PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

Ambulatory Surgical Center Application Form

Type of Action	
New Facility* ☐	License # _____
License Renewal* ☐ **(due 12/1)**	Accredited? ◯Y / ◯N Accrediting Agency? _____
Name/Address Change ☐	Add/Remove Services ☐ *(If yes, please complete section IV)*
Ownership Change ☐	Procedure Room Increase/Decrease* ☐
Other ☐	
(Specify) _____	
Effective Date of Change: _____	

*Fee Payment Required (See back of this form for amount). There is no fee required for procedure room decreases, name or address changes.

Facility Information		
Facility E-Mail:		
Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Name of Administrator & Phone:		
Administrator Email:		
Name of Facility Manager:		
Emergency Contact Person & Phone:		
Days and Hours of Operation:	Number of Procedure Rooms:	

Owner Information (If partnership or corporation, list each person having 5% or more interest on an additional page)			
Ownership Category (Choose One):			
Individual ◯	State ◯	Health District ◯	Partnership ◯
City ◯	County ◯	Church ◯	Corporation ◯
Ownership Type: For Profit ◯ Non- Profit ◯			Tax ID#:
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:	County:	

Description of Service – please mark the services provided with an "X". If there has been a change, indicate "A" if adding or "D" if deleting services.							
X	**A**	**D**	**Service**	**X**	**A**	**D**	**Service**
☐	☐	☐	Cardiovascular	☐	☐	☐	Ophthalmology
☐	☐	☐	Foot	☐	☐	☐	Oral
☐	☐	☐	General	☐	☐	☐	Orthopedic
☐	☐	☐	Neurological	☐	☐	☐	Otolaryngology
☐	☐	☐	Obstetrics/Gynecology	☐	☐	☐	Plastic
☐	☐	☐	Thoracic	☐	☐	☐	Urology
☐	☐	☐	Other:				

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct, and complete. I will notify Health Care Regulation and Quality Improvement, in writing, of any changes in this information within 30 days of any such change. Oregon Administrative Rule Chapter 333, Divisions 500-535 requires that all accredited ASC provide to the Health Care Regulations and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all correction actions and progress reports related to accrediting surveys.

_____ _____

Administrator's Signature ***Print Name***

_____ _____

Print Title ***Date (mm/dd/year)***

Fee Schedule	
$1750.00	CMS Certified & High Complexity Non-Certified Ambulatory Surgical Centers with more than two procedure rooms*
$1250.00	CMS Certified & High Complexity Non-Certified Ambulatory Surgical Centers with no more than two procedure rooms*
$1000.00	Moderate Complexity Non-Certified Ambulatory Surgical Centers

***Per OAR 441.020(14)(b), Procedure Rooms are defined as a room where surgery or invasive procedures are performed.**

Make check payable to: **Oregon Health Authority**
Mail payment and application to: **HFLC**
PO Box 14260
Portland, OR 97293

Questions about this application? Phone: 971-673-0540 **Email:** mailbox.hclc@odhsoha.oregon.gov

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **797** initial/QC **798** renewal