Mississippi State Department of Health
Application for License Renewal of Ambulatory Surgical Facility
Licensure Year: July 1, 2018 - June 30, 2019

As authorized and required by Chapter 433, Laws of Mississippi, 1983, Regular Legislative Session, application is made for license to operate an Ambulatory Surgical Facility under the name and at the address shown below. In support of this application, the following and assurances are given:

1. _____

Name of Facility Telephone No.

_____

Street Address City State Zip

A. In the above space, give the name of the facility as it will be known to the public. Every Ambulatory Surgical Facility shall be designated by a permanent and distinctive name which shall be used in applying for a license and shall not be changed without first notifying the licensing agency in writing and receiving written approval of the change from the licensing agency. Only the official name by which the Ambulatory Surgical Facility is licensed shall be used in telephone listings, on stationery, in advertising, etc.

2. _____

Name of Administrator or Chief Executive Officer Mailing Address City State Zip Tel. No.

Email Address of Contact Person _____

B. The Governing Authority shall appoint a qualified person as Chief Executive Officer of the facility to represent the Governing Authority, and who shall be responsible for the management of the facility, implementation of the policies of the Governing Authority, and authorized and empowered to carry out the provisions of the licensing regulations.

3. _____

Owner(s) of Physical Plant Street Address City State Zip Tel. No

A. In the above space, give the name of the person(s) or other legal entity having title to the physical plant and/or land of the facility.

B. Is the owner(s) of the physical plant and/or land the same person(s) or legal entity which manage and operate the Ambulatory Surgical Facility?
Yes [ ] No [ ]

C. Does the owner(s) of the physical plant and/or land LEASE the physical plant and/or land to a person(s) or other legal entity for the establishment and operation of the Ambulatory Surgical Facility? Yes [ ] No [ ]

D. If the answer is YES, submit one (1) copy of the Lease Agreement between the afore named parties **unless a copy has previously been submitted.**

4. _____

Name of Legal Entity Responsible for Operations of Ambulatory Surgical Facility | Street Address | City | State | Zip | Tel. No.

A. In the above space, give the name of the legal entity having responsibility for the day-to-day management and operation of the Ambulatory Surgical Facility. If the entity is a corporation, give the corporate name; if a partnership, give the name of the partnership and the partners; if a single entrepreneur, give the name of the individual.

B. The facility is organized: For profit [ ] Not for profit [ ].

C. Is the management and operation of the Ambulatory Surgical Facility by means of a MANAGEMENT CONTRACT? Yes [ ] No [ ].

D. If the answer is YES, submit one (1) copy of the MANAGEMENT CONTRACT between the affected parties to the contract, **unless a copy has previously been submitted.**

5. _____

Governing Authority | Mailing Address | City | State | Zip | Tel. No.

A. In the above space, give the name of the person(s) or legal entity in which the ultimate responsibility and authority for the management and day-to-day operation of the Ambulatory Surgical Facility is vested. Governing Authority means any of the following: Owner(s) association, county Board of Supervisors, corporate Board of Directors, Board of Trustees, or any other comparable designation of any individual or group individuals in which the ultimate responsibility and authority of the Ambulatory Surgical Facility is vested.

IMPORTANT NOTE: The Ambulatory Surgical Facility LICENSE is granted to that person(s) or other legal entity in which the ultimate responsibility and authority of the Ambulatory Surgical Facility is vested.

B. Has the Governing Authority made any changes in the past year in the Bylaws, Rules and Regulations applicable to this Ambulatory Surgical Facility?
Yes [ ] No [ ]

C. If the answer is YES, submit one (1) copy of the Governing Authority Bylaws, Rules and Regulations, signed by the Chairman and Secretary of the Governing Authority, **unless a copy has previously been submitted.**

D. The following Trustees [ ] Partners [ ] Directors [ ] Other [ ]_____ constitute the entire Governing Authority of the operating organization :

NAME	NAME
1. _____ Chair	5. _____
2. _____ V. Chair	6. _____
3. _____ Sec.	7. _____
4. _____	8. _____

6. Is the Medical Staff organized? Yes [ ] No [ ].

How often are Medical Staff meetings scheduled? _____

Average attendance at meetings_____

Name of Chief of Medical Staff _____

Number of Members-Medical Staff:

Active (Admitting) _____

Associate _____

Consulting _____

Other _____

Total _____

7. Give the name of each member of the Medical Staff and his/her specialty, if any:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

{If additional space is needed, continue the list on separate page.)

8. Has the Medical Staff made any changes in the past year in the Bylaws, Rules and Regulations, and has the Governing Authority approved such Bylaws, which are applicable to this Ambulatory Surgical Facility? Yes [ ] No [ ].

A. If answer is YES, submit one (1) copy of the Medical Staff Bylaws, Rules and Regulations signed by the President (or Chief) of the Medical Staff, including a signed statement that such Bylaws have been approved by the Governing Authority, **unless a copy has previously been submitted.**

9. List the Surgical services provided:
(License will be limited to services applied for and approved.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(If additional space is needed, continue the list on separate page.)

10. Check the types of anesthesia used:
Local [ ] Spinal [ ] Intravenous [ ] Inhalation [ ] Other [ ] _____

11. Give the name, degree, if any, or other qualifications of the person(s) who are responsible for the following departments:

DEPARTMENT	NAME & DEGREE, IF ANY	BOARD CERTIFICATION/ OTHER QUALIFICATIONS
Administration		
Nursing Service		
Laboratory		
Radiology		
Anesthesia		
Medical Records		
Pharmacy		
Housekeeping		
Maintenance		
Other		
Other		
Other		

12. Have any changes been made in the building during the past year? Yes [ ] No [ ].

If the answer is yes, please describe the changes in the space below.

_____
_____
_____
_____
_____
_____
_____
_____

13. How many employees do you have in each of the following classifications: (Use fraction to denote division of time where one person fills two or more positions).

Administration & Business Office _____
Nursing Service _____
RN's _____
LPN's _____
Aides & Orderlies _____
Laboratory _____
Radiology Medical Records _____

Anesthetists _____
Dietary _____
Housekeeping _____
Maintenance _____
Pharmacy _____
All Others _____
Total Employees _____

Our check for $3,450.00 (the renewal fee), payable to the Mississippi State Department of Health is enclosed.

I certify that I have prepared the above application, or have verified the accuracy of all the information it contains.

Signature _____

Name (Typed) _____
Chairman, Governing Authority

Date _____

Signature _____

Name (Typed) _____
Chief Executive Officer

Date _____

Mail to:
Mississippi State Dept of Health
Health Facilities
Licensure & Certification
P.O. Box 1700
Jackson, MS 39215