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:

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND I

License Number: FAS01025

Profession: Freestanding Amb. Surg. Center

License Type: Freestanding Amb. Surg. Center

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND I
345 WHITNEY AVENUE
NEW HAVEN CT 06511-1059

1/9/13 cl

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:**<br>(Leave blank if N/A) | Federal Provider Number: [redacted] | |
| **License Sub-Type:**<br>Please select one | **Non-Profit** | Change: ☐ Profit ☐ Non-Profit No Change ☒ |
| **Medical Director Information:**<br>Please provide the name of the Medical Director for this facility.<br>**NOTE: This section must be completed as a requirement of your license renewal.** | Name:<br>TIMOTHY PATRICK SPURRELL<br>License Number:<br>MD10395 | Change: No Change ☒<br>_____<br>_____ |

# State of Rhode Island and Providence Plantations
## Department of Health

| | |
|---|---|
| **Facility Name:**<br>Please provide the name of the facility (as known to the public). | Name: Planned Parenthood of Southern New England, Inc. |
| **Facility Contact Person:**<br>Please provide the name and telephone number of a person we can contact concerning this facility. | Name: Mary Bauzo, CPA<br>Phone Number: 203 752-2832 |
| **Facility Mailing Information:**<br>Please provide the mailing information for all communication regarding this license.<br>(Not published on HEALTH website). | Address Line 1: 345 Whitney Ave<br>Address Line 2:<br>Address Line 3:<br>Address City, State, ZipCode: NH, CT 06511<br>Address Country:<br>Phone: (203) 752-2832<br>Fax: (203) 752-3258<br>Email Address: mary.bauzo@ppsne.org |
| **Facility Location Information:**<br>Please provide the location information for this facility.<br>(Published on HEALTH website). | Address Line 1: 111 Point St<br>Address Line 2:<br>Address Line 3:<br>Address City, State, ZipCode: Providence, RI 02903<br>Address Country:<br>Phone: (401) 421-9620<br>Fax: (401) 421-9608<br>Email Address: |
| **Ownership Type:**<br>Please check ONE | ☒ Corporation<br>☐ Governmental Entity<br>☐ Partnership<br>☐ Partner<br>☐ Limited Liability Company<br>☐ Sole Proprietorship<br>☐ Limited Partnership |
| **Ownership Information: (Licensee)**<br>Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity. | Name: Planned Parenthood of SNE, Inc.<br>(License Holder)<br>DBA: |

| | |
|---|---|
| **Ownership Address Information:**<br><br>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: 345 Whitney Ave<br>Address Line 2:<br>Address Line 3:<br>Address City, State, Zip code: New Haven, CT 06511<br>Phone: (203) 865-5158<br>Fax: (203) 624-1333<br>Email Address: |
| **Parent Organization, Group Affiliation:**<br><br>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:<br>Name of Organization:<br>Address Line 1:<br>Address Line 2:<br>Address Line 3:<br>Address City, State, Zipcode:<br>Phone:<br>Fax:<br>Email Address: |
| **Land/Building Info:**<br><br>If the owner of the land and building is other than the operator of this agency/facility, please complete the following: | Name: Planned Parenthood of SNE, INC.<br>Address Line 1: 345 Whitney Avenue<br>Address Line 2:<br>Address Line 3:<br>Address City, State, Zip code: New Haven, CT 06511<br>Phone: (203) 865-5158 |
| **Number of Operating Rooms:**<br><br>(Please write the number of operating rooms in your facility) | Number of Operating Rooms: 0 2 |
| **Number of Recovery Beds:**<br><br>(Please write the number of treatment stations in your facility) | Number of Recovery Beds: 1 0 |

**Services Provided:**

Please check which services are provided in your facility.

Surgical:

- ☐ Orthopedic
- ☐ Plastic
- ☐ Urology
- ☐ Ear, Nose and Throat
- ☐ Ophthalmology
- ☒ Other; List Additional Services

Family planning
and surgical
abortion procedures
Colposcopy, LEEP
procedures
Tissue sterilization
procedures

Non-Surgical:

- ☐ Radiology
- ☐ Nursing Services
- ☐ Anesthesia
- ☒ Conscious Sedation
- ☐ Laboratory
- ☐ Other; List Additional Services

## Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 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 the 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 a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

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 application 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 change in the answers to these questions after this application and 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 due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Judy Tabar
Signature of Authorized Person

10/26/09
Date of Signature (MM/DD/YY)

Judy Tabar
Printed Name of Authorized Person

President & CEO
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.

Planned Parenthood®
of Southern New England, Inc.

Serving Connecticut & Rhode Island

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**BOARD OF DIRECTORS, 2012–2013**

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371058
12/31/2012

# State of Rhode Island and Providence Plantations
## Department of Health
Renewal Application for PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND INC
Freestanding Amb. Surg. Center Non-Profit

**Facility Name:**

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

Name: **PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND I**

No Change ☒

Change: _____
Name

**Facility Contact Person:**

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

Name:
MARY BAWZA COO

Phone Number:
(203) 752-2832

Change: _____ No Change ☒

**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).**

345 WHITNEY AVENUE
NEW HAVEN CT 06511-1059

Phone: 2037522832
Fax: 2037523258
Email Address: MARY.BAWZA@PPSNE.ORG

Change: _____ No Change ☒

**Facility Location Information:**

Please provide the location information for this facility.

**Note: Fax and e-mail fields are required.**

**(Published on HEALTH website).**

111 POINT STREET
PROVIDENCE RI 02940

Phone: 4014219620
Fax: 4014219668
Email Address:

Change: _____ No Change ☒

**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: Planned Parenthood of SNE, Inc.

DBA: _____

**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 _____

Address Line 2 _____

Address Line 3 _____

Address City, State and Zipcode _____

Phone: _____

Fax: _____

Email Address: _____

**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 _____

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 _____

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State and Zipcode _____

Phone: _____

**Number of Operating Rooms:**

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

Number of Operating Rooms:

| | | | | |
|---|---|---|---|---|
| | | | 0 | 2 |

**Number of Recovery Beds:**

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

Number of Recovery Beds:

| | | | | |
|---|---|---|---|---|
| | | | 1 | 0 |

**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) Surgical abortion, colposcopy, LEEP and Essure procedures | ☐ | Other: List Additional Service(s) Family Planning Services |

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: 060263565

SSN/F.E.I.N. Number: 06-0263565

**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.**

Judy Talzer
**Signature of Authorized Person**

11/26/12
**Date of Signature (MM/DD/YY)**

Judy Talzer
**Printed Name of Authorized Person**

President + CEO
**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.**