

Ambulatory Surgical Center License Renewal Addendum

1. Services:

Mark all surgical specialties that are offered at this facility:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> General | <input type="checkbox"/> Oral | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Neurological | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Thoracic |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Other: _____ | | |

2. Accreditation: Attach a copy of the approval letter or certificate from the accrediting agency.

- Accreditation Association for Ambulatory Healthcare (AAAHC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Osteopathic Association (AOA)
- The Joint Commission
- Other: _____
- None
- Pending

3. Treatment & Procedure Rooms:

- a. Total Number of Operating Rooms: _____
- b. Total Number of Treatment/Procedure Rooms: _____

4. Medical Staff:

- a. Provide the total number of physicians, dentists, podiatrists, and/or advanced practice registered nurses providing services at the facility.

Physicians _____ Dentists _____ Podiatrists _____ APRNs _____

- b. Facility Administrator:

| | | |
|------|-------|--------------|
| Name | Email | Phone Number |
|------|-------|--------------|

- c. Medical Chief of Staff:

| | | |
|------|-----------|-----------------|
| Name | License # | Expiration Date |
|------|-----------|-----------------|

- d. Director of Nurses:

| | | |
|------|-----------|-----------------|
| Name | License # | Expiration Date |
|------|-----------|-----------------|