



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

## How to Become a Licensed General or Special Hospital

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a General or Special Hospital. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 133, Hospital Licensing Rules, §133.22 Application and Issuance of Initial License. Information regarding licensure for health care facilities, including contact information for the zone office for your location is located on the department's website at <http://www.dshs.texas.gov/facilities/default.aspx>.

The following documents, fees, and actions shall be completed and approved before a license will be issued:

### Initial Application

- A hospital license application form submitted approximately 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$39.00 per bed shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
  - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
  - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or <http://www.dshs.texas.gov/facilities/architectural-review.aspx>).
- The hospital CEO or Administrator shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Please contact the designated Zone Office to schedule attendance (<http://www.dshs.texas.gov/facilities/compliance-zones.aspx>). (***Note: It is required that an individual listed on the license application attend the conference.***)

### Relocation Application

- A hospital license application form submitted approximately 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$39.00 per bed shall be submitted. ***License fees are not refundable.***

### **Relocation Application Continued:**

- Patient Transfer Documents:
  - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
  - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or <http://www.dshs.state.tx.us/facilities/architectural-review.aspx>).

### **Change of Ownership (CHOW) Application**

- A hospital license application form submitted prior to the date of the change of ownership or not later than 10 calendar days following the date of the change of ownership.
- A license fee of \$39.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
  - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- A copy of two completed Fire Safety Survey Report forms shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
- The hospital CEO or Administrator shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Please contact the designated Zone Office to schedule attendance or to request a waiver (<http://www.dshs.texas.gov/facilities/compliance-zones.aspx>). (*Note: It is required that an individual listed on the license application attend the conference*).
- A Bill of Sale or other legal document shall be submitted. The document shall include the effective date of the change of ownership and both parties signed agreement to the transaction.

**Important Items to Note:**

- The D/B/A or Assumed Name listed on the application must match the D/B/A or Assumed Name listed on applications filed with the Texas State Board of Pharmacy, Texas Department of Public Safety – Controlled Substances Registration, and the Drug Enforcement Agency.
- The D/B/A or Assumed name of the facility is the name that will appear on the license certificate and should match advertisements and signage of the facility.
- The Legal Name is the name of the direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership. The Legal Name and EIN on the application should be an exact match with the IRS letter.
- The organizational chart showing ownership structure should reflect all levels of ownership and include EIN numbers. The chart should start with the D/B/A or Assumed Name, continue with the Legal Name (direct owner), and end with any additional ownership levels. An example has been attached for your reference.

**Additional Information:**

Medicare certification information may be obtained from the zone office for your location (<http://www.dshs.texas.gov/facilities/compliance-zones.aspx>). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Department of State Health Services' responsibilities. For information on obtaining provider certification, please contact zone office staff.

CLIA information is located on the department's website at <http://www.dshs.texas.gov/facilities/default.aspx>. For more information, please contact the Zone Office for your location <http://www.dshs.texas.gov/facilities/compliance-zones.aspx>.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Hospital Licensing Section: phone (512) 834-6648, fax (512) 834-4514.

**Mailing address for applications with fees:**

**DEPARTMENT OF STATE HEALTH SERVICES  
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP  
MAIL CODE 2003  
P.O. BOX 149347  
AUSTIN, TEXAS 78714-9347**

**Overnight mailing address for applications with fees:**

**DEPARTMENT OF STATE HEALTH SERVICES  
FACILITY LICENSING GROUP  
MAIL CODE 2003  
1100 WEST 49<sup>TH</sup> STREET  
AUSTIN, TEXAS 78756**

**EXAMPLE**  
**OWNERSHIP STRUCTURE**

HIGHER LEVEL  
OF OWNERSHIP

EIN #

*(Add Boxes as Needed)*

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)

or ASSUMED NAME



# Application for a License to Operate a General or Special Hospital

Initial  
 Projected date facility will open: \_\_\_\_\_ Architectural Project #: \_\_\_\_\_

Change of Ownership  
 Effective Date: \_\_\_\_\_ Current License #: \_\_\_\_\_

Relocation  
 Projected Date Facility Will Open: \_\_\_\_\_ Current License #: \_\_\_\_\_  
 Architectural Project #: \_\_\_\_\_

## 1. HOSPITAL INFORMATION:

a. Hospital within a hospital:  Yes  No

b. Name the hospital will be doing business as (d/b/a):

\_\_\_\_\_ *This is the name that will appear on the license and should match advertisements and signage of the hospital.*

c. Street Address: \_\_\_\_\_  
 Street Number \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ County \_\_\_\_\_

d. Mailing Address: \_\_\_\_\_  
 (If different) Street or P.O. Box Number \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_

e. Telephone Number (include area code) \_\_\_\_\_ f. Fax Number (include area code) \_\_\_\_\_  
 \_\_\_\_\_  
*Leave blank if number is unknown at this time.* *Leave blank if number is unknown at this time.*

## 2. OWNERSHIP INFORMATION:

a. Legal Name (*Name of direct owner legally responsible for the day to day operation of the hospital, whether by lease or ownership*)

\_\_\_\_\_ b. Mailing Address \_\_\_\_\_ c. City/State/Zip \_\_\_\_\_

\_\_\_\_\_ d. EIN Number \_\_\_\_\_ e. Telephone Number \_\_\_\_\_ f. Email Address \_\_\_\_\_

g. Status:  Profit  Non-Profit

**2. OWNERSHIP INFORMATION CONTINUED:**

- h. Type of Ownership:
- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> City         | <input type="checkbox"/> Hospital District/Authority         | <input type="checkbox"/> LTD                       |
| <input type="checkbox"/> Corporation  | <input type="checkbox"/> Limited Liability Company (LLC)     | <input type="checkbox"/> Partnership               |
| <input type="checkbox"/> County       | <input type="checkbox"/> Limited Liability Partnership (LLP) | <input type="checkbox"/> Sole Owner/Proprietorship |
| <input type="checkbox"/> Hospital     | <input type="checkbox"/> Limited Partnership (LP)            | <input type="checkbox"/> State                     |
| <input type="checkbox"/> Other: _____ |  |  |

i. Provide a copy of the IRS letter assigning the federal employer identification number (EIN).

j. Provide a copy of the Certificate of Filing from the Office of the Secretary of State.

k. Attach an organizational chart showing the ownership structure. *See Example.*

**3. HOSPITAL SERVICES:** *(Please select either General or Special)*

**GENERAL** - The term “general hospital” means any establishment offering services, facilities, and beds for use for more than twenty-four (24) hours for two (2) or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy, and regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

Services: (Please check all services offered)

- Surgery
- Obstetrical Care
- Clinical Laboratory Services *(required)*
- Diagnostic X-ray Services *(required)*
- Emergency Department *(required)*
- Pediatric *(if 15 or more beds)*
- Comprehensive Medical Rehabilitation
- ESRD – Acute Services\*
- Mental Health Services *(in an identifiable part of the hospital)*
- Chemical Dependency *(in an identifiable part of the hospital)*     Inpatient     Outpatient
- Other Definitive Medical or Surgical Treatment: \_\_\_\_\_

**SPECIAL** - The term “special hospital” means any establishment offering services, facilities, and beds for use for more than twenty-four (24) hours for two (2) or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care, and has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment, has a medical staff in regular attendance, and maintains records of the clinical work performed for each patient.

Services: (Please check all services offered):

- Medical
- Emergency Department
- Emergency Treatment Room *(required if no Emergency Department)*
- Clinical Laboratory Services *(contracted or onsite)*
- Diagnostic X-ray Services *(includes MRI, ultrasound, portable x-ray)*
- Pediatric *(if 15 or more beds)*
- Comprehensive Medical Rehabilitation
- ESRD – Acute Services\*
- Mental Health Services *(in an identifiable part of the hospital)*
- Chemical Dependency *(in an identifiable part of the hospital)*     Inpatient     Outpatient
- Other Definitive Medical Treatment: \_\_\_\_\_

**\*Answer the questions below if ESRD Stations are provided for treatment within a designated area of the hospital:**

- What patient populations are being served?     Pediatric     Adult
- Does the hospital provide peritoneal dialysis?     Yes     No
- How many stations does the hospital have? \_\_\_\_\_ *(not included in bed count)*

4. NICHE: Is this hospital a Niche hospital?  Yes  No

The term "Niche hospital" means that, (A) two-thirds of the hospital's Medicare patients or all patients are classified in no more than two major diagnosis related groups (DRG) or surgical diagnosis-related groups; or (B) specializes in one or more of the following areas: cardiac, orthopedics, surgery, or women's health and is not a public hospital, is not a hospital for which the majority of inpatients claims are for major DRG relating to rehabilitation, psychiatry, alcohol and drug treatment, or children or newborns, or is not a hospital with fewer than ten (10) claims per bed per year.

5. OTHER SERVICES: (Please select any of the following if applicable)

Long Term Acute Care Hospital  Critical Access Hospital  Skilled Nursing Unit  None

6. LICENSED BEDS:

a. How many total licensed beds are at this hospital location? \_\_\_\_\_ (total bed design capacity of this hospital only)  
\* A change in the bed design capacity requires prior Department approval and possible fees.

b. How many emergency treatment room beds and/or emergency department beds are at this hospital location? \_\_\_\_\_  
\* This count is not included in the licensed bed count above and will not affect fees. A minimum of one bed is required.

c. Please provide the total number of licensed beds in each unit or area of service at this hospital location:

- \_\_\_\_\_ Medical/Surgical (may include pediatric beds if pediatric bed count is less than 15 beds)
- \_\_\_\_\_ ICU/CCU
- \_\_\_\_\_ Intermediate Care
- \_\_\_\_\_ Universal Care
- \_\_\_\_\_ Neonatal ICU
- \_\_\_\_\_ Continuing Care Nursery
- \_\_\_\_\_ Antepartum
- \_\_\_\_\_ Labor/Delivery/Recovery/Postpartum
- \_\_\_\_\_ Postpartum
- \_\_\_\_\_ Adolescent
- \_\_\_\_\_ Pediatric (if 15 or more beds)
- \_\_\_\_\_ Skilled Nursing
- \_\_\_\_\_ Comprehensive Medical Rehabilitation
- \_\_\_\_\_ Mental Health
- \_\_\_\_\_ Chemical Dependency

7. FEES: Fees paid to the department are not refundable – Make checks payable to Department of State Health Services

Total number of licensed beds: \_\_\_\_\_ (Include all licensed beds at all locations under a common license)

Total fee due is \$39.00 per bed. Amount paid: \$ \_\_\_\_\_

8. MEDICARE CERTIFICATION (CHOWS and RELOCATIONS ONLY)

Is the hospital certified to participate in the Title XVIII Medicare Program?  Yes  No

If YES, please provide the hospital's Medicare Provider Number: \_\_\_\_\_

9. IS THE HOSPITAL DESIGNATED AS A COMMUNITY WIDE DESIGNATED HOSPITAL FOR SEXUAL ASSAULT SURVIVORS:

Yes  No

10. ACCREDITATION (CHOWS and RELOCATIONS ONLY)

(Please check the category(ies) that apply – attach a copy of the most recent accreditation letter or certificate)

- Joint Commission (JC)
- American Osteopathic Association (AOA)
- DNV GL
- Center for Improvement in Healthcare Quality (CIHQ)
- Not accredited

**11. FIRE SAFETY SURVEY:**

A completed Fire Safety Survey Report shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority. For change of ownership applications, a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months shall be submitted.

**12. PATIENT TRANSFER POLICY/MEMORANDUM OF TRANSFER/PATIENT TRANSFER AGREEMENT:**

- Submit a copy of the hospital's Memorandum of Transfer form and the Patient Transfer Policy developed in accordance with the rules governing patient transfer policies and agreements which is signed by both the chairman and secretary of the hospital's governing body attesting to the date of adoption of the policy and the policy's effective date.
- Submit copies of all Patient Transfer Agreements between the hospital and another hospital licensed under Health and Safety Code (HSC), Chapter 241, developed in accordance with the rules governing hospital patient transfer policies and agreements (unless you have a written waiver granted by DSHS). If you have a written waiver, please attach a list of hospitals that your hospital has agreements with and include the effective dates of the agreements. Only submit agreements between hospitals that are licensed under HSC Chapter 241.

**13. SIGNATURE AND ATTESTATION:**

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 133, Hospital Licensing Rules. I attest that all information contained in this application is true and correct. I attest that all copies submitted with the application are original copies or copies of the original documents. In compliance with Health and Safety Code §241.022(c)(1) and the Hospital Licensing Rules, this is to attest that the physicians on the medical staff of this hospital are currently licensed by the Texas State Board of Medical Examiners and are qualified legally, professionally and ethically for the positions to which they are appointed.

\_\_\_\_\_  
Chief Executive Officer Signature\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Printed Name of CEO\_\_\_\_\_  
Title\_\_\_\_\_  
Telephone Number\_\_\_\_\_  
Email Address**14. HOSPITAL ADMINISTRATOR (onsite administrator in charge of day-to-day operations at the hospital):**\_\_\_\_\_  
Onsite Administrator in charge of day-to-day operations\_\_\_\_\_  
Title\_\_\_\_\_  
Telephone Number\_\_\_\_\_  
Email Address

**Mailing address for applications with fees:** Department of State Health Services, Facility Licensing Group, Mail Code 2003, PO Box 149347, Austin, TX 78714-9347

**Overnight mailing address for applications with fees:** Department of State Health Services, Facility Licensing Group, Mail Code 2003, 1100 West 49<sup>th</sup> Street, Austin, TX 78756

**OWNERSHIP ADDENDUM**

Please complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147).

**The owner is a:**

**N/A**

**Partnership - List each general partner who is an individual.**

Print Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Corporation - List any individual who has an ownership interest of 25% or more in the corporation.**

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

OWNERSHIP ADDENDUM (cont.)

N/A

Please complete if the hospital is a Niche Hospital. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147).

Niche Hospital - the name, social security number, address and license number of any physician licensed by the Texas Medical Board who has a financial interest in the ownership of the hospital.

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Texas Medical Board License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

## MEMORANDUM OF TRANSFER (sample)

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### SECTION A (To Be Filled Out At Transferring Hospital)

<p>1. Name of Transferring Hospital: _____                  Address: _____                  Phone Number: (____) _____</p> <p>2. Patient Information (If Known)                  Patient's full name: _____                  Address: _____                  Phone Number: (____) _____                  Sex: ____M ____F Age: _____                  National origin: _____ Race: _____                  Religion: _____ Physical Handicap: _____</p> <p>3. Next of Kin:(If Known) _____                  Address: _____                  Phone Number: (____) _____                  Next of Kin notified? (____) Yes (____) No</p> <p>4. Date of Arrival: __/__/__ Time: _____</p> <p>5. Initial contact with receiving hospital administration:                  Date: __/__/__ Time: _____                  Name of contact person at receiving hospital: _____</p> <p>6. Receiving physician secured by transferring physician:                  Date: __/__/__ Time: _____                  Name of receiving physician: _____</p>	<p>7. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____                  Name of transferring physician: _____                  Phone Number: (____) _____                  Address: _____</p> <p>8. Accepting hospital secured by transferring hospital:                  Date: __/__/__ Time: _____                  Name of receiving hospital administration person: _____</p> <p>9. Transferring hospital administration who contacted the receiving hospital:                  Signature: _____                  Title: _____ Time: _____</p> <p>10. Type of vehicle and company used:                  Equipment needed: _____                  Personnel needed: _____</p> <p>11. Facility transported to: _____                  City: _____</p> <p>12. Diagnosis: _____</p> <p>13. Attachments:                  X-rays _____ MD Progress Notes _____                  Lab Reports _____ Nurses Progress Notes _____                  History _____ Medication Record _____                  Other _____</p>
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PHYSICIAN CERTIFICATION: based upon the information available at the time of the transfer the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.

Summary of Risks and Benefits \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

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### SECTION B (To Be Filled Out At Receiving Hospital)

<p>1. Name of Receiving Hospital: _____                  Address: _____                  Phone Number: (____) _____</p> <p>2. Date of Arrival: __/__/__ Time: _____</p> <p>3. Receiving Hospital Administration Signature:                  _____                  Title: _____ Date: __/__/__</p>	<p>4. Receiving physician assumed responsibility for the patient:                  Date: __/__/__ Time: _____                  Receiving Physician's signature: _____                  Name: _____                  Address: _____                  Phone Number: (____) _____</p> <p>5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any agreed time extensions. Use additional sheet, if necessary.                  _____                  _____                  _____</p>
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DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.