Texas Department of State Health Services Regulatory Licensing Unit - Facility Licensing Group Delivery Code 2835

PO Box 149347, MC 2003

(512) 834-6646

Austin, Texas 78714-9347 (512) 834-4514 FAX

Department Use Only

License #:

Remittance Number:



Application for a License to Operate An Ambulatory Surgical Center

Remittance Date: Remittance Amount: Change of Ownership – Effective Date: _____ Relocation (Treated as an Initial) – Date the facility will open: Previous address: 1. Facility Information a. Name the facility will be doing business as (d.b.a.): b. Street Address: Street Number City/State/Zip County c. Mailing Address:_ (If different) Street or P.O. Box Number City/State/Zip d. Telephone Number (include area code) Fax Number (include area code) 2. Owner: a. Name & Address of Owner: SS# or Tax ID Number Name City/State/Zip Mailing Address Profit b. Type of Ownership: Non-Profit Partnership Individual Corporation Limited Liability Company Hospital/Hospital District State of Texas Other (Specify): Local Government Type (e.g., city, county): _____ c. Name of Center Administrator:

3.	Ch (inc. Re	itial nange of Ownership lude Bill of Sale with app location	\$5,200.00			
	Fees paid to the Department are	not refundable. Applica	ation will not be processed	without the appropriate f	ee.	
4.	Services:					
	Mark all surgical specialties that are offered at this facility:					
	Cardiovascular Neurological Oral Plastic Other (Specify)	Foot OB/GYN Orthopedic Thoracic	General Ophthalmology Otolaryngology Urology	Gastroenterolog Pain Manageme Chiropractic Endoscopy		
5. A	Accreditation Status:	☐ JCAHO If applicable, attach	AAAHC [one rediting agency.	
6. 7	Fotal # of Surgery Suites:					
7. N	Medical Staff:					
a	. Provide the total number	of physicians, denti	ists, podiatrists, and/or	r advanced practice n	surses on staff at the facility.	
	Physicians Dentists Podiatri		Podiatrists	Advanced Practice Nurses		
b	. Medical Chief of Staff	Name		License #	Expiration Date	
C.	. Director of Nurses	Name		License #	Expiration Date	
8. A	Administrator's Signature	:				
Administrator's Signature				Date		
Printed Name				Administrator's Email Address		

MAIL LICENSE FEE AND COMPLETED APPLICATION TO:

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP
(DEPT ID ZZ101 – FUND 168)
DELIVERY CODE 2835
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347
PHONE 512-834-6646
FAX 512-834-4514

PRIVACY NOTIFICATION/NOTIFICACION SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003, and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recibir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorrecta. Dirijase a http://www.dshs.state.tx.us Para mass informacion sobre la Notificacion sobre privacidad. (Referencia: *Government Code*, seccion 552.021, 522.023, 559.003 y 559.004)