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## BIRTHING CENTERS

### License Application Form

QC-793 -Initial

*Health Care Licensure and Certification*

QC-795 -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		CAPACITY _____
NAME OF FACILITY MANAGER					
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.					
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 \$250.00*

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WITHDRAWN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