



Make payable to: DHHS, Licensure Unit

See license renewal letter for fees

Expiration Date

2/28/2018

Health Clinic Licensure Renewal Application

- Health Clinic Type: Please Check
- Facility providing labor and delivery services
 - Public Health Clinic
 - Ambulatory Surgical Center
 - Facility providing 10 or more abortions per week
 - Other _____ (please specify)
 - Facility providing hemodialysis services

IDENTIFYING INFORMATION

- NAME AND ADDRESS OF FACILITY:
 BELLEVUE HEALTH CENTER
 1002 WEST MISSION
 BELLEVUE, NE 68005
- PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

- LICENSE NO: HC001
- TELEPHONE NUMBER: (402) 292-4164
- FAX NUMBER: (402) 291-4643
- ADMINISTRATOR: MARY CARHART, ADMIN *Chelsea Sauter, MPH Director of Clinical Services*
- FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [REDACTED]
- NUMBER OF PATIENT ADMISSIONS IN PAST YEAR: 917 (Not Applicable to Ambulatory Surgical Centers)
- NUMBER OF OPERATING/PROCEDURE ROOMS: NA (Only Applicable to Ambulatory Surgical Centers)
- DEEMED STATUS FOR LICENSURE: (Check if applicable) TJC AAAHC Medicare or Medicaid

RECEIVED
 FEB 12 2018

LICENSURE UNIT
 X 2-13-18

7. Current Provided Services. Circle any services NOT listed in the box below:

Ambulatory Surgery, Hemodialysis, Home Hemodialysis, Peritoneal Dialysis, Home Peritoneal Dialysis, Public Health Clinic, Reuse, Transplantation, Labor and Delivery

Draw a line through any services no longer being provided

SATELLITE CLINIC(S) CURRENTLY LISTED IN OUR FILES (If Any)

NA

REC'D HHS ACCOUNTING
 2018 FEB 13 A 11 28

OWNERSHIP INFORMATION

- OWNERSHIP OF FACILITY: LEROY H. CARHART, M.D.
 (Legal Name of individual or business organization)
- MAILING ADDRESS: 1002 WEST MISSION
BELLEVUE, NE 68005

- BUSINESS ORGANIZATION: (Check one):
 - Sole Proprietorship
 - Partnership
 - Limited Partnership
 - Corporation
 - Limited Liability Company
 - Governmental (_____ State, _____ District, _____ County, _____ City or Municipal)
 - Other (Please Specify) _____

(check one)
 Profit Non Profit

per owner
 2-13-18 kji

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by

- the owner, if the applicant is an individual or partnership,
- two of its members, if the applicant is a limited liability company,
- two of its officers, if the applicant is a corporation, or
- the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

LeRoy H. Carhart, M.D.
 AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

[REDACTED]
 SIGNATURE

DATE

AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

SIGNATURE

DATE