RI Department of Health
3 Capitol Hill - Room 306
Providence, RI 02908-5097
www.health.ri.gov

RI Department of Health

Renewal Application and Instructions for:

WOMENS MEDICAL CENTER OF RHODE ISLAND

License Number: FAS01001

Profession: Freestanding Amb. Surg. Center

License Type: Freestanding Amb. Surg. Center

WOMENS MEDICAL CENTER OF RHODE ISLAND
1725 BROAD STREET
CRANSTON RI 02905

12-31-12

DO NOT DUPLICATE THIS FORM
PLEASE DO NOT REMOVE ANY FULL PAGES FROM THIS BOOKLET

INSTRUCTIONS

- Please answer all questions. Indicate any changes to current or missing information. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be renewed. Please use a ball point pen.
- If you have any questions concerning this renewal application, call the Office of **Facilities Regulation** at (401) 222 - 2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- There is no fee for this renewal.
- Please mail completed application with attachments to: Rhode Island Department of Health, Facilities Regulation, Room 306, 3 Capitol Hill, Providence, RI 02908-5097.
- Please do not hand deliver this booklet to the Department of Health.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidary corporation owning stock.

Attachments: If you have been requested to submit attachment(s)with this application, please label and staple each separate attachment and securely affix any and all attachments to this application. Please attach evidence of Accreditation if applicable.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please review the information below from your last renewal and make changes as appropriate:

Federal Provider Number: (Leave blank if N/A)	Federal Provider Number: 05-0511216	
License Sub-Type: Please select one	**Profit**	Change: ☐ Profit ☐ Non-Profit No Change ☑
Medical Director Information: Please provide the name of the Medical Director for this facility. **NOTE: This section must be completed as a requirement of your license renewal.**	Name: JOHN DIORIO, JR. License Number: MD05123	Change: ☑ No Change Change

42117
12/31/2012

State of Rhode Island and Providence Plantations
Department of Health
Renewal Application for WOMENS MEDICAL CENTER OF RHODE ISLAND
Freestanding Amb. Surg. Center Profit

Facility Name:

Please provide the name of the facility (as known to the public) for which you are renewing this license

Name: **WOMENS MEDICAL CENTER OF RHODE ISLAND**

No Change ☑

Change: _____
Name

Facility Contact Person:

Please provide the name and telephone number of a person we can contact concerning this facility.

Name:
JOHN DIORIO JR, MD

Phone Number:
( )

Change: No Change ☐

Ashlee Dunn, Assistant Administrator
401-467-9111

Facility Mailing Information:

Please provide the mailing information for all communication regarding this license.

Note: Fax and e-mail fields are required.

(Not published on HEALTH website).

1725 BROAD STREET
CRANSTON RI 02905

Phone: 4014679111
Fax: 4014611390
Email Address: AMANDAK@WMCRI.COM

Change: No Change ☐

ashleed@wmcri.com

Facility Location Information:

Please provide the location information for this facility.

Note: Fax and e-mail fields are required.

(Published on HEALTH website).

1725 BROAD STREET
CRANSTON RI 02905

Phone: 4014679111
Fax: 4014611390
Email Address: AMANDAK@WMCRI.COM

Change: No Change ☐

ashleed@wmcri.com

Ownership Type:

Please check ONE

- ☐ Corporation
- ☐ Governmental Entity
- ☐ Partnership
- ☐ Partner
- ☑ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Limited Partnership

Ownership Information:

Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Limited Liability Company or Corporation, Governmental Entity.

Name: RJ Holding Company, LLC

DBA: Women's Medical Center of Rhode Island

Ownership Address Information:

Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

Address Line 1: 1725 Broad Street
Address Line 2:
Address Line 3:
Address City, State and Zipcode: Cranston, RI 02905
Phone: (401) 467-9111
Fax: (401) 467-1390
Email Address: N/A

Parent Organization, Group Affiliation:

Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control

Corporation Type: N/A
Name of Organization:
Address Line 1:
Address Line 2:
Address Line 3:
Address City, State and Zipcode:
Phone:
Fax:
Email Address:

Land/Building Info:

If the owner of the land and building is other than the operator of this agency/facility, please complete the following:

Name of Organization: LSP of RI
Address Line 1: 500 Kings Highway North
Address Line 2:
Address Line 3:
Address City, State and Zipcode: Cherry Hill, NJ 08034
Phone: (856) 356-4000

Number of Operating Rooms:

(Please write the number of operating rooms in your facility)

Number of Operating Rooms:

0	0	0	0	2

Number of Recovery Beds:

(Please write the number of recovery beds in your facility)

Number of Recovery Beds:

0	0	0	0	7

Services Provided:

Please check which services are provided by your employees or through written agreement with others.

Surgical:		Non-Surgical:	
☐	Orthopedic	☐	Radiology
☐	Plastic	☑	Nursing Services
☐	Urology	☑	Anesthesia
☐	Ear, Nose and Throat	☑	Conscious Sedation
☐	Ophthalmology	☑	Laboratory
☑	Other: List Additional Service(s) Gynecological Termination of Pregnancy	☑	Other: List Additional Service(s) Gynecological

Compliance with conditions of Approval

Please check Yes or No.

This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal).

☑ Yes ☐ No

Acknowledgements

I am aware of Chapter 23-17 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operations of Freestanding Amb. Surg. Center.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social security Number.

Pursuant to Chapter 75 of Title 5 of Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

If the below SSN/FEIN is missing or incorrect, please provide:

SSN.F.E.I.N. Number: [redacted]

SSN/F.E.I.N. Number: [redacted]

Affidavit of Applicant:

Read, sign and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing applications and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any changes in the answers to these questions after this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes dur to state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

[signature]
Signature of Authorized Person

11/8/12
Date of Signature (MM/DD/YY)

Ashlee N. Dunn
Printed Name of Authorized Person

Assistant Administrator
Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

WMCRI
Women's Medical Center
of Rhode Island

1725 Broad Street
Cranston, R.I. 02905

401.467.9111
Toll Free **800.877.6339**
Fax **401.461.1390**

www.wmcri.com

info@wmcri.com

Ownership

RJ Holding Company, LLC

Owners	Ownership Percentage	Title
John DiOrio, JR., M.D.	50%	Managing Member
Randy Lazarus	50%	Member