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 . 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, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

INITIAL APPLICATION FOR LICENSE OF SERVICES FOR PHYSICIAN OFFICES

1. NAME AND PHYSICIAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE

Kamilia Kozlowski, M.D., d/b/a Knoxville Comprehensive Breast Center
Name

1400 Dowell Springs Blvd., Suite 200
Address

Knoxville	**Tennessee**	**37909**
City	**State**	**ZIP**

2. CEO/ADMINISTRATOR OF PROVIDER

Kamilia Kozlowski, M.D.	**Physician/Owner**
Name	**Title**

imagesmatter@outlook.com
Email Address

Knoxville Comprehensive Breast Center
Company Name

1400 Dowell Springs Blvd., Suite 200
Address

Knoxville	**Tennessee**	**37909**
City	**State**	**ZIP**

865-283-9099
Phone Number

3. BILLING INFORMATION FOR FACILITY

Kamilia Kozlowski. M.D.	Physician/Owner	
Name	**Title**	
imagesmatter@outlook.com		
Email Address		
Knoxville Comprehensive Breast Center		
Company Name		
1400 Dowell Springs Blvd., Suite 200		
Address		
Knoxville	**Tennessee**	**37909**
City	**State**	**ZIP**
865-283-9099		
Phone Number		

4. OWNERSHIP OF FACILITY

Kamilia Kozlowski, M.D., d/b/a Knoxville Comprehensive Breast Center		
Name of Owner		
1400 Dowell Springs Blvd., Suite 200		
Address		
Knoxville	**Tennessee**	**37909**
City	**State**	**ZIP**
865-283-9099		
Phone Number		

Legal Entity:

X Individual	**□ Limited Liability**	**□ 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.)*

Kamilia Kozlowski, M.D.
(1) Name

1400 Dowell Springs Blvd., Suite 200
Address

Knoxville	**Tennessee**	**37909**
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** □ **No N/A**

If no, why:

Is this facility chain affiliated? □ **Yes X No**

If a corporation, is there a holding company? □ **Yes** □ **No N/A**

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

N/A
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? X Yes □ No

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

Start Date: **12-01-25** **End Date:** **12-01-27**

Comprehensive Breast Care Center of Texas, Inc.
Name of Firm

15601 Dallas Pkwy., Suite 300
Address

Addison	**Texas**	**75001**
City	**State**	**ZIP**

469-398-4072
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.

X <u>ESTABLISHING MRI UNIT/SERVICE:</u> *(If more than one unit, use ATTACHMENT – A.)* **(Note: This is an existing MRI Provider**

Physical Address of Service: **1400 Dowell Springs Blvd., Suite 200, Knoxville, Tennessee 37909**

Name Brand of Unit **Canon**

Tesla **1.5**

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

Unit's Serial Number **WKB2522021**

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

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

If ACCREDITED, What Organization? **Accreditation is expected from the American College of Radiology**

(Attach certificate or proof of accreditation.) N/A

If no, why: **Newly acquired unit**

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

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.

	12-01-25
Signature	**Date**
Kamilia Kozlowski, M.D.	
Printed Name	

Attachment A
(Additional MRI Unit)

X ESTABLISHING MRI UNIT/SERVICE: *(If more than one unit, use ATTACHMENT – A.)* **(Note: This is an existing MRI Provider**

Physical Address of Service: **1400 Dowell Springs Blvd., Suite 200, Knoxville, Tennessee 37909**

Name Brand of Unit **Canon**

Tesla **1.5**

Type (i.e. Close, Short Bore, etc.) **Closed**
Unit's Serial Number **WKB2442011**

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

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

If ACCREDITED, What Organization? **Accreditation is expected from the American College of Radiology**

(Attach certificate or proof of accreditation.) N/A

If no, why: **Newly acquired unit.**

The MRI unit will be registered with the Health Facilities Commission. X 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)