Oklahoma State Department of Health
Protective Health Services
Medical Facilities
123 Robert S. Kerr Ave., Ste 1702
Oklahoma City, OK 73102
Telephone: (405) 426-8470
Fax: (405) 900-7559

APPLICATION FOR LICENSE TO OPERATE AN AMBULATORY SURGICAL CENTER

INSTRUCTIONS

I. Read carefully and complete all portions of the application. Please print or type.

II. Application for license shall be made by any person, corporation, partnership, association or other legal entity desiring to obtain a license to establish, or to obtain a renewal license. Any changes are to be reported promptly to the address above.

III. **License FEES must accompany the application and should be submitted directly to Financial Management at the post office box listed below.** Please do not submit fees to the Medical Facilities Division. Checks, money orders or bank drafts must be made payable to OKLAHOMA STATE DEPARTMENT OF HEALTH, must clearly identify the facility which the payment is associated and be mailed to:

Financial Management - Receipting Unit
Oklahoma State Department of Health
P.O. Box 268823
Oklahoma City, OK 73126-8823

IV. Indicate the type of application submitted:

☐ Initial Application --$2,000.00 ☐ CHOW Application -- $2,000.00 ☐ Renewal Application-- $500.00

1. Doing Business as Name (DBA): **License No.** _______________

____

Finding Address:

____
(Number & Street) (City) (State) (Zip)

Mailing Address:

____
(Number & Street) (City) (State) (Zip)

Tel. No. (___) ____-____________ **Fax No. (___) ____-________________**

2. Operating Entity (Legal Name) Information:

____
(Name of Entity)

____
(Business Address)

Governmental: ☐ **State** ☐ **County** ☐ **City**
☐ **City/County** ☐ **Hospital Authority or District**

Non-Governmental Not-for-Profit: ☐ **Church Related** ☐ **Corporation** ☐ **Other (specify)**

Non-Governmental For-Profit: ☐ **Individual** ☐ **Partnership** ☐ **Corporation**

3. Chief Executive Officer/Director Name:____

4. Hours of Operation:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From (AM):							
To (PM):							

5. *The undersigned hereby makes application for license to maintain an Ambulatory Surgery Center (ASC) subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the Oklahoma State Board of Health. By my signature below, I certify that the foregoing is true and correct to the best of my knowledge and belief.*

SIGNATURE OF APPLICANT:

Signature: ____

Printed Name: ____

Title or Position: ____

Email address: ____

Date: ____