State of Alaska

Department of Health & Social Services

Ambulatory Surgical Center

Licensure Renewal Application

Print Form

DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Department Use Only
License Number _____

Pursuant **to** the AS 47.32 **Licensing Statute and the regulations of the Department of Health & Social Services Ambulatory** Surgical **Center (ASC) Licensing requirements (**7 AAC 10 **and** 7 AAC 12**)**

I. NAME AND LOCATION OF THE AMBULATORY SURGICAL CENTER (ASC)

Exact Legal Name:

Doing Business As:

Street and Number:

City State Zip Code

Premises Located At:

Main Phone Number for Public Use:

Administration Phone Number for HFL&C Use:

Administration Fax Number for HFL&C Use:

E-Mail Address for HFL&C Use:

II. OWNERSHIP AND CONTROL

A. Type of Control (check one)

GOVERNMENTAL

☐ State ☐ Borough ☐ City

NOT FOR PROFIT CORPORATION

☐ Church Operated or Affiliated ☐ Other Non-Profit

PROPRIETARY

☐ Individual ☐ Partnership ☐ Corporation

☐ Other (Explain)

THE DEPARTMENT IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER AS 47.32.040

B. If Individual or Partnership owned (list all persons who own the ASC)

Name	Address

C. Names under which persons in B. do business (other than this ASC)

Name	Business

D. Corporate Ownership

(1) Name of Corporation

(2) State where Parent Firm or Organization is Incorporated or Registered

(3) List title, name and address of each corporate officer

Title	Name	Address

E. List names and address of each shareholder holding more than 5 percent of shares

Name	Address	Percent of Shares

F. For other than individual ownership, list the name and address of the Alaska registered agent or the person(s) legally authorized to receive service of process for the facility.

Name of Registered Agent	Address

G. List the names and addresses of all persons under contract to manage or operate the facility

☐ (Check here if not applicable)

H. Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? **(If yes, attach explanation as Exhibit I.)**

1. Applicant ☐ Yes ☐ No
2. Any member of a firm or partnership ☐ Yes ☐ No
3. Any officer or director of a corporation ☐ Yes ☐ No
4. Administrator or manager of the ASC ☐ Yes ☐ No

III. ADMINISTRATION AND PERSONNEL

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)

B. Medical Director

Name

Address

Telephone Number License Number

C. Supervising Nurse

Name

Address

Telephone Number License Number

D. List the types of procedures performed in the center

E. Number of Operating Rooms

F. Medical Staff: List specialty, name, and license number of each physician, anesthesiologist, podiatrist, or dentist granted privileges to perform procedures in the center.

Specialty	Name	License No.

G. Personnel: List position and/or classification; name, education, experience, professional licensure or certification

Position and/or Classification	Name	License Number, Registration, Certification, Education or years Experience

G. Personnel: (Continued)

Position and/or Classification	Name	License Number, Registration, Certification, Education or years Experience

IV. ACCREDITATION

A. Is the facility fully approved by the Accreditation Association for Ambulatory Health Care or another approved accrediting body?

☐ Yes ☐ No ☐ Full ☐ Provisional

B. Has the facility requested appraisal by an accrediting body?

☐ Yes ☐ No

C. Accrediting body

D. Date of last Accrediting Body Survey

E. Type of survey

D. Date accreditation expires

V. FUTURE EXPANSION

A. Does your facility plan to add new or delete present services and/or facilities during the next period for which this license is issued?

☐ Yes ☐ No Specify

B. Certificate of Need Application Submitted? ☐ Yes ☐ No

(If a Certificate of Need Application has been submitted attach a copy of the Application and CON Planning Section decision as Exhibit II.)

VI. INSURANCE

A. Does the facility have current Malpractice Insurance?

☐ Yes ☐ No

B. If yes please provide the following:

Company

Address

Expiration Date

VII. CRIMINAL BACKGROUND CHECKS

A. Does the facility have a system in place for performing criminal background checks in accordance with AS 47.05 and 7 AAC 10.900 - 990?

☐ Yes ☐ No BCU Provider Identification Number

VIII. FLOOR PLAN

Provide a copy of the facility floor plan as Exhibit III

IX. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in 7 AAC 10.900 - 990 (Barrier Crimes, Criminal History Checks, and Centralized Registry), 7 AAC 10.9500 - 9535 (General Variance), 7 AAC 10.9600 - 9620 (Inspections and Investigations), the applicable requirements of 7 AAC 12.350 - 370 (Ambulatory Surgical Facilities) and the applicable requirements of 7 AAC 12.600 - 990 (General Provisions).

The undersigned gives assurance that the facility is in compliance to the best of his/her knowledge and he/she is prepared for an on-site inspection to validate compliance. ☐ **Yes** ☐ **No**

Administrator or Designee Name

Signature of Administrator or Designee

Date

Please submit this application to:

Patricia Erickson, Administrative Assistant
Health Facilities Licensing & Certification
4501 Business Park Blvd., Suite 24, Bldg. L
Anchorage, Alaska 99503

Phone: (907) 334-2483
Fax. (907) 561-3011
E-Mail Submissions: patricia.erickson@alaska.gov

[Note: To submit by E-mail, print the document, sign above, and scan to a PDF file. Attach the signed PDF document to an E-mail and send to the above E-mail address.]

Print Form