State of Illinois
Illinois Department of Public Health

Birthing Center Renewal Licensure Application

Pursuant to Section 265 of the Alternative Health Care Delivery Act [210 ILCS 3] and the rules of the Illinois Department of Public Health entitled "Birth Center Demonstration Program Code" (77 Ill. Adm. Code 265)

1. Name and Address of Facility

Name _____

Address _____

City _____ County _____ State _____ ZIP Code _____

Phone Number (area code) _____ Fax Number _____

E-mail _____

2. Description of Services to be Provided by the Birthing Center

_____

_____

_____

_____

Number of beds _____

Please attach a copy of your current admissions criteria as **"Exhibit I."**

3. Ownership and Management

○ Individual ○ Partnership ○ Association ○ Corporation ○ Government ○ Other _____

A. If individual, partnership or association, list all owners.

Name	Address

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 3. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

B. If government owned, provide the following information for the CEO.

Name _____

Address _____

Phone Number (area code) _____

C. Provide corporation information.

Name of Corporation _____

List name, title and address of each corporate officer.

Name	Title	Address

☐ Attach a copy of the Certification of Incorporation (Identify as "**Exhibit II**").

List name and address of each shareholder holding more than 7.5 percent of shares.

Name	Address	Percent of Shares

D. For other than individual ownership, list the name and address of the Illinois registered agent or the person(s) legally authorized to receive service or process for the facility.

Name of Registered Agent	Address

E. List the names and addresses of all persons who will manage or operate the facility.

☐ (Check here if not applicable).

Name	Address

F. Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? (If yes, attach explanation as "**Exhibit IIA.**")

1. Applicant	☐ Yes	☐ No
2. Any member of a firm, partnership or association	☐ Yes	☐ No
3. Any officer or director of a corporation	☐ Yes	☐ No
4. Administrator or manager of	☐ Yes	☐ No

4. Administrator, Personnel, Services

A. Administrator (If not previously submitted with prior application or if this information has changed, then attach resume indicating experience/credentials as "**Exhibit III**")

Name _____

Address _____

Phone Number (area code) _____ License or Certification Number (if applicable) _____

B. Medical Director (If not previously submitted with prior application or if this information has changed, then attach resume indicating experience/credentials as "**Exhibit IV.**")

Name _____

Address _____

Phone Number (area code) _____ License Number _____

C. Director of Nursing and Midwifery Services (If not previously submitted with prior application or if this information has changed, then attach resume indicating experience/credentials as "**Exhibit V.**")

Name _____

Address _____

Phone Number (area code) _____ License Number _____

D. Medical Staff: List name and license number of each staff member.

Name	License Number

E. Personnel: List name, position/title, professional licensure or certification.

Name	Position/Title	License Number/Registration, Certification

5. Services

The following information must accompany the application:

- ☐ $500 application fee, plus $100 for each licensed birthing bed, made payable to the Illinois Department of Public Health
- ☐ A description of services to be provided by the facility *(**Page 1, Section 2**)*
- ☐ A letter of agreement with a perinatal center for referral of high-risk infants based upon the Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) *(Submit as **Exhibit VII**)*
- ☐ A written narrative on the perinatal care and community education services offered by the birth center, and how these services are being coordinated with other health services in the community *(Submit as **Exhibit VIII**)*
- ☐ A copy of the contract/transfer agreement between the birth center and the hospital *(Submit as **Exhibit IX**)*
- ☐ A copy of a document that shows the services of a medical director or his or her physician designee shall be available on the premises or within a close proximity. Close proximity means being able to be physically present in the facility within 30 minutes after being called. (Section 35(6) of the Act) *(Submit as **Exhibit X**)*
- ☐ A copy of a document that shows that a medical director/physician, licensed to practice medicine in all its branches, who is certified or eligible for certification by the American College of Obstetricians and Gynecologists or the American Board of Osteopathic Obstetricians and Gynecologists or has hospital privileges is available to be provided in the birth center. (Section 35(6) of the Act) *(Submit as **Exhibit XI**)*

6. Verification

I (we) swear or affirm that this application and accompanying documents are true and complete. I (we) further certify that I (we) have knowledge of and understand the action required to comply with the act and licensing requirements.

Signature _____ Title _____

Signature _____ Title _____

Section 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR) ☐ Yes ☐ No

The following question must be answered only if the applicant is an individual (sole proprietor):
I hereby certify, under penalty of perjury, that (check one):

☐ I am more than 30 days delinquent in complying with a child support order.

☐ I am **not** more than 30 days delinquent in complying with a child support order.

Signature _____ Date _____

FAILURE TO SO CERTIFY MAY RESULT IN DENIAL OF THE LICENSE AND MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT. (5 ILCS 100/10-65(c)

Signed and Sworn (or attested) to before me this _____ day of _____ 20____ .

_____
Notary Public

My commission expires _____ 20____ .

Submit licensure application and fee to:
Illinois Department of Public Health
Division of Healthcare Facilities and Programs
525 W. Jefferson St., Fourth Floor
Springfield, IL 62761