**DEPARTMENT OF HEALTH**
**AMBULATORY SURGICAL TREATMENT CENTER**
**APPLICATION**

## AMBULATORY SURGICAL TREATMENT CENTER APPLICATION

To: Health Regulations and Licensing Administration
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

We, (1) _____ and (2) _____

Resident at (1) _____

(2) _____
Street Address City State Zip Code

Officers of the center named below, certifying that we are twenty-one years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a center during the _____ calendar year subject to the provisions of District of Columbia Law 2-66, and to any regulations and standards adopted thereunder.

Name of ambulatory surgical treatment center: _____

Location: _____ _
Street Address City State Tele. Zip Code

Name of person in charge: _____

Medical director or principal physician: _____

_____ _____
Street Address City State Zip Code

Name of organization owning and conducting center: _____

Type of organization: Non-Profit Corp. _____, Private Corp. _____ _____
(Attach lists of board officers and members)

Class of institution for which application is made: (Check one)

[ ] General Surgery [ ] Family Planning [ ] Other (Specify)

Transfer agreement with a hospital within twenty minutes ambulance time [ ] Yes [ ] No

Name of hospital: _____

Number of surgical procedures performed in the previous fiscal year _____

Application and license fee* of _____ drawn payable to: "D.C. Treasurer" is attached to this application. (Fee is not refundable.) There is also attached documentary evidence of financial responsibility on the part of the applicant institution in the sum of not less than One Hundred Thousand Dollars ($100,000.00) per occurrence and Three Hundred Thousand Dollars in the aggregate which become readily available for the benefit of any person who may become aggrieved as the result of the center.

Signatures of Applicants (1) _____ Title _____

(2) _____ Title _____

Sworn and subscribed to before me this _____ day of _____, _____

Notary Public for the District of Columbia

My commission expires _____

**NOTE**: THIS FORM FOR APPLICATION OF ASSOCIATION OR OTHER NON-INDIVIDUAL APPLICANT

* Refer to license fees for ambulatory surgical centers for correct fee