Ambulatory Surgical Facility License Application Packet

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In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Ambulatory Surgical Facilities
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

Join our Listserv:

Receive information by email about Ambulatory Surgical Facilities (ASF)

Sign up online at: **http://listserv.wa.gov** (scroll down and choose ASF)

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Application Instructions Checklist

When your application for an ambulatory surgical facility license is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

Indicate type of application—new, change of ownership, amended, renewal, or annual update.

New—First time requesting an ambulatory surgical facility license or license expired.

Change of Ownership—When name of legal owner/operator changes resulting from the sale of the licensed ambulatory surgical facility.

Amended—Request the addition of a Service Category; add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations.

Renewal—Renewing ambulatory surgical facility license.

Annual update—Annual update of ambulatory surgical facility license.

☐ **New—Submit the following:**

- Application and fee. You can check the online fee page for current fees.
- Name of managing personnel, officers, and administrator.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.
- Copy of accreditation or certification approval letter, if applicable.

☐ **Change of Ownership—Requires current and prospective owners to submit application.**

The current owner must submit the following:

- Full name, address, and phone number of the current and new owner.
- Name, address, and phone number of ambulatory surgical facility.
- Name under which the agency will operate.
- Date of the proposed change of ownership.
- Any changes in office location.

The prospective owner must submit the following:

- Application and change of ownership fee.
- Name of managing personnel, officers, and administrator.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.

☐ **Amended:**

- Submit application to request the addition of new construction, days and times surgeries will be performed, add or eliminate surgical procedures, change accreditation information, change administrator, lead nurse or preferred contact information.

☐ **Renewal:**

- Submit the renewal notice and online **fee**. Please make any corrections on the renewal notice.

☐ **Annual Update:**

- Submit the application. Please note any changes on the application form.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ 1. Demographic Information:

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI #'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax numbers.

Email and Web Address: Enter the owner's email and agency Web addresses, if applicable.

Facility Name: Enter the facility's name as advertised on signs, brochures or Web site.

Physical Address: Enter the facility's physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the facility's phone and fax numbers.

Mailing Address: Enter the facility's mailing address, if different than physical address.

☐ 2. Facility Specific Information:

Check One: Please check which type of ambulatory surgical facility you are applying for: Association, Corporation, Federal Government Agency, Limited Liability Company, Limited Liability Partnership, Limited Partnership, Municipality (City), Municipality (County), Non-Profit Corporation, Partnership, Public Hospital District, Sole Proprietor, State Government Agency, Tribal Government Agency,Trust.

A. Surgery Information

Indicate total number of procedures done per year, number of surgery rooms, and number of employees.

Check all days in a week when surgeries will be performed.

Check the time of day the facility will be open.

B. Surgical Procedures

Check all that apply.

C. Certification—Accreditation

Check yes or no if you are accredited by one of the accreditation organizations listed, and enter date of last accreditation survey. Check yes or no if you are medicare certified and list provider number.

D. Building

Check yes or no. If yes, enter the approved project number, facility/building name and physical site address of building. If you are uncertain, call the Office of Customer Service at 360-236-4700.

If you have more than one approved project, use the second entry. For three or more projects, use an additional page and return with your application.

E. Certificate of Need

Prior to applying to get your initial license, contact the Certificate of Need. Enter your Certificate of Need number or exemption number.

☐ **3. Contact Information:** Provide license number if this person is a licensed health professional.

Administrator: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

Lead Nurse: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

Preferred Contact: Enter name, phone number, fax number, email address, and license number (if they are a licensed health care professional).

☐ **4. Change of Ownership:**

List the previous legal owner name, previous name of facility, previous ASF license #, effective date of ownership change, and physical address.

☐ **Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

Additional Information:

Policies and Procedures:
As you read through the Ambulatory Surgical Facilities licensing rules (chapter 246-330 WAC), you will notice that certain sections of the rules require the applicant to develop various policies and procedures (P&Ps). These individual P&Ps, when put together, will create a P&P manual that DOH must review and approve before your license can be issued. Applicants can write the P&Ps themselves or choose to purchase generic manuals on-line or choose to hire business consultants. Do not submit your P&P manual with your application – our survey office will request them at a later point in the licensing process.

Use of Artificial Intelligence:
If artificial intelligence tools or templates were used to generate policy and procedure documents submitted with this application, they must be thoroughly reviewed by the applicant prior to submission. This includes verifying legal and regulatory accuracy, Washington Administrative Code provisions and applicability, and ensuring the facility's workflows and staff responsibilities reflect the current practice.

Washington State Department of HEALTH

Date Stamp Here

Revenue: 0597627190

Ambulatory Surgical Facility License Application

This is for: ☐ New ☐ Change of Ownership ☐ Amended ☐ Renewal ☐ Annual Update

Check One

☐ Association	☐ Limited Partnership	☐ Public Hospital District
☐ Corporation	☐ Municipality (City)	☐ Sole Proprietor
☐ Federal Government Agency	☐ Municipality (County)	☐ State Government Agency
☐ Limited Liability Company	☐ Non-Profit Corporation	☐ Tribal Government Agency
☐ Limited Liability Partnership	☐ Partnership	☐ Trust

1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address:	
Facility Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Facility Information

A. Surgery Information

Number of:

Procedures per year _____ Surgery rooms _____ Employees_____

Days surgeries performed:

Sun _____ Mon_____ Tues ____ Wed _____ Thurs ____ Fri _____ Sat _____

Times surgeries performed:

Morning _____ Afternoon _____ Evening_____ All day _____

B. Check all surgical procedures:

- ☐ Ear, Nose, & Throat
- ☐ Gastroentology
- ☐ General Surgery
- ☐ Gynecology
- ☐ Maxio Facial
- ☐ Opthamology
- ☐ Oral Surgery
- ☐ Orthopedics
- ☐ Pain Management
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Urology
- ☐ Other _____

C. Certification – Accreditation:

Medicare Certified? ☐ Yes ☐ No Provider # _____

Joint Commission? ☐ Yes ☐ No Last Accreditation Survey Date _____

Accreditation Association for Ambulatory Health Care? ☐ Yes ☐ No

Last Accreditation Survey Date _____

American Association for Accreditation of Ambulatory Surgery Facilities? ☐ Yes ☐ No

Last Accreditation Survey Date _____

Other Accreditation _____ Last Accreditation Survey _____

D. Building:

Project 1 DOH Construction Review approved? ☐ Yes ☐ No CRS approval # _____

Building name _____

Site address_____

Project description_____

_____

_____

Project 2 DOH Construction Review approved? ☐ Yes ☐ No CRS approval # _____

Building name _____

Site address_____

Project description_____

_____

_____

E. Certificate of Need:

Facility Certificate of Need # or Exemption # _____

3. Contact Information

Provide license number if this person is a licensed health care professional

Administer Name		**License #**
Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address
Lead Nurse		**License #**
Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address
Preferred Contact		**License #**
Phone (enter 10 digit #)	Fax (enter 10 digit #)	Email Address

4. Change of Ownership

Previous Name of Legal Owner:

Previous Name	Previous ASF License #	Effective Date of Ownership Change
Physical Address		

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

_____ _____

Signature of Owner/Authorized Representative Date

_____ _____

Print Name Print Title

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Ambulatory Surgical Facilities Laws, RCW 70.230

Ambulatory Surgical Facilities Rules, WAC 246-330

Online

Ambulatory Surgical Facilities Program, Web Page

Ambulatory Surgical Facilities Survey Checklist, Web Page