SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Application for Birthing Centers for Deliveries by Midwives Regulation 61-102

Reason for Application			
☐ Initial	☐ Renewal		☐ Change Request *(Complete Part C and D)*
	License Number:	Expiration Date:	

Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Days and Hours of Operation:			
☐ Monday		___________ AM to___________PM	
☐ Tuesday		___________ AM to___________PM	
☐ Wednesday		___________ AM to___________PM	
☐ Thursday		___________ AM to___________PM	
☐ Friday		___________ AM to___________PM	
☐ Saturday		___________ AM to___________PM	
☐ Sunday		___________ AM to___________PM	
Number of Birthing Rooms:			
Name of Hospital with which transfer agreement has been made: **(attach a description of arrangements for emergency transportation of patients from facility; also attach a description of arrangements for obstetric and pediatric consultation and referral)			

Contact Person and Correspondence Mailing Address: *(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.)*		
Name:		Title:
Address:		
City:	State:	Zip:
Telephone Number:	Fax:	
Email Address:		

Administrator:		
Name:		
Address:		
City:	State:	Zip:
Telephone Number:		Fax:
Email Address:		

Director of Midwifery		
Name:		
Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Email Address:		

Part B. Operation Disclosure		
Licensee Information: *(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)* ***This can be found on your current license OR your documentation from the Secretary of State.**		
Licensee Name:		
Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Ownership Type		
☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership	☐ Corporation* ☐ Limited Liability Company (LLC)* ☐ Government	☐ Other: __________________
*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		
☐ Change of Facility Name and/or Location (Complete Section 1)	☐ Change of Ownership (Complete Section 2)	☐ Change in Capacity (Complete Section 3)

Section 1 (FACILITY INFORMATION)		
PRIOR TO CHANGE		
Current License Number:		
Current Facility Name:		
Current Facility Address:		
City:	Zip:	County:
Facility Telephone Number:	Fax Number:	
AFTER CHANGE		
New Facility Name:		
New Facility Address:		
City:	Zip:	County:
New Facility Telephone Number:	Fax Number:	

Section 2 (LEGAL IDENTITY OF OWNERSHIP) *Application must be completed by new owner, as licenses are not transferable.*		
PRIOR TO CHANGE		
Name of Current Owner:	License Number:	
Address of Current Owner:		
City:	Zip:	County:
Telephone Number of Current Owner:		
Signature of current owner:	Date:	
AFTER CHANGE		
Name of New Owner:		
Address of New Owner:		
City:	Zip:	County:
Telephone Number of New Owner:		
Signature of new owner:	Date:	

Section 3 (CHANGE IN CAPACITY)			
License Number:			
Facility Name:			
Facility Address:			
City:	State:	Zip:	County:
☐ **Increase**	☐ **Decrease**		
Number of Birthing 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 61-102. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-102.

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**