Pregnancy Termination Center (ASTC) Licensure Renewal Application

ASTC ID NUMBER
PROGRAM CATEGORY - 86
Department Use Only

☐ $300 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.

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 ______________________

IMPORTANT NOTICE

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.

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.) 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	% 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

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 ____________________

Please note that, in accordance with section 205.710(b)(1), the information concerning medical staff and other personnel required in Section 205.120(b)(5) through (7) must be maintained at the facility and be available for inspection by the Department.

4. SURGICAL PROCEDURES

A list of surgical procedures being performed at the facility must be included with the renewal application. (Identify as Exhibit V).

5. VERIFCATION

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
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF FINANCIAL SERVICES
VALIDATION UNIT
535 W. JEFFERSON ST. -4TH FLOOR
SPRINGFIELD, IL 62761-0001

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 (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)).

Pregnancy Termination Specialty Center Renewal Application Checklist

- ☐ Completed application for ASTC Renewal Licensure
- ☐ 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 205.540(d))
- ☐ Transfer Agreement, etc. (Section 205.540(d))
- ☐ Organizational plan
- ☐ Local Building, utility and safety codes
- ☐ License fee of $500