APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
Telephone 701.328.2352
SFN 8001 (R09-21)

ACCOUNTING/DEPARTMENT USE ONLY

Check Number	License Number
Amount	Bed Capacity
Date	Licensure Period

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Include the completed request for waiver, if applicable. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities, 1720 Burlington Dr, Suite A, Bismarck ND 58504-7736. Keep a copy for your records.

Official Name of Hospital			NPI Number
Street Address	City	State	ZIP Code
Business Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Bed Capacity Change ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ Other Change:

Check Category:
☐ General Acute Hospital ☐ Primary Care Hospital ☐ Specialized Hospital

North Dakota Administrative Code Section 33-07-01.1-06 requires hospitals submit all accreditation survey results, recommendations, plans of correction, and revisit documentation to our Department.

In addition, Section 33-07-01.1-35 of the North Dakota Administrative Code requires specialized rehabilitation services of a hospital submit all Commission on Accreditation of Rehabilitation Facilities (CARF) survey results, recommendations, and plans of corrections to the Department.

Provide copies of all written correspondence relative to your accreditation survey findings or plan of corrective action.

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds (with room numbers identified) and services.

Total Number of Beds (Excluding Nursing Bassinets and Addiction Beds):

Is the Hospital Accredited?
☐ No ☐ Yes – Accrediting Body: ☐ TJC ☐ CARF ☐ DNV GL ☐ Other _____

Does the hospital participate in the Federal swing bed program?
☐ Yes ☐ No

Name of Hospital's General Liability Insurance Company

Name of Agent

Address of Agent

City	State	ZIP Code

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation		
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

Name of Exact Ownership of Premises			
Mailing Address	City	State	ZIP Code
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code

Has ownership of this hospital changed in the last twelve months?	Has the legal entity responsible for operation of this hospital changed in the last twelve months?	Is the hospital operating under a management agreement?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Name of Administrator	Title		
Name of Director of Nursing Services	Director of Nurses' E-mail Address	License Number	
Name of Chief of Medical Staff		License Number	
Name and Title of Emergency Contact	Emergency Contact's Cell Phone Number		
Environmental Services Contact	Environmental Service Contact E-Mail Address		

SERVICES Check the services offered as of the date of application:

	REQUIRED SERVICES:	☐	Mammography
☐	Medical Staff	☐	Medical Unit
☐	Nursing Services	☐	Neonatal Level I (normal newborn)
☐	Dietary Services	☐	Nursery: # Bassinets
☐	Medical Record Services	☐	Occupational Therapy
☐	Pharmaceutical Services	☐	Oncology Services
☐	Laboratory Services	☐	Orthopedics
☐	Radiology Services	☐	Outpatient Department
☐	Emergency Services (inpatient)	☐	Pediatric Department
☐	Social Services	☐	Physical Therapy
☐	Basic Rehabilitation Services	☐	Psychiatric Services
☐	Housekeeping & related services including laundry	☐	Radiation Therapy
☐	Central Services	☐	Respite Care
	COMPLEMENTARY SERVICES:	☐	Specialized Rehabilitation Services
☐	Nuclear Medical Services	☐	Speech Pathology
☐	Surgical Services: Number of OR Rooms _____	☐	Transplant Services (List):
☐	Recovery Services	☐	Isolation
☐	Anesthesia Services	☐	Off-site Provider-Based locations – **Please complete page 4**
☐	Respiratory Care Services	☐	Other: (List)
☐	Obstetrical Services	☐	
☐	Cardiac Rehab	☐	
☐	Chemical Dependency Treatment		**INTENSIVE CARE UNITS:**
☐	Coronary Care Unit	☐	Burn: Number of Beds _____
☐	Detoxification	☐	Cardiac: Number of Beds _____
☐	Dialysis: # Stations	☐	Neonatal Level II (not normal newborn): Number of Beds _____
☐	Education, Patient/Community Health	☐	Neonatal Level III (not normal newborn): Number of Beds _____
☐	Emergency Services (Outpatient/Public)	☐	Respiratory Pulmonary: Number of Beds _____
☐	Gynecology Services	☐	Medical / Surgical: Number of Beds _____
☐	Bariatrics	☐	Ventilators: Number of _____

Inpatient Census for 12 Months Acute: High _____ Low _____ Average _____	Swing Bed: High ____ Low ____Average ____ NA ____

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the hospital shall not sign the application unless he/she is also a board member. The application must be signed by official(s) of the entity responsible for the operation of the hospital. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit, the application is to be signed by the head of the department having jurisdiction over the hospital.)

The undersigned hereby makes application for a license to operate a hospital subject to the provisions of North Dakota Century Code Chapter 23-16 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Signature	Date
Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	

Please list all of the off-site provider-based locations that bill for services under the hospital's provider number. Attach additional pages if needed.

Name of Off-Site Provider-Based Facility			Facility / Provider Type	
Street Address		City	State	ZIP Code
County	Business Telephone Number		Fax Number	

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