APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8001 (10-12)

Telephone 701.328.2352

DEPARTMENT USE ONLY

License Number
Bed Capacity
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

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Bed Capacity Change ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ 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 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 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 and services.

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

Is the Hospital Accredited?
☐ No ☐ Yes – Accrediting Body: ☐ JC ☐ CARF ☐ 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	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation		
PROPRIETARY	☐ Individual	☐ Partnership	☐ 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

FOR ACCOUNTING USE ONLY

Name of Chairman of Governing Body			
Mailing Address	City	State	Zip Code
Name of Administrator	Title		
Name of Director of Nursing Services	Director of Nurses' E-mail Address	License Number	
Name of Chief of Medical Staff		License Number	
Name and Title of Emergency Contact	Emergency Contact's Cell Phone Number		
Environmental Services Contact	Environmental Service Contact E-Mail Address		

SERVICES Check the services offered as of the date of application:

	REQUIRED SERVICES:	☐	Home Health
☐	Medical Staff	☐	Hospice Care
☐	Nursing Services	☐	Mammography
☐	Dietary Services	☐	Medical Unit
☐	Medical Record Services	☐	Neonatal Level I (normal newborn)
☐	Pharmaceutical Services	☐	Nursery: # Bassinets
☐	Laboratory Services	☐	Occupational Therapy
☐	Radiology Services	☐	Oncology Services
☐	Emergency Services (inpatient)	☐	Orthopedics
☐	Social Services	☐	Outpatient Department
☐	Basic Rehabilitation Services	☐	Pediatric Department
☐	Housekeeping & related services including laundry	☐	Physical Therapy
☐	Central Services	☐	Psychiatric Services
	COMPLEMENTARY SERVICES:	☐	Radiation Therapy
☐	Nuclear Medical Services	☐	Respite Care
☐	Surgical Services	☐	Specialized Rehabilitation Services
☐	Recovery Services	☐	Speech Pathology
☐	Anesthesia Services	☐	Transplant Services (List):
☐	Respiratory Care Services	☐	Isolation
☐	Obstetrical Services	☐	Off-site Provider-Based locations – **Please complete page 3**
☐	Cardiac Rehab	☐	Other: (List)
☐	Chemical Dependency Treatment		**INTENSIVE CARE UNITS:**
☐	Coronary Care Unit	☐	Burn
☐	Detoxification	☐	Cardiac
☐	Dialysis: # Stations	☐	Neonatal Level II (not normal newborn)
☐	Education, Patient/Community Health	☐	Neonatal Level III (not normal newborn)
☐	Emergency Services (Outpatient/Public)	☐	Respiratory Pulmonary
☐	Gynecology Services	☐	Medical / Surgical
☐	Bariatrics		

Inpatient Census for 12 Months	
Acute: High _____ Low _____ Average _____	Swing Bed: High _____ Low _____ Average ___

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the hospital shall not sign the application unless he/she is also a board member. The application must be signed by official(s) of the entity responsible for the operation of the hospital. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit, the application is to be signed by the head of the department having jurisdiction over the hospital.)

The undersigned hereby makes application for a license to operate a hospital subject to the provisions of North Dakota Century Code Chapter 23-16 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

_____ Signature _____ Date

_____ Signature _____ Date

State of _____)
) SS.
County of _____)

On this _____day of _____, 20_____, before me personally appeared_____

_____who having been sworn states that to the best of his/her knowledge and beliefs the statements in the foregoing application are true.

_____
Notary Public

(Seal)

My commission expires _____

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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