



## PROCEDURES FOR APPLYING FOR INITIAL LICENSURE OF SERVICE LINES FOR PHYSICIAN OFFICES

1. Beginning December 1, 2025, and thereafter you must submit an MRI and/or PET licensure application to the Health Facilities Commission followed by the designated fee.

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. Please review HFC's Medical Equipment Registry to ensure information submitted on the licensure application is consistent with previously submitted data.
5. 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.
6. Once the license fees have been received, a provisional approval letter will be sent to the listed CEO/Administrator. The application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification.
  - 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.
  - 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 Phone: 615-741-2364 hsda.staff@tn.gov

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**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR PHYSICIAN OFFICES**

**1. NAME AND PHYSICAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE**

Delta Clinics PLC

**Name**

17 Centre Plaza Drive

**Address**

Jackson

TN

38305

**City**

**State**

**ZIP**

**2. CEO/ADMINISTRATOR OF PROVIDER**

Meagan Hardison

Practice Manager

**Name**

**Title**

mhardison@deltaclinics.net

**Email Address**

Delta Clinics PLC

**Company Name**

17 Centre Plaza Drive

**Address**

Jackson

TN

38305

**City**

**State**

**ZIP**

731-512-0104 ext 106

**Phone Number**

**3. BILLING INFORMATION FOR FACILITY**

Meagan Hardison	Practice Manager	
Name	Title	
mhardison@deltaclinics.net		
Email Address		
Delta Clinics PLC		
Company Name		
17 Centre Plaza Drive		
Address		
Jackson	TN	38305
City	State	ZIP
731-512-0104 ext 106		
Phone Number		

**4. OWNERSHIP OF FACILITY**

Dr. Nirav Patel, CEO		
Name of Owner		
23 Woodcrest Drive		
Address		
Jackson	TN	38305
City	State	ZIP
731-225-7189		
Phone Number		

**Legal Entity:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Individual                   | <input type="checkbox"/> Limited Liability                                 | <input type="checkbox"/> Corporation (For Profit) |
| <input type="checkbox"/> Corporation (Not for Profit) | <input type="checkbox"/> Government  | <input type="checkbox"/> Limited Partnership      |
| <input type="checkbox"/> Joint Venture                | <input checked="" type="checkbox"/> Professional Limited Liability Company |   |
| <input type="checkbox"/> 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.)

Dr. Simon Okewole

(1) Name

40 Hollinsworth Cove

Address

Jackson

TN

38305

City

State

ZIP

Dr. Najji Bourji

(2) Name

33 Hollinsworth Cove

Address

Jackson

TN

38305

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  No

If no, why:

Is this facility chain affiliated?  Yes  No

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

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

Is there a contract with a management firm to operate this facility?  Yes  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  No
- Had a license suspended or revoked by any state licensure agency?  Yes  No
- Been subject to a final order or judgement in a state licensure action?  Yes  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  No

**Exclusion**

➤ Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past?  Yes  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  No

**Termination/Suspension**

➤ Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?  Yes  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  No

**Corporate Integrity Agreement**

➤ Is presently an entity covered by and subject the terms of a corporate integrity agreement?  Yes  No  
(If yes, please provide a copy of CIA.)

**Bankruptcy**

➤ Filed bankruptcy under any provision of the United States Bankruptcy Code:  Yes  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  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

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

Physical Address of Service: 17 Centre Plaza Drive

Name Brand of Unit Siemens

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

Unit's Serial Number 60017

Will the PET Unit be Accredited?:  Yes  No

If PET Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? ACR

(Attach certificate or proof of accreditation.)

If no, why:

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



### Non-Refundable Licensing Fees for Listed Licensed Services

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

#### 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)*

AMERICAN COLLEGE OF RADIOLOGY®

# Certificate of Accreditation



**Delta Clinics, PLC**  
17 Centre Plaza Drive  
Jackson, Tennessee 38305

was surveyed by the ACR® Committee on Computed Tomography  
Accreditation of the Commission on Quality and Safety

The following unit was approved

**Siemens Medical Systems  
Biograph mCT 2023**

for

**Adult Patients  
Abdomen, Cardiac, Chest**

**Accredited from  
June 28, 2024 through June 28, 2027**

Chair, Committee ON  
Computed Tomography Accreditation

Chair, Commission on  
Quality and Safety