State of Illinois
Illinois Department of Public Health

Ambulatory Surgical Treatment Center Initial Licensure Application

ASTC ID NUMBER:
PROGRAM CATEGORY - 86
Department Use Only

☐ $500 Application Fee

Pursuant to the Ambulatory Surgical Treatment Center Licensing Act (210 ILCS 5/1 et seq.) and the rules of the Department of Public Health entitled "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205).

1. FACILITY NAME/ADDRESS

Name of ASTC _____

Address _____

City _____ County _____ State _____ Zip Code _____

Telephone Number (Area Code) _____ Fax Number _____ E-mail _____

2. OWNERSHIP AND MANAGEMENT

A. Type of Ownership of the ASTC

☐ Individual ☐ Association

☐ Partnership ☐ Corporation

☐ Other _____

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 5/1 ET SEQ. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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B. If Individual-Partnership or Association-owned, list all persons who own the ASTC:

Name	Address

C. Names under which persons in #2 do business (other than this ASTC)

Name	Business

D. Corporate Ownership

(1.) Name of Corporation

(2.) Submit a copy of the Certificate of Incorporation (Identify as Exhibit I)

(3.) List title, name and address of each corporate officer.

Title	Name	Address

E. List name and address of each shareholder holding more than 5 percent of shares

Name	Address	Percent of Shares

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

Name of Registered Agent	Address

G. List the names and addresses of all persons under contract to manage or operate the facility.

☐ (Check here if not applicable).

Name	Address

H. 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 IA.)

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 ASTC	☐ Yes	☐ No

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3. ADMINISTRATION AND PERSONNEL

A. Administrator (Attach resume as Exhibit II.)

Name _____

Address _____

Telephone Number _____

License or Certification Number (if applicable) _____

B. Medical Director (Attach resume as Exhibit III)

Name _____

Address _____

Telephone Number _____ License Number _____

C. Supervising Nurse (Attach resume as Exhibit IV).

Name _____

Address _____

Telephone Number _____ License Number _____

D. Medical Staff: List specialty, name, and license number of each physician, podiatrist, or dentist granted priveleges to perform surgical procedures in the center.

Specialty	Name	License No.

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D. Medical Staff (Continued)

Specialty	Name	License No.

E. Personnel: List position and/or classification; name, education, experience, professional licensure or certification

Position and/or Classification	Name	License Number, Registration, Certification, Education and Years Experience

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E. Personnel: (Continued)

Position and/or Classification	Name	License Number, Registration, Certification, Education, and Years Experience

4. FACILITIES, SERVICES AND PROCEDURES

The following must be included with the initial application:

A. A narrative of the facility including but not limited to interviewing, examination, surgical and recovery room facilities. (Identify as Exhibit V)

B. A description of services to be provided by the facility including a list of surgical procedures to be performed subject to approval in accordane with the requirements of Section 205.130. (Identify as Exhibit VI)

C. Documentation of compliance with Section 205.350, Laboratory Services. (Identify as Exhibit VII)

D. A copy of the transfer agreement with a licensed hospital within approximately 15 minutes travel time of the facility or other documentation demonstrating compliance with Section 205.540(d). (Identify as Exhibit VIII)

E. A copy of the organizational plan of the facility (see Section 205.220). (Identify as Exhibit IX)

F. Schematic architectural plans (or evidence of prior submission). (Identify as Exhibit X)

G. Documentation of a permit as required by the Illinois Health Facilities Planning Act. (20 ILCS 3960/1 et. seq.) (Identify as Exhibit XI)

H. Documentation of compliance with all applicable local building , utility and safety codes. (Identify as Exhibit XII)

5. 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.

Signed _____ Signed _____

Title _____ Title _____

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

_____
Notary Public

My commission expires _____ 20 _____

SUBMIT APPLICATION AND FEE TO:

VALIDATION UNIT
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF FINANCIAL SERVICES
535 WEST JEFFERSON STREET, 4th Floor
SPRINGFIELD, ILLINOIS 62761

APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility applications:

Ambulatory Surgical Treatment Center

Home Health Agency

Hospice Program

Hospital

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 ☐ I am ☐ am not (chek one) more than 30 days delinquent in complying with a child support order.

Signed: _____

Date: _____

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

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ASTC Initial Licensure Application Checklist

- ☐ Completed application
- ☐ Articles of Incorporation
- ☐ Administrator's Resume
- ☐ Medical Director's Resume
- ☐ Supervising Nurse's Resume
- ☐ List of Medical staff
- ☐ Separate list of Personnel staff
- ☐ Narrative Description of facility
- ☐ Surgical Procedures and services provided
- ☐ Lab Services (Section 205.330)
- ☐ Transfer Agreement, etc. (Section 205.540(d)
- ☐ Organizational plan
- ☐ CON (Certificate of Need)
- ☐ Local Building, utility and safety codes
- ☐ License fee of $500