Department of Health & Human Services
DHHS
NEBRASKA

STATE OF NEBRASKA - Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986, Lincoln, NE 68509-4986

Make payable to: DHHS, Licensure Unit
See license renewal letter for fees

Health Clinic Licensure Renewal Application

Expiration Date: 2/28/2018

Health Clinic Type: Please Check

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

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:
   BELLEVUE HEALTH CENTER
   1002 WEST MISSION
   BELLEVUE, NE 68005

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

RECEIVED
FEB 12 2018
LICENSURE UNIT

LICENSE NO: HC001
TELEPHONE NUMBER: (402) 292-4164
FAX NUMBER: (402) 291-4643
ADMINISTRATOR: ~~MARY CARHART, ADMIN~~ Chelsea Sauder, MPH Director of Clinical Services X 2-13-18

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [redacted]
4. NUMBER OF PATIENT ADMISSIONS IN PAST YEAR: 917 (Not Applicable to Ambulatory Surgical Centers)
5. NUMBER OF OPERATING/PROCEDURE ROOMS: NA (Only Applicable to Ambulatory Surgical Centers)
6. DEEMED STATUS FOR LICENSURE: (Check if applicable) TJC ___ AAAHC ___ Medicare or Medicaid ___

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

2018 FEB 13 A 11:28
RECD HHSS ACCOUNTING

OWNERSHIP INFORMATION

8. OWNERSHIP OF FACILITY: LEROY H. CARHART, M.D.
(Legal Name of individual or business organization)

MAILING ADDRESS: 1002 WEST MISSION
BELLEVUE, NE 68005

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

(check one) X Profit ___ Non Profit

per email 2-13-18 kpi

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

LeRoy M. Carhart, M.D. | [redacted] | 2/8/18
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT | SIGNATURE | DATE

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