



## 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**

Urology Associates, P.C.

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**Name**

2801 Charlotte Avenue

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**Address**

Nashville

TN

37209

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**City**

**State**

**ZIP**

**2. CEO/ADMINISTRATOR OF PROVIDER**

Leslie Jacobs

CEO

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**Name**

**Title**

LJacobs@ua-pc.com

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**Email Address**

Urology Associates, P.C.

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**Company Name**

2801 Charlotte Avenue

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**Address**

Nashville

TN

37209

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**City**

**State**

**ZIP**

615-250-9260

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**Phone Number**

**3. BILLING INFORMATION FOR FACILITY**

Ryn Sledge	Administrative Services Supervisor	
<b>Name</b>	<b>Title</b>	
UA_AP@ua-pc.com		
<b>Email Address</b>		
Urology Associates, P.C.		
<b>Company Name</b>		
2801 Charlotte Avenue		
<b>Address</b>		
Nashville	TN	37209
<b>City</b>	<b>State</b>	<b>ZIP</b>
615-250-9255		
<b>Phone Number</b>		

**4. OWNERSHIP OF FACILITY**

Urology Associates, P.C.		
<b>Name of Owner</b>		
2801 Charlotte Avenue		
<b>Address</b>		
Nashville	TN	37209
<b>City</b>	<b>State</b>	<b>ZIP</b>
615-250-9260		
<b>Phone Number</b>		

- Legal Entity:**
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Individual                   | <input type="checkbox"/> Limited Liability                      | <input checked="" 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 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.)

SEE ATTACHMENT

(1) Name

Address

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  No

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

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  No

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

Urology Surgery Center, L.P.  
2801 Charlotte Avenue  
Nashville, TN 37209  
  
All UAPC Partners have Ownership in USC

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: 03/06/1997 End Date: 03/05/2037

Urology Healthcare Group, d/b/a CIMplify, Inc.

Name of Firm

302 Innovation Drive, Suite 240

Address

Franklin TN 37067

City State ZIP

615-261-6700

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? (If yes, please provide a copy of CIA.)  Yes  No

**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: 2801 Charlotte Avenue, Nashville, TN 37209

Name Brand of Unit Siemens Biograph mCT-S(40)

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

Unit's Serial Number 60077

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

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.



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Signature

12/03/2025

Date

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CEO

Title of Signee

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Leslie Jacobs

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.

### **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)*

## UROLOGY ASSOCIATES, P.C.

Partner	Home Address	City	Zip
MICHAEL J. BELSANTE, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
ADNAN DERVISHI, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
DAVID DUONG, M.D., PhD	[REDACTED]	[REDACTED]	[REDACTED]
J. MATTHEW HASSAN, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
C. HEATH HAWKINS, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
GREGORY HEAD, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
GAUTAM JAYRAM, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
GRANT JOHNSON, D.O.	[REDACTED]	[REDACTED]	[REDACTED]
PAUL KNOLL, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
DAVID MORRIS, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
VIVEK NARAIN, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
DANIEL RAMIREZ, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
ALBERIC ROGMAN, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
ELIZABETH SCHIFTAN, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
J. PATRICK SELPH, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
JAY SULEK, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
WILLIAM TISSOT, M.D.	[REDACTED]	[REDACTED]	[REDACTED]
SCOTT WENDLAND, D.O.	[REDACTED]	[REDACTED]	[REDACTED]

**From:** [Wood, Chanda L.](#)  
**To:** [Alecia L. Craighead](#)  
**Subject:** [EXTERNAL] RE: Quality Service License Questions  
**Date:** Thursday, February 19, 2026 7:57:59 AM  
**Attachments:** [image001.png](#)  
[image003.png](#)  
[image004.png](#)

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**This Message Is From an External Sender**

This message came from outside your organization.  
Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security

Good morning Alecia

I apologize , the correct SN is 60077. Do I need to correct and resubmit the paperwork ?

Chanda Wood, RT(R), NMTCB(CI)  
Imaging Supervisor  
Urology Associates, P.C.  
2801 Charlotte Ave.  
Nashville, TN 37209  
(615)250-9373 Office  
(615)714-5558 Cell

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**From:** Alecia L. Craighead <[Alecia.L.Craighead@tn.gov](mailto:Alecia.L.Craighead@tn.gov)>  
**Sent:** Thursday, February 19, 2026 7:40 AM  
**To:** Wood, Chanda L. <[CLWood@ua-pc.com](mailto:CLWood@ua-pc.com)>  
**Subject:** FW: Quality Service License Questions

**CAUTION: This email originated outside of the CIMplify organization. DO NOT click links or open attachments unless you recognize the sender and know the content is safe.**

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Following up on the below question. We are needing a response immediately to complete the review of your Quality Service License application.

If you have any questions, please let me know.

Alecia

[Alecia Craighead](#) | Data and Analysis Administrator  
Health Facilities Commission  
Andrew Jackson State Office Building, 9<sup>th</sup> Floor

502 Deaderick Street, Nashville, TN 37243  
p. 615-253-2782  
c: 615.674.0370  
[alecia.l.craighead@tn.gov](mailto:alecia.l.craighead@tn.gov)  
[www.tn.gov/hfc](http://www.tn.gov/hfc)

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**From:** Alecia L. Craighead  
**Sent:** Thursday, December 18, 2025 2:04 PM  
**To:** 'CLWood@ua-pc.com' <[CLWood@ua-pc.com](mailto:CLWood@ua-pc.com)>  
**Subject:** Quality Service License Questions

This is to notify you that your application for a quality license for Urology Associates is missing the following information:

- PETs serial number listed on application. Application has SN 60077 while Medical Equipment Registry has SN 259081903. Are both of these for the same unit?

We need this information to continue processing your application. You will have ten (10) days from the date of this email to return the requested information to [hfc.service@tn.gov](mailto:hfc.service@tn.gov). In the subject line of the email please include the name of your facility/Physician Practice.

If the information is not returned within the allotted time, the processing of your application will be delayed.

Should you have any questions or if I can be of assistance to you, please call me at 615-253-2782 or you may email me at [alecia.l.craighead@tn.gov](mailto:alecia.l.craighead@tn.gov) .

**Alecia Craighead** | Data and Analysis Administrator  
Health Facilities Commission  
Andrew Jackson State Office Building, 9<sup>th</sup> Floor  
502 Deaderick Street, Nashville, TN 37243  
p. 615-253-2782  
c: 615.674.0370  
[alecia.l.craighead@tn.gov](mailto:alecia.l.craighead@tn.gov)  
[www.tn.gov/hfc](http://www.tn.gov/hfc)



Urology Associates, P.C.

2801 Charlotte Ave  
Nashville, Tennessee 37209

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 (40) 2017

For

Adult Patients  
Abdomen, Chest

Accredited from:

April 04, 2024 through April 04, 2027

CHAIR, COMMITTEE ON COMPUTED TOMOGRAPHY  
ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

CTAP# 60285-01

AMERICAN COLLEGE OF RADIOLOGY®

# Certificate of Accreditation



## Urology Associates, P.C.

2801 Charlotte Ave  
Nashville, Tennessee 37209

was surveyed by the ACR® Committee on Nuclear Medicine Accreditation of the Commission on Quality and Safety

The following unit was approved

**Siemens Medical Systems  
BIOGRAPH 40 2017**

for

**Oncology**

Accredited from  
June 12, 2024 through June 12, 2027

Chair, Committee ON  
Nuclear Medicine Accreditation

Chair, Commission on  
Quality and Safety