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. Administrative 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

A. Please Indicate the Type of Ownership: *RA - Registered Agent

☐ Sole Proprietorship

☐ Corporation (*RA)

☐ Partnership (Registered within County)

☐ Limited Partnership (*RA)

☐ Limited Liability Partnership (*RA)

☐ Limited Liability Company (LLC) (*RA)

☐ Other ____________

B. Registered Agent

If your facility ownership indicated above requires a registered agent, please indicate the name, address (including zip code plus four), and telephone number of this person or company. (If you are unable to identify this person or company, contact the Secretary of State's Office to identify the facility's registered agent.)

Name of Illinois Registered Agent: ____________

Address of Illinois Registered Agent: ____________

City, State, Zip Code plus four: ____________

Telephone of Illinois Registered Agent (including area code): ____________

C. Ownership Information

If your facility is required to have a Registered Agent (see B above) or is required to have at least three officers, list the name of the state where the home or parent firm is incorporated or registered.

Name of Parent Firm or Organization: ______________________________

State where Parent Firm or Organization is Incorporated / Registered: ______________________________

Title	Name	Full Address
President		
Vice - President		
Secretary		
Treasurer		

D. Shareholder Information

If your ASTC is a Corporation, list the number of shares held by shareholders with more than five percent of common stock or the top five stockholders, whichever is less. Also, indicate the percentage of total shares that each stockholder holds.

Name of Stockholder	Shares Held	Percent of Shares

** Submit a copy of the Articles of Incorporation **

E. Other Ownership

Owners

If your facility is a Sole Proprietorship, Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, or Other - owned, list the name of the owner, the address of each owner, the owner(s) profession, and the business that employs each owner. If the owner is self-employed, indicate this by entering "Self" in the Profession column.

Names of Owners	Full Address	Profession	Business Name

1. Applicant ** Submit a copy of the Articles of Organization **

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 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 any ASTC	☐ Yes	☐ No

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 privileges to perform surgical procedures in the center.

Specialty	Name	License Number

D. Medical Staff (Continued)

Specialty	Name	License Number

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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 Number of Years Experience

E. Personnel (Continued)

Position and / or Classification	Name	License Number, Registration, Certification, Education, and Number of 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 accordance 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 organizational plan of the facility (see Section 205.220). (Identify as Exhibit IX)

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

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

G. 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(s) required to comply with the Act and licensing requirements.

Name ______________________	Name ______________________
Signature ______________________	Signature ______________________
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:

Illinois Department of Public Health
Division of Health Care Facilities and Programs, 4th Floor
525 West Jefferson Street
Springfield, IL 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 licenses 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 ☐ I am not (check 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))

ASTC Initial Licensure Application Checklist

- ☐ Completed Application
- ☐ Articles of Incorporation and / or Organization
- ☐ 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 and Approved by Consulting Committee
- ☐ Lab Services (Section 205.330)
- ☐ Organizational Plan
- ☐ CON (Certificate of Need)
- ☐ Local Building, Utility, and Safety Codes
- ☐ License Fee of $500