State of Illinois
Illinois Department of Public Health

Freestanding Emergency Center (FEC) Initial Licensure Application

Pursuant to Section 32.5 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and the rules of the Department of Public Health entitled "Freestanding Emergency Center Code (77 Ill. Adm. Code 518)

1. Name and Address of Facility

Name _____

Address _____

City _____ County _____ State____ ZIP Code_____

Telephone Number (area code) _____ Fax Number_____

E-mail _____

2. Description of the proposed site of FEC.

_____

_____

_____

_____

Number of procedure rooms _____ Number of observation rooms _____

Number of treatment rooms _____

3. Ownership and Management

◯ Individual ◯ Partnership ◯ Association ◯ Corporation ◯ Government ◯ Other _____

A. If individual, partnership or association, list all owners

Name	Address

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 50. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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B. If Government owned, provide the following information for the CEO

Name _____

Address _____

Phone number (area code) _____

C. Corporation Information

Name of Corporation _____

List name, title and address of each corporate officer.

Name	Title	Address

☐ Attach copy of the Certification of Incorporation (Identify as Exhibit 1)

List name and address of each shareholder holding more than 7.5 percent of shares

Name	Address	Percent of Shares

D. For other than individual ownership, list the name and address of the Illinois registered agent or the person(s) legally authorized to receive service of process for the facility.

Name of Registered Agent	Address

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E. List the names and addresses of all persons under contract to manage or operate the facility.

☐ (Check here if not applicable).

Name	Address

F. Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? (If yes, attach explanation as Exhibit IA.)

1. Applicant ☐ Yes ☐ No
2. Any member of a firm, partnership or association ☐ Yes ☐ No
3. Any officer or director of a corporation ☐ Yes ☐ No
4. Administrator or manager of ASTC ☐ Yes ☐ No

4. Administration, Personnel, Services

A. Administrator (Attach resume as Exhibit II)

Name _____

Address _____

Telephone Number (area code) _____

License or Certification Number (if applicable) _____

B. Medical Director (Attach resume as Exhibit III)

Name _____

Address _____

Telephone Number _____ License Number _____

C. Nurse Manager (Attach resume as Exhibit IV)

Name _____

Address _____

Telephone Number _____ License Number _____

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D. Medical Staff: List name, license number, and speciality of each staff member.

Name	License No.	Specialty

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E. Personnel: List name, position/title, professional licensure or certification.

Name	Position/title	License number/registration, certification

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5. Services

The following information must accompany the application:

- ☐ Proof of ownership or control by an Associate or Resource Hospital, copy of the facility's FEIN, tax number
- ☐ A description of services to be provided by the facility
- ☐ A copy of the facility's organizational plan
- ☐ Copy of the approved Certificate of Need (CON) issued by the Health Facilities Planning Board
- ☐ $2,000.00 application fee, made payable to the Illinois Department of Public Health
- ☐ Signed statement assuring compliance with all state and federal patient rights and provisions, including, but not limited to the Emergency Medical Treatment Act and the federal Emergency Medical Treatment and Active Labor Act (Section 32.5 (a)(8) of the Act)
- ☐ Signed statement verifying that the licensed FEC is within 20 miles of the hospital that owns or controls the FEC and within 20 miles of the Resource Hospital affiliated with the FEC as part of the EMS system (Section 32.5(a)(1) of the Act

6. Architectural drawings and plans

Architectural drawings and plans need to be submitted under separate cover to the Design Standards Unit. They must accompanied by the Freestanding Emergency Center Project Submission Form.

The form is located on the Department's Web site at www.idph.state.il.us - publications - forms - Freestanding Emergency Centers. For questions regarding the submission of drawings and plans, please contact the Design Standards Unit at 217-785-4264.

7. Verification

I (we) swear or affirm that this application and accompanying documents are true and complete. I (we) further certify that I (we) have knowledge of and understand the action required to comply with the act and licensing requirements.

Signature _____ Title _____

Signature _____ Title _____

Section 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR):

☐ Yes

☐ No

The following question must be answered only if the applicant is an individual (sole proprietor):

I hereby certify, under penalty of perjury, that (check one):

☐ I am more than 30 days delinquent in complying with a child support order.

☐ I am **not** more than 30 days delinquent in complying with a child support order.

Signature _____ Date: _____

FAILURE TO SO CERTIFY MAY RESULT IN A DENIAL OF THE LICENSE AND MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT. (5 ILCS 100/10-65-(c)

Signed and Sworn (or attested) to before me this _____ day of _____ 20 ____

_____

Notary Public

My commission expires _____ 20 ____

Submit licensure application and fee to:

Validation Unit
Illinois Department of Public Health
DIvision of Financial Services
535 West Jefferson Street, Fourth Floor
Springfield, IL 62761