LICENSURE APPLICATION
for
AMBULATORY SURGICAL
FACILITY REGULATION 60-91

Return the completed application to:

Email address (preferred method):
ASF@dph.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
P.O. Box 2046
West Columbia, SC 29171

For additional questions, contact us at: 803-545-4370.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

NOTICE: *Your license must be renewed **prior** to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.*

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the facility must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you ONLY complete Parts C & D.

Part A: Facility Information

- Facility Information: Please complete the applicant information for the facility.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- Qualified Administrator: Please complete each field. If there is more than one Qualified Administrator, please provide the information on a separate piece of paper. Submit a copy of each Administrator's qualifications FOR INITIAL APPLICATIONS ONLY.
- Medical Director: Please complete each field. Submit a copy of the Medical Director's qualifications FOR INITIAL APPLICATIONS ONLY.

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate the ambulatory surgical facility at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
    - For partnerships, you must provide the name of each partner;
    - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
    - For a corporation, you must provide the name and title of each corporate officer.
- If this is an LLC or Corporation list all persons/entities who have ownership interest in the entity applying for licensure.

Part C: Licensure Changes

- For Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For changes in Capacity, complete Section 3.

Part D: Verification

- The application shall be signed by the following:
    - If an individual partnership, ***the owner(s)***
    - If a corporation, ***two*** of its ***officers*** if a corporation
    - If governmental unit, the ***head of the governmental department*** having jurisdiction
- This page needs to be notarized.

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Application for Ambulatory Surgical Facilities
Regulation 60-91

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 Operating Rooms:	Number of Endoscopy Rooms:	Number of Procedure Rooms:	

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:		
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: *(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:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Name of Presiding Officer of the Registered Organization's Governing Body:		
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 Section1)	☐ Change of Ownership (Complete Section2)	☐Change in Licensed Units (Complete Section 3)

Section 1 (FACILITY INFORMATION)		
PRIOR TO CHANGE		
Current License Number:		
Current Facility Name:		
Current Facility Address:		
City:	State:	Zip:
Facility Telephone Number:	Fax Number:	
AFTER CHANGE		
New Facility Name:		
New Facility Address:		
City:	State:	Zip:
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:	State:	Zip:
Telephone Number of Current Owner:		
Signature of current owner:		Date:
AFTER CHANGE		
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:	
☐ **Increase**	☐ **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 60-91. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 60-91.

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**

Application for Licensure Ambulatory Surgical Facility
Instructions for Completing 3288-ENG-DPH

PURPOSE: This is an external form used by customers to apply for a health license or service regulated by Healthcare Quality.

AUDIENCE: DPH Customers.

INSTRUCTIONS: Customers will complete this application when applying for a healthcare facility or service regulated by Healthcare Quality. This application is to be used in conjunction with the facility's regulation.

OFFICE MECHANICS & FILING: The completed form will be stored on the Bureau of Operations Support's SharePoint Site / OneDrive. This form is maintained by retention schedule 16327 — Masterfiles. Once the 10-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.