



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:

<input type="checkbox"/>	<b>REQUIRED SERVICES:</b>
<input type="checkbox"/>	Medical Staff
<input type="checkbox"/>	Nursing Services
<input type="checkbox"/>	Dietary Services
<input type="checkbox"/>	Medical Record Services
<input type="checkbox"/>	Pharmaceutical Services
<input type="checkbox"/>	Laboratory Services
<input type="checkbox"/>	Radiology Services
<input type="checkbox"/>	Emergency Services (inpatient)
<input type="checkbox"/>	Social Services
<input type="checkbox"/>	Basic Rehabilitation Services
<input type="checkbox"/>	Housekeeping & related services including laundry
<input type="checkbox"/>	Central Services
<input type="checkbox"/>	<b>COMPLEMENTARY SERVICES:</b>
<input type="checkbox"/>	Nuclear Medical Services
<input type="checkbox"/>	Surgical Services: Number of OR Rooms _____
<input type="checkbox"/>	Recovery Services
<input type="checkbox"/>	Anesthesia Services
<input type="checkbox"/>	Respiratory Care Services
<input type="checkbox"/>	Obstetrical Services
<input type="checkbox"/>	Cardiac Rehab
<input type="checkbox"/>	Chemical Dependency Treatment
<input type="checkbox"/>	Coronary Care Unit
<input type="checkbox"/>	Detoxification
<input type="checkbox"/>	Dialysis: # _____ Stations
<input type="checkbox"/>	Education, Patient/Community Health
<input type="checkbox"/>	Emergency Services (Outpatient/Public)
<input type="checkbox"/>	Gynecology Services
<input type="checkbox"/>	Bariatrics

<input type="checkbox"/>	Mammography
<input type="checkbox"/>	Medical Unit
<input type="checkbox"/>	Neonatal Level I (normal newborn)
<input type="checkbox"/>	Nursery: # _____ Bassinets
<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Oncology Services
<input type="checkbox"/>	Orthopedics
<input type="checkbox"/>	Outpatient Department
<input type="checkbox"/>	Pediatric Department
<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Psychiatric Services
<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	Respite Care
<input type="checkbox"/>	Specialized Rehabilitation Services
<input type="checkbox"/>	Speech Pathology
<input type="checkbox"/>	Transplant Services (List):
<input type="checkbox"/>	Isolation
<input type="checkbox"/>	Off-site Provider-Based locations – <b>Please complete page 4</b>
<input type="checkbox"/>	Other: (List)
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	<b>INTENSIVE CARE UNITS:</b>
<input type="checkbox"/>	Burn: Number of Beds _____
<input type="checkbox"/>	Cardiac: Number of Beds _____
<input type="checkbox"/>	Neonatal Level II (not normal newborn): Number of Beds _____
<input type="checkbox"/>	Neonatal Level III (not normal newborn): Number of Beds _____
<input type="checkbox"/>	Respiratory Pulmonary: Number of Beds _____
<input type="checkbox"/>	Medical / Surgical: Number of Beds _____
<input type="checkbox"/>	Ventilators: Number of _____

Inpatient Census for 12 Months		Swing Bed:	
Acute: High _____ Low _____ Average _____		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
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Signed and sworn to (or affirmed) before me on	Date
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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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