

Health Care Facility Amended License Application

Ohio Department of Health, Radiology Technology Section
 Attn: Revenue Processing-3600
 Post Office Box 15278, Columbus, Ohio 43215-0278

Date

Facility # (ODH USE ONLY)

— Please complete **ONLY** the items which need to be amended —

PLEASE PRINT LEGIBLY IN INK OR TYPE

I. Facility Information

1. Facility name (DBA)		Telephone number ()	
Address		County	
City		State	ZIP
Site contact person	Telephone number ()	Federal Tax I.D. number	
2. Mailing address, if different from above			
Name			
Address			
City		State	ZIP
3. Name of person completing this application		Telephone number ()	

II. Capacity

4. Has there been a change in capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain

5. Mark a "✓" by the type of license you are applying for, and indicate the **number of units** on the lines provided

<input type="checkbox"/> Freestanding diagnostic imaging center _____ # of MRIs _____ # of PETs _____ # of CTs _____ # of fluoroscopy units _____ # and type of nuclear medicine units Radiopharmaceuticals being proposed for use _____ _____ _____	<input type="checkbox"/> Freestanding radiation therapy center _____ # of linear accelerators _____ # of cobalt radiation therapy units _____ # of gamma knives _____ # of simulators _____ # other Radiopharmaceuticals being proposed for use _____ _____ _____	<input type="checkbox"/> Mobile diagnostic imaging center _____ # of MRIs _____ # of PETs _____ # of CTs _____ # of fluoroscopy units _____ # and type of nuclear medicine units Radiopharmaceuticals being proposed for use _____ _____ _____
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III. Freestanding or Mobile Diagnostic Imaging Centers—only

6. Is this facility a radioactive materials licensee? Yes No N/A

If yes, name on license	License #	Date of last inspection
Type(s) of materials		

7. Does the licensee have multiple sites? Yes No

8. Has there been any incidents in which equipment malfunction contributed or may have contributed to patient injury or death within the last year?

Yes No If yes, please attach a report of the incident(s)

IV. Freestanding Radiation Therapy Centers — Only

9. Is this facility a radioactive materials licensee? Yes No N/A

If yes, name on license	License #	Date of last inspection
Type(s) of materials		

10. Does the licensee have multiple sites? Yes No

11. Has there been any incidents in which equipment malfunction contributed or may have contributed to patient injury, illness or death within the last year?

Yes No If yes, please attach a report of the incident(s)

V. Building/Management Information

12. The building housing for this health care facility is Owned Leased Rented

13. Building owner's name Telephone number
()

Address

City State ZIP

14. Name of management firm/business employed to manage this facility

Name Telephone number
()

Address

City State ZIP

VI. Accreditation

15. Is this health care facility accredited or certified (i.e., JCAHO)? Yes No

If yes, type

VII. Administration

16. Name of the on-site administrator	
17. Name of the medical director or individual responsible for the provision of health care services	License/certification number

18. Has the owner(s), administrator or medical director been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?

Yes No

If yes, provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition.

19. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04 (A) (1) (c) of the OAC within five years prior to the date of this application?

Yes No

If yes, provide in writing the individual's name, a listing of the name(s) and address(es) of the facilities.

VIII. Statement of Declaration

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the change occurs.

I certify that I am an owner of the facility or the *authorized representative**** of the owner.

Print/type owner's or representative's name and title	Signature of owner/representative	Date of signature
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Any owner named in question #25 on the original application may sign this application.

***If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

Print/type medical director	Signature of medical director	Date of signature
Print/type administrator	Signature of administrator	Date of signature

Before mailing this application, please make sure that **all** amended items have been listed, all signatures have been obtained, and any of the *applicable* documents have been enclosed:

1. Report of Compliance, within the past 12 months with all state fire codes
2. Final Use and Occupancy Permit (if applicable)**
3. Notarized Affidavit (if applicable)***

Submit a check or money order in the amount of \$150.00 payable to "Treasurer, State of Ohio" for any increase in the number or change in the type of equipment or radiopharmaceuticals being used (OAC 3701-83-04).

** New Final Use and Occupancy permit issued as a result of building renovations.