

APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

INSTRUCTIONS

1. Read carefully and complete all portions of the application. Please print or type.
2. Application for license may be made by owner, administrative officer, managing agent, or member of the governing body who has responsibility for maintaining approved standards for the institution. Any changes are to be reported promptly to the address above.
3. License fee must accompany the application. Checks, money orders or bank drafts must be made payable to **Oklahoma State Department of Health**. *Application and forms with license fee must be mailed to the following: OSDH, Attn: Financial Management – Receipting Unit, PO Box 268823, Oklahoma City, OK 73126-8816.* No such fee shall be refunded. License fee shall be calculated at ten dollars (\$10.00) per licensed bed, crib, and bassinet.
4. Complete and attach ODH Forms 891, 892, 911, 928, 929 and 931
5. Indicate if this is an initial application or renewal application: Initial Application Renewal Application

Hospital Classification (check one): <input type="checkbox"/> General Medical Surgical Hospital <input type="checkbox"/> Specialized Hospital: Psychiatric <input type="checkbox"/> Specialized Hospital: Rehabilitation <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Birthing Center <input type="checkbox"/> Emergency Hospital	Number of Licensed Beds, Cribs, and Bassinets	
	Number of Licensed Beds:	
	Number of Licensed Cribs:	
	Number of Licensed Bassinets:	
	TOTAL:	
TOTAL FEE: (total above x \$10.00)		\$_____.00

The undersigned hereby makes application for license to maintain a hospital subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the State Board of Health for:

1. **NAME OF INSTITUTION** _____
DBA _____
 Telephone No: () _____ - _____ Fax No: () _____ - _____ License No. _____
2. **Finding Address** _____
 (Number & Street)

 (City) (County) (State) (Zip)
3. **Finding Addresses of Additional Sites Under this License:**
 (Number) (Street) (City) (County) (State) (Zip) (Telephone)
- a) _____
- b) _____
- c) _____
- d) _____
4. **Mailing Address** _____
 (Number) (Street) (City) (County) (State) (Zip)
5. **Name and Title of Chief Executive Officer/Director** _____
6. **Institution's Fiscal Year Ending Date** Month _____ Day _____

7. OPERATING ENTITY

(Name of Entity)

(Business Address)

Governmental: State County City
 City/County Hospital Authority or District

Non-Governmental Not-for-Profit: Church Related Corporation Other (specify)

Non-Governmental For-Profit: Individual Partnership Corporation

8. SIGNATURE OF APPLICANT(S):

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

Title or Position: _____ Title or Position: _____

Email Address: _____ Email Address: _____

Date: _____ Date: _____

9. AFFIDAVIT

STATE OF: _____ **COUNTY OF:** _____

On this _____ day of _____ 20____, before me personally appeared _____
and _____ who after being duly sworn states, that to the best of _____ knowledge and
belief, the statements in the foregoing application are true.

(Notary Public, State of Oklahoma) (My Commission Number) My Commission Expires: _____

S-E-A-L

All REQUIRED FEES should be submitted directly to Financial Management at the post office box listed below. Please do not submit fees to the Medical Facilities Division. Checks, money orders or bank drafts must be made payable to the **OKLAHOMA STATE DEPARTMENT OF HEALTH**, must clearly identify the facility which the payment is associated and be mailed to:

**Oklahoma State Department of Health
Attn: Financial Management – Receiving Unit
P.O. Box 268823
Oklahoma City, OK 73126-8816**

FOR DEPARTMENT USE ONLY

Receipt # _____ License # _____ Certificate # _____

Amount \$ _____ Issued: _____

Date: _____ Expires: _____

Changes: _____

