Health Care Facility Initial License Application

Ohio Department of Health, Radiology Technology Section
Attn: Revenue Processing-3600
Post Office Box 15278, Columbus, Ohio 43215-0278

Date	Facility # (ODH Use Only)

PLEASE PRINT LEGIBLY IN INK OR TYPE

I. Facility Information

1. Facility name (DBA)		Telephone number ( )	
Address		County	
City		State	ZIP
Site contact person	Telephone number ( )	Federal Tax I.D. number	
2. Mailing address, if different from above Name			
Address			
City		State	ZIP
3. Name of person completing this application		Telephone number ( )	
4. Date of operation or projected opening date			

II. Capacity

5. Mark a "✔" by the type of license you are applying for, and indicate the ***number of units*** on the lines provided

☐ **Freestanding diagnostic imaging center**	☐ **Freestanding radiation therapy center**	☐ **Mobile diagnostic imaging center**
_____# of MRIs	_____# of linear accelerators	_____# of MRIs
_____# of PETs	_____# of cobalt radiation therapy units	_____# of PETs
_____# of CTs	_____# of gamma knives	_____# of CTs
_____# of fluoroscopy units	_____# of simulators	_____# of fluoroscopy units
_____# of nuclear medicine units	_____# other	_____# of nuclear medicine units
Radiopharmaceuticals being proposed for use	Radiopharmaceuticals being proposed for use	Radiopharmaceuticals being proposed for use
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. Freestanding or Mobile Diagnostic Imaging Centers–only

6. Is this facility a radioactive materials licensee? ☐ Yes ☐ No ☐ N/A

If yes, name on license	License #	Date of last inspection
Type(s) of materials		

7. Does the licensee have multiple sites? ☐ Yes ☐ No

8. Has there been any incidents in which equipment malfunction contributed or may have contributed to patient injury or death within the last year?
   ☐ Yes ☐ No If yes, please attach a report of the incident(s)

9. Is this health care facility accredited or certified (i.e., JCAHO)? ☐ Yes ☐ No

If yes, type

IV. Freestanding Radiation Therapy Centers — Only

10. Is this facility a radioactive materials licensee? ☐ Yes ☐ No ☐ N/A

If yes, name on license	License #	Date of last inspection
Type(s) of materials		

11. Does the licensee have multiple sites? ☐ Yes ☐ No

12. Has there been any incidents in which equipment malfunction contributed or may have contributed to patient injury, illness or death within the last year?
    ☐ Yes ☐ No If yes, please attach a report of the incident(s)

13. Is this health care facility accredited or certified (i.e., JCAHO)? ☐ Yes ☐ No

If yes, type

V. Building/Management Information

14. The building housing for this health care facility is ☐ Owned ☐ Leased ☐ Rented

15.

Building owner's name		Telephone number ( )
Address		
City	State	ZIP

16. Name of management firm/business employed to manage this facility

Name		Telephone number ( )
Address		
City	State	ZIP

VI. Statement of Ownership

17. This business is a/an ☐ Individual ☐ Partnership ☐ Limited Liability Company
☐ Corporation ☐ Association ☐ Other_____

Individual owner - complete questions 18 through 20 only.

More than one owner, partnership, corporation, limited liability company or association, answer questions 21 through 24 only.

VII. Individual Owner

18. Owner's name		
Address		
City	State	ZIP
19. Owner's occupation		
20. Owner's business address, if different from above Name		
Address		
City	State	ZIP

VIII. Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other

21. Name of entity		Telephone number ( )
Address		
City	State	ZIP
22. Business activity		
23. Is the partnership, limited liability company or corporation a ☐ For profit ☐ Not for profit ☐ Government	Date of incorporation or registration / /	Charter/registration number
24. If corporation, statutory agent's name		Telephone number ( )
Address		
City	State	ZIP

IX. Owners

25. List the name of each person who has an ownership interest of five percent or more in the business (attach additional sheets if necessary).

_____ _____

_____ _____

_____ _____

_____ _____

X. Administration

26. Name of the on-site administrator	
27. Name of the medical director or individual responsible for the provision of health care services	License/certification number

XI. Affiliations

28. Has the owner(s), administrator or medical director been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?

☐ Yes ☐ No *If yes, provide in writing the individual's name, a listing of the name(s) and address(es) of the facilities.*

29. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04 (A) (1) (c) of the OAC within five years prior to the date of this application?

☐ Yes ☐ No *If yes, provide in writing the individual's name, a listing of the name(s) and address(es) of the facilities.*

XII. Statement of Declaration

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the change occurs.

I certify that I am an owner of the facility or the authorized representative of the owner.*

If the signatory is not an owner, enclose a copy of the notarized affidavit **from an owner authorizing the representative to sign on the owner's behalf.

Print/type owner's or representative's name and title*	Signature of owner/representative	Date of signature

Any owner named in question #25 may sign this application.

Print/type medical director	Signature of medical director	Date of signature
Print/type administrator	Signature of administrator	Date of signature

Before mailing this application, please make sure that ***all*** questions have been answered, all signatures have been obtained, and the following items have been enclosed:

1. $300.00 Application Fee
2. Inspection report within last 12 months indicating compliance with all state fire codes (performed by a government agency)
3. Final Use and Occupancy Report
4. Notarized Affidavit (if applicable)**

Section 3702.30 of the Ohio Revised Code and 3701-83-04 of the Ohio Administrative Code requires that the Director of Health be notified in writing of any change in ownership and/or any change in accreditation status no later than thirty days after the change occurs.