MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
DIVISION OF LICENSING AND CERTIFICATION
P.O. BOX 30664, LANSING, MI 48909

HOSPITAL LICENSE APPLICATION

1. **TYPE OF APPLICATION:** ___ **Initial** ___ **Amendment** ___ **Change of Ownership** ___ **Bed Changes**

2. **FACILITY NAME:** ____

3. **FACILITY PHYSICAL ADDRESS:** ____
   (Street)
   ____
   (City) (State) (Zip) (County)

4. **FACILITY MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS:** ____
   (Street)
   ____
   (City) (State) (Zip) (County)

5. **MAIN/GENERAL PUBLIC PHONE NUMBER: (________) - ________ - ____________**

6. **FAX NUMBER: (________) - ________ - _____________**

7. **TOTAL NUMBER OF BEDS TO BE LICENSED:** __________

(Fees are based on open date within the billing cycle of 8/1 through 7/31 of each year and the per bed fee of $8.28. Change of Ownership fees and bed increases are equal to 1 year fees regardless of billing cycle. Do not send fees without receiving an Invoice.)

LICENSED BED CATEGORIES:

MEDICAL / SURGICAL __________
OBSTETRIC __________
PEDIATRIC __________
NEONATAL INTENSIVE CARE __________

Authority: P.A. 368 of 1978 as amended Completion: Mandatory BHS-LC-100 (Rev. 9/08) Page 1 of 3	The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

8. PERSON IN CHARGE:

A. Name: ____
(Salutation) (First) (Middle Initial) (Last)

B. Title: ____

C. Administrative/Emergency Phone Number: (________) - ________ - _____________

D. Hire Date of Administrator at Provider: __________

E. Chairperson of Board: ____
(Salutation) (First) (Middle Initial) (Last)

____
(Street) (City) (State) (Zip)

9. OWNERSHIP (legal entity which directly owns the facility):

A. Company/Owner Legal Name: ____

B. Company/Owner Address: ____
(Street) (City) (State) (Zip)

C. Company/Ownership Start Date: __________ **D. Company/Ownership End Date:** __________

E. Company/Owner Phone: (________) - ________ - _____________

F. Federal ID Number: 38- __ __ __ __ __ __ __

G. Primary Owner or Contact: ____
(Salutation) (First) (Middle Initial) (Last)

H. Type of ownership:

_____ Individual
_____ Partnership
_____ Corporation
_____ Non-Profit Church
_____ Non-Profit Other
_____ State
_____ County
_____ City
_____ City/County
_____ Hospital Authority
_____ Other (Specify)__________________________

I. Corporation officers/directors/trustees: (Attach additional pages if necessary.)

First Name	Last Name	Address

J. Individuals with 5% or more interest: (Attach additional pages if necessary.)

First Name Last Name Percent of Interest

____

____

K. Are any persons who have an ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchange Act of 1934 [15 U.S.C. 78p, Sec. 16(a)]?

Yes: _____ No: _____ If yes, attach copies of such reports.

10. PARENT ORGANIZATION:

If the entity in 9(A) is owned by a parent organization, please complete the following:

Parent Organization Name: ____

Address: ____
(Street)

____
(City) (State) (Zip)

11. CERTIFICATION BY APPLICANT:

A. Authority: P.A. 368 of 1978 as amended. The Issuance and processing of this form is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete form in a timely manner may result in denial of licensure or certification. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978 as amended).

By authority vested in me by the governing body of this hospital, I hereby certify that all phases of this hospital's operations including its training programs are without discrimination on the basis of race, creed, color, national origin, age or sex and that the selection and appointment of physicians to the medical staff is without discrimination solely on the basis of their license or registration or their professional education as doctors of medicine or doctors of osteopathy and that all of the foregoing information is accurate and complete.

B. The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.

Applicant's Name: ____
(First) (Middle Initial) (Last)

Applicant's Title: ____

Telephone Number: (________) - ________ - _____________

Applicant's SIGNATURE: ____________________________________**Date:** __________