

Jim Perkins, Director
Health Facilities Program
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Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

The enclosed information needed to:

Renewal of the current Birth Center license.

Closure of the existing Birth Center license. Please read the instructions carefully and complete all forms as required.

These forms may not be used for any other purpose than to request the renewal or closure of the current license. If there has been a change in ownership or location, do not use this form, please contact our office for further directions. *If the Birth Center has Professional Liability Insurance, please submit a copy of the current Declaration Page for our records.* Return the original renewal application, renewal fee, and required documentation to Health Facilities Program and keep a copy for your records.

Please complete and return this application and the renewal fee within 30 days from date on letter to

Kansas Department of Health and Environment
Bureau of Community Health Systems
Health Facilities Program
Curtis State Office Building
1000 SW Jackson Street, Suite 330
Topeka, Kansas 66612-1365

If you have any questions about the renewal process, please contact Lois at (785) 296-1258.

Thank you,

Jim Perkins, Director
Health Facilities Program

Enclosure

Part I

This form shall be used only for the Renewal of Birth Center License or the Birth Center Closure. Please contact our office at (785) 296-1258 for questions about any other activity.

Request for License Renewal-Submit the following documents:

- Completed application form for license renewal
- License fee of \$75.00 payable to Kansas Department of Health and Environment

Request for Closure-Submit the following documents:

- Application to renew the license form with Section A completed.
- Return the Original License (not a copy), and the retention location of the clinical records for 25 years from the date of discharge.

***Note: Incomplete information will delay the processing of your request.*

Fire Safety Information:

To access fire safety information you may contact the State Fire Marshal's office at (785) 296-3401 or at their website at www.accesskansas.org/firemarshal.

Check one of the following:

- This document is a request to renew the current license.
- This document is a request to close this Birth Center, holding license number _____.

This Birth Center is no longer providing services, the effective date of closure

_____.

Select One:
___ Renewal
or
___ Closure

Kansas Department of Health & Environment
Bureau of Community Health Systems
Health Facilities Program
Birth Center Application for
Renewal or Closure Application

Part II

Name of Birth Center: _____

Street Address _____ City _____ County _____ Zip Code _____

Phone No.: _____ Web address _____

Fax No.: _____

Administration:

Name of Administrator who oversee the operation of the birth center:

Discipline of Administrator: _____ License No. _____

Phone No. _____ Email Address _____

Clinical Director Name: _____

Discipline of Clinical Director: _____ License No. _____

Phone No. _____ Email Address _____

Acting Clinical Director Name: _____

Discipline of Acting Clinical Director: _____ License No. _____

Phone No. _____ Email Address _____

_____ ****Do not write below this line**** _____

License Effective Date: _____ License ID No.: _____

Annual Renewal Date: _____ Reviewed By: _____

Birth Center Staffing Information:

Number of Health Professionals Employed at this Birth Center			
	Total Number	Full-time Staff	Part-time Staff
Physicians			
Certified Nurse Midwife's			
Certified Professional Midwife			
Certified Midwife			
Registered Nurses			
Licensed Practical Nurses			

List the Services provided at this Birth Center: (feel free to add an attachment)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Total Number of Birthing Rooms _____

Total Number of Births since Previous Renewal _____

Part III

Disclosing Entity Name: _____

Disclosing Address: _____

Type of Entity:

- Sole Proprietorship
 Partnership
 Joint Venture
 Limited Liability Company
 Professional Association
 Corporation for profit
 Corporation nonprofit

1. List the name and addresses of each person who has any direct or indirect ownership in the Birth Center. Please indicate what percentage of ownership for each individual in the box below.
2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility. *Please list the percentage of ownership per holder.*
3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.
4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 10 percent owner, and for all general partners. *Please list the percentage of ownership per holder.*

5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

Indicate with "X"		Individual Name	Address	City	State
Owner	Mortgagor	3. Limited Liability Company Describe for each Limited Partnership & LLC the Limited for Each 10% Owner and for all General	4. Directors /Officers	5. Elected Officials	(or provide an attachment listing)

AGREEMENTS AND AUTHORIZED SIGNATURE(S). Read each statement and sign the application when completed.

I/We the undersigned, am/are the person(s) named as the Licensee or the person(s) authorized to represent the owner listed above.

I/We have read the laws and regulations governing the operation of this center and understand that it is my/our responsibility to maintain the center in compliance with applicable laws and regulations at all times.

In accordance with K.S.A. 44-10009, I/we shall not exclude any person from care for reason of race, religion, color, sex, physical handicap, national origin, or ancestry.

I/We attest, under penalty of perjury that to the best of my /our knowledge that the information provided in this application is true and correct.

Signature Title Print Name

Date Telephone Number

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Health Facilities Program
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 Topeka, Kansas 66612
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