Trinion	PET/CT	28468	YES	FDA	NO
MRI	1500 West Poplar Ave Collierville TN 38107	Siemens Magnetom Altea	MRI 1.5 TESLA closed bore	18962	yes	ACR	NO

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 APPLICATION FOR LICENSE OF SERVICES FOR HOSPITAL OR OUTPATIENT DIAGNOSTIC CENTER

1. **NAME AND PHYSICIAL ADDRESS OF FACILITY OF SERVICE**

Provider Type (Check One): X **Hospital** = **Outpatient Diagnostic Center (ODC)**

Baptist Hospital Collierville
Name

1500 West Poplar Ave
Address

Collierville	TN	38017
City	State	ZIP

00000000104
License Number:

2. **CEO/ADMINISTRATOR OF PROVIDER**

Lindsay Stencel	CEO
Name	Title

Linsey.stencel@bmhcc.org
Email Address

Baptist Hospital Collierville
Company Name

1500 West Poplar Ave
Address

Collierville	TN	38017
City	State	ZIP

901-861-9411
Phone Number

3. **BILLING INFORMATION FOR FACILITY**

Patricia Conrad	Accounts Payable	
Name	Title	
Patricia.conrad@bmhcc.org		
Email Address		
Baptist Memorial Corp		
Company Name		
350 Humphries Blvd		
Address		
Memphis	TN	38120
City	State	ZIP
901-227-7742		
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 x No

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

☐ **ESTABLISHMENT 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: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Magnetom Altea

Tesla 1.5

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

Unit's Serial Number 18962

Will the MRI Unit be Accredited?: ☒X Yes ☐ No

If MRI Unit will be Accredited, is it ☐ PENDING ☒X ACCREDITED

If ACCREDITED, What Organization? ACR hospital Joint Commission Accredited
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission. ☐ Yes ☒X No

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

Physical Address of Service: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Biograph Trinion

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

Unit's Serial Number 28468

Will the PET Unit be Accredited?: ☒X Yes ☐ No

If PET Unit will be Accredited, is it ☐ PENDING ☒X ACCREDITED

If ACCREDITED, What Organization? TJC Hospital Joint Commission Accredited
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission. ☒ **Yes** ☐ **No**

Baptist Memorial Hospital - Collierville - MRI

1500 West Poplar Ave.
Collierville, Tennessee 38017

was surveyed by the
ACR Committee on MRI Accreditation
of the Commission on Quality and Safety

The following magnet was approved

Siemens Medical Systems MAGNETOM Altea 2021

For

Body, Head, MRA, MSK, Spine

Accredited from:

December 07, 2023 through March 29, 2027

CHAIR, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP=0282148

Distribution List:
Purchaser
Assembler
State Radiation Health Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION
REPORT OF ASSEMBLY OF A DIAGNOSTIC X-RAY SYSTEM

Form Approved: OMB No. 0910-0025
Expiration Date: February 28,2026
See Reverse for PRA Statement

Assembler/Purchaser Control Number
904196 06-25-2025

1. EQUIPMENT LOCATION

a. NAME OF HOSPITAL, DOCTOR OR OFFICE WHERE INSTALLED
Akumin / Alliance Healthcare Services

b. STREET ADDRESS
18201 Von Karman- Suite 800

c. CITY
Irvine

d. STATE
CA

e. ZIPCODE
92612

f. TELEPHONE NUMBER
502-708-6290

2. ASSEMBLER INFORMATION

a. COMPANY NAME
Siemens Medical Solutions USA, Inc.

b. STREET ADDRESS
221 Gregson Drive

c. CITY
Cary

d. STATE
NC

e. ZIPCODE
27511

f. TELEPHONE NUMBER
919-804-8395

3. GENERAL INFORMATION

a. THIS REPORT IS FOR ASSEMBLY OF CERTIFIED COMPONENTS WHICH ARE (Check appropriate box(es))

- [X] NEW ASSEMBLY- FULLY CERTIFIED SYSTEM
- [ ] REASSEMBLY-FULLY CERTIFIED SYSTEM
- [ ] REASSEMBLY-MIXED SYSTEM (Both certified and non-certified components)
- [ ] REPLACEMENT COMPONENTS IN AN EXISTING SYSTEM
- [ ] AN ADDITION TO AN EXISTING SYSTEM

b. INTENDED USE(S) (Check appropriate box(es))

- [ ] GENERAL PURPOSE RADIOGRAPHY
- [ ] GENERAL PURPOSE FLUOROSCOPY
- [ ] TOMOGRAPHY (Other than CT)
- [ ] ANGIOGRAPHY
- [ ] PODIATRY
- [ ] UROLOGY
- [ ] MAMMOGRAPHY
- [ ] CHEST
- [ ] CHIROPRACTIC
- [X] CT HEADSCANNER
- [X] CT WHOLE BODY SCANNER
- [ ] HEAD-NECK (Medical)
- [ ] DENTAL-INTRAORAL
- [ ] DENTAL-CEPHALOMETRIC
- [ ] DENTAL-PANORAMIC
- [ ] RADIATION THERAPY SIMULATOR
- [ ] C-ARM FLUOROSCOPIC
- [X] DIGITAL
- [ ] BONE MINERAL ANALYSIS
- [ ] DENTAL-CT
- [ ] OTHER (Specify in comments)

c. THE X-RAY SYSTEM IS (Check one)

- [X] STATIONARY
- [ ] MOBILE

d. THE MASTER CONTROL IS IN ROOM
Mobile Control room

e. DATE OF ASSEMBLY
06/25/2025
(mm) (dd) (yyyy)

4.COMPONENT INFORMATION *(If additional space is needed for the section use another form, replacing the preprinted number with this Form Number, and complete Items 1, 4, and 5 only)*

a. THE MASTER CONTROL IS

- [X] NEW INSTALLATION
- [ ] EXISTING (Certified)
- [ ] EXISTING (Non-certified)

b. CONTROL MANUFACTURER
Siemens AG

c. CONTROL SERIAL NUMBER
28468

d. DATE MANUFACTURED
03/2025

e. CONTROL MODEL NUMBER
11061357

f. SYSTEM MODEL NAME (CT Systems Only)
Biograph Trinion

Complete the following information for the certified components listed below which you installed. For beam limiting devices, tables and CT gantries enter the manufacturer and Model number in the indicated spaces. For other certified components, enter in the appropriate blocks how many of each you installed in the system.

g. SELECTED COMPONENTS

	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	Siemens AG	11061232	04/2025
	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	Siemens AG	10755469	04/2025
	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	Siemens AG	11884100	04/2025

h. OTHER CERTIFIED COMPONENTS
(Enter number of each installed in appropriate blocks)

1	X-RAY CONTROL	0	CRADLE
1	HIGH VOLTAGE GENERATOR	0	FILM CHANGER
0	VERTICAL CASSETTE HOLDER	0	IMAGE INTENSIFIER
1	TUBE HOUSING ASSEMBLY	0	SPOT FILM DEVICE
0	DENTAL TUBE HEAD	0	FLUOROSCOPIC IMAGING ASSEMBLY
0	CEPHALOMETRIC DEVICE	0	IMAGE RECEPTOR
0	IMAGE RECEPTOR SUPPORT DEVICE	0	FLUOROSCOPIC AIR KERMA DISPLAY DEVICE
0	OTHER		

5.ASSEMBLER CERTIFICATION

I affirm that all certified components assembled or installed by me, for which this report is being made, were adjusted and tested by me according to the instructions provided by the manufacturer(s), were of the type required by the manufacturer(s), were of the type required by the diagnostic x-ray performance standard (21 CFR Part 1020), were not modified to adversely affect performance, and were installed in accordance with provisions of 21 CFR Part 1020. I also affirm that all instruction manuals and other information required by 21 CFR Part 1020 for the assembly have been furnished to the purchaser and, within 15 days following completion of the assembly, a copy of this form will be submitted to the purchaser and, where applicable, to the State agency responsible for radiation protection.

a. PRINTED NAME
Headrick,Steve

b. SIGNATURE
Signature: Sandi E. Christianson
Electronically signed by Sandi Christianson
Reason: I have reviewed this document
Date: Jun 26, 2025 11:19 EDT
Email: sandi.christianson@siemens-healthineers.com
Signed for Headrick Steve
6/25/2025

6.COMMENTS

New Install. Biograph Trinion FL400-904196

FORM FDA 2579 (02/23) PREVIOUS EDITIONS MAY BE USED

Contact information for State Radiation Health Offices is available on the website of the Conference of Radiation Control Program Directors (CRCPD). https://www.crcpd.org/page/Map

Form may be downloaded at: https://www.fda.gov/media/144454/download

Alliance HealthCare Radiology

Plantation, FL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Ambulatory Health Care Accreditation Program

February 11, 2023

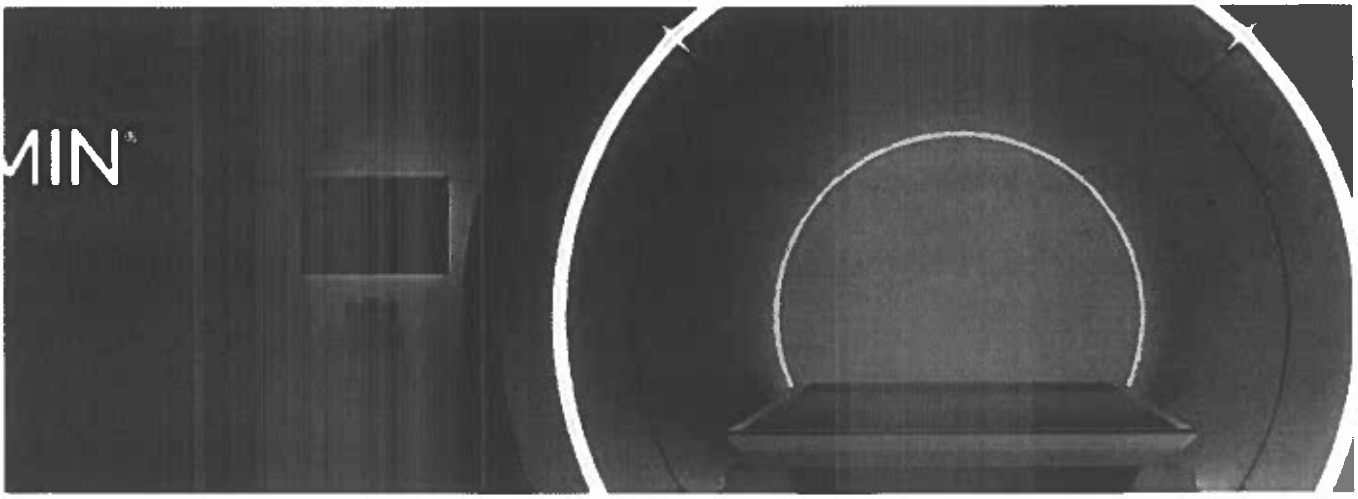
Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #600902
Print/Reprint Date: 04/10/2023

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



Unit Name: Akumin Standard Siemens Trinion PETCT

Manufacturer: Siemens **Model:** Biograph Trinion EP CT64

Software Version: VK10A **Serial Number:** 100239

Slice Count or # of Channels: 64 Slice

Bore Size (cm) : 70 **Weight Limit (kg) :** 227

Baptist Memorial Hospital - Memphis

Memphis, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

February 24, 2024

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7869
Print/Reprint Date: 05/22/2024

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

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 APPLICATION FOR LICENSE OF SERVICES FOR HOSPITAL OR OUTPATIENT DIAGNOSTIC CENTER

1. NAME AND PHYSICIAL ADDRESS OF FACILITY OF SERVICE

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

Baptist Hospital Collierville
Name

1500 West Poplar Ave
Address

Collierville	**TN**	**38017**
City	**State**	**ZIP**

00000000104
License Number:

2. CEO/ADMINISTRATOR OF PROVIDER

Lindsay Stencel	**CEO**
Name	**Title**

Linsey.stencel@bmhcc.org
Email Address

Baptist Hospital Collierville
Company Name
1500 West Poplar Ave
Address

Collierville	**TN**	**38017**
City	**State**	**ZIP**

901-861-9411
Phone Number

3. **BILLING INFORMATION FOR FACILITY**

Patricia Conrad	Accounts Payable	
Name	Title	
Patricia.conrad@bmhcc.org		
Email Address		
Baptist Memorial Corp		
Company Name		
350 Humphries Blvd		
Address		
Memphis	TN	38120
City	State	ZIP
901-227-7742		
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 x No

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

□ **ESTABLISHMENT 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: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Magnetom Altea

Tesla 1.5

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

Unit's Serial Number 18962

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

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

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

If no, why:

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

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

Physical Address of Service: 1500 west poplar Ave Collierville TN 38017

Name Brand of Unit Siemens Biograph Trinion

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

Unit's Serial Number 28468

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

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

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

If no, why:

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

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

Physical Address of Service: _____

Choose Designation Type: □ **First Time Self Designation/Initial NICU License**

□ **Designation at Different Level**

What is the Current License Level of Care? _____

What is the Requested Level? _____

□ **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.

Tracy Vest 12/1/2025

Signature **Date**

Tracy Vest

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)

Distribution List:
Purchaser
Assembler
State Radiation Health Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION
REPORT OF ASSEMBLY OF A DIAGNOSTIC X-RAY SYSTEM

Form Approved: OMB No. 0910-0025
Expiration Date: February 28,2026
See Reverse for PRA Statement

Assembler/Purchaser Control Number
904196 06-25-2025

1. EQUIPMENT LOCATION

a. NAME OF HOSPITAL, DOCTOR OR OFFICE WHERE INSTALLED: **Akumin / Alliance Healthcare Services**

b. STREET ADDRESS: **18201 Von Karman- Suite 600**

c. CITY: **Irvine** | d. STATE: **CA**

e. ZIPCODE: **92612** | f. TELEPHONE NUMBER: **502-706-9290**

2. ASSEMBLER INFORMATION

a. COMPANY NAME: **Siemens Medical Solutions USA, Inc.**

b. STREET ADDRESS: **221 Gregson Drive**

c. CITY: **Cary** | d. STATE: **NC**

e. ZIPCODE: **27511** | f. TELEPHONE NUMBER: **919-804-8395**

3. GENERAL INFORMATION

a. THIS REPORT IS FOR ASSEMBLY OF CERTIFIED COMPONENTS WHICH ARE (Check appropriate box(es))

- ☒ NEW ASSEMBLY- FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY-FULLY CERTIFIED SYSTEM
- ☐ REASSEMBLY-MIXED SYSTEM (Both certified and non-certified components)
- ☐ REPLACEMENT COMPONENTS IN AN EXISTING SYSTEM
- ☐ AN ADDITION TO AN EXISTING SYSTEM

b. INTENDED USE(S) (Check appropriate box(es))

☐ GENERAL PURPOSE RADIOGRAPHY	☐ UROLOGY	☒ CT WHOLE BODY SCANNER	☐ RADIATION THERAPY SIMULATOR	☐ OTHER (Specify in comments)
☐ GENERAL PURPOSE FLUOROSCOPY	☐ MAMMOGRAPHY	☐ HEAD-NECK (Medical)	☐ C-ARM FLUOROSCOPIC	
☐ TOMOGRAPHY (Other than CT)	☐ CHEST	☐ DENTAL-INTRAORAL	☒ DIGITAL	
☐ ANGIOGRAPHY	☐ CHIROPRACTIC	☐ DENTAL-CEPHALOMETRIC	☐ BONE MINERAL ANALYSIS	
☐ PODIATRY	☒ CT HEADSCANNER	☐ DENTAL-PANORAMIC	☐ DENTAL-CT	

c. THE X-RAY SYSTEM IS (Check one)
- ☒ STATIONARY
- ☐ MOBILE

d. THE MASTER CONTROL IS IN ROOM: **Mobile Control room**

e. DATE OF ASSEMBLY: **06/25/2025** (mm) (dd) (yyyy)

4.COMPONENT INFORMATION *(If additional space is needed for the section use another form, replacing the preprinted number with this Form Number, and complete Items 1, 4, and 5 only)*

a. THE MASTER CONTROL IS
- ☒ NEW INSTALLATION
- ☐ EXISTING (Certified)
- ☐ EXISTING (Non-certified)

b. CONTROL MANUFACTURER: **Siemens AG**

d. CONTROL SERIAL NUMBER: **28468**

e. DATE MANUFACTURED: **03/2025**

c. CONTROL MODEL NUMBER: **11061357**

f. SYSTEM MODEL NAME (CT Systems Only): **Biograph Trinion**

Complete the following information for the certified components listed below which you installed. For beam limiting devices, tables and CT gantries enter the manufacturer and Model number in the indicated spaces. For other certified components, enter in the appropriate blocks how many of each you installed in the system.

g. SELECTED COMPONENTS

	MANUFACTURER	MODEL NUMBER	DATE MANUFACTURED
	Siemens AG	11061232	04/2025
	Siemens AG	10755469	04/2025
	Siemens AG	11664100	04/2025

h. OTHER CERTIFIED COMPONENTS (Enter number of each installed in appropriate blocks)

1	X-RAY CONTROL	0	CRADLE
1	HIGH VOLTAGE GENERATOR	0	FILM CHANGER
0	VERTICAL CASSETTE HOLDER	0	IMAGE INTENSIFIER
1	TUBE HOUSING ASSEMBLY	0	SPOT FILM DEVICE
0	DENTAL TUBE HEAD	0	FLUOROSCOPIC IMAGING ASSEMBLY
0	CEPHALOMETRIC DEVICE	0	IMAGE RECEPTOR
0	IMAGE RECEPTOR SUPPORT DEVICE	0	FLUOROSCOPIC AIR KERMA DISPLAY DEVICE
0	OTHER		

5.ASSEMBLER CERTIFICATION

I affirm that all certified components assembled or installed by me, for which this report is being made, were adjusted and tested by me according to the instructions provided by the manufacture(s), were of the type required by the manufacturer(s), were of the type required by the diagnostic x-ray performance standard (21 CFR Part 1020), were not modified to adversely affect performance, and were installed in accordance with provisions of 21 CFR Part 1020. I also affirm that all instruction manuals and other information required by 21 CFR Part 1020 for this assembly have been furnished to the purchaser and, within 15 days following completion of the assembly, a copy of this form will be submitted to the purchaser and, where applicable, to the State agency responsible for radiation protection.

a. PRINTED NAME: **Headrick,Steve**

b. SIGNATURE

Signature: Sandi G. Christianson *Electronically signed by: Sandi Christianson Reason: I have reviewed this document Date: Jun 26, 2025 11:19 EDT*

Email: sandi.christianson@siemens-healthineers.com

Signed for: Headrick,Steve 6/25/2025

6.COMMENTS

New Install:Biograph Trinion FL:400-904196

FORM FDA 2579 (02/23) PREVIOUS EDITIONS MAY BE USED

Contact Information for State Radiation Health Offices is available on the website of the Conference of Radiation Control Program Directors (CRCPD), https://www.crcpd.org/mpage/Map
Form may be downloaded at: https://www.fda.gov/media/144454/download

Contact Information for State Radiation Health Offices is available on the website of the Conference of Radiation Control Program Directors (CRCPD), https://www.crcpd.org/mpage/Map

Form may be downloaded at: https://www.fda.gov/media/144454/download

This section applies only to requirements of the Paperwork Reduction Act of 1995

DO NOT SEND YOUR COMPLETED FORM TO THE PRA STAFF EMAIL ADDRESS BELOW.

The burden time for this collection of information is estimated to average 18 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden, to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."

Baptist Memorial Hospital - Collierville - MRI

1500 West Poplar Ave.
Collierville, Tennessee 38017

was surveyed by the
ACR Committee on MRI Accreditation
of the Commission on Quality and Safety

The following magnet was approved

Siemens Medical Systems MAGNETOM Altea 2021

For

Body, Head, MRA, MSK, Spine

Accredited from:

December 07, 2023 through March 29, 2027

CHAIR, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 02821-04

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

REGISTRATION OF MEDICAL EQUIPMENT

Public Chapter 780, Acts of 2002, as amended, requires that owners of the following medical equipment register with the Tennessee Health Services and Development Agency: computerized axial tomographers, magnetic resonance imagers, linear accelerators, and positron emission tomography. Registration should occur within 90 days of acquisition.

Should you wish to provide information not specifically requested or further information with regard to information reported, please attach a separate page to provide such narrative.

□X **Correct As Is** □ **Correction** □ **New Facility with Equipment**

1. NAME AND ADDRESS OF PROVIDER

Baptist Hospital Collierville
(Name)
1500 West Poplar Ave — Shelby
(Street Address) — (County)
(Mailing Address, if different from Street Address) — 901-861-8907
Collierville TN 38017
(City) (State) (Zip) — (Telephone Number)

Type of Provider:
□ ASTC X□ Hospital □ Hospital Imaging Department (off site) □ ODC
□ Physician's Office □ Other (specify) _____

2. NAME AND ADDRESS OF OWNER OF HEALTH CARE PROVIDER

Baptist Memorial Healthcare Corporation
(Name)
350 Humphries Blvd
(Mailing Address)
Memphis TN 38120 — 901-227-2727
(City) (State) (Zip) — (Telephone Number)

3. CONTACT PERSON *(Responsible for registration and utilization requests)*

Tracy Vest — Director of radiology
(Name) — (Title)
Baptist Hospital Collierville — Tracy.vest@bmhcc.org
(Company) — (Email Address)
1500 West Poplar Ave — 901-861-8907
(Mailing Address) — (Telephone Number)
Collierville TN 38017 —
(City) (State) (Zip) — (Fax Number)

4. EQUIPMENT OWNERSHIP INFORMATION

NOTE: Before you begin – the information below is required for each piece of equipment. If you have two or more of the same type of equipment, please copy this page for each, complete, and attach all pages to the first page of the Registration Form.

A. CT:

□ Add Unit □ Replacement Unit (Which unit is it replacing) _____

□ Owned □ Leased □ Shared X□ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Scanner Type: □ 16 Slice □ 40 Slice □X 64 Slice □ 128 Slice □ Other _____

B. Cyberknife/Gamma Knife/Proton Therapy:

(Check appropriate equipment) □ Cyberknife □ Gamma Knife □ Proton Therapy

□ Add Unit □ Replacement Unit (Which unit is it replacing) _____

□ Owned □ Leased □ Shared □ Fixed Site

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

C. Linear Accelerator:

□ Add Unit □ Replacement Unit (Which unit is it replacing) _____

□ Owned □ Leased □ Shared □ Fixed Site

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

□ MeV: _____ □ Single Energy □ Dual Energy □ Photon □ Photon Electron

Special Types: □ SRS □ IMRT □ IGRT □ Other _____

E. MRI:

□ Add Unit □ Replacement Unit (Which unit is it replacing) _____

□X Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Tesla Strength: □ 0.2 □ 0.5 □ 0.7 □ 1.0 X□ 1.5 □ 3.0 □ Other _____

Magnet Type: □ Breast □ Closed □ Extremity □ Open □ Short Bore □ Other

Magnet Age Use: □ Pediatric Only (14 years old and younger) □ Adult Only □ All Ages

F. PET:

□X Add Unit □ Replacement Unit (Which unit is it replacing) _____

□ Owned X□ Leased □ Shared □ Fixed Site □ Mobile (Full) □X Mobile (Part)

□ Number of Mobile/Shared Days in Use: 1 Days Per 1 week (week,month,etc.)

Shared With and/or Leased By: Leased by Baptist Collierville from Akumin Alliance healthcare svs

Date Acquired: 8/6/2025 Name Brand: Siemens Biograph Trinion

Initial Cost: Leased Serial No.: 28468

Expected Useful Life (Yrs): 8 Assigned No.: _____

Scanner Type: □ PET Only □X PET/CT Combination □ PET/MRI Combination

G. Other:

□ Add Unit □ Replacement Unit (Which unit is it replacing) _____

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Equipment Description: _____

I hereby certify that this information is true to the best of my knowledge, information and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.

Signature

12/1/2025
Date

Alliance HealthCare Radiology

Plantation, FL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Ambulatory Health Care Accreditation Program

February 11, 2023

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #600902

Print/Reprint Date: 04/10/2023

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Unit Name: Akumin Standard Siemens Trinion PETCT

Manufacturer: Siemens Model: Biograph Trinion EP CT64

Software Version: VK10A Serial Number: 100239

Slice Count or # of Channels: 64 Slice

Bore Size (cm) : 70 Weight Limit (kg) : 227

Software Features:

PET Cardiac gating, MI Cardio Add-On-, MI Routine Onco-, FAST IRS, Multi-index RTP overlay, ultraHDPET, CT Lung Cancer Screening, Care Dose 4D, CARE kV, CARE Profile, Adaptive Dose Shield, DICOM Viewer, CARE Bolus, CARE Dashboard, Digital PET Signal, HD Field of View Pro, iMAR (Metal Artifact Reduction), PET Cardiac Metal Artifact Reduction, Prompts Gamma Correction, SureView

Other Features/Accessories:

2- Patient Recliners, Complete Hotlab, Flat Table Top for Treatment Planning, Low Contrast Test Tool with Holder, Uniform Source Shield,