State of Illinois
Illinois Department of Public Health

Ambulatory Surgical Treatment Center Renewal Licensure

IMPORTANT NOTICE: Pursuant to the Ambulatory Surgical Treatment Center Licensing Act (210 ILCS 55/1 et seq.) and the rules of the Department of Public Health entitled "Ambulatory Surgical Treatment Center Licensing Requirements" (77 IL Adm Code 205).

ASTC ID NUMBER:

Program Category - 86

☐ $300 Application Fee

1. **Facility Name / Address**

Name of ASTC _____

Address _____

City _____ County _____ State _____ Zip Code _____

Telephone Number (Area Code) _____ Fax Number _____

E-mail _____

The Administrator of the facility must review this application for completeness and accuracy, then sign and date in the spaces below to certify that, to the best of his/her knowledge, the information provided is complete and accurate.

Typed or Printed Administrator Name	Administrator Signature *(Original Only)*	Date of Completion

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

_____
Notary Public

My commission expires _____ 20 _____

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under (210 ILCS 5/1 et seq.). Disclosure of this information is mandatory, this form has been approved by the Forms Management Center

DUE DATE: 30 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE

2. **Ownership**

1. **Please indicate type of ownership:** * RA - Registered Agent

- ☐ Sole Proprietorship
- ☐ Corporation (*RA)
- ☐ Partnership (Registered within County)
- ☐ Limited Partnership (*RA)
- ☐ Limited Liability Partnership (*RA)
- ☐ Limited Liability Company (LLC) (*RA)
- ☐ Other _____

2. **Registered Agent**
If your facility ownership indicated above requires a registered agent, please indicate the name, address (including zip code plus four), and telephone number of this person or company. (If you are unable to identify this person or company, contact the Secretary of State's office to identify the facility's registered agent)

Name of Illinois Registered Agent: _____

Address of Illinois Registered Agent: _____

City, State, Zip Code, plus four: _____

Telephone of Illinois Registered Agent (including area code): _____

3. **Ownership Information**
If your facility is required to have a Registered Agent (see #2 above) or is required to have at least three officers, list the name of the state where the home or parent firm is incorporated or registered.

Name of Parent Firm or Organization: _____

State where Parent Firm or Organization is Incorporated / Registered: _____

Title	Name	Full Address
President		
Vice - President		
Secretary		
Treasurer		

4. **Shareholder Information**
If your ASTC is a CORPORATION, list the number of shares held by shareholders with more than five percent of common stock or the top five stockholders, whichever is less. Also, indicate the percentage of total shares that each stockholder holds.

Name of Stockholder	Shares Held	Percent of Shares

**** Submit a copy of the Articles of Incorporation ****

5. **Other Ownership**

Owners
If your facility is a Sole Proprietorship, Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, or Other - owned, list the name of the owner, the addresses of each owner, the owner(s) profession, and the business that employs each owner. If the owner is self-employed, indicate this by entering "Self" in the Profession column.

Names of Owners	Full Address	Profession	Business Name

**** Submit a copy of the Articles of Organization ****

6. **Contract Management**

If management or operations of the ASTC is performed by independent contractor(s) and not an employee, list the individuals name(s) and address(es) of the independent contractor(s). If management or operations is not performed by independent contractor(s), indicate this by checking the box. ☐ Check here if not applicable

Name	Full Address

7. **History of Conviction**

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 I)

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

3. **Administration and Personnel**

1. **Administrator (Attach Resume as Exhibit II)**

Name _____

Address _____

Telephone Number _____ License Number _____

2. **Medical Director (Attach Resume as Exhibit III)**

Name _____

Address _____

Telephone Number _____ License Number _____

3. **Supervising Nurse (Attach Resume as Exhibit IV)**

Name _____

Address _____

Telephone Number _____ License Number _____

Application Addendum

This addendum must be completed as part of the following program / facility application(s):

Ambulatory Surgical Treatment Center

Home Health

Hospice

Hospital

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 I ☐ am ☐ am not (check one) more than 30 days delinquent in complying with a child support order.

Signed: _____

Date: _____

Failure to so certify may result in a denial of the license. Making a false statement may subject the licensee to contempt of court. (5 ILCS 100 / 10 - 65 - (c)).

Supplement I

Medical Staff: List Specialty, Name, and License Number of each Physician, Podiatrist, or Dentist granted privileges to perform surgical procedures in the center.

Specialty	Name	License Number

Medical Staff (Continued)

Specialty	Name	License Number

Supplement II

Personnel: List Position and / or Classification, Name, Education, Experience, Professional Licensure, or Certification.

Position and / or Classification	Name	License Number, Registration Certification, and Years of Experience

Personnel (Continued)

Position and / or Classification	Name	License Number, Registration Certification, and Years of Experience

Supplement III

List Consulting Committee Approved Surgical Specialties and Procedures

Effective January 1st, 2018, the Illinois Health Facilities and Services Review Board implemented a provision requiring a Certificate of Need Permit for the addition of Surgical Specialty that had not been approved prior to January 1st, 2018. Therefore, your application should *not* include specialties that require Planning Board approval. Surgical specialties can be added under your license once the Planning Board approval has been obtained.

ASTC Renewal Licensure Application Attachments Checklist:

- ☐ Completed Application
- ☐ Articles of Incorporation or Organization
- ☐ Administrator's Resume
- ☐ Medical Director's Resume
- ☐ Supervising Nurse's Resume
- ☐ List of Medical Staff
- ☐ Separate List of Personnel Staff
- ☐ Surgical Procedures and Services Provided and Approved by Consulting Committee
- ☐ Renewal Fee of $300

Submit Application and Fee to:

Illinois Department of Public Health
Division of Health Care Facilities and Programs, 4th Floor
525 West Jefferson Street
Springfield, IL 62761