AMBULATORY SURGICAL TREATMENT CENTER
RENEWAL APPLICATION

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://tennessee.gov/health/topic/hcf-professionals. 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 __________

1. Check classification of institution for which application is made:

____ General Surgical ____ Maternity ____ Gynecological ____Other (specify)

____ Abortion ____ Plastic Surgery ____ Ophthalmological

____ EENT ____ Urological ____ Gastroenterology

____ Dental ____ Acupuncture ____ Cancer Treatment

2. Briefly state the overall objective of the surgical treatment center: ______________________

____

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

____

Name Address City, State, Zip

____

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? Yes _____ No _____

   b. If yes, list the name, address and phone number of the holding company.

   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 _____

   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