



Virginia Department of Health
Office of Licensure and Certification

Application for Abortion Facility Licensure

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MAR 27 2015
VDH/OLC

AF-0005

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: <u>2015</u>
Application is for <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility <u>A Capital Womens Health Clinic</u>		Main Telephone Number <u>(804) 754 1569</u>	
Street Address <u>1511 Starling Drive</u>		Fax <u>(804) 754 0261</u>	
City <u>Henrico</u>	County <u>Henrico</u>	State <u>VA</u>	Zip <u>23229</u>
Web Address <u>Capitalwomenshealth.com</u>		Federal Employer ID Number: <u>62-1855598</u>	
Mailing address (if different from above) <u>same</u>			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: <u>Shelley Abrams</u>		Title: <u>Administrator</u>	
Telephone Number: <u>(804) 754 1569</u>		Email Address: <u>StatumSA@aol.com</u>	

Ownership of the facility			
Owner: <u>all Womens Richmond, Inc</u>		Tel. Number: <u>804 754 1569</u>	
Street Address: <u>1511 Starling Drive</u>		Fax Number: <u>804 754 0261</u>	
City: <u>Henrico</u>	County: <u>Henrico</u>	State: <u>VA</u>	Zip: <u>23229</u>

Is any part or program of the abortion facility licensed by another state agency:	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
If Yes, Agency name: <u>Clin</u>	Program/part:

VDH/Office of Licensure and Certification
 Application for Abortion Facility Licensure

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:		Fax:	
Street Address:			
City:		County:	
		State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
<i>If an ambulance was needed, 911 would be called and the nearest ambulance would be sent.</i>	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other: <i>National Abortion Federation NAF</i>	Accreditation period:
E. Number of procedure/treatment rooms: <i>2</i>	

- Application attachments: Initial applications only**
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure

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AFFIDAVIT

I, Shelley Alrams, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

Shelley Alrams - Administrator
Signature and Title of Applicant

3/27/15
Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov



Virginia Department of Health
Office of Licensure and Certification

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type: Application is for:	License year:
<input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility A Tidewater Women's Health Clinic		Main Telephone Number (757) 461 0011	
Street Address 891 Norfolk Sq.		Fax (757) 461 5762	
City Norfolk	County	State VA	Zip 23501
Web Address www.yourchoice-va.com		Federal Employer ID Number: 20-4029066	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: Kim Finley		Title: Admin Director	
Telephone Number: (757) 461-0011		Email Address: ATWHC@ME.COM	

Ownership of the facility			
Owner: David R. Peters		Tel. Number: (757) 461-0011	
Street Address: 891 Norfolk Sq.		Fax Number: (757) 461 5762	
City: Norfolk	County:	State: VA	Zip: 23502

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 3112 Amt \$ 750
 Receipt 3315 Ck Date 2-23-15
 Dpt Date 3115 Dpt # 7050376

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Application for Abortion Facility Licensure

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name: DAVID R. PETERS			Fax: (757) 461-5762
Street Address: 891 NORFOLK SQ.			
City: NORFOLK		County:	State: VA Zip: 23502
Email Address: ATWHC@ME.COM		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Medical Transport 5792 Arrowhead Dr. Norfolk, VA 23502	Norview Medical Transport 1285 Wellington Ct. Norfolk VA 23513
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Sentara Leigh Hospital 830 Kempsville Rd. Norfolk, VA 23502	Sentara Norfolk General Hosp. 600 Gresham Dr. Norfolk VA 23510
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

- Application attachments: Initial applications only**
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure

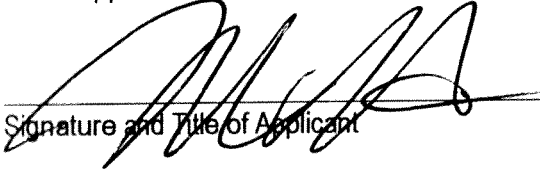
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AFFIDAVIT

I, David R Peters, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.


Signature and Title of Applicant

2/24/15
Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov



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Application for Abortion Facility Licensure

AF-0014

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type: Doctor's office; Abortion Facility		License year: 2015-2016	
Application is for:			
<input type="checkbox"/> Initial Licensure	<input type="checkbox"/> Change of Name		
<input checked="" type="checkbox"/> License Renewal	<input type="checkbox"/> Change of Ownership		
<input type="checkbox"/> Change of Address			
All sections of this application must be completed for all application types			

Facility identification			
Name of abortion facility Women's Health Clinic, INC dba Alexandria Women's Health Clinic		Main Telephone Number (703) 370-0550	
Street Address 101 S. Whiting St. Suite #215		Fax (703) 350-4026	
City Alexandria	County	State VA	Zip 22304
Web Address www.alexandriawomenshealth.com		Federal Employer ID Number: 54-1407740	
Mailing address (if different from above) Same			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: Maria Elizabeth Flandes		Title: Administrator	
Telephone Number: (703) 370-0550		Email Address: elizabethflandes@gmail.com	

Ownership of the facility			
Owner: Women's Health Clinic, INC		Tel. Number: 703-370-0550	
Street Address: 101 S. Whiting St. Suite 215		Fax Number: 703-350-4026	
City: Alexandria	County:	State: VA	Zip: 22304

Is any part or program of the abortion facility licensed by another state agency:		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:		Program/ part:

Check # 9446 Amt \$ 7500
Receipt 3-23-15 Ck Date 3-16-15
Dpt Date 3-24-15 Dpt # 70563782
682

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Application for Abortion Facility Licensure**

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name: <u>Maria Elizabeth Flandes</u>			Fax: <u>703-350-4626</u>
Street Address: <u>101 S. Whiting St. Suite 215</u>			
City: <u>Alexandria</u>		County:	State: <u>VA</u> Zip: <u>22304</u>
Email Address: <u>elizabethflandes@gmail.com</u>		Web Address: <u>www.alexandriawomenshealth.com</u>	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
<u>911 City and County of Alexandria</u>	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
<u>As transported by all usually Inova Health System facilities</u>	
<u>Inova Fairfax Hospital or Inova Alexandria Hospital</u>	
<u>3800 Ballows Rd Falls Church VA 22042 4320 Seminary Rd Alexandria VA 22304</u>	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms: <u>two (2)</u>	

- Application attachments: Initial applications only**
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

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VDH/OLC

AFFIDAVIT

I, Maria Elizabeth Flandes, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

E Flandes Administrator
Signature and Title of Applicant

MAR 16 2015
Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Office of Licensure and Certification

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APR 02 2015

Application for Abortion Facility Licensure

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Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type: Application is for:	License year:
<input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility identification			
Name of abortion facility ANNANDALE WOMEN & FAMILY CENTER		Main Telephone Number (703) 751 4702	
Street Address 2839 DUKE ST		Fax (703) 751 2983	
City ALEXANDRIA	County	State VA	Zip 22314
Web Address WWW.AWFC.NET		Federal Employer ID Number: 54-1243393	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name:		Title:	
Telephone Number: ()		Email Address:	

Ownership of the facility			
Owner: METRO MEDICAL CENTER, INC		Tel. Number: 703 751 4702	
Street Address: 2839 DUKE ST		Fax Number: 703 751 2983	
City: ALEXANDRIA	County:	State: VA	Zip: 22314

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name: _____	Program/ part: _____

Check # 8340 Amt \$ 75⁰⁰
Receipt 4-7-15 Ck Date 3-30-15
Dpt Date 7-4-15 Dpt # 70503685

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Application for Abortion Facility Licensure**

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:	County:	State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
PRIVATE COMPANY OPERATED BY CITY OF ALEXANDRIA	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
INDVA ALEXANDRIA HDSP	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms: ONE	

Application attachments: Initial applications only
<ol style="list-style-type: none"> 1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure

AFFIDAVIT

GAILE FRANCES (100% OWNER METRO MEDICAL CENTER INC), hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

GAILE FRANCES
Signature and Title of Applicant

3/31/15
Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

check sent separately

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Virginia Department of Health
Office of Licensure and Certification

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015 - 2016
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility identification			
Name of abortion facility Charlottesville Medical Center for Women		Main Telephone Number (434) 973-4888	
Street Address 2321 Commonwealth Dr		Fax (434) 973-0678	
City Charlottesville	County Albemarle	State VA	Zip 22901
Web Address richmondmedctrforwomen.com		Federal Employer ID Number: 54-0944108	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: Jill C. Abbey		Title: Administrator	
Telephone Number: (434) 973-4888		Email Address: jabbey1232@aol.com	

Ownership of the facility			
Owner: W.K. & J., Incorporated		Tel. Number: (804) 359-5066	
Street Address: 118 N. Boulevard		Fax Number: (804) 353-2718	
City: Richmond	County:	State: VA	Zip: 23220

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 2571 Amt \$ 75.00
 Receipt # 32-15 Ck Date 3-2-15
 Dpt Date 3-1-15 Dpt # 70503676

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VDH/CCLC

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit:		Not for Profit:	
<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Charitable organization	Public:	
<input type="checkbox"/> Partnership	<input type="checkbox"/> Church	<input type="checkbox"/> State	<input type="checkbox"/> County
<input type="checkbox"/> Limited Liability Co.	<input type="checkbox"/> Corporation	<input type="checkbox"/> City	<input type="checkbox"/> Multijurisdictional
<input type="checkbox"/> Individual	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:			
Is the abortion facility operated by the owner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
911	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
University of Virginia Health Systems Martha Jefferson Hospital	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other: <i>Cigna, Anthem</i>	Accreditation period:
E. Number of procedure/treatment rooms:	
1	

Application attachments: Initial applications only
<ol style="list-style-type: none"> 1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

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**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Jill C. Abbey, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

Jill C. Abbey, President W.K.G. and J., Inc.
Signature and Title of Applicant

2-27-15
Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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**Virginia Department of Health
Office of Licensure and Certification**

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility: FALLS CHURCH MEDICAL CENTER, LLC H/O FALLS CHURCH HEALTHCARE CENTER		Main Telephone Number: (703) 532-2500	
Street Address: 900 SOUTH WASHINGTON ST, SUITE 300		Fax: (703) 237-1184	
City: FALLS CHURCH	County: _____	State: VA	Zip: 22046
Web Address: WWW.FALLSCHURCHHEALTHCARE.COM		Federal Employer ID Number: 331007364	
Mailing address (if different from above): SAME			
City:	State:	Zip:	
Administrator of record, if different than owner/operator			
Name: Penny Smith, RN, Carla Turcios		Title: Co-Administrators	
Telephone Number: (703) 532-2500		Email Address: WomenFirst@FallsChurchHealthcare.com	

Ownership of the facility			
Owner: FALLS CHURCH MEDICAL CENTER, LLC		Tel. Number: 703 532-2500	
Street Address: 900 S. Washington St, Suite 300		Fax Number: 703 237-1184	
City: FALLS CHURCH	County: _____	State: VA	Zip: 22046

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/part:

Check # 5425 Amt \$ 75.00
 Receipt 31375 Ck Date 2-23-15
 Deposit Date 3-11-15 Dpt # 2056368

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MAR 13 2015

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:	County:	State:	Zip:
Email Address: <i>Women First @ Falls Church Healthcare, com</i>		Web Address: <i>www.Falls Church healthcare, com.</i>	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
<i>911 - City of Falls Church</i>	
<i>County of Fairfax</i>	
<i>County of Arlington</i>	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
<i>As transported by 911 usually: INOVA Health Facility -</i>	
<i>3300 Gallows Rd, Falls Church, VA 22042</i>	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None <i>NATIONAL ABORTION Federation</i>	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other: <i>Insurance Providers including: CareFirst, BC/BS, Cigna, Anthem et c.</i>	Accreditation period:
E. Number of procedure/treatment rooms: <i>3</i>	

- Application attachments: Initial applications only**
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Rosemary W. Coddins, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

Rosemary W Coddins, Director Governor
Signature and Title of Applicant Boady

03-09-2015
Date

ATTACHED Variance Request Renewal

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Virginia Department of Health
Office of Licensure and Certification

7

Application for Abortion Facility Licensure

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Application type:	License year: 2015-2016
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility identification			
Name of abortion facility Peninsula Medical Center for Women		Main Telephone Number (757) 599-6389	
Street Address 10758A Jefferson Ave		Fax (757) 599-0347	
City Newport News	County	State VA	Zip 23601
Web Address richmondmedctrforwomen.com		Federal Employer ID Number: 54-0944108	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: Monica Hunter, RN		Title: Administrator	
Telephone Number: (757) 599-6389		Email Address: monica.hunter2@rin.com	

Ownership of the facility			
Owner: W.K.G. and J., Incorporated		Tel. Number: (804) 359-5066	
Street Address: 118 N Boulevard		Fax Number: (804) 353-2718	
City: Richmond	County:	State: VA	Zip: 23220

Is any part or program of the abortion facility licensed by another state agency:	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

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Check # 2572 Amt \$ 7500
 Receipt 3215 Ck Date 3-2-15
 Dpt Date 3-11-15 Dpt # 70503676

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit:		Not for Profit:	
<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Charitable organization	<input type="checkbox"/> Church
<input type="checkbox"/> Limited Liability Co.	<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:			
Public:			
<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> City	<input type="checkbox"/> Multijurisdictional
<input type="checkbox"/> Other:			
Is the abortion facility operated by the owner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	
State:		Zip:	
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
911	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Riverside Health Systems	
Sentara Careplex Hospital	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms:	
1	

Application attachments: Initial applications only
<ol style="list-style-type: none"> 1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

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**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, J. H. C. Abbey, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

J. H. C. Abbey President, W. K. G. and J., 2-27-15
Signature and Title of Applicant Incorporated Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Office of Licensure and Certification

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015
Application is for:	
<input type="checkbox"/> Initial Licensure	<input type="checkbox"/> Change of Name
<input checked="" type="checkbox"/> License Renewal	<input type="checkbox"/> Change of Ownership
<input type="checkbox"/> Change of Address	
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility <u>Planned Parenthood Metropolitan Washington-Falls Church Health Center</u>		Main Telephone Number (703) 533-5656	
Street Address <u>303 S. Maple Ave., Suite 300</u>		Fax (703) 533-1929	
City <u>Falls Church</u>	County <u>Fairfax</u>	State <u>VA</u>	Zip <u>22046</u>
Web Address <u>www.ppmw.org</u>		Federal Employer ID Number: 53-0204621	
Mailing address (if different from above) <u>Planned Parenthood Metropolitan Washington 1108 16th St., NW</u>			
City <u>Washington</u>	State <u>DC</u>	Zip <u>20036</u>	
Administrator of record, if different than owner/operator			
Name: <u>Laura Meyers</u>		Title: <u>President and CEO</u>	
Telephone Number: (202) <u>347-8500x7233</u>		Email Address: <u>Laura.Meyers@ppmw.org</u>	

Ownership of the facility			
Owner: <u>Planned Parenthood Metropolitan Washington</u>		Tel. Number: <u>202-347-8500x7233</u>	
Street Address: <u>1108 16th St. NW</u>		Fax Number: <u>202-783-3219</u>	
City: <u>Washington</u>	County:	State: <u>DC</u>	Zip: <u>20036</u>

Is any part or program of the abortion facility licensed by another state agency:	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
If Yes, Agency name: <u>Board of Pharmacy</u>	Program/ part:

Check # 121 Amt \$ 7500
Receipt 3-26-15 Ck Date 3-17-15
Dpt Date 3-24-15 Dpt # 7056367
682

VDH/Office of Licensure and Certification
Application for First Trimester Abortion Facility Licensure

Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input checked="" type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Fairfax County Fire and Rescue Department	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
INOVA Healthcare Services	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: July 2014
Other:	Accreditation period: July 2017
E. Number of procedure/treatment rooms: 2	

- Application attachments: Initial applications only**
1. If applicable, a plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

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**VDH/Office of Licensure and Certification
Application for First Trimester Abortion Facility Licensure**

AFFIDAVIT

I, Laura Meyers, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

Meyers
Signature and Title of Applicant

3/19/15
Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type	License year: 2015
Application is for:	
<input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal AF-0013 <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility Planned Parenthood South Atlantic		Main Telephone Number (540) 951-7009	
Street Address 700-J North Main Street		Fax (540) 951-5192	
City Blacksburg	County Montgomery	State VA	Zip 24600
Web Address www.ppsat.org (not live yet)		Federal Employer ID Number: 561282557	
Mailing address (if different from above) P.O. Box 3258			
City Chapel Hill		State NC	Zip 27515-3258
Administrator of record, if different than owner/operator			
Name: Emily Adams		Title: Vice President for Patient Services	
Telephone Number: (919) 929-5402, ext 233		Email Address: emily.adams@pphs.org	

Ownership of the facility			
Owner: Planned Parenthood South Atlantic		Tel. Number: 919-929-5402	
Street Address: 100 South Boylan Avenue		Fax Number: 919-933-5271	
City: Raleigh	County: wake	State: NC	Zip: 27603

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

CHECK #: 92062 CHECK \$: 75⁰⁰
 REC. DATE: 2-5-15 CHECK DATE: 2-15
 DEPOSIT DATE: 2-11-15
 TICKET #: 70563675

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 Application for Abortion Facility Licensure

Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

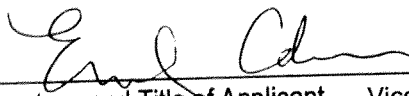
General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Ambulances responding to "911"	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
LewisGale Hospital Montgomery 3700 S. Main St. Blacksburg, VA	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: 3 years
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

Application attachments: Initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFRIP-VIT

I, Emily Adams, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.



Signature and Title of Applicant Vice President for Patient Services

1-31-15

Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov



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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015
Application is for:	
<input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal AF-0018 <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility Planned Parenthood South Atlantic		Main Telephone Number (540) 562-3457	
Street Address 2964 Hydraulic Road		Fax (434) 975-3424	
City Charlottesville	County Albemarle	State VA	Zip 22901
Web Address www.ppsat.org (not live yet)		Federal Employer ID Number: 561282557	
Mailing address (if different from above) P.O. Box 3258			
City Chapel Hill		State NC	Zip 27515-3258
Administrator of record, if different than owner/operator			
Name: Emily Adams		Title: Vice President for Patient Services	
Telephone Number: (919) 929-5402, 233		Email Address: emily.adams@pphs.org	

Ownership of the facility			
Owner: Planned Parenthood South Atlantic		Tel. Number: 919-929-5402	
Street Address: 100 South Boylan Avenue		Fax Number: 919-933-5271	
City: Raleigh	County: Wake	State: NC	Zip: 27603

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

CHECK #: 92063 CHECK \$: 75⁰⁰
 REC. DATE: 2-5-15 CHECK DATE: 2-2-15
 DEPOSIT DATE: 2-11-15
 TICKET #: 10563675

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Application for Abortion Facility Licensure**

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Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Ambulances responding to "911"	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
University of Virginia Hospital 1215 Lee St. Charlottesville, VA	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: 3 years- Spring 2017
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

Application attachments: Initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Emily Adams, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.



Signature and Title of Applicant Vice President for Patient Services

1-31-15

Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:		License year: 2015
Application is for:		
<input type="checkbox"/> Initial Licensure	<input type="checkbox"/> Change of Name	
<input checked="" type="checkbox"/> License Renewal AF-0011	<input type="checkbox"/> Change of Ownership	
<input type="checkbox"/> Change of Address		
All sections of this application must be completed for all application types		

Facility Identification			
Name of abortion facility Planned Parenthood South Atlantic		Main Telephone Number (540) 562-3457	
Street Address 2207 Peters Creek Road		Fax (540) 562-5124	
City Roanoke	County	State VA	Zip 24017
Web Address www.ppsat.org (not live yet)		Federal Employer ID Number: 561282557	
Mailing address (if different from above) P.O. Box 3258			
City Chapel Hill		State NC	Zip 27515-3258
Administrator of record (if different than owner/operator)			
Name: Emily Adams		Title: Vice President for Patient Services	
Telephone Number: (919) 929-5402, ext. 233		Email Address: emily.adams@pphs.org	

Ownership of the facility			
Owner: Planned Parenthood South Atlantic		Tel. Number: 919-929-5402	
Street Address: 100 South Boylan Avenue		Fax Number: 919-933-5271	
City: Raleigh	County: Wake	State: NC	Zip: 27603

Is any part or program of the abortion facility licensed by another state agency?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

CHECK #: 92044 CHECK \$: 75⁰⁰
 REC. DATE: 2-3-15 CHECK DATE: 2-2-15
 DEPOSIT DATE: 2-4-15
 TICKET #: 90503675

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Ambulances responding to "911"	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Carilion Roanoke Memorial Hospital 1906 Belleview Ave SE Roanoke, VA	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: 3 years - Spring 2017
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2 (MAB only)	

Application attachments: Initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Emily Adams, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.



Signature and Title of Applicant Vice President for Patient Services

1-31-15

Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Virginia Department of Health
Office of Licensure and Certification

Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015-2016
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types.	

Facility identification		Main Telephone Number	
Name of abortion facility Richmond Medical Center for Women		(804) 359-5066	
Street Address 118 North Boulevard		Fax (804) 353-2718	
City Richmond	County	State VA	Zip 23220
Web Address Richmond med ctr for Women.com		Federal Employer ID Number: 54-0944108	
Mailing address (if different from above)			
City Ri		State	Zip
Administrator of record, if different than owner/operator		Title: Administrator	
Name: Jill C. Abbey		Email Address: peel1232@AOL.com	
Telephone Number: (804) 539-9599			

Ownership of the facility		Tel. Number:	
Owner: W.K.G. + J., Incorporated		(804) 359-5066	
Street Address: 118 N. Boulevard		Fax Number: (804) 353-2718	
City: Richmond	County:	State: VA	Zip: 23220

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 2570 Amt \$ 7500
Receipt 3215 Ck Date 3-2-15
Dpt Date 3-1-15 Dpt # 70503076

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Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
911	
Richmond Ambulance Authority	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
As dictated by 911 - usually	
Henrico Drs. Hospital	
Virginia Commonwealth University	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other: Anthem, Cigna	Accreditation period:
E. Number of procedure/treatment rooms:	
1	

Application attachments: Initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

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**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Jill C. Abbey, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

JCA President, W.K.G. + J, Inc.
Signature and Title of Applicant

2.27.15
Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Virginia Department of Health
Office of Licensure and Certification

Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015-2016
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types.	

Facility identification		Main Telephone Number	
Name of abortion facility Roanoke Medical Center for Women		(540) 981-1246	
Street Address 1119 2nd St SW		Fax (540) 342-0786	
City Roanoke	County	State VA	Zip 24016
Web Address richmondmedctrforwomen.com		Federal Employer ID Number: 54-0944100	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name: Kim Fitch		Title: Administrator	
Telephone Number: (540) 981-1246		Email Address: Kimchi.75769@yahoo.com	

Ownership of the facility		Tel. Number:	
Owner: W.K.G. & J., Incorporated		(804) 359-5066	
Street Address: 118 N Boulevard		Fax Number: (804) 353-2718	
City: Richmond	County:	State: VA	Zip: 23220

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

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Check # 25104 Amt \$ 7500
Receipt 3215 Ck Date 3-2-15
Dpt Date 3-11-15 Dpt # 70503026

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If no, complete section below:	
Operator Name:		Fax:	
Street Address:			
City:	County:	State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
911	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Roanoke Memorial Hospital (Outpatient)	
Lewis Gale Medical Center	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input type="checkbox"/> None	Accreditation period:
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other: Anthem, Cygnus	
E. Number of procedure/treatment rooms:	
1	

Application attachments: initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Jill C. Abbe, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

[Signature], President, W.K.G. and J.,
Signature and Title of Applicant Inc

2-27-15
Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Virginia Department of Health
Office of Licensure and Certification

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:		License year:	
Application is for:			
<input type="checkbox"/> Initial Licensure	<input type="checkbox"/> Change of Name		
<input checked="" type="checkbox"/> License Renewal	<input type="checkbox"/> Change of Ownership		
<input type="checkbox"/> Change of Address			
All sections of this application must be completed for all application types			

Facility identification			
Name of abortion facility: Virginia League for Planned Parenthood		Main Telephone Number (804)355-4358	
Street Address: 201 N. Hamilton St.		Fax (804)355-5216	
City: Richmond	County	State: VA	Zip: 23221
Web Address: www.vlpp.org		Federal Employer ID Number: 54-0505973	
Mailing address (if different from above)			
City	State	Zip	
Administrator of record, if different than owner/operator			
Name: Paulette McElwain		Title: President & CEO	
Telephone Number: (804)482-6136		Email Address: paulettmcelwain@vlpp.org	

Ownership of the facility			
Owner: The Virginia League for Planned Parenthood		Tel. Number: 804-355-4358	
Street Address: 201 N. Hamilton St.		Fax Number: 804-355-5216	
City: Richmond	County:	State: VA	Zip: 23221

Is any part or program of the abortion facility licensed by another state agency?	No	Yes X
If Yes, Agency name: Board of Pharmacy	Program/ part: Pharmacy	

Check # 73 7232 Amt \$ 150.00
Receipt 4-11-15 Ck Date 4-4-15
Dpt Date 4-16-15 Dpt # 70563685

VDH/Office of Licensure and Certification
Application for First Trimester Abortion Facility Licensure

Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input checked="" type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes		No If no, complete section below:	
Operator Name:		Fax:	
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Richmond Ambulance Authority	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Virginia Commonwealth University Health System Authority	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: July 2012-July 2016
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

- Application attachments: Initial applications only**
1. If applicable, a plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

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VDH/Office of Licensure and Certification
Application for First Trimester Abortion Facility Licensure

I, Paulette McElwain, hereby swear (or affirm) that the information contained
in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.



Signature and Title of Applicant

4/6/2015

Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year:
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility The Virginia League for Planned Parenthood: Virginia Beach Health Center		Main Telephone Number (757) 499-7526	
Street Address 515 Newtown Rd		Fax (757) 309-4813	
City Virginia Beach	County	State VA	Zip 23462
Web Address www.vlpp.org		Federal Employer ID Number: 54-0505973	
Mailing address (if different from above) 201 N. Hamilton St.			
City Richmond	State VA	Zip 23221	
Administrator of record, if different than owner/operator			
Name: Paulette McElwain		Title: CEO	
Telephone Number: (804) 482-6136		Email Address: paulettemcelwain@vlpp.org	

Ownership of the facility			
Owner: The Virginia League for Planned Parenthood, Inc.		Tel. Number: 804-482-6136	
Street Address: 201 N. Hamilton St.		Fax Number: 804-355-5216	
City: Richmond	County:	State: VA	Zip: 23221

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 7232 Amt \$ 150⁰⁰
 Receipt # 4415 Ck Date 4-9-15
 Dpt Date 4-16-15 Dpt # 205623013
 1 check ful both AF sp.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input checked="" type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:	County:	State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Virginia Beach 911 Service	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Sentara Leigh Hospital	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input checked="" type="checkbox"/>	Accreditation period: June 2012 - September 2016
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

Application attachments: Initial applications only
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

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**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, Paulette McElwain, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.


Signature and Title of Applicant

April 09, 2015

Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year: 2015
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility VIRGINIA HEALTH GROUP		Main Telephone Number (703) 205-9310	
Street Address 8316 ARLINGTON BLVD #220		Fax (703) 205-9314	
City FAIRFAX	County FAIRFAX	State VA	Zip 22031
Web Address WWW.4AWS.COM		Federal Employer ID Number: 90-0127330	
Mailing address (if different from above) 200 West Somerdale Rd Suite C			
City VOORHEES		State NJ	Zip 08043
Administrator of record, if different than owner/operator			
Name: TAMIKA CUNNINGHAM		Title: Administrator	
Telephone Number: (703) 205-9311		Email Address: DOOP@4APS.ORG	

Ownership of the facility			
Owner: VIRGINIA Health group, PC		Tel. Number: 856-616-2393	
Street Address: 200 W SOMERDALE RD STE C		Fax Number: 856-428-4748	
City: VOORHEES	County: CAMDEN	State: NJ	Zip: 08043

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 2449 Amt \$ 75.00
 Receipt 3-11-15 Ck Date 2-22-15
 Dpt Date 3-11-15 Dpt # 70503677

Variance Not Included -
Resending letter

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:		Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
		Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:		County:	State: Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Fairfax County Fire & Rescue	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
INOVA Fairfax Hospital	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms: 2	

Application attachments: Initial applications only
<ol style="list-style-type: none"> 1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

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Application for Abortion Facility Licensure

AFFIDAVIT

I, Kirsey Japa, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

[Signature]
Signature and Title of Applicant

DOO

02-25-15
Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov

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Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year:
Application is for: <input type="checkbox"/> Initial Licensure <input checked="" type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility Identification			
Name of abortion facility Virginia Women's Wellness		Main Telephone Number (757) 306-4706	
Street Address 224 Groveland Rd		Fax (757) 306-4710	
City Virginia Beach	County Virginia Beach	State VA	Zip 23452
Web Address www.yaws.com		Federal Employer ID Number: 52-2040772	
Mailing address (if different from above) 1 Alpha Ave Suite 20			
City Voorhees		State NJ	Zip 08043
Administrator of record, if different than owner/operator			
Name: Michelle Nelson LPM		Title: Administrator	
Telephone Number: (757) 306-4706		Email Address: Michelle.Nelson@aov.com	

Ownership of the facility			
Owner: Professional Medical Services PC		Tel. Number: 856-616-2393	
Street Address: 1 Alpha Ave Suite 20		Fax Number: 856-427-6151	
City: Voorhees	County: Camden	State: NJ	Zip: 08043

Is any part or program of the abortion facility licensed by another state agency:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

Check # 5204 Amt \$ 75.00
 Receipt 2-27-15 Ck Date 2-27-15
 Dpt Date 3-11-15 Dpt # 10543676

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Application for Abortion Facility Licensure**

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Type of Ownership and Control			
For Profit: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	Not for Profit: <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	Public: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:	County:	State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
Medical Transport, LLC	
5792 Arrowhead Dr	
Virginia Beach VA 23462	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
Sentara Norfolk General Hospital	
600 Gresham Dr	
Norfolk VA 23507	
C. Certification: <input checked="" type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms:	

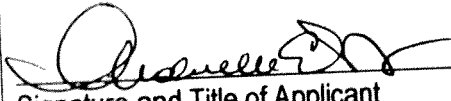
- Application attachments: Initial applications only**
1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure;
 2. The proposed organizational chart;
 3. The facility's disaster preparedness plan
 4. Patient Rights and Procedures; and
 5. The job description, qualifications and specific responsibilities of the Administrator.

VDH Office of Licensure and Certification
Application for Abortion Facility Licensure

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FEB 27 2015
VDH/OLC

AFFIDAVIT

I, Michelle Nelson, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

 Administrator
Signature and Title of Applicant

2/23/2015
Date

Return this completed application and a check for \$75.00 to:

Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov