

**Application for Ambulatory Surgical Facilities
Regulation 61-91**

Reason for Application			
<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change Request	
	License Number:	Expiration Date:	<i>(Complete Part C and D)</i>
Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Days and Hours of Operation:			
<input type="checkbox"/> Monday	_____ AM to _____ PM		
<input type="checkbox"/> Tuesday	_____ AM to _____ PM		
<input type="checkbox"/> Wednesday	_____ AM to _____ PM		
<input type="checkbox"/> Thursday	_____ AM to _____ PM		
<input type="checkbox"/> Friday	_____ AM to _____ PM		
<input type="checkbox"/> Saturday	_____ AM to _____ PM		
<input type="checkbox"/> Sunday	_____ AM to _____ PM		
Number of Operating Rooms:	Number of Endoscopy Rooms:	Number of Procedure Rooms:	
Contact Person and Correspondence Mailing Address:			
<i>(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)</i>			
Name:		Title:	
Address:			
City:	State:	Zip:	
Telephone Number:			
Email address:			
Qualified Administrator: (For INITIAL Applicants ONLY, MUST provide a copy of qualifications)			
Name:			
Address:			
City:	State:	Zip:	
Telephone Number:		Fax:	
Email Address:			
Medical Director: (For INITIAL Applicants ONLY, MUST provide a copy of qualifications)			
Name:			
Address:			
City:	State:	Zip:	
Telephone Number:		Fax:	
Email Address:			

Part B. Operation Disclosure		
Licensee Information: <i>(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)</i> *This can be found on your current license OR your documentation from the Secretary of State.		
Licensee Name:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Name of Presiding Officer of the Registered Organization's Governing Body:		
Ownership Type:		
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Corporation*	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Liability Company (LLC)*	
<input type="checkbox"/> Limited Partnership	<input type="checkbox"/> Government	
*Submit SC Secretary of State documentation, if applicable		

Licensee or Owner Documents Required

1. Secretary of State documentation, if applicable Attached N/A
2. If the licensee is a corporation or partnership, attach a list identifying all officers. Attached N/A
3. If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership. Attached N/A
4. If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent and type of claim. Attached N/A

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES		
<input type="checkbox"/> Change of Facility Name and/or Location (Complete Section1)	<input type="checkbox"/> Change of Ownership (Complete Section2)	<input type="checkbox"/> Change in Licensed Units (Complete Section 3)
Section 1 (FACILITY INFORMATION)		
<i>PRIOR TO CHANGE</i>		
Current License Number:		
Current Facility Name:		
Current Facility Address:		
City:	State:	Zip:
Facility Telephone Number:	Fax Number:	
<i>AFTER CHANGE</i>		
New Facility Name:		
New Facility Address:		
City:	State:	Zip:
New Facility Telephone Number:	Fax Number:	
Section 2 (LEGAL IDENTITY OF OWNERSHIP)		
<i>Application must be completed by new owner, as licenses are not transferable.</i>		
<i>PRIOR TO CHANGE</i>		
Name of Current Owner:	License Number:	
Address of Current Owner:		
City:	State:	Zip:
Telephone Number of Current Owner:		
Signature of current owner:	Date:	
<i>AFTER CHANGE</i>		
Name of New Owner:		
Address of New Owner:		
City:	State:	Zip:
Telephone Number of New Owner:		
Signature of new owner:	Date:	
Section 3 (CHANGE IN LICENSED UNITS)		
License Number:		
Facility Name:		
Facility Address:		
City:	State:	Zip:
Facility Telephone Number:	Fax Number:	
<input type="checkbox"/> Increase	<input type="checkbox"/> Decrease	
Number of Operating Rooms	From:	To:
Number of Endoscopy Rooms	From:	To:
Number of Procedure Rooms	From:	To:

Part D: Verification

The application shall be signed by the following:

- If an individual, the **owner(s)**
- If a limited liability company, the **head of the limited liability company**
- If a corporation, **two** of its **officers**
- If governmental unit, the **head of the governmental department** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 61-91. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-91.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Subscribed and sworn to before me this _____ day of _____, _____.

(Month) (Year)

NOTARY PUBLIC _____

My commission expires _____

NOTARY SEAL