Oklahoma State Department of Health
Protective Health Services
Medical Facilities
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102
Telephone: (405) 426-8470
FAX: (405) 900-7559

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 ☐ Specialized Hospital: Psychiatric ☐ Specialized Hospital: Rehabilitation ☐ Critical Access Hospital ☐ Birthing Center ☐ Emergency Hospital ☐ Rural Emergency Hospital	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. 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 Commisioner 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.

_____ _____ My Commission Expires: _____
(Notary Public, State of Oklahoma) (My Commission Number)

S-E-A-L

CREDENTIALED 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.