

If you need this document in large print, please advise.

AMBULATORY SURGICAL CENTERS

License Application Form

QC-797 -Initial

Health Care Licensure and Certification

QC-798 -Chow/Renewal

P. O. Box 14450, Portland, OR 97293

License # _____

Phone: 971-673-0540 Fax: 971-673-0556

<u>OWNERSHIP CATEGORY (choose one)</u> <input type="checkbox"/> Individual <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Church <input type="checkbox"/> Health District <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership		<u>EFFECTIVE DATE OF OWNERSHIP CHANGE</u> <u>FISCAL YR END DATE</u>	<u>TYPE OF ACTION</u> <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Ownership Change* <input type="checkbox"/> License Renewal* <input type="checkbox"/> New Facility* <input type="checkbox"/> Add/Remove Services <input type="checkbox"/> Other _____ <small>*Fee payment required **Fee schedule listed on page 2 of this form. Make checks payable to DHS and mail to Public Health Division, Fiscal Services, P.O. Box 14260, Portland, OR 97293. Check or money order must accompany this application. There is no fee required for bed decreases, name or address changes. NOTE: If this is an initial license application, the initial license fee will be collected after the facility/agency has been approved for licensure.</small>
OWNERSHIP TYPE <input type="checkbox"/> PROFIT <input type="checkbox"/> NON-PROFIT			
FACILITY NAME ASSUMED BUSINESS NAME (IF ANY)			
FACILITY PHONE NO. FAX NO.			
E-MAIL ADDRESS:			
FACILITY ADDRESS			
FACILITY MAILING ADDRESS			
NAME OF OWNER(S) See page 2 of this form for additional information, if applicable. (attach additional pages if necessary)			
OWNER(S) STREET ADDRESS (not P.O. Box)			
CITY	STATE	ZIP	PHONE
NAME OF ADMINISTRATOR			
NAME OF CEO		DAYS AND HOURS OF OPERATION	NUMBER OF SURGICAL SUITES _____
NAME OF FACILITY MANAGER			
<p>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 Licensure and Certification, 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 JCAHO and CHAOA accredited hospitals provide to the Health Care Licensure and Certification Section all JCAHO and CHAOA survey and inspection reports, and written evidence of all corrective actions and progress reports related to JCAHO and CHAOA surveys.</p>			
SIGNATURE OF ADMINISTRATOR		DATE	
NAME AND TITLE (PRINTED OR TYPEWRITTEN)			

If partnership or corporation, list each person/corporation(s) having 5% or more interest. (attach separate page if necessary)

NAME & TITLE	TAX ID #	ADDRESS	PHONE NO.	PERCENT %

FEE SCHEDULE
Flat Fee of \$1,000.00

HCLC OFFICE USE ONLY		
INITIAL LICENSURE		
APPROVED	DENIED	WITHDRAWN
IF APPROVED, EFFECTIVE DATE OF INITIAL LICENSURE		
SURVEYOR SIGNATURE		DATE
SECTION MANAGER'S SIGNATURE		DATE