



**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 and APPLICATION should be submitted directly to Financial Management at the post office box listed below.** 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**

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

**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. Rural Emergency Hospitals Only:**

I, \_\_\_\_\_, the authorized representative, attest the Hospital is in compliance with the Rural Emergency Hospital requirements regarding a transfer agreement with a level I or level II trauma center and the facility may not have inpatient beds in accordance with 310:667-63-5. Please submit an [ODH-929 Hospital Designation of Licensed Beds form](#) with the application.

**6. 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 and the Commissioner of Health.*

**7. 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: \_\_\_\_\_

**8. I, \_\_\_\_\_, the authorized representative, attest the Hospital is in compliance with the provisions of sections 3112 through 3117 of Title 63 of the Oklahoma Statutes regarding Lay Caregivers. [Oklahoma Hospital Licensing Act Title 63 of the Oklahoma Statutes - §63-3112 through 3118, and pursuant to §63-1-703 and §63-1-704]**

**9. 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

# CREDENTIALLED STAFF INFORMATION SHEET

## INSTRUCTIONS

List the name, mailing address, professional degree, type of appointment, specialty, board certification status, and Oklahoma license number and expiration date for each member of the Medical Staff for the named facility. If additional space is required, attach extra sheets. This information may be provided in another format, such as computer generated lists, if applicable.

License Number: \_\_\_\_\_

Date: \_\_\_\_\_

NAME OF FACILITY (DBA): \_\_\_\_\_

Address: \_\_\_\_\_

Name of Physician	Address	M.D., D.O., D.D.S., etc.	Type of Appointment *	Specialty	Board Certified? (Yes or No)	OK License # & Expiration Date

\*Active, Courtesy, Honorary, Consulting, Etc.