FOR OFFICE USE ONLY
Check Amount: _____
Check Number: _____
License Expiration: _____

STATE OF DELAWARE

OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

APPLICATION FOR FREE STANDING EMERGENCY CENTER LICENSE

FSEC - _____

LEGAL NAME _____

DBA NAME _____

FACILITY ADDRESS _____
Address 1

_____
Address 2

_____ _____ _____
City State Zip Code

Administrator/CEO/Email _____

Medical Director/Email _____

MD LICENSE # _____ EXP DATE _____

Director of Nursing/Email _____

RN LICENSE # _____ EXP DATE _____

Facility Contact _____ _____
Name Title

Email _____

Phone Numbers _____ _____ _____
FACILITY PHONE # CONTACT PHONE # CONTACT FAX #

Emergency Contact _____ _____
Name Phone

Email _____

(Emergency contact should be available at all times in case of weather emergency, natural disaster, etc.)

NUMBER OF EMERGENCY BAYS _____

ACCREDITED? ☐ YES BY WHOM: _____
☐ NO

ALL PHYSICIANS ARE CERTIFIED IN ACLS OR EMERGENCY MEDICINE ☐ YES ☐ NO

AT LEAST ONE NURSE ON EACH SHIFT IS CERTIFIED IN ALCS ☐ YES ☐ NO

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES, ADDRESSES AND PERCENT OF INTEREST OF EACH OFFICER, DIRECTOR, AND OWNER HAVING AN INTEREST IN THE FACILITY.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. EMAIL A COPY OF THE ACCREDITATION CERTIFICATE, OFFICIAL ACCREDITATION REPORT, AND PLAN OF CORRECTION TO: AMY-JOY.ANDREWS@DELAWARE.GOV
4. FIRE SAFETY REPORT
5. EMAIL A COPY OF YOUR EMERGENCY PREPAREDNESS PLAN TO: AMY-JOY.ANDREWS@DELAWARE.GOV
6. OTHER: _____
   _____

****PLEASE ATTACH A TABLE SHOWING TWENTY-FOUR (24) HOUR STAFFING****

NAME OF PERSON COMPLETING THIS FORM: _____

SIGNATURE: _____ Date : _____

Title/Email: _____

CHECKS SHOULD BE MADE PAYABLE TO: **STATE OF DELAWARE**

INITIAL APPLICATION FEE: $250.00

ANNUAL LICNESURE FEE: $150.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO

OFFICE OF HEALTH FACILITIES LICENSING
261 CHAPMAN ROAD, SUITE 200
NEWARK, DE 19702
(302)292-3930

FOR OFFICE USE ONLY

Application Reviewed & Approved by: _____ Date: _____

Director/Designee: _____ Date: _____

Type of License: ☐ Annual ☐ Provisional

Licensure Period: _____ to _____

License Sent – Date: _____ Initials: _____

Tracking Update – Date: _____ Initials: _____