LICENSURE APPLICATION
for
AMBULATORY SURGICAL FACILITY

REGULATION 61-91

Return the completed application to:

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

OR

Mailing address:
Bureau of Health Facilities Licensing
2600 Bull Street
Columbia, SC 29201

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 complete Part 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. Submit a copy of the Administrator's qualifications.
- Medical Director: Please complete each field. Submit a copy of the Medical Director's qualifications.

Part B: Operation 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.
- 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.

Part C: Ownership Disclosure

- If this is an LLC or Corporation list all persons/entities who have ownership interest in the entity applying for licensure.

Part D: Licensure Changes

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

Part E: 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.

Application for Ambulatory Surgical Facilities
Regulation 61-91

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

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:	Telephone Number: ( )	
City:	State:	Zip:
Primary Email:		

Qualified Administrator: (MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number: ( )	Fax: ( )
Email Address:	

Medical Director: (MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number: ( )	Fax: ( )
Email Address:	

Part B. Operation Disclosure		
Licensee Information *(name of the person(s) or entity to be licensed to operate the facility at that site as indicated in Part A)*		
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		

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is ***not for profit,*** the name of each Officer, Director or Trustee.
- If the licensee is a ***corporation (Inc),*** the name and title of each corporate officer.
- If the licensee is a ***limited liability company (LLC),*** the name of the managing members.
- If the licensee is a ***partnership or limited liability partnership (LLP),*** the name of each partner.
- If the licensee is a ***governmental unit,*** the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.
- If the licensee is another type of organization, the name of each Officer, Director or Trustee.

Executive Officer, General Partner, Members		
Name:	Telephone Number: ( )	Fax Number: ( )
Address:		
City:	State:	Zip:
Name:	Title:	
Name:	Title:	
Name:	Title:	
Name:	Title:	
Name:	Title:	

Part C. Ownership Disclosure

OWNERS, PRINCIPLES, SHAREHOLDERS, MEMBERS

Complete the information below on all individuals who are owners, principles, shareholders, or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. If you are the only owner, complete the information below, listing the percentage interest as 100%.

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Name:		
Address:		
City:	State:	Zip:
Telephone: ( )	Fax: ( )	
Email Address:		
Percentage interest in this licensed facility:	Title:	

Part D: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES		
☐ Change of Facility Name and/or Location (Complete Section 1)	■ Change of Ownership (Complete Section 2)	☐ Change of Licensed Units (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:		
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		
☐ Increase	☐ Decrease	
Number of Operating Rooms	From:	To:
Number of Endoscopy Rooms	From:	To:
Number of Procedure Rooms	From:	To:

Part E: 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 (Only required if notarized outside of South Carolina.)