FOR OFFICE USE ONLY
Check Amount: ______________
Check Number: ______________
License Expiration: ____________

STATE OF DELAWARE

OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

(302) 292-3930

APPLICATION FOR FREE STANDING SURGICAL CENTER LICENSE

FSSC - ____________

LEGAL NAME ____

DBA NAME ____

FACILITY ADDRESS ____
Address 1

____
Address 2

______________________ ______ ____________
City State Zip Code

DIRECTOR/Email ____

MEDICAL DIRECTOR/Email ____

MD LICENSE #______________________EXP DATE ______________

CLINICAL DIRECTOR/Email ____

RN LICENSE #______________________EXP DATE ______________

FACILITY CONTACT ______________________________ ____________
Name Title

E-MAIL ____

PHONE NUMBERS ______________ ______________ ______________
FACILITY PHONE # CONTACT PHONE # CONTACT FAX #

EMERGENCY CONTACT: ______________________ ______________________
Name Phone

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

FACILITY TYPE:

☐ Single Specialty (identify): ______________________________

☐ Multi-Specialty (identify): ______________________________

____

Facility Hours of Operation:

Monday:	______________________
Tuesday:	______________________
Wednesday:	______________________
Thursday:	______________________
Friday:	______________________
Saturday:	______________________
Sunday:	______________________

Complete the following section using the square footage requirements of the Design and Construction Guidelines in use at the time of initial licensure as well as the "American College of Surgeons Classes of Surgical Facilities". If there is ambiguity or conflict, prior written clarification from this office is required.

Total Number of Prep-Recovery Beds (Dual Use) ______	Number of Operating Rooms ______
Total Number of Prep Beds ______	Number of Procedure Rooms ______
Total Number of Recovery Beds ______	

Check each type of procedure performed at the FSSC and include number of procedures performed in the last 12 months.

- ☐ Cardiovascular____________
- ☐ Chiropractic______________
- ☐ Endoscopy_______________
- ☐ Podiatry_________________
- ☐ Gastroenterology_________
- ☐ Otolaryngology____________
- ☐ Neurological______________
- ☐ Gynecology ______________
- ☐ Ophthalmology ___________
- ☐ Oral___________________
- ☐ Orthopedic_____________
- ☐ Pain Management _______
- ☐ Plastic_________________
- ☐ Thoracic_______________
- ☐ Urology________________
- ☐ General________________
- ☐ Other (Specify) __________ ______________________

Complete each section below. If none, indicate with a "0".	**Total**
Number of patient deaths while under the care of the FSSC	
Number of patient transfers to a hospital	
Number of thefts of drugs and/or diversion of controlled drugs	
Number of fires in the FSSC	
Number of patient stays exceeding 23 hours 59 minutes	
Average length of stay during the reporting period (average length of stay = from time anesthesia is administered to the time patient is discharged)	

Accredited: If “yes”, by whom: ______________________ Effective date: __________
Expiration date: __________

Deemed: If “yes”, by whom: ______________________ Effective date: __________
Expiration date: __________

Laboratory Services Provided: If “yes”, by whom: ______________________

Radiology Services Provided: If “yes”, by person or company: ______________________

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. FOR RE-LICENSURE: PHONE DIRECTORY (include work email address if available to OHFLC for use)
6. DOCUMENTATION OF ANNUAL REVIEW OF FACILITY POLICIES.
7. EMAIL A COPY OF YOUR EMERGENCY PREPAREDNESS PLAN TO: AMY-JOY.ANDREWS@DELAWARE.GOV
8. OTHER: ____
____

NAME OF PERSON COMPLETING THIS FORM: ______________________

SIGNATURE: ______________________ TITLE: ______________________

DATE: ______________________

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

INITIAL APPLICATION FEE:	ANNUAL LICNESURE FEE:
$250.00	$150.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO:

OFFICE OF HEALTH FACILITIES
LICENSING 261 CHAPMAN ROAD
SUITE 200
NEWARK, DE 19702

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: ________________