



## PROCEDURES FOR APPLYING FOR INITIAL SERVICE LINE FOR HOSPITALS OR OUTPATIENT DIAGNOSTIC CENTERS

1. Beginning December 1, 2025, NICU, Burn Unit, MRI, and PET service lines must submit a licensure application to the Health Facilities Commission (HFC) followed by the designated fee.

A licensing fee schedule is listed at the end of the application.

2. 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.
3. All applications will need to be emailed to [hfc.service@tn.gov](mailto: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.
4. Any hospital seeking to initiate a new NICU/Burn service line that was previously not licensed, or seeks to modify NICU (Level II-IV) or Burn Unit services, must submit architectural plans to Plans review through the online portal at <https://apps.tn.gov/tnhcf/>

If a hospital is modifying an existing NICU/Burn service line (e.g. renovations, increasing a NICU level, or increasing bed capacity), the hospital must submit architectural plans to Plans Review as well.

5. If an initial service is being implemented, after Plans Review has been completed and approved, a Life Safety Inspector will be sent out within ten (10) days. Within thirty (30) to forty-five (45) days, a health licensure surveyor will be sent out to determine approval.
6. If the application is for a new Burn or NICU service, after the Plans Review approval, a HFC surveyor will conduct an on-site review for the initial occupancy approval.
7. 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.
8. Upon receipt of the application, HFC staff will review the application for completeness. Once determined to be complete, a service license number will be assigned, and 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.

9. Once the license fees have been received, a provisional approval letter will be sent to the Administrator. When complete, the application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification.
  - a. If the Commission ratifies the application, the license certificate will then be created and mailed to the licensee. You should receive the physical license in ten (10) to fourteen (14) days.
  - b. If the Commission does not ratify the initial approval of your application, a letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

*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, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-2364 [hsda.staff@tn.gov](mailto:hsda.staff@tn.gov)

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**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR HOSPITAL OR OUTPATIENT DIAGNOSTIC CENTER**

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

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

Volunteer  
Parkway Imaging  
Center

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Name

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1230 Volunteer Parkway  
Address

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Bristol	TN	37620
City	State	ZIP

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131

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License Number:

**2. CEO/ADMINISTRATOR OF PROVIDER**

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John Jeter	CEO
Name	Title

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John.Jeter@balladhealth.org  
Email Address

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Volunteer Parkway Imaging Center  
Company Name-  
Hospital Name)

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1230 Volunteer Parkway  
Address

---

Bristol	TN	37620
City	State	ZIP

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423-764-2566  
Phone Number

**3. BILLING INFORMATION FOR FACILITY**

John Jeter CEO  
Name Title

[John.Jeter@balladhealth.org](mailto:John.Jeter@balladhealth.org)  
Email Address

Volunteer Parkway Imaging Center  
Company Name-  
(So each facility name)

1230 Volunteer Parkway  
Address

Bristol TN 37620  
City State ZIP

423-764-2566  
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?:

**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: 1230 Volunteer Parkway Bristol, TN 37620

Name Brand of Unit Siemens Altea

Tesla 1.5

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

Unit's Serial Number 189538

Will the MRI Unit be Accredited?:  X Yes  No

If MRI Unit will be Accredited, is it  PENDING  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.  X 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  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

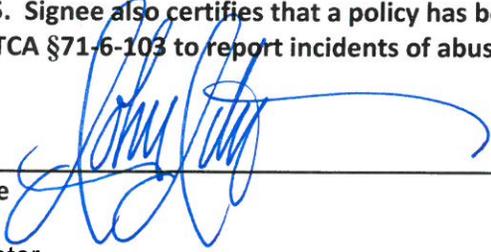
\_\_\_\_\_  
Name Title

\_\_\_\_\_  
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.

Signature



Date

11/24/2025

John Jeter

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)*

**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)

**ATTACHMENT – B-Legal Entity**

**INDIVIDUAL OWNERS INFORMATION**

Name	Address	City	State	ZIP
Wellmont Health System	303 Med Tech. Parkway, Suite 300	Johnson City	TN	37604

AMERICAN COLLEGE OF RADIOLOGY®

# Certificate of Accreditation



**Bristol Reg. Med. Ctr., Volunteer Pkwy. Imaging Ctr.**  
1230 Volunteer Parkway  
Bristol, Tennessee 37620

**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 2019**

**for**

**Body, Head, MRA, MSK, Spine**

**Accredited from  
August 30, 2024 through December 27, 2027**

A handwritten signature in black ink, appearing to be "K. A. H.", written over a horizontal line.

**Chair, Committee ON  
MRI Accreditation**

A handwritten signature in black ink, reading "David B. Fuson", written over a horizontal line.

**Chair, Commission on  
Quality and Safety**