RI Department of Health

Licensing Application

and instructions for

Physician / Podiatry

(Please circle one of the above license types)

Ambulatory Surgery Center

RI General Law Chapter 23-17-10

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

- ☐ Initial Licensure
- ☐ Change of address:
  What is your current license number: _____
- ☐ Change of ownership:
  What is your current license number: _____
- ☐ Licensee Name Change

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Indicate any changes to current or missing information. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be renewed. Please use a ballpoint pen.
- The fee for this application is $500.00
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application, return it with the required fee and mail to

  Rhode Island Department of Health
  Facilities Regulation
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097.

- If you have any questions concerning this application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Accreditation: Please note that within 24 months of initial licensure, the provider is required to attain appropriate certification from an accreditation agency.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please review the information below from your last renewal and make changes as appropriate:

Medical Director Information: Please provide the name of the Medical Director for this facility. **NOTE: This section must be completed as a requirement of your license renewal.**	Name _____ License Number _____

	State of Rhode Island and Providence Plantations Department of Health
Licensee Name: Please provide the name of the licensee (as known to the public) for which you are applying for licensure.	Name _____
Contact Person: Please provide the name and telephone number of a person we can contact.	Name _____ Phone Number _(_____)_____
Licensee Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____
Licensee Location Information: Please provide the location information for this license. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name _____ DBA _____

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Ownership Address Information:

Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip code _____

Phone _____

Fax _____

Email Address _____

Parent Organization, Group Affiliation:

Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control

Corporation Type _____

Name of Organization _____

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip code _____

Phone _____

Fax _____

Email Address _____

Land/Building Info:

If the owner of the land and building is other than the operator of this agency/facility, please complete the following:

Name _____

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip code _____

Phone _____

Number of Operating Rooms:
(Please write the number of operating rooms in your facility)

Number of Operating Rooms:

Number of Recovery Beds:
(Please write the number of recovery beds in your facility)

Number of Recovery Beds:

Services Provided:

Please check which services are provided by your employees or through written agreement with others.

Surgical:

- ☐ Orthopedic
- ☐ Plastic
- ☐ Urology
- ☐ Ear, Nose and Throat
- ☐ Ophthalmology
- ☐ Other: List Additional Service(s) _____

Non-Surgical:

- ☐ Radiology
- ☐ Nursing Services
- ☐ Anesthesia
- ☐ Conscious Sedation
- ☐ Laboratory

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Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number _____

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature of Authorized Person

Date of Signature (MM/DD/YY)

Printed Name of Authorized Person

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Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.