INITIAL APPLICATION FOR LICENSE OF SERVICES FOR PHYSICIAN OFFICES

1. NAME AND PHYSICIAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE

APEX CARDIOLOGY			
Name			
327 SUMMART DRIVE			
Address			
JACKSON	TN	38301	
City	State	ZIP	

2. CEO/ADMINISTRATOR OF PROVIDER

MOHSIN ALHADDAD	CEO/PHYSICIAN	
Name	Title	
CORDIS10@GMAIL.COM		
Email Address		
APEX CARDIOLOGY		
Company Name		
327 SUMMAR DRIVE		
Address		
JACKSON	TN	38301
City	State	ZIP
731-423-8200		
Phone Number		

3. BILLING INFORMATION FOR FACILITY

HOPE MCGHEE	PRACTICE MANAGER	
Name	Title	
hmcghee@apexcardio.com		
Email Address		
APEX CARDIOLOGY		
Company Name		
327 SUMMAR DRIVE		
Address		
JACKSON	TN	38301
City	State	ZIP
731-780-5829		
Phone Number		

4. OWNERSHIP OF FACILITY

MOSHIN ALHADDAD, MD		
Name of Owner		
327 SUMMAR DRIVE		
Address		
JACKSON	TN	38301
City	State	ZIP
731-423-8200		
Phone Number		

Legal Entity:

□ Individual	□ Limited Liability	□X Corporation (For Profit)
□ Corporation (Not for Profit)	□ Government	□ Limited Partnership
□ Joint Venture	□ Professional Limited Liability Company	
□ Other _____		

List name(s) and addresses of individual owners, partners, directors of the corporation, or head of the government entity. *(If more than two (2), please use ATTACHMENT – B.)*

MOHSIN ALHADDAD
(1) Name

327 SUMMAR DRIVE
Address

JACKSON	TN	38301
City	State	ZIP

(2) Name

Address

City	State	ZIP

If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? □ Yes X□ No

If no, why: PRIVATELY OWNED

Is this facility chain affiliated? □ Yes □X No

If a corporation, is there a holding company? □ Yes □X No

If yes, please complete the following information of the holding company.

Name of Owner

Address

City	State	ZIP

Phone Number

Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? □ Yes □X No

If yes, list their names and addresses of all facilities.:	

Is there a contract with a management firm to operate this facility? □ Yes □X No

If yes, please specify the dates of the contract and complete the firm's information.

Start Date: _____ **End Date:** _____

_____
Name of Firm

_____
Address

_____
City **State** **ZIP**

_____
Phone Number

5. **LEGAL**

If any of the items within this section (LEGAL), please identify, explain, and provide documentation of the item(s) noted if response is "yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states listed, or the management firm listed been subjected to any of the following within the past five (5) years?

Licensure			
	➢ **Denied a License**	□ Yes	□X No
	➢ **Had a license suspended or revoked by any state licensure agency?**	□ Yes	□ X No
	➢ **Been subject to a final order or judgement in a state licensure action?**	□ Yes	□X No
Convictions			
	➢ **If convicted of a criminal offense related to that person's involvement in any program under any state or federal health care program – including Medicare, Medicaid, and TriCare?**	□ Yes	□X No

Exclusion			
	➢ Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past?	□ Yes	□X No
	(Excluded is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare.)	□ Yes	□X No
Termination/Suspension			
	➢ Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?	□ Yes	□ X No
Fraud and Abuse	➢ Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services?	□ Yes	□X No
Corporate Integrity Agreement	➢ Is presently an entity covered by and subject the terms of a corporate integrity agreement? (If yes, please provide a copy of CIA.)	□ Yes	□X No
Bankruptcy	➢ Filed bankruptcy under any provision of the United States Bankruptcy Code:	□ Yes	□X No
Civil Monetary Penalty (CMP)	➢ Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than $250,000 as a result of an enforcement action during a survey?	□ Yes	□X No

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

□ **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**

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

Physical Address of Service: **327 SUMMAR DRIVE JACKSON TN 38301**

Name Brand of Unit

UNITED IMAGING UMI PANVIVO S

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

Unit's Serial Number **11MI5100005**

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

If PET Unit will be Accredited, is it □**X** **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. □ **X Yes** □ **No**

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.

Hope McGhee — 1/30/2026

Signature — Date

PRACTICE MANAGER

Title of Signee

HOPE MCGHEE

Printed Name