



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243
(615) 741-7221

**PRESCRIBED CHILD CARE CENTER
RENEWAL APPLICATION**

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. Please check this website periodically for updates.

Name of the Facility/Agency _____

Facility License Number _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Administrator _____

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:
 Individual Partnership Corporation Limited Liability Company
 Church Related Government/County Other
- b. Check One: For Profit Non-profit
- c. Legal Entity checked in 1.a:
Name _____ Phone Number (_____) _____
Street _____
City _____ State _____ Zip _____
- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
- | Name | Address | City, State, Zip |
|-------|---------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
- (If additional space is needed, please use a separate sheet)*
2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?
Yes No Expiration Date _____
- b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?
Yes No Expiration Date _____
3. a. Is this facility chain affiliated? Yes No
- b. If yes, list name, address and phone number of the parent company.
Name _____ Phone Number (_____) _____
Street _____
City _____ State _____ Zip _____
4. a. If a corporation, is there a holding company/parent corporation? Yes No
- b. If yes, list the name, address and phone number of the holding company/parent corporation.
Name _____ Phone Number (_____) _____
Street _____
City _____ State _____ Zip _____
5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes No
- b. If yes, list names and addresses of all such facilities:

6. a. Do you have a contract with a management firm to operate this facility? Yes _____ No _____

If yes, specify dates: From _____ To _____

b. If yes, specify name of firm: _____

Street _____ Phone Number (_____) _____

City _____ State _____ Zip _____

**FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION.
FEES ARE NON-REFUNDABLE.**

VERIFICATION BY APPLICANT:

Signee for application verifies 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 agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) §68-11-201.

Signee also verifies 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.

Applicant Signature Title or Position Date