

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



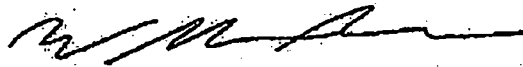
**Planned Parenthood Arizona, Inc., dba
Planned Parenthood Southern Arizona Regional Health Center
2255 North Wyatt Drive
Tucson, AZ 85712**

This facility is licensed to operate as a(n) Outpatient Treatment Center Providing Abortion Services

From: November 1, 2018


To: October 31, 2019

Issued: August 20, 2018



Recommended By: William Alcock, Bureau Chief

License: OTCAC4360



Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

**PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE**



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

August 20, 2018

Mr. James Washington, Administrator
Planned Parenthood Arizona, Inc.
4751 North 15th Street
Attention: Catherine Pisani
Phoenix, AZ 85014

RE: OTCAC4360
Planned Parenthood Southern Arizona Regional Health
2255 North Wyatt Drive
Tucson, AZ 85712

Dear Mr. Washington:

Enclosed is the license to operate a(n) Outpatient Treatment Center. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

REMINDER: Renewal Applications are processed via the online portal system only. It is your responsibility to register and access the online portal system to renew your license, refer to rules 9 A.A.C. 10, Article 1 regarding "renewal license application". Pursuant to Arizona Revised Statutes (A.R.S.) 36-425 (C)(2), a health care institution's license becomes invalid if the fees are not paid before the licensing fee due date. It is a violation of A.R.S. 36-407(a) to operate a health care institution without a current and valid license. Once your license is no longer valid, an initial application is required to recommence operations.

Sincerely,

William Alcock, R.N., J.D.
Bureau Chief
Bureau of Medical Facilities Licensing

WA:MA



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: PLANNED PARENTHOOD SOUTHERN ARIZONA REGIONAL HEALT		License No. OTCAC4360
Street Address: 2255 NORTH WYATT DRIVE		
City: TUCSON	State: AZ	Zip Code: 85712
Mailing Address: 4751 NORTH 15TH STREET		
City: PHOENIX	State: AZ	Zip Code: 85014
Phone No. (520) 624-1766	E-mail: cpisani@ppaz.org	

Select one class or subclass (Listed in A.A.C. R9-10-102):

- | | | |
|--|---|--|
| <input type="checkbox"/> General hospital | <input type="checkbox"/> Rural general hospital | <input type="checkbox"/> Special hospital |
| <input type="checkbox"/> Behavioral health inpatient facility | <input type="checkbox"/> Home health agency | <input type="checkbox"/> Unclassified health care institutions |
| <input type="checkbox"/> Recovery care center | <input type="checkbox"/> Hospice inpatient facility | <input type="checkbox"/> Hospice service agency |
| <input type="checkbox"/> Outpatient surgical center | <input checked="" type="checkbox"/> Outpatient treatment center | <input type="checkbox"/> Abortion clinic |
| <input type="checkbox"/> Substance abuse transitional facility | Respite on the premises capacity: 0 | <input type="checkbox"/> Counseling facility |
| <input type="checkbox"/> Behavioral health specialized transitional facility | Number of dialysis stations: 0 | |
| | Number of observation/stabilization chairs: 0 | |

What is the health care institution's scope of practice:

Reproductive health care

Health care institution's days and hours of operation:(i.e. 8-5, 8:00a-5:00p):

	Sun	M	T	W	T	F	Sat
Admv Hours:	Closed	9-5	8-6	8-5	8-5	8-5	Closed
Clinic Hours:	Closed	9-5	8-6	8-5	8-5	8-5	Closed
Respite Hours:	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Is health care institution accredited? YES NO

Name of accrediting organization (must be from a nationally recognized organization):

Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO



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II. OWNER INFORMATION

Owner's Name: PLANNED PARENTHOOD ARIZONA, INC.

Street Address: 4751 NORTH 15TH STREET

City: PHOENIX State: AZ Zip Code: 85014

Phone No. (602) 277-7526 Fax No. (602) 277-5243

The owner is a (select one):

Sole proprietorship Corporation Partnership

Limited liability partnership Limited liability company Governmental agency

If the owner is a partnership or a limited liability partnership, the name of each partner;
 If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
 If the owner is a corporation, the name and title of each corporate officer; or
 If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:

Name: Bryan Howard Title: CEO

Name: Title:

Name: Title:

Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:
 The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license:



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III.SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

If applicable, the licensed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age:

Individuals 18 years of age and older:

IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to renewal license application.



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PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

SUPPLEMENTAL APPLICATION – HOSPITALS ONLY(cont'd)

In addition to the supplemental application requirements above and if a hospital is requesting a single group license, authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license:

Name of Satellite Facility:		
Street Address:		
City:	State:	Zip Code:
Phone No.		
Name of Administrator:		
Hours of Operation:		
Name of Satellite Facility:		
Street Address:		
City:	State:	Zip Code:
Phone No.		
Name of Administrator:		
Hours of Operation:		
Name of Satellite Facility:		
Street Address:		
City:	State:	Zip Code:
Phone No.		
Name of Administrator:		
Hours of Operation:		



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PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

IV. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITIES ONLY

Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals

Under 18 years of age

18 years of age and older

Inpatient services to individuals under 18 years of age, including the licensed capacity requested

V. SUPPLEMENTAL APPLICATION – HOSPICE ONLY

For a hospice service agency:

Hours of operation for the hospice's administrative office:

Geographic region served:

For a hospice inpatient facility, requested licensed capacity:

VI. SUPPLEMENTAL APPLICATION – HOME HEALTH AGENCIES ONLY

For a home health agency:

Name of Proposed Branch Office:

Street Address:

City: State: Zip Code:

Geographic region served:

Name of Proposed Branch Office:

Street Address:

City: State: Zip Code:

Geographic region served:

Name of Proposed Branch Office:

Street Address:

City: State: Zip Code:

Geographic region served:



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VII. SUPPLEMENTAL APPLICATION - AFFILIATED OUTPATIENT TREATMENT CENTERS ONLY

In addition to the supplemental application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an Affiliated Outpatient Treatment Center, as defined in R9-10-1901, applying for an initial or renewal license for the Affiliated Outpatient Treatment Center shall submit the following information for each counseling facility for which the Affiliated Outpatient Treatment Center is providing administrative support:

Name of Counseling Facility:			
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator:			
Hours of Operation:			
Name of Counseling Facility:			
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator:			
Hours of Operation:			
Name of Counseling Facility:			
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator:			
Hours of Operation:			



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VIII. SUPPLEMENTAL APPLICATION - COLOCATION

R9-10-1031 Colocation Requirements: The following information for each proposed colocator that may share a common area and non-treatment personnel at the collaborating outpatient treatment center. For each proposed associated licensed provider:

<p>Associated license provider's name:</p> <p>Associated licensed provider's license number:</p> <p>Proposed Scope of Services:</p> <p>Name of associated licensed provider's governing authority:</p> <p>Will the associated licensed provider share medical records with the collaborating outpatient treatment center?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (in the written agreement) about which party will obtain a patient's:</p> <ul style="list-style-type: none"> -General consent or informed consent (if applicable) -Consent to allow a colocator access to the patient's medical record -Consent to allow a colocator access to the patient's advance directives <p>SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.</p>	
<p>Associated license provider's name:</p> <p>Associated licensed provider's license number:</p> <p>Proposed Scope of Services:</p> <p>Name of associated licensed provider's governing authority:</p> <p>Will the associated licensed provider share medical records with the collaborating outpatient treatment center?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (in the written agreement) about which party will obtain a patient's:</p> <ul style="list-style-type: none"> -General consent or informed consent (if applicable) -Consent to allow a colocator access to the patient's medical record -Consent to allow a colocator access to the patient's advance directives <p>SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.</p>	



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IX. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: Dan Pasternak	Title: Squire Sanders - Attorney
Street Address: 1 E. Washington Street, Suite 2700	
City: Phoenix	State: AZ Zip Code: 85004
Phone No. (602) 528-4187	

X. GOVERNING AUTHORITY

Name: Planned Parenthood Arizona	
Street Address: 4751 N 15th Street	
City: Phoenix	State: AZ Zip Code: 85014

XI. CHIEF ADMINISTRATIVE OFFICER

Name: James Washington	Title: VP of Patient Services
Highest Educational Degree: MPH	
Work experience related to the health care institution class or subclass related to licensing requested:	
See resume	

XII. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency.

Bryan Howard

Signature

James Washington

Signature

CEO

Title

VP of Patient Services

Title

XIII. ADDITIONAL DOCUMENTATION

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility. YES NO

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



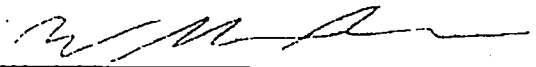
**Planned Parenthood Arizona, Inc., dba
Planned Parenthood Southern Arizona Regional Health Center
2255 North Wyatt Drive
Tucson, AZ 85712**

This facility is licensed to operate as a(n) Outpatient Treatment Center Providing Abortion Services


From: July 12, 2018

To: October 31, 2018

Issued: July 13, 2018


Recommended By: William Alcock, Bureau Chief

**License: OTCAC4360
(Amend-Classification Status & Name Change)**


Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
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ARIZONA DEPARTMENT
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150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

July 13, 2018

Mr. James Washington, Administrator
Planned Parenthood Arizona, Inc.
4751 North 15th Street
Attention: Catherine Pisani
Phoenix, AZ 85014

RE: OTCAC4360
Planned Parenthood Southern Arizona Regional Health Center
2255 North Wyatt Drive
Tucson, AZ 85712

Dear Mr. Washington:

Per your request, enclosed is an amended license number OTCAC4360 which reflects the recent Classification Status and Name Change of your facility. This license limits the capacity of your facility to 0 and will no longer be valid after October 31, 2018. In accordance with A.R.S. § 36-407(C), this license is only valid for the location indicated on the license.

Please be advised that A.R.S. § 36-425(A) requires this license to be conspicuously posted in the reception area of your facility. In addition, A.R.S. § 36-422(D) requires the Department to be notified of a change of ownership at least thirty (30) days prior to the effective date.

If this office can be of any further assistance, please call (602) 364-3030.

Sincerely,

William Alcock, R.N., J.D.
Bureau Chief
Bureau of Medical Facilities Licensing

WA:ij

Enclosure

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



**Planned Parenthood Arizona, Inc., dba
Planned Parenthood - Sanger
2255 North Wyatt Drive
Tucson, AZ 85712**

This facility is licensed to operate as a(n) Outpatient Treatment Center

From: November 1, 2017

To: October 31, 2018

Issued: August 15, 2017

Recommended By: Connie Belden, Bureau Chief

License: OTC4360

Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

**PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
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DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

August 15, 2017

Mr. James Washington, Administrator
Planned Parenthood Arizona, Inc.
4751 North 15th Street
Phoenix, AZ 85014

RE: OTC4360
Planned Parenthood - Sanger
2255 North Wyatt Drive
Tucson, AZ 85712

Dear Mr. James Washington:

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Should you have any questions, or need more information, please contact our office at (602) 364-3030.

Sincerely,

Connie Belden, R.N.
Bureau Chief
Bureau of Medical Facilities Licensing

CB:ag



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: PLANNED PARENTHOOD - SANGER		License No. OTC4360																																	
Street Address: 2255 NORTH WYATT DRIVE																																			
City: TUCSON		State: AZ	Zip Code: 85712																																
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Is health care institution requesting certification under Title XIX of the Social Security Act? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																			



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PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

II. OWNER INFORMATION

Owner's Name: PLANNED PARENTHOOD ARIZONA, INC.

Street Address: 5651 NORTH 7TH ST

City: PHOENIX

State: AZ

Zip Code: 85014

Phone No. (602) 263-2237

Fax No. (602) 604-0159

The owner is a (select one):

Sole proprietorship

Corporation

Partnership

Limited liability partnership

Limited liability company

Governmental agency

If the owner is a partnership or a limited liability partnership, the name of each partner;
If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
If the owner is a corporation, the name and title of each corporate officer; or
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:

Name: Bryan Howard

Title: CEO

Name: Annet Ruitter

Title: COO

Name:

Title:

Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license:



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III.SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

If applicable, the licensed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age:

Individuals 18 years of age and older:

IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to renewal license application.



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

SUPPLEMENTAL APPLICATION – HOSPITALS ONLY (cont'd)

In addition to the supplemental application requirements above and if a hospital is requesting a single group license, authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license:

<p>Name of Satellite Facility:</p> <p>Street Address:</p> <p>City: State: Zip Code:</p> <p>Phone No.</p> <p>Name of Administrator:</p> <p>Hours of Operation:</p>
<p>Name of Satellite Facility:</p> <p>Street Address:</p> <p>City: State: Zip Code:</p> <p>Phone No.</p> <p>Name of Administrator:</p> <p>Hours of Operation:</p>
<p>Name of Satellite Facility:</p> <p>Street Address:</p> <p>City: State: Zip Code:</p> <p>Phone No.</p> <p>Name of Administrator:</p> <p>Hours of Operation:</p>



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

IV. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITIES ONLY

<input type="checkbox"/> Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals <ul style="list-style-type: none"> <input type="checkbox"/> Under 18 years of age <input type="checkbox"/> 18 years of age and older
<input type="checkbox"/> Inpatient services to individuals under 18 years of age, including the licensed capacity requested

V. SUPPLEMENTAL APPLICATION – HOSPICE ONLY

For a hospice service agency: Hours of operation for the hospice's administrative office: Geographic region served: For a hospice inpatient facility, requested licensed capacity:

VI. SUPPLEMENTAL APPLICATION – HOME HEALTH AGENCIES ONLY

For a home health agency: Name of Proposed Branch Office: Street Address: City: State: Zip Code: Geographic region served:
Name of Proposed Branch Office: Street Address: City: State: Zip Code: Geographic region served:
Name of Proposed Branch Office: Street Address: City: State: Zip Code: Geographic region served:



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

VII. SUPPLEMENTAL APPLICATION - AFFILIATED OUTPATIENT TREATMENT CENTERS ONLY

In addition to the supplemental application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an Affiliated Outpatient Treatment Center, as defined in R9-10-1901, applying for an initial or renewal license for the Affiliated Outpatient Treatment Center shall submit the following information for each counseling facility for which the Affiliated Outpatient Treatment Center is providing administrative support:

Name of Counseling Facility: Street Address: City:	State:	Zip Code:
Phone No. Name of Administrator: Hours of Operation:		
Name of Counseling Facility: Street Address: City:	State:	Zip Code:
Phone No. Name of Administrator: Hours of Operation:		
Name of Counseling Facility: Street Address: City:	State:	Zip Code:
Phone No. Name of Administrator: Hours of Operation:		



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

VIII. SUPPLEMENTAL APPLICATION - COLOCATION

R9-10-1031 Colocation Requirements: The following information for each proposed colocator that may share a common area and non-treatment personnel at the collaborating outpatient treatment center. For each proposed associated licensed provider:

<p>Associated license provider's name:</p> <p>Associated licensed provider's license number:</p> <p>Proposed Scope of Services:</p> <p>Name of associated licensed provider's governing authority:</p> <p>Will the associated licensed provider share medical records with the collaborating outpatient treatment center?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (in the written agreement) about which party will obtain a patient's:</p> <ul style="list-style-type: none"> -General consent or informed consent (if applicable) -Consent to allow a colocator access to the patient's medical record -Consent to allow a colocator access to the patient's advance directives <p>SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.</p>	
<p>Associated license provider's name:</p> <p>Associated licensed provider's license number:</p> <p>Proposed Scope of Services:</p> <p>Name of associated licensed provider's governing authority:</p> <p>Will the associated licensed provider share medical records with the collaborating outpatient treatment center?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (in the written agreement) about which party will obtain a patient's:</p> <ul style="list-style-type: none"> -General consent or informed consent (if applicable) -Consent to allow a colocator access to the patient's medical record -Consent to allow a colocator access to the patient's advance directives <p>SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.</p>	



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

IX. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: Dan Pasternak	Title: Squire Sanders - Attorney
Street Address: 1 East Washington Street, Suite 2700	
City: Phoenix	State: AZ Zip Code: 85004
Phone No. (602) 528-4187	

X. GOVERNING AUTHORITY

Name: Planned Parenthood Arizona
Street Address: 4751 N 15th Street
City: Phoenix State: AZ Zip Code: 85014

XI. CHIEF ADMINISTRATIVE OFFICER

Name: James Washington	Title: VP of Patient Services
Highest Educational Degree: Master of Public Health	
Work experience related to the health care institution class or subclass related to licensing requested:	
See Resume	

XII. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency.

Bryan Howard

Signature

CEO

Title

Annet Ruitter

Signature

COO

Title

XIII. ADDITIONAL DOCUMENTATION

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility. YES NO

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



Planned Parenthood Arizona, Inc., dba
PLANNED PARENTHOOD - SANGER
2255 North Wyatt Drive
Tucson, Arizona 85712

This facility is licensed to operate as a(n) **OUTPATIENT TREATMENT CENTER**

From: November 1, 2016

To: October 31, 2017

Issued: December 14, 2016

A handwritten signature in cursive script, appearing to read "Connie Belden".

Recommended By: Connie Belden, Bureau Chief

License: OTC4360

A handwritten signature in cursive script, appearing to read "Colby Bower".

Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

December 14, 2016

Patricia Gross, Administrator
Attn: Gretchen Parnham
Planned Parenthood Arizona, Inc.
4751 North 15th Street
Phoenix, AZ 85014

RE: OTC4360
Planned Parenthood - Sanger
2255 North Wyatt Drive
Tucson, AZ 85712

Dear Patricia Gross:

Enclosed is the license to operate a(n) Outpatient Treatment Center. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

Sincerely,

Connie Belden, R.N.
Bureau Chief
Bureau of Medical Facilities Licensing

CB:ag

10/31



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES - BUREAU OF MEDICAL FACILITIES LICENSING

Arizona Department of Health Services
Division of Public Health
Medical Facility Licensing Services
C.P.D. 0.1.2016

In accordance with A.R.S. §41-1030

- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact.
D. This section may be enforced in a private civil action and relief may be awarded against the state.
E. A state employee may not intentionally or knowingly violate this section.
F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

CE# 171058
\$ 415.00

I. HEALTH CARE INSTITUTION INFORMATION Med 2375. App#

Name of Health Care Institution: Planned Parenthood Sanger License No. OTC AC4360
Street Address: 2255 N. Wyatt Dr.
City: Tucson State: AZ Zip Code: 85712
Mailing Address: 4751 N 15th Street
City: Phoenix State: AZ Zip Code: 85014
Phone No. 520-624-1766 E-mail: gparham@ppaz.org

Select one class or subclass (Listed on A.A.C. R9-10-102):

- General hospital, Rural general hospital, Special hospital, Behavioral health inpatient facility, Home health agency, Unclassified health care institutions, Recovery care center, Hospice inpatient facility, Hospice service agency, Outpatient surgical center, Outpatient treatment center, Abortion clinic, Substance abuse transitional facility, Behavioral health specialized transitional facility, Counseling facility

Number of Observation/Stabilization Chairs: Number of Dialysis Stations:

What is the health care institution's scope of practice: Reproductive Health Care

Health care institution's days and hours of operation (i.e. 8-5, 8:00a-5:00p):

Sun Closed M 9:00-5:00 T 10:00-5:00 W 9:00-5:00 Th 9:00-5:00 F 9:00-5:00 Sat Closed

Is health care institution accredited? YES NO

Name of accrediting organization (must be from a nationally recognized organization):

Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

I. OWNER INFORMATION

Owner's Name: <u>Planned Parenthood Arizona, Inc.</u>	
Street Address: <u>4751 N. 15th Street</u>	
City: <u>Phoenix</u>	State: <u>AZ</u> Zip Code: <u>85014</u>
Phone No. <u>602-200-2145</u>	Fax No <u>602-277-8093</u>
The owner is a (select one): <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability partnership <input type="checkbox"/> Limited liability company <input type="checkbox"/> Governmental agency	
If the owner is a partnership or a limited liability partnership, the name of each partner; If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company; If the owner is a corporation, the name and title of each corporate officer; or If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency: Name: <u>Bryan Howard</u> Title: <u>President and CEO</u> Name: <u>Patricia Gross</u> Title: <u>COO</u> Name: <u>Annete Ruitter</u> Title: <u>VP of External Affairs</u>	
Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, indicate: The reason for denial, revocation, or suspension:	
The date of the denial, revocation, or suspension: _____ The name and address of the licensing agency that denied, revoked, or suspended the license or certification: _____	



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

If applicable, the licensed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age: _____

Individuals 18 years of age and older: _____

IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to renewal license application.

SEP 21 2016



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

SUPPLEMENTAL APPLICATION – HOSPITALS ONLY (cont'd)

In addition to the supplemental application requirements above and if a hospital is requesting a single group license, authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license :

Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

V. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITIES ONLY

<input type="checkbox"/>	Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals
<input type="checkbox"/>	Under 18 years of age
<input type="checkbox"/>	18 years of age and older
<input type="checkbox"/>	Inpatient services to individuals under 18 years of age, including the licensed capacity requested

VI SUPPLEMENTAL APPLICATION – HOSPICE ONLY

For a hospice service agency:

Hours of operation for the hospice’s administrative office: _____

Geographic region served: _____

For a hospice inpatient facility, requested licensed capacity: _____

VII. SUPPLEMENTAL APPLICATION – HOME HEALTH AGENCIES ONLY

For a home health agency:

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

SUBMIT to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for the applicant, if the applicant is an individual; or each individual with a 10% or greater ownership of the business organization, if the applicant is a business organization.



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

VIII. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: <u>Dan Pasternak</u>	Title: <u>Attorney- Squire Sanders</u>
Street Address: <u>1 East Washington Street, Suite 2700</u>	
City: <u>Phoenix</u>	State: <u>AZ</u> Zip Code: <u>85004</u>
Phone No. <u>602-528-4187</u>	

IX. GOVERNING AUTHORITY

Name: <u>Planned Parenthood Arizona, Inc.</u>	
Street Address: <u>4751 N. 15th Street</u>	
City: <u>Phoenix</u>	State: <u>Arizona</u> Zip Code: <u>85014</u>

X. CHIEF ADMINISTRATIVE OFFICER

Name: <u>Patricia Gross</u>	Title: <u>COO</u>
Highest Educational Degree: <u>See Resume</u>	
Work experience related to the health care institution class or subclass related to licensing requested: <u>See Resume</u>	

SEP 01 2016
ADMS BUREAU OF MEDICAL FACILITIES LICENSING



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

XI. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency

<p><i>[Handwritten Signature]</i></p> <hr/> <p align="center">Signature</p>	<p align="center"><i>PRESIDENT</i></p> <hr/> <p align="center">Title</p>
<p><i>[Handwritten Signature]</i></p> <hr/> <p align="center">Signature</p>	<p align="center"><i>COO</i></p> <hr/> <p align="center">Title</p>

XII. ADDITIONAL DOCUMENTATION

<p>Is health care institution located in a leased facility?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If yes, provide a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.</p>	
<p>Does the licensee have an accreditation report from a nationally recognized accrediting organization?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization.</p>	

SEP 01 2010

**Planned Parenthood Arizona, Inc., dba
PLANNED PARENTHOOD - SANGER
2255 North Wyatt Drive
Tucson, Arizona 85712**

**This facility is licensed to operate as a(n) OUTPATIENT TREATMENT CENTER
ABORTION SERVICES**

From: November 1, 2015

To: October 31, 2016

Issued: September 14, 2015

**Recommended by: Connie Belden, RN
Bureau Chief**



License: OTCAC4360

**Issued By: Colby Bower
Assistant Director**



Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

September 14, 2015

Patricia Gross, Administrator
Planned Parenthood Arizona, Inc.
4751 North 15th Street
Attn: Meredith Hinds
Phoenix, AZ 85014

RE: OTCAC4360
Planned Parenthood - Sanger
2255 North Wyatt Drive
Tucson, AZ 85712

Dear Patricia Gross:

Enclosed is the license to operate a(n) Outpatient Treatment Center. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

Sincerely,

Connie Belden, R.N.
Bureau Chief
Bureau of Medical Facilities Licensing

CB:zp

10/31



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES - BUREAU OF MEDICAL FACILITIES LICENSING

Case # 108035
#41522

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02

App # 2375
App # 21158

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: <u>Planned Parenthood Sanger</u>		License No. <u>OTC AC4360</u>
Street Address: <u>2255 N. Wyatt Dr.</u>		
City: <u>Tucson</u>	State: <u>AZ</u>	Zip Code: <u>85712</u>
Mailing Address: <u>4751 N 15th Street</u>		
City: <u>Phoenix</u>	State: <u>AZ</u>	Zip Code: <u>85014</u>
Phone No. <u>520-624-1766</u>	E-mail: <u>mhinds@ppaz.org</u>	

AUG 17 2015

Select one class or subclass (Listed on A.A.C. R9-10-102):

<input type="checkbox"/> General hospital	<input type="checkbox"/> Rural general hospital	<input type="checkbox"/> Special hospital
<input type="checkbox"/> Behavioral health inpatient facility	<input type="checkbox"/> Home health agency	<input type="checkbox"/> Unclassified health care institutions
<input type="checkbox"/> Recovery care center	<input type="checkbox"/> Hospice inpatient facility	<input type="checkbox"/> Hospice service agency
<input type="checkbox"/> Outpatient surgical center	<input checked="" type="checkbox"/> Outpatient treatment center	<input checked="" type="checkbox"/> Abortion clinic
<input type="checkbox"/> Substance abuse transitional facility	<input type="checkbox"/> Behavioral health specialized transitional facility	<input type="checkbox"/> Counseling facility

Number of Observation/Stabilization Chairs: _____ Number of Dialysis Stations: _____

What is the health care institution's scope of practice: Reproductive Health Care

Health care institution's days and hours of operation (i.e. 8-5, 8:00a-5:00p):

Sun Closed M 9:00-5:00 T 9:00-5:00 W 9:00-5:00 Th Closed F Closed Sat Closed

Is health care institution accredited? YES NO

Name of accrediting organization (must be from a nationally recognized organization): _____

Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

I. OWNER INFORMATION

Owner's Name: <u>Planned Parenthood Arizona, Inc.</u>		
Street Address: <u>4751 N. 15th Street</u>		
City: <u>Phoenix</u>	State: <u>AZ</u>	Zip Code: <u>85014</u>
Phone No. <u>602-200-2145</u>		Fax No. <u>602-277-8093</u>
<p>The owner is a (select one):</p> <p> <input type="checkbox"/> Sole proprietorship <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability partnership <input type="checkbox"/> Limited liability company <input type="checkbox"/> Governmental agency </p>		
<p>If the owner is a partnership or a limited liability partnership, the name of each partner;</p> <p>If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;</p> <p>If the owner is a corporation, the name and title of each corporate officer; or</p> <p>If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:</p>		
Name: <u>Bryan Howard</u>		Title: <u>President and CEO</u>
Name: <u>Patricia Gross</u>		Title: <u>COO</u>
Name: <u>Annete Ruitter</u>		Title: <u>VP of External Affairs</u>
<p>Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If yes, indicate: The reason for denial, revocation, or suspension:</p>		
<p>The date of the denial, revocation, or suspension: _____</p> <p>The name and address of the licensing agency that denied, revoked, or suspended the license or certification: _____</p>		



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

If applicable, the licensed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age: _____

Individuals 18 years of age and older: _____

IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to renewal license application.



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

SUPPLEMENTAL APPLICATION – HOSPITAL ONLY (cont'd)

In addition to the supplemental application requirements above and if a hospital is requesting a single group license, authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license :

Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____

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PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

V. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITIES ONLY

<input type="checkbox"/>	Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals
<input type="checkbox"/>	Under 18 years of age
<input type="checkbox"/>	18 years of age and older
<input type="checkbox"/>	Inpatient services to individuals under 18 years of age, including the licensed capacity requested

VI SUPPLEMENTAL APPLICATION – HOSPICE ONLY

For a hospice service agency:

Hours of operation for the hospice’s administrative office: _____

Geographic region served: _____

For a hospice inpatient facility, requested licensed capacity: _____

VII. SUPPLEMENTAL APPLICATION – HOME HEALTH AGENCIES ONLY

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For a home health agency:

AUG 17 2015

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

SUBMIT to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for the applicant, if the applicant is an individual; or each individual with a 10% or greater ownership of the business organization, if the applicant is a business organization.



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

VIII. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: Lawrence Rosenfeld Title: Attorney- Squire Sanders
 Street Address: One East Washington Street, Suite 2700
 City: Phoenix, AZ 85004 State: _____ Zip Code: _____
 Phone No. 602-528-4000

IX. GOVERNING AUTHORITY

Name: Planned Parenthood Arizona, Inc.
 Street Address: 4751 N. 15th Street
 City: Phoenix State: Arizona Zip Code: 85014

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 17

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Arizona Department of Health Services
 Public Health Licensing

X. CHIEF ADMINISTRATIVE OFFICER

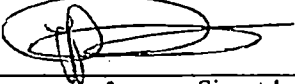
Name: Patricia Gross Title: COO
 Highest Educational Degree: See Resume
 Work experience related to the health care institution class or subclass related to licensing requested:
See Resume



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

XI. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency

 _____ Signature	VP of External Affairs _____ Title
_____ Signature	COO _____ Title

XII. ADDITIONAL DOCUMENTATION

Is health care institution located in a leased facility?
 YES NO

If yes, provide a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.

Does the licensee have an accreditation report from a nationally recognized accrediting organization?
 YES NO

AUG 17 2015

If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization.

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



**Planned Parenthood Arizona, Inc, dba
PLANNED PARENTHOOD - SANGER
2255 North Wyatt Drive
Tucson, Arizona 85712**

This facility is licensed to operate as an OUTPATIENT TREATMENT CENTER

From: November 1, 2014 To: October 31, 2015

Issued: September 17, 2014

License: OTCAC 4360

A handwritten signature in cursive script, reading "Carrie Bolden".

Recommended By: Bureau Chief

A handwritten signature in cursive script, reading "C. M. [unclear] MD".

Issued By: Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION,
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



**Division of Licensing Services
Bureau of Medical Facilities Licensing**

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

JANICE K. BREWER, GOVERNOR
WILL HUMBLE, DIRECTOR

September 17, 2014

Patricia Gross, Administrator
Planned Parenthood Arizona, Inc
5651 North 7th Street
Phoenix, Arizona 85014

RE: OTCAC4360
Planned Parenthood-Sanger
2255 North Wyatt Drive
Tucson, Arizona 85712

Dear Patricia Gross:

Enclosed is the license to operate a(n) Outpatient Treatment Center. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

Sincerely,

A handwritten signature in cursive script, appearing to read "Connie Belden" with a small "for" written below it.

Connie Belden, R.N.
Bureau Chief
Bureau of Medical Facilities Licensing

CB:jd



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

10/14

MOD 2375
 app # 18567

check # 165 638
 41500

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: Planned Parenthood - Sanger License No. OTCAC4360
 Mailing Address: 5651 North 7th Street
 City: Phoenix State: Arizona Zip Code: 85014
 Phone No. 602-263-4210 Fax No. 602-604-0159 E-mail: mhinds@ppaz.org

Select one class or subclass (Listed in A.A.C. R9-10-102):

<input type="checkbox"/> General hospital	<input type="checkbox"/> Rural general hospital	<input type="checkbox"/> Special hospital
<input type="checkbox"/> Behavioral health inpatient facility	<input type="checkbox"/> Home health agency	<input type="checkbox"/> Unclassified health care institution
<input type="checkbox"/> Recovery care center	<input type="checkbox"/> Hospice inpatient facility	<input type="checkbox"/> Hospice service agency
<input type="checkbox"/> Outpatient surgical center	<input checked="" type="checkbox"/> Outpatient treatment center	<input type="checkbox"/> Abortion clinic
<input type="checkbox"/> Substance abuse transitional facility	<input type="checkbox"/> Behavioral health specialized transitional facility	<input type="checkbox"/> Counseling facility

What is the health care institution's scope of practice:
Reproductive Health Care

Health care institution's days and hours of operation (i.e. 8-5, 8:00a-5:00p):
 Sun Closed M 9-5 T 9-5 W 9-6 Th 7-3 F 7-3 Sat Closed

Is health care institution accredited? YES NO
 Name of accrediting organization (must be from a nationally recognized organization):
Planned Parenthood Federation of America, Inc.

SUBMIT, if applicable, a copy of the full accreditation report and cover letter.

Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO

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RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

II. OWNER INFORMATION

Owner's Name: <u>Planned Parenthood Arizona, Inc.</u>		
Street Address: <u>5651 North 7th Street</u>		
City: <u>Phoenix</u>	State: <u>Arizona</u>	Zip Code: <u>85014</u>
Phone No. <u>602-263-2237</u>	Fax No. <u>602-604-0159</u>	
The owner is a (select one): <input type="checkbox"/> Sole proprietorship <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability partnership <input type="checkbox"/> Limited liability company <input type="checkbox"/> Governmental agency		
If the owner is a partnership or a limited liability partnership, the name of each partner; If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company; If the owner is a corporation, the name and title of each corporate officer; or If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:		
Name: <u>Bryan Howard</u>	Title: <u>President & CEO</u>	
Name: <u>Patricia Gross</u>	Title: <u>Chief Operating Officer</u>	
Name: <u>Anette Ruitter</u>	Title: <u>VP of External Affairs</u>	
Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, indicate: The reason for denial, revocation, or suspension: _____ The date of the denial, revocation, or suspension: _____ The name and address of the licensing agency that denied, revoked, or suspended the license : _____		

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RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension: _____

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: <u>Lawrence J. Rosefeld</u>	Title: <u>Attorney - Squire Sanders</u>	
Street Address: <u>One East Washington Street, Suite 2700</u>		
City: <u>Phoenix</u>	State: <u>Arizona</u>	Zip Code: <u>85004</u>
Phone No. <u>602-528-4000</u>		

IV. GOVERNING AUTHORITY

Name: <u>Planned Parenthood Arizona, Inc.</u>		
Street Address: <u>5651 North 7th Street</u>		
City: <u>Phoenix</u>	State: <u>Arizona</u>	Zip Code: <u>85014</u>



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION
 ARIZONA DEPARTMENT OF HEALTH SERVICES
 PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

V. CHIEF ADMINISTRATIVE OFFICER

Name: Patricia Gross Title: Chief Operating Officer

Highest Educational Degree: See Resume

Work experience related to the health care institution class or subclass related to licensing requested:
See Resume

VI. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency.

<u>Bryz SHZ</u> Signature	<u>PRESIDENT</u> Title
<u>Patricia Gross</u> Signature	<u>COO</u> Title

VII. ADDITIONAL DOCUMENTATION

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.

Does the licensee have an accreditation report from a nationally recognized accrediting organization?
 YES NO

If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization.

PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES



**Planned Parenthood Arizona, Inc., dba
PLANNED PARENTHOOD-SANGER
2255 North Wyatt Drive
Tucson, Arizona 85712**

This facility is licensed to operate as an **OUTPATIENT TREATMENT CENTER
ABORTION SERVICES**

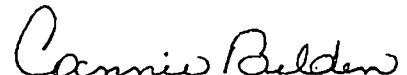
This license has been issued under the authority of Title 36, Chapter 4, Arizona Revised statutes and pursuant to Department of Health Services' Rules, is not transferable and is valid only for the location identified above.

License Effective:

From: **November 1, 2013** To: **October 31, 2014**

Issued: **September 11, 2013**

Number: **OTCAC4360**


Recommended By:


Issued By: Assistant Director

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 364-4764 FAX

JANICE K. BREWER, GOVERNOR
WILL HUMBLE, DIRECTOR

September 11, 2013

Rosa Class, Administrator
2255 North Wyatt Drive
Tucson, AZ 85712

RE: PLANNED PARENTHOOD-SANGER-OTCAC4360

Dear Rosa Class:

Enclosed is the license to operate a Outpatient Treatment Services. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

Sincerely,

A handwritten signature in cursive script that reads "Connie Belden".

Connie Belden, R.N., B.S.H.S.A.
Interim Bureau Chief
Bureau of Medical Facilities Licensing

CB:ag

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ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES

150 N. 18th Avenue, Suite 450, Phoenix, Arizona 85007

RENEWAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

Handwritten notes:
Case # 1163119
\$41500
08/08/13
jd

Handwritten: 10/13
ADHS DIVISION OF LICENSING SERVICES
FACILITIES LICENSING

Handwritten: m 802375
app # 15746

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution Planned Parenthood - Sanger			
Physical Address (optional) 2255 N. Wyatt Drive		City Tucson	State AZ
Mailing Address same as above		City	State AZ
Telephone number 520-624-1766	Fax number 520-682-3069	E-mail address clocke@ppaz.org	
Health care institution class or subclass: OTC/Abortion Services	License Number OTC 4360	Expiration Date October 31, 2013	

II. OWNER INFORMATION (Name of Corporation or LLC, etc.)

Owner's name Planned Parenthood Arizona, Inc.		
Address 5651 N. 7th Street		
City Phoenix	Zip code 85014	
Telephone number 602-263-2237	Fax number 602-604-0159	
The owner is a: (check one)	<input type="checkbox"/> Proprietary (For Profit)	<input type="checkbox"/> Non-proprietary (Non-Profit)
The owner is a: (check one)	<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Partnership
<input type="checkbox"/> Limited liability company	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Governmental Agency

- A. PLEASE LIST IN THE SPACE PROVIDED BELOW:
 If the owner is a partnership, the name of each partner;
 If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
 If the owner is a corporation, the name and title of each corporate officer; or
 If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name Bryan Howard	Title President & CEO
Name Patricia Gross	Title Chief Operating Officer
Name	Title
Name	Title

- B. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended since the last application was submitted?
 Yes No.
- C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended since the last application was submitted?
 Yes No.
- D. If either of the previous questions is answered yes, include on a separate sheet of paper for each yes answer:
 1. The reason for the denial, suspension, or revocation;
 2. The date of the denial, suspension, or revocation;
 3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name Larry Rosenfeld	Title Squire Sanders
Address One East Washington St., Phoenix, AZ 85004	Telephone number 602-528-4000

III. GOVERNING AUTHORITY

Name Planned Parenthood Arizona, Inc.

IV. CHIEF ADMINISTRATIVE OFFICER (Facility Administrator)

Name Rosa Class	Title Center Manager
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
"See Resume"	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. § 36-422(B) the application must be signed, as follows:

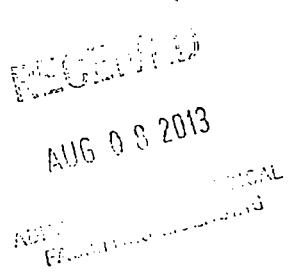
- (1) If an individual, by the owner of the institution;
- (2) If a partnership or corporation, by two of the partners or corporate officers; or
- (3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

<p><u>Bryson</u> <u>8-2-13</u></p> <p>Signature Date</p> <p>President & CEO</p> <p>_____</p> <p style="text-align: center;">Title</p>	<p><u>Patricia Green</u> <u>7/22/13</u></p> <p>Signature Date</p> <p>Chief Operating Officer</p> <p>_____</p> <p style="text-align: center;">Title</p>
---	--

For DHS use only: Correct application fee enclosed: Yes No Check #:

NOTE: The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. An extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.


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 PHYSICIAN LICENSING