

**INSTRUCTIONS FOR COMPLETING APPLICATION FOR
KANSAS ABORTION FACILITY LICENSE**

I. IDENTIFICATION

A facility means any clinic, hospital, or ambulatory surgical center, in which any second or third trimester elective abortion, or five or more first trimester abortions are performed in a month, and is required to be licensed by the Kansas Department of Health and Environment under the provisions of 2011 House Substitute for Senate Bill No. 36.

Provide the full legal name of the facility and an e-mail address.

Provide the physical address of the facility including the nine-digit zip code. Include the telephone number, fax number, and e-mail address.

Identify the person designated by the governing authority to be responsible for the daily management of the facility. This person is usually referred to as the administrator/chief executive officer. Include telephone and fax numbers and e-mail address.

Identify the individual designated as the medical director of the facility who is licensed to practice medicine and surgery in Kansas. Include the individual's physician license number, street address and city, including the nine digit zip code. Also list a telephone and fax number and e-mail address.

II. OWNER INFORMATION

Give the legal name of the organization that owns and controls the abortion facility. List the ownership's street address, city, and nine digit zip code. Also include a telephone and fax number and e-mail address and web address, if applicable.

Provide the name and title of the principle contact person for the organization owning and operating the facility.

III. ORGANIZATIONAL INFORMATION

Identify the type of structure which describes the organizational structure of the entity which owns and operates the facility. Check the appropriate box and include on a separate, attached sheet the requested information for the organization checked.

IV. GENERAL INFORMATION

- A. Provide the name and license number of each physician who will be performing abortions at the facility and identify the hospital(s) within 30 miles of the facility at which each physician has clinical privileges. Provide the name and address of the hospital(s).
- B. Provide the name and license number of a physician who will be available to patients of the facility and who has admitting privileges at an accredited hospital within 30 miles of the facility. Provide the name and address of the hospital(s).

Provide the number of health professionals, other than physicians, the facility plans to have on staff at the time of application. Indicate if the staff positions will be full time or part time.

V. CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) CERTIFICATION

Indicate the facility's CLIA status and submit a copy of the certificate of registration or waiver.

VI. STATUTORY REQUIREMENTS

Indicate that each of the physical environment requirements specified by law is available at the facility. A check by each standard affirms presence of the requirement at the facility.

(OVER)

A non refundable license fee of \$500 must accompany the license application. A check or money order shall be submitted for payment to: **Kansas Department of Health and Environment**. A license, once issued shall be effective for one year following the date of issuance and shall apply only to the premises described in Section I. B. **The applicant must submit an application for an amended license to the Department within 30 days of a change of ownership by purchase or lease; or a change in the facility's name or address.**

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH
Bureau of Child Care & Health Facilities

LICENSE APPLICATION FOR ABORTION FACILITY

<input type="checkbox"/> Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Amended (Change of Ownership or Address)

The undersigned affirms that the facility named herein has the ability to comply with the requirements for licensure as an abortion facility under the provisions of 2011 House Substitute for Senate Bill No. 36 and provide the following information.

I. Facility Identifying Information

Name of Facility: _____

Street Address: _____

City: _____ Zip _____

Telephone: _____ Fax: _____ E-mail: _____

Chief Executive Officer: _____

Telephone: _____ Fax: _____ E-mail: _____

Medical Director: _____ License Number: _____

Street Address: _____

City: _____ Zip _____

Telephone: _____ Fax: _____ E-mail: _____

II. Owner Information

Name of Owner: _____

Street Address: _____

City: _____ Zip _____

Telephone: _____ Fax: _____ E-mail: _____

Name and Title of Contact: _____

Do Not Write in this Box	
License ID No.: _____	Effective Date: _____
Approved By: _____	Renewal Date: _____

III. Organizational Information

Identify the structure under which the Owner is organized.

- Sole Proprietorship** [On a separate, attached sheet please provide the name, address, telephone number, fax number and e-mail address for the sole proprietor, if different from the Owner Information.]
- Partnership** [On a separate attached sheet please provide the name, address, telephone number, fax number and e-mail address for each partner.]
- Joint Venture** [On a separate, attached sheet please provide the name, address, telephone number, fax number and e-mail address for each participant in the joint venture.]
- Limited Liability Company** [On a separate, attached sheet please provide the name, address, telephone number, fax number and e-mail address for each member of the LLC and identify the managing member.]
- Corporation (for profit)** [On a separate, attached sheet please provide the name, address, telephone number, fax number and e-mail address for each officer and director of the corporation.]
- Corporation (not for profit)** [On a separate, attached sheet please provide the name, address, telephone number, fax number and e-mail address for each officer and director of the corporation.]
- Other** [On a separate, attached sheet please explain the organizational structure and provide the name, address, telephone number, fax number and e-mail address for all participants in the facility ownership.]

IV. General Information

- A. Provide the name and license number of each physician who will be performing abortions at the facility and identify the hospital(s) at which the physician has clinical privileges within 30 miles of the facility. (If necessary use additional sheet.)
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- B. Provide the name and license number of a physician who has admitting privileges at an accredited hospital within 30 miles of the facility and identify the hospital. (If necessary use additional sheet.)
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What is the planned number of health professional staff other than physicians:

Nurse Practitioner:	Full time _____	Part time _____
Registered Nurse:	Full time _____	Part time _____
Physician Assistant:	Full time _____	Part time _____
Licensed Practical Nurse:	Full time _____	Part time _____
CRNA:	Full time _____	Part time _____

V. CLIA Requirements

Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver? Provide the CLIA number and a copy of certificate or waiver.

- CLIA certificate number: _____ Waiver

