



Washington State Department of

Health

Health Systems Quality Assurance

P.O. Box 47877

Olympia, WA 98504-7877

Ambulatory Surgical Facility License Application Packet

Contents:

1. 505-069.... Ambulatory Surgical Facility License Application Packet Index Page..... 1 Page
2. 505-070.... Application Checklist & Instructions 3 Pages
3. 505-071.... Ambulatory Surgical Facility License Application..... 3 Pages

Important Information:

In order to process your request:

Return completed application and [licensing fee](#) based on the number of surgical procedures.

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Department of Health
Health Systems Quality Assurance
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Checklist and Instructions

You can use this checklist by checking off each required entry or document.

Indicate type of application – new, change of ownership, amended, renewal, or annual update.

New – Submit the following:

- Application and [Fee](#).
- Name of managing personnel, officers, and administrator.
- Description of the organizational structure.
- Name, address and phone numbers of all office locations.
- Copy of current business license.
- Proof of completion of the department’s construction review process.
- Copy of safety & emergency training program.
- Proof that a certificate of occupancy by the local building official has been approved and issued.

Change of Ownership – Requires current & prospective owners to submit application. The current owner must submit.

- Full name, address, and phone number of the current and new owner.
- Name, address, and phone number of ambulatory surgical facility.
- Name under which the agency will operate.
- Date of the proposed change of ownership.
- Any changes in office location.

The prospective owner must submit

- Application and change of [ownership fee](#).
- Name of managing personnel, officers, and administrator.
- Description of the organizational structure.
- Name, address and phone numbers of all office locations.
- Copy of current business license

Amended – Submit application to request the addition of new construction, days and times surgeries will be performed, add or eliminate surgical procedures, change accreditation information, change administrator, lead nurse or preferred contact information.

Renewal – submit the following:

- Application and [Fee](#).

Annual Update – submit:

- Application.

Check One:

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

Section #1: Demographic Information:

- ___ **Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.
- ___ **Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.
- ___ **Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/Master Business License.
- ___ **Mailing Address:** Enter the owner's complete mailing address.
- ___ **Phone and Fax Numbers:** Enter the owner's phone and fax number.
- ___ **Email and Web Address:** Enter the owner's email and agency Web addresses, if applicable.
- ___ **Facility/Agency Name:** Enter the agency's name as advertised on signs, brochures or Web site.
- ___ **Physical Address:** Enter the agency's physical street location including city, state, zip and county.
- ___ **Phone and Fax Numbers:** Enter the agency's phone and fax number.
- ___ **Mailing Address:** Enter the agency's mailing address, if different than physical address.

Section #2: Facility Specific Information:

___ **A. Surgery Information**

Indicate total number of procedures done per year, number of surgery rooms, and number of employees.

Check all days in a week when surgeries will be performed.

Check the time of day the facility will be open.

___ **B. Surgical Procedures**

Check all that apply.

___ **C. Certification – Accreditation**

Check yes or no if you are accredited by one of the accreditation organizations listed, and last accreditation survey date. Check yes or no if you are medicare certified and list provider number.

___ **D. Building**

Check yes or no and if yes, approval number. If uncertain, call Construction Review at 360.236.2944. Provide facility/building name and physical site address of building.

If you have more than one building or approved projects use the second entry. For three or more buildings, use a blank page and return with your application.

Section #3: Key Individuals: Provide license number if this person is a licensed health professional.

- ___ **Administrator:** Enter name, phone number, fax number, email address, and license number.
- ___ **Lead Nurse:** Enter name, phone number, fax number, email address, and license number.
- ___ **Preferred Contact:** Enter name, phone number, fax number, email address, and license number.

Section #4: Additional Information:

— **Change of Ownership Information:**

List the previous legal owner name, previous name of facility/agency, previous IHS license #, effective date of ownership change and physical address.

— **Initial Application Only:**

Complete this section if this is for a new Ambulatory Surgical Facility after July 1, 2009.

Signature:

— Signature of legal owner or authorized representative.

— Date signed.

— Print name of legal owner or authorized representative.

— Print title of legal owner or authorized representative.

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Date
Stamp
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Revenue: 0299664600

Ambulatory Surgical Facility License Application

This is for: New Change of Ownership Amended Renewal Annual Update

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Public Hospital District |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | <input type="checkbox"/> Trust |

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
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Legal Owner/Operator Name

Mailing Address

City	State	Zip	County
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Phone# ()	Fax# ()
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Email Address	Web Address:
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Facility/Agency Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip	County
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Facility Phone# ()	Fax# ()
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Mailing Address (If different than physical address)

City	State	Zip	County
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For Office Use Only

Credential # _____

2. Facility Information

A. Surgery Information

Number of:

Procedures per year _____ Surgery rooms _____ Employees _____

Days surgeries performed:

Sun _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____

Times surgeries performed:

Morning _____ Afternoon _____ Evening _____ All day _____

B. Check all surgical procedures:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Ear, Nose, & Throat | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Maxio Facial | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Other _____ | | | |

C. Certification – Accreditation:

Medicare Certified? Yes No Provider # _____

Joint Commission? Yes No Last Accreditation Survey Date _____

Accreditation Association for Ambulatory Health Care? Yes No

Last Accreditation Survey Date _____

American Association for Accreditation of Ambulatory Surgery Facilities? Yes No

Last Accreditation Survey Date _____

Other Accreditation _____ Last Accreditation Survey _____

D. Bulding:

DOH Construction Review approved? Yes No CRS approval # _____

Facility/Building name _____

Facility site address _____

DOH Construction Review approved? Yes No CRS approval # _____

Facility/Building name _____

Facility site address _____

DOH Construction Review approved? Yes No CRS approval # _____

Facility/Building name _____

Facility site address _____

3. Key Individuals [For information about license #, see instructions.](#)

Administrator Name		License #
Phone #	Fax #	Email Address
Lead Nurse		License #
Phone #	Fdfax #	Email Addresssd
Preferred Contact		License #
Phone #	Fax #	Email Address

4. Additional Information

Change of Ownership Information

Previous Name of Legal Owner:

Previous Name	Previous ASF License #	Effective Date of Ownership Change
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Physical Address

Complies with certificate of need requirements, RCW 70.38? Yes No N/A

Initial Application Only (After July 1, 2009)

Safety and emergency training program attached? Yes No

Met Certificate of Need requirements: Yes No N/A

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

_____ Signature of Owner/Authorized Representative	_____ Date
_____ Print Name	_____ Print Title