



Child Birth Center License Application Packet

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In order to process your request:

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

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Child Birth Center Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Checklist and Instructions

General Information

When your application for Child Birth Center is received by the Department of Health, your application will be reviewed and you will be notified of any outstanding documentation needed to complete the application process.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

Indicate type of application: **New** **Change of Ownership**
 Amended **Renewal**

- **New**—First time requesting a child birth center license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed child birth center.
- **Amended**—Request the addition of a Service Category; add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director, or Direct Supervisor information, or add Other Office Locations.
- **Renewal**—Request renewal of child birth center license.

New—Submit the following:

- Application and fee.
- Disclosure statements and criminal history background checks for the administrator, owner, and director of services.
- Name of managing personnel, officers, administrator, director of clinical services, or supervisor of clinical services.
- 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.
- Proof of compliance with local codes and ordinances.
- Approval from the state fire marshal.
- Proof that a certificate of occupancy by the local building official has been approved and issued.

Change of Ownership—must submit in writing:

- Application and fee of \$178.00.
- Full name, address, and phone number of the current and new owner.
- Name, address, and phone number of the currently licensed acute care hospital.
- 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 of \$178.00.
- Disclosure statements and criminal history background checks for the Administrator, Owner, and Director of Services.
- Name of managing personnel, officers, administrator, director of clinical services or supervisor of clinical services.
- Description of the organizational structure.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.

Amended—To request the addition of a Service Category; add or eliminate Service(s), change Accreditation information, add or eliminate Service Area(s), change Administrator, Clinical Director, or Direct Supervisor information, or add Other Office Locations.

Renewals—Submit the following:

- Application and fee of \$178.00.
- Disclosure statements and background checks on the administrator, owner, and director of services when they are new to the birth center since initial license or last renewal.

Return completed application and the following information:

- **Disclosure Statement**—Attach a copy of the Disclosure Statement for the on-site Administrator/Director and owner dated within three months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in [WAC 246-329-075](#).
- **Criminal History Background Check (CBC)**—Attach a copy of the current CBC for the on-site Administrator/Director and owner dated within three months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in [WAC 246-329-075](#).

Application Instructions and Checklist

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

Application Fee:
You can check the [Fee Page](#) for current fees.

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, Fax and Cell Numbers: Enter the owner's phone, cell, and fax numbers.

Email and Web Address: Enter the owner's email and facility 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 code, and county.

Phone, Fax and Cell Numbers: Enter the facility's phone, cell, and fax numbers.

Mailing Address: Enter the facility's mailing address, if different than the physical address.

2. Facility Specific Information:

A. In-patient beds:
Indicate total of licensed birthing rooms and average daily patient census.

B. Services provided:
Check all that apply.

C. Certification—Accreditation:
List name of accreditation agency, last accreditation survey date, and expiration date.

D. Transfer Agreement:
List name of hospital with a signed transfer agreement to admit birth center patients.

3. Key Individuals:

Administrator: Enter name, phone number, fax number, email address, and license number (as applicable). This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

Director of Services: Enter name, phone number, fax number, email address, and hire date.

Preferred Contact: Enter name, phone number, fax number, and email address.

4. Additional Information:

Legal Owner Information: List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, and individuals owning 10 percent or more of the agency. Attach more sheets of paper as needed.

Change of Ownership Information: List the previous legal owner name, previous name of facility, agency, previous HIS license number, effective date of ownership change and physical address, if applicable.

5. 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.

Date
Stamp
Here

Revenue 0520632340

Child Birth Center License Application

This is for: **New** **Change of Ownership** **Amended** **Renewal**

Check One

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

1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip	County
Phone (enter 10 digit #)	Cell (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
Email address		Web Address	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip	County
Facility Phone (enter 10 digit #)	Cell (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
Mailing Address			
City	State	Zip	County

For Office Use Only

Credential #

2. Facility Information

A. In-patient beds:

Total Licensed Birthing Rooms _____ Average Daily Patient Census _____

B. Check all services provided:

ARNP Midwife Medical Physician Midwife Naturopathic Physician

C. Accreditation:

Name of Accreditation Agency _____

Last Accreditation Survey Date _____ Expiration Date _____

D. Transfer Agreement:

Name of hospital with a signed transfer agreement to admit birth center patients:

3. Key Individuals (fill in as applicable)

Administrator Name		License #
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Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address
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Director of Services		License #
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Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address
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Preferred Contact		License #
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Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address
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4. Additional Information

Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone (enter 10 digit #)	Title

Change of Ownership Information

Previous Name of Legal Owner

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

5. 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 (mm/dd/yyyy)

Print Name

Print Title



RCW/WAC and Online Web Site Links

RCW/WAC Links

Birthing Center Laws (RCW)	<u>RCW 18.46</u>
Childbirth Center Rules (WAC)	<u>WAC 246-329</u>

On-Line

Child Birth Center	<u>Web Page</u>
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