



**Medical Facilities
Protective Health Services**

**Oklahoma State
Department of Health**

Oklahoma State Department of Health

Protective Health Services
Medical Facilities
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6576
FAX: (405) 271-1141

APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

INSTRUCTIONS

- I. Read carefully and complete all portions of the application. Please print or type.
- II. The entity responsible for operation of the hospital and appointment of the medical staff shall be considered the applicant for the license. Any changes are to be reported promptly to the address above.
- III. **All REQUIRED FEES should be submitted directly to Financial Management at the post office box listed below.** Please do not submit fees to the Medical Facilities Division. Checks, money orders or bank drafts must be made payable to OKLAHOMA STATE DEPARTMENT OF HEALTH, must clearly identify the facility which the payment is associated and be mailed to:

**Financial Management - Receipting Unit
Oklahoma State Department of Health
P.O. Box 268823
Oklahoma City, OK 73126-8823**

- IV. Complete and attach ODH Forms 892, 911, 928, and 929.

Type of application: <input type="checkbox"/> Initial Application <input type="checkbox"/> New Hospital <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Renewal Application <input type="checkbox"/> Amended Application _____ (specify)	Hospital Classification (check one): <input type="checkbox"/> General Medical Surgical Hospital <input type="checkbox"/> Specialized Hospital: Psychiatric <input type="checkbox"/> Specialized Hospital: Rehabilitation <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Birthing Center <input type="checkbox"/> Emergency Hospital	Number of Licensed Beds, Cribs, and Bassinets	
		Number of Licensed Beds:	
		Number of Licensed Cribs:	
		Number of Licensed Bassinets:	
		TOTAL:	
		TOTAL FEE: (total above x \$10.00)	\$ _____ .00

License No. _____

1. NAME OF FACILITY (DBA): _____

Finding Address _____
 (Number & Street) (City) (State) (Zip)

Mailing Address _____
 (Number & Street) (City) (State) (Zip)

Telephone No. () _____ - _____ **Fax No.** () _____ - _____

2. OPERATING ENTITY:

 (Name of Entity)

 (Business Address)

Governmental: State County City Other (specify): _____

City/County Hospital Authority or District

Non-Governmental Not-for-Profit: Church Related Corporation LLC Other (specify): _____

Non-Governmental For-Profit: Individual Partnership Corporation LLC

3. Ownership of Building and Grounds:

(Name of Owner)

(Business Address)

(Telephone Number)

4. Additional Sites:

For additional sites under this hospital's license, please include an attachment with the name and address of each site.

5. Chief Executive Officer/Administrator:_____

The undersigned hereby makes application for license to maintain a hospital subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the State Board of Health.

6. SIGNATURE OF APPLICANTS: (§63-1-703 An application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof, or by its managing agent, and shall furnish like information.)

Signature:_____

Signature:_____

Print Name:_____

Print Name:_____

Title or Position: _____

Title or Position:_____

Email Address: _____

Email Address:_____

Date: _____

Date: _____

7. AFFIDAVIT:

STATE OF _____ **COUNTY OF** _____

On this _____ day of _____ 20____, before me personally appeared _____ and _____ who after being duly sworn states, that to the best of his/her knowledge and belief, the statements in the foregoing application are true.

(Notary Public, State of Oklahoma) (My Commission Number)

My Commission Expires: _____

S-E-A-L

