Department of Health

OHIO DEPARTMENT OF HEALTH
NEW HOSPITAL REGISTRATION FORM
SUBMISSION DATE: __________

Please return to: Ohio Department of Health
Bureau of Regulatory Operations
246 N. High Street
Columbus, OH 43215-2412

Completion of this report is required pursuant to section 3701.07 of the Ohio Revised Code.

SCHEDULE A. IDENTIFICATION

Name of Hospital:

Hospital Registration Number:

Medicare Name: (if different from registration)

Medicare Provider Number:

National Provider Identifier:

Hospital Address/Location: (street name and number, city, county and zip code)

Telephone Number:

County:

Mailing Address: (if different from above)

Hospital E-mail Address:

Name of Chief Executive Officer:

Title:

Name of Person Submitting Report:

Title:

Telephone Number:

Accreditation/Certification Status:

Joint Commission (JC)
Date of last accreditation survey: (mmddyyyy) ________________________________

Accreditation Commission for Health Care (HFAP)
Date of last accreditation survey: (mmddyyyy) ________________________________

Det Norske Veritas (DNV)
Date of last accreditation survey: (mmddyyyy) ________________________________

Medicare Certification (if not accredited by other entities prior)
Date of last accreditation survey: (mmddyyyy) ________________________________

NEW HOSPITAL REGISTRATION ONLY

SCHEDULE B. CLASSIFICATION

1. Indicate the type of organization responsible for establishing policy concerning overall operation of your hospital. **CHECK ONLY ONE**

□ Government

□ Non-Federal
- □ State
- □ County
- □ City
- □ City-County
- □ Hospital District or Authority

□ Non-Government

□ Not-For-Profit
- □ Church-Operated
- □ Other Not-For-Profit

□ Investor-Owned
- □ For-Profit
- □ Individual
- □ Partnership
- □ Corporation

2. Is this hospital part of a multi-hospital system? □ yes □ no

3. Name of System:

4. Medicare Hospital Classification:

□ Children's
□ Critical Access
□ Long-term acute care
□ Psychiatric
□ Rehabilitation
□ Short-term acute care

4. Hospital's primary or specialty classification (if different from Medicare):

□ Alcohol and drug
□ Burn care
□ Cancer
□ Children's
□ General
□ Heart
□ Psychiatric
□ Rehabilitation
□ Other: ____

5. Business name and Medicare certification number or state licensure number, if entities below are contained within hospital:

Distinct-part psychiatric unit:____

Distinct-part rehabilitation unit: ____

Transplant center: ____

Maternity unit: ____

SCHEDULE D. BEDS AND UTILIZATION

1. Inpatient Services

Bed Category	**Number of Registered Beds**
Adult medical/surgical	
Adult special care (ICU/CCU)	
Alcohol or drug abuse rehabilitation	
Burn	
Hospice	
Long-term care	
LTAC – LTA less than 30 days stay	
Newborn care – level I	
Newborn care – level II	
Newborn care – level III	
Obstetrics – level I	
Obstetrics – level II	
Obstetrics – level III	
Pediatric - general	
Pediatric intensive care (PICU)	
Physical rehabilitation	
Psychiatric	
Special skilled nursing	
Total of all bed categories	