State of Illinois
Illinois Department of Public Health

RENEWAL APPLICATION FOR POSTSURGICAL RECOVERY CARE CENTER LICENSE

☐ $500 Application Fee Attached

☐ $100 for each Postsurgical Recovery Care bed

Total $ _____

Postsurgical Recovery Care Center ID Number: _____

- DEPARTMENT USE ONLY-

Pursuant to Section 265 of the Alternative Health Care Delivery Act [210 ILCS 3] and the rules of the Illinois Department of Public Health entitled "Postsurgical Recovery Care Center Demonstration Program Code" (77 Ill. Adm. Code 210)

1. ☐ Hospital ☐ Ambulatory Surgical Treatment Center

2. NAME/ADDRESS OF FACILITY (REPRESENTING #1 ABOVE)

Name _____

Address _____

City _____ State _____ Zip Code _____ County _____

Telephone Number (Including Area Code) _____

3. NAME/LOCATION OF POSTSURGICAL RECOVERY CARE CENTER

Name _____

Address (if in a freestanding building) _____

City _____ County _____ State _____ Zip Code _____

Telephone Number (Including Area Code) _____

4. Number of Postsurgical Recovery Care Center Beds _____

5. Name and address of the Illinois Registered Agent or other individual(s) authorized to receive Service of Process for the facility.

Name(s) of Registered Agent(s)	Address

IMPORTANT NOTICE

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 3. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

RENEWAL APPLICATION FOR POSTSURGICAL RECOVERY CARE CENTER LICENSE

6. List the name(s) of person(s) under whose management or supervision the Postsurgical Recovery Care Centers will be operated, including at least:

Title	Name	Illinois License Number
Administrator		
Medical Director		
Supervisory Nurse		

7. The following must be included with the renewal application, if changed since last application filed with the Department:

☐ A. Copy of the transfer agreement with a licensed hospital in accordance with the requirements of Section 210.1200 (b)(9). (Identify as Exhibit I)

☐ B. Documentation of compliance with Section 210.2500. (Laboratory, Pharmacy and Radiological Services) (Identify as Exhibit II)

☐ C. Documentation of compliance with Section 210.2800. (Food Service) (Identify as Exhibit III)

☐ D. Copy of admission protocol and transfer criteria as required by Section 210.1800. (Identify as Exhibit IV)

☐ E. Information regarding any conviction of the owner or operator of a felony or any crime under the laws of Illinois or of the United States arising out of connection with the operation of a health care facility or a statement that such a conviction does not exist. (Identify as Exhibit V)

☐ F. There have been no changes in items A-E since the most recent application filed with the department.

RENEWAL APPLICATION FOR POSTSURGICAL RECOVERY CARE CENTER LICENSE

8. 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.

Signed _____ Signed _____

Title _____ Title _____

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

_____
Notary Public

My commission expires _____ 20 _____

SUBMIT APPLICATION AND FEE TO:

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION HEALTH CARE FACILITIES AND PROGRAMS
525 WEST JEFFERSON STREET, 4th Floor
SPRINGFIELD, ILLINOIS 62761