DEPARTMENT OF HEALTH

For MDH Use Only

Check #_____
Fee Deposit #_____
Deposit Date_____
Initials_____
SFM Date_____

2021 Application for a License to Operate a Freestanding Outpatient Surgical Center

In accordance with Minnesota Statute §13.41, **ALL DATA SUBMITTED ON THIS APPLICATION SHALL BE CLASSIFIED PUBLIC INFORMATION UPON ISSUANCE OF A LICENSE.**

Please answer all questions completely and accurately to avoid unnecessary delay. This application shall be returned to the address noted below no later than **December 31, 2020**.

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby makes application for license to operate a Freestanding Outpatient Surgical Center subject to the provisions of Minnesota Statutes, and to the regulations adopted thereunder by the State Department of Health.

A. Type of Application (check one)

☐Initial License ☐License Renewal ☐Change of Ownership*

*If a change of ownership application, proposed effective date:_____

B. Identification

1. Please correct name and address if incorrect:
    a. Name_____
    b. Street_____
    c. City/Zip_____
2. Telephone number_____Fax number _____
3. Name of county in which facility is located_____
4. Name of administrator_____
5. Administrator's email address_____

C. Ownership

1. Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

   Ownership Code_____

GOVERNMENTAL NONFEDERAL	NONGOVERNMENTAL NONPROFIT	NONGOVERNMENTAL FOR PROFIT	OTHER
11. State 12. County 13. City 14. City-County 15. Hospital District or Authority	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust	27. Tribal

2. Give the name of the corporation, association, governmental unit, person or partners legally responsible for the operation of this facility.

   _____

   Federal ID #_____State Tax ID #_____

3. If the above is a corporation, association, governmental unit, give the legal name of the governing body, such as Board of Directors _____
4. Give the date and place of incorporation_____
5. President/Chairperson_____
6. Secretary_____

D. Personnel as of date of application. If this is an initial application, indicate anticipated staff.

Administration

1. Administrator _____

2. Name and title of person in charge in the absence of the administrator

   _____

Physician Services

1. Medical Director _____

2. Number of physicians on active staff _____

3. Number of physician assistants _____

Nursing Services

1. Director of Nurses _____ License #_____

2. Please provide the number of employees in the following categories:

   a. Registered Nurses _____

   b. Licensed Practical Nurses _____

   c. Nursing Assistants _____

   d. Operating Room Technicians _____

Anesthesia Services

1. Director_____

2. Number of Anesthesiologists _____

3. Number of Nurse Anesthetists _____

E. Utilization data

Utilization data for the period of October 1, 2018 through September 30, 2019. (If initial application, indicate anticipated procedures/operations.) If data is for a different 12-month period, indicate the time period used:

____	____	____	To	____	____	____
mo.	day	year		mo.	day	year

1. Number of surgical procedures _____

2. Five most common operations performed:

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

3. Number of operating rooms _____

F. Written Agreements

1. Name of emergency transfer hospital _____
2. Name of emergency ambulance service _____

Affidavit

The law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures.** All other applications require one (1) signature.

The applicant(s), being first duly sworn, state that as the holders of the titles or positions under their signatures have authority to make this application: that they are not less than 18 years of age, and that the statements made in this application are true.

Signature	Signature
Name	Name
Date	Date
Title or Position	Title or Position

Fee

$1,512.00 Plus $2,200.00 (Minnesota Adverse Health Care Events Reporting Act)

Total Fee - $3,712.00

Make checks payable to "Minnesota Department of Health"

NOTE: If you have questions concerning this license application, please email MDH at health.fpc-licensing@state.mn.us.

Ownership Information Sheet

Legal Entity (same as Item B.2. on Page 2)

_____

Name of Facility_____City_____

Zip Code_____County_____Date _____

This form must be completed by all freestanding outpatient surgical centers licensed by the Minnesota Department of Health. This requirement is applicable to facilities of all categories of ownership - nonprofit corporation, city, county, district, state, proprietary, church, etc.

The requirement stems from Mn. Rule 4675.0300 of the Department of Health Freestanding Outpatient Surgical Center rules.

Please provide the following information:

1. Full disclosure of ownership.
2. In case of corporate ownership, the name and address of each officer and director.
3. In case of out-of-state corporate ownership attach a copy of the certificate of authority to do business in the State of Minnesota.

Name of Officers, Directors and Owners	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	% of Ownership (if proprietary, for profit)

Evidence of Compliance with Workers' Compensation Coverage Provisions

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

1. ___ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of a renewal license.

2. ___ **"Certificate of Exemption"** from the Commissioner of Commerce permitting an organization to self-insure pursuant to Minn. Statute 79A and Minn. Rules Chapter 2780. The Certificate of Exemption is available to privately owned or publicly held companies and groups. The Certificate of Exemption must be renewed every five years. Questions regarding the Certificate of Exemption should be directed to the Minnesota Department of Commerce at 651-296-4026. **For multiple providers merged under one group, please include Attachment A with the Certificate of Exemption.**

3. ___ Written confirmation from your Third Part Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government Entity/Political Subdivision** pursuant to Minn. Statute 176.81, Subd. 2. The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

Minnesota Department of Health
Heath Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
www.health.state.mn.us

10/20- FPC929 SURG CTR
To obtain this information in a different format, call: 651-201-4101.