



**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 PHYSICAL ADDRESS OF FACILITY OF SERVICE

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

Name

West Tennessee Healthcare Camden Hospital

Address

175 Hospital Drive

City

Camden

State

Tennessee

ZIP

38320

License Number: 3

2. CEO/ADMINISTRATOR OF PROVIDER

Name

Tina Prescott

Title

President and CEO

Email Address

Tina.prescott@wth.org

Company Name

Camden General Hospital, Inc.

Address

620 Skyline Drive

City

Jackson

State

Tennessee

ZIP

38301

Phone Number

(731) 541-6767

3. BILLING INFORMATION FOR FACILITY

Name Victoria S. Lake		Title Director, Community Health Institute	
Email Address Vicki.lake@wth.org			
Company Name Jackson-Madison County General Hospital			
Address 620 Skyline Drive			
City Jackson		State Tennessee	ZIP 38301
Phone Number	(731) 984-1260		

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: 175 Hospital Drive

Name Brand of Unit Siemens

Tesla 1.5

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

Unit's Serial Number R518

Will the MRI Unit be Accredited?: Yes No

If MRI Unit will be Accredited, is it PENDING ACCREDITED

If ACCREDITED, What Organization? The Joint Commission
(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

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 *Tina Prescott* Date *11/21/25*

Printed Name Tina Prescott



ORGANIZATION

Camden General Hospital

HCO ID: 167713

DBA: West Tennessee Healthcare Camden Hospital

175 Hospital Drive
Camden, Tennessee 38320

<http://www.wth.org>



	Accredited Programs	Decision	Effective Date
	Ambulatory Care	Accredited	June 29, 2023
	Critical Access Hospital	Accredited	July 8, 2023
	Deemed and CMS-Recognized Programs		
	Critical Access Hospital		
	Sites		
<p>Camden General Hospital DBA: West Tennessee Healthcare Camden Hospital 175 Hospital Drive, Camden, TN, 38320</p>	<p>Available Services</p> <ul style="list-style-type: none"> • Acute Care • CT Scanner • EEG/EKG/EMG Lab • Inpatient Unit • Magnetic Resonance Imaging • Mammography 	<ul style="list-style-type: none"> • Medical /Surgical Unit • Non-Sterile Medication Compounding • Sleep Laboratory • Sleep Studies • Swing Beds • Ultrasound 	
	<p>Accredited Programs</p> <ul style="list-style-type: none"> • Ambulatory Care; Critical Access Hospital 		

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