Ambulatory Surgical Center License Application

Click Here For Ambulatory Surgery Center Rules

Type of Action		
New facility license*: ☐		
License renewal*: ☐ **(due December 1 before the annual renewal)**	License #:	
Change request: ☐ **(Select all that apply)**	☐Name ☐Address ☐Ownership* ☐Administrator ☐Procedure room (Increase*/ decrease) ☐Add/remove services ☐Other (Please Specify)	Effective date(s) of change(s): Additional information about the requested changes (please attach additional pages as needed):

*Fee payment required (see page 2 for details).

Facility Information – For change-only applications, complete the Facility Name and any changes selected above		
Facility Legal Name:		
Facility Doing Business As (DBA) Name (if applicable):		
Facility physical address, city, state & zip:		
Phone:	Fax:	County:
Facility mailing address (if different from above):		
Facility email:		
Administrator name:	Administrator phone:	
Administrator email:		
Emergency contact name:	Emergency contact phone:	
Emergency contact e-mail:		
Name of facility manager:		

Days and hours of operation:
Number of procedure rooms:
Name of ASC's Accrediting Organization (if applicable):

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 or LLC ☐
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 check all services currently (C) provided for renewal application or planning to provide for initial application. If adding (A) or deleting (D) services, check all changes that apply.

C	A	D	Service		C	A	D	Service
☐	☐	☐	Cardiovascular		☐	☐	☐	Ophthalmology
☐	☐	☐	Foot		☐	☐	☐	Oral
☐	☐	☐	General		☐	☐	☐	Orthopedic
☐	☐	☐	Neurological		☐	☐	☐	Otolaryngology
☐	☐	☐	Obstetrics/Gynecology		☐	☐	☐	Plastic
☐	☐	☐	Thoracic		☐	☐	☐	Urology
☐	☐	☐	Other (please list):					

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, Division 076 requires that all accredited ASCs provide to the Health Care Regulation 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)**

The person who filled out this application form	
Name:	Email:
Title:	Phone:

Fee schedule applies to initial and renewal licenses and to applications for procedure room increases and Changes of Ownership (CHOWs). (No fee is required for procedure room decreases.)	
$1,750.00	CMS Certified & High Complexity Non-Certified Ambulatory Surgical Centers with more than two procedure rooms
$1,250.00	CMS Certified & High Complexity Non-Certified Ambulatory Surgical Centers with no more than two procedure rooms
$1,000.00	Moderate Complexity Non-Certified Ambulatory Surgical Centers

Make check payable to: Oregon Health Authority

Mail payment and application to: HFLC / PO Box 14260 / Portland, OR 97293

HCRQI Office Use Only
Renewal Licensure/change: Approved:_____ Denied:_____ Withdrawn:_____ Initials:_____ Date:_____
CASH OFFICE: QC 797 initial / QC 798 renewal