MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH FACILITY REGULATION

APPLICATION FOR AMBULATORY SURGICAL CENTER LICENSE

P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102-0570

☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION

In accordance with the requirements of the Missouri Ambulatory Surgical Center Licensing Law (Sections 197.200 through 197.240, RSMo), application is hereby made for a license to conduct and maintain an Ambulatory Surgical Center (see Missouri Ambulatory Surgical Center Licensing Law "Definitions" Section 197.200, subsection (1), RSMo).

DO NOT WRITE IN THIS SPACE
LICENSE NO.
DATE
CERTIFICATE NO.
DATE MAILED

NAME OF FACILITY (NAME TO APPEAR ON LICENSE) | TELEPHONE NO.

ADDRESS (STREET AND NUMBER) (CITY) (ZIP CODE)

COUNTY | ADMINISTRATOR

MANAGEMENT

NON PROFIT

☐ CORPORATION

☐ OTHER (SPECIFY)

PROPRIETARY

☐ INDIVIDUAL ☐ CORPORATION

☐ PARTNERSHIP ☐ OTHER (EXPLAIN)

CHIEF OFFICER OF GOVERNING BODY | LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

ACTIVE STAFF

TOTAL	PHYSICIANS	DENTISTS	PODIATRISTS

CERTIFICATION

STATE OF MISSOURI

City of _____

County of _____

_____ and _____
PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP — ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability and intention of the _____ Ambulatory Surgical Center to comply with the
EXACT LEGAL NAME
regulations and codes promulgated under the Missouri Ambulatory Surgical Center Licensing Law (section 197.200 through 197.240, RSMo), Regulations and Codes.

It is further certified that the _____ will comply with all
NAME OF FACILITY
recommendations for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Ambulatory Surgical Center.

Signed _____
PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

Signed _____
ADMINISTRATOR

Signed and sworn to before me this _____ day of _____, 20 ____

_____
NOTARY PUBLIC

My commission expires _____, 20 ____