



Ambulatory Surgical Facility License Application Packet

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In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Ambulatory Surgical Facilities
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

Join our Listserv:

Receive information by email about Ambulatory Surgical Facilities (ASF)

Sign up online at: <http://listserv.wa.gov> (scroll down and choose ASF)

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Application Instructions Checklist

When your application for an ambulatory surgical facility license is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

Indicate type of application—new, change of ownership, amended, renewal, or annual update.

New—First time requesting an ambulatory surgical facility license or license expired.

Change of Ownership—When name of legal owner/operator changes resulting from the sale of the licensed ambulatory surgical facility.

Amended—Request the addition of a Service Category; add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations.

Renewal—Renewing ambulatory surgical facility license.

Annual update—Annual update of ambulatory surgical facility license.

New—Submit the following:

- Application and fee. You can check the online [fee page](#) for current fees.
- Name of managing personnel, officers, and administrator.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.
- Copy of accreditation or certification approval letter, if applicable.

Change of Ownership—Requires current and prospective owners to submit application.

The current owner must submit the following:

- Full name, address, and phone number of the current and new owner.
- Name, address, and phone number of ambulatory surgical facility.
- Name under which the agency will operate.
- Date of the proposed change of ownership.
- Any changes in office location.

The prospective owner must submit the following:

- Application and change of [ownership fee](#).
- Name of managing personnel, officers, and administrator.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.

Amended:

- Submit application to request the addition of new construction, days and times surgeries will be performed, add or eliminate surgical procedures, change accreditation information, change administrator, lead nurse or preferred contact information.

Renewal:

- Submit the renewal notice and online [fee](#). Please make any corrections on the renewal notice.

Annual Update:

- Submit the application. Please note any changes on the application form.

Check One:

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

1. Demographic Information:

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI #'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax numbers.

Email and Web Address: Enter the owner's email and agency Web addresses, if applicable.

Facility Name: Enter the facility's name as advertised on signs, brochures or Web site.

Physical Address: Enter the facility's physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the facility's phone and fax numbers.

Mailing Address: Enter the facility's mailing address, if different than physical address.

2. Facility Specific Information:

Check One: Please check which type of ambulatory surgical facility you are applying for: Association, Corporation, Federal Government Agency, Limited Liability Company, Limited Liability Partnership, Limited Partnership, Municipality (City), Municipality (County), Non-Profit Corporation, Partnership, Public Hospital District, Sole Proprietor, State Government Agency, Tribal Government Agency, Trust.

A. Surgery Information

Indicate total number of procedures done per year, number of surgery rooms, and number of employees.

Check all days in a week when surgeries will be performed.

Check the time of day the facility will be open.

B. Surgical Procedures

Check all that apply.

C. Certification—Accreditation

Check yes or no if you are accredited by one of the accreditation organizations listed, and enter date of last accreditation survey. Check yes or no if you are medicare certified and list provider number.

D. Building

Check yes or no. If yes, enter the approved project number, facility/building name and physical site address of building. If you are uncertain, call the Office of Customer Service at 360-236-4700.

If you have more than one approved project, use the second entry. For three or more projects, use an additional page and return with your application.

E. Certificate of Need

Prior to applying to get your initial license, contact the Certificate of Need.

Enter your Certificate of Need number or exemption number.

- 3. Contact Information:** Provide license number if this person is a licensed health professional.

Administrator: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

Lead Nurse: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

Preferred Contact: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

- 4. Change of Ownership:**

List the previous legal owner name, previous name of facility, previous ASF license #, effective date of ownership change, and physical address.

- Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

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Date
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Revenue: 0597627190

Ambulatory Surgical Facility License Application

This is for: New Change of Ownership Amended Renewal Annual Update

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Public Hospital District |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | <input type="checkbox"/> Trust |

1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address:	
Facility Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Facility Information

A. Surgery Information

Number of:

Procedures per year _____ Surgery rooms _____ Employees _____

Days surgeries performed:

Sun _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____

Times surgeries performed:

Morning _____ Afternoon _____ Evening _____ All day _____

B. Check all surgical procedures:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Ear, Nose, & Throat | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Maxio Facial | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Opthamology | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Other _____ | | | |

C. Certification – Accreditation:

Medicare Certified? Yes No Provider # _____

Joint Commission? Yes No Last Accreditation Survey Date _____

Accreditation Association for Ambulatory Health Care? Yes No

Last Accreditation Survey Date _____

American Association for Accreditation of Ambulatory Surgery Facilities? Yes No

Last Accreditation Survey Date _____

Other Accreditation _____ Last Accreditation Survey _____

D. Building:

Project 1 DOH Construction Review approved? Yes No CRS approval # _____

Building name _____

Site address _____

Project description _____

Project 2 DOH Construction Review approved? Yes No CRS approval # _____

Building name _____

Site address _____

Project description _____

E. Certificate of Need:

Facility Certificate of Need # or Exemption # _____

3. Contact Information

Provide license number if this person is a licensed health care professional

Administer Name**License #**

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Email Address

Lead Nurse**License #**

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Email Address

Preferred Contact**License #**

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Email Address

4. Change of Ownership

Previous Name of Legal Owner:

Previous Name

Previous ASF License #

Effective Date of Ownership Change

Physical Address

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

Signature of Owner/Authorized Representative_____
Date_____
Print Name_____
Print Title

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RCW/WAC and Online Web Site Links

RCW/WAC Links

[Ambulatory Surgical Facilities Laws, RCW 70.230](#)

[Ambulatory Surgical Facilities Rules, WAC 246-330](#)

Online

[Ambulatory Surgical Facilities Program, Web Page](#)

[Ambulatory Surgical Facilities Survey Checklist, Web Page](#)