Health Care Facility Amended 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 complete *ONLY* the items which need to be amended —

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 ( )	

II. Capacity

4. Has there been a change in capacity? ☐ Yes ☐ No
If yes, explain

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
_____# and type of nuclear medicine units	_____# other	_____# and type 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)

IV. Freestanding Radiation Therapy Centers — Only

9. 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		

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

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

V. Building/Management Information

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

13.

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

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

Name		Telephone number ( )
Address		
City	State	ZIP

VI. Accreditation

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

If yes, type

VII. Administration

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

18. 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, full explanation stating the charge(s), date(s) and disposition.

19. 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.

VIII. 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.

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

Any owner named in question #25 on the original application may sign this application.
***If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

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*** amended items have been listed, all signatures have been obtained, and any of the *applicable* documents have been enclosed:

1. Report of Compliance, within the past 12 months with all state fire codes
2. Final Use and Occupancy Permit (if applicable)**
3. Notarized Affidavit (if applicable)***

Submit a check or money order in the amount of $150.00 payable to "*Treasurer, State of Ohio*" for any increase in the number or change in the type of equipment or radiopharmaceuticals being used (OAC 3701-83-04).

** New Final Use and Occupancy permit issued as a result of building renovations.