

**APPLICATION FOR LICENSE TO OPERATE A HOSPITAL**

ACCOUNTING/DEPARTMENT USE ONLY

NORTH DAKOTA DEPARTMENT OF HEALTH
 DIVISION OF HEALTH FACILITIES
 Telephone 701.328.2352
 SFN 8001 (R10-15)

Check Number	License Number
Amount	Bed Capacity
Date	Licensure Period

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Include the completed request for waiver, if applicable. Return one completed, notarized copy to: ND Department of Health, Division of Accounting, 600 East Boulevard Ave. Dept. 301, Bismarck ND 58505-0200. Keep a copy for your records.

Official Name of Hospital		NPI Number	
Street Address	City	State	Zip Code
Business Address	City	State	Zip Code
County	Business Telephone Number	Fax Number	
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change of Facility Ownership	<input type="checkbox"/> Bed Capacity Change	<input type="checkbox"/> Name Change
<input type="checkbox"/> Location Change	<input type="checkbox"/> Change in Services	<input type="checkbox"/> Change in Facility Operator	<input type="checkbox"/> Other Change:	

Check Category:

General Acute Hospital Primary Care Hospital Specialized Hospital

North Dakota Administrative Code Section 33-07-01.1-06 requires hospitals submit all Joint Commission or DNV GL accreditation survey results, recommendations, plans of correction, and revisit documentation to our Department.

In addition, Section 33-07-01.1-35 of the North Dakota Administrative Code requires specialized rehabilitation services of a hospital submit all Commission on Accreditation of Rehabilitation Facilities (CARF) survey results, recommendations, and plans of corrections to the Department.

Provide copies of all written correspondence relative to your Joint Commission, DNV GL, and/or CARF survey findings or plan of corrective action.

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds (with room numbers identified) and services.

Total Number of Beds (Excluding Nursing Bassinets and Addiction Beds):

Is the Hospital Accredited?

No Yes – Accrediting Body: TJC CARF
 DNV GL Other

Does the hospital participate in the Federal swing bed program?

Yes No

Name of Hospital's General Liability Insurance Company

Name of Agent

Address of Agent

City State Zip Code

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)

GOVERNMENTAL	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> County & City	<input type="checkbox"/> Municipal
NONPROFIT	<input type="checkbox"/> Association	<input type="checkbox"/> Corporation		
PROPRIETARY	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	

Name of Exact Ownership of Premises

Mailing Address City State Zip Code

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)

Mailing Address City State Zip Code

Has ownership of this hospital changed in the last twelve months?
 Yes No

Has the legal entity responsible for operation of this hospital changed in the last twelve months?
 Yes No

Is the hospital operating under a management agreement?
 Yes No

Please list all of the off-site provider-based locations that bill for services under the hospital's provider number. Attach additional pages if needed.

Name of Off-Site Provider-Based Facility		Facility / Provider Type	
Street Address		City	State ZIP Code
County	Business Telephone Number		Fax Number

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