Application
for
License
#2

Rejected
No Clinic Administration

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☑ New Facility ☐ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Whole Woman's Health Alliance

Street Address *(number and street)*: 3511 Lincolnway West | P.O. Box:

City: South Bend | County: St. Joseph | ZIP Code +4: 46628-1411

Telephone Number: ( ) | Fax Number: ( )

Abortion Clinic e-mail address: _____

Internet Web Address: _____

B. Mailing Address *(If different from abortion clinic location)*

Street Address *(number and street)* | P.O. Box:

City | County | ZIP Code +4:

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state
Whole Woman's Health Alliance

Street Address *(number and street)*: 1812 Centre Creek Drive, Suite 205 | P.O. Box:

City: Austin | State: Texas | ZIP Code+4: 78754

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(512) 835-6858	(512) 835-6568	46-5318393	12/31

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: ☐ Laboratory: CLIA Certificate Number _____ ☐ Radiology ☐ Counseling

☐ Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Surgical Services: ☐ Gynecology ☐ Other *(List)*: _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: 1 Registered Nurses: ☐ Licensed Practical Nurses: ☐

Licensed Social Workers: ☐ Other *(List title and number)*: 1 ACP

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic 0 Moderate/Conscious Sedation 0

F. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☑ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Federal
		☐ Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*:

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Amy Hagstrom Miller	1812 Centre Creek Dr. Suite 205 Austin TX 78754
Vice-President/Vice Chairperson/COO	N/A	
Treasurer/CFO	Brenda Tolbert	1812 Centre Creek Dr. Suite 205 Austin TX 78754
Secretary	John H. Bucy II	1812 Centre Creek Dr. Suite 205 Austin TX 78754

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number
n/a		

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated thereunder, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	Jeffrey D. Glazer
Printed Name and Title:	Jeffrey D. Glazer Med Dir
Date of Signature *(mm/dd/yyyy)*:	
Signature of the Clinic Administrator:	
Printed Name and Title:	
Date of Signature *(mm/dd/yyyy)*:	

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
✓	Zero to 799	$500.00
	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236

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Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic		
Whole Woman's Health Alliance		
Street Address *(number and street)*		**P.O. Box**
3511 Lincoln Way West		
City	**County**	**ZIP Code +4**
South Bend	St. Joseph	46628-1411

Telephone Number	Fax Number
( )	( )

Abortion Clinic e-mail address:_____

Internet Web Address:_____

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*		P.O. Box
City	**County**	**ZIP Code +4**

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state		
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City	**State**	**ZIP Code+4**
Austin	Texas	78754

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(512) 835-6858	(512) 835-6668	46-5318393	12/31

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E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☐ 0 Moderate/Conscious Sedation ☐ 0

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Vice-President/Vice-Chairperson/COO	N/A	
Treasurer/CFO	Brenda Tolbert	1812 Centre Creek Dr, Suite 200 Austin TX 78754
Secretary	John M. Burg II	1812 Centre Creek Dr, Suite 200 Austin TX 78754

H. Current/Parent/ Change in Ownership

[illegible]

Name	Business Address/City/State/ZIP	EIN Number
n/a		

CERTIFICATION OF APPLICATION

[illegible]

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I (we) comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director	[signature]
Printed Name and Title	Jeffrey D. Glazer Med Dir
Date of Signature (mm/dd/yyyy)	07/25/2017
Signature of the Clinic Administrator	
Printed Name and Title	
Date of Signature (mm/dd/yyyy)	

See the following page for instructions regarding licensure fees and submission of this application.

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Signature of the Medical Director:	
Printed Name and Title:	Jeffrey D. Glazer, Med Dir
Date of Signature ***(mm/dd/yyyy)*****:**	07/25/2017
Signature of the Clinic Administrator:	
Printed Name and Title:	Lisa Morley
Date of Signature ***(mm/dd/yyyy)*****:**	10/03/2017

See the following page for Instructions regarding licensure fees and submission of this application.

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Check One	Total First Trimester Procedures in the Clinic	Fee
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3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236

Bucy & Associates, PLLC

6633 Highway 290 East, Suite 104
Austin, Texas 78723
Phone: (512) 291-6505
Fax: (512) 291-6558
E-Mail: john@johnbucy.com

August 1, 2017

Jerome M. Adams, MD, MPH
State Health Commissioner
Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204

Dear Dr. Adams,

Whole Woman's Health Alliance, a 501c3 nonprofit organization is submitting an abortion clinic licensing application to the Indiana State Department of Health ("ISDH") for a clinic to be located at 3511 Lincoln Way West, South Bend, Indiana 46628. Our clinic on Lincoln Way West will not provide surgical abortions, but rather will only offer women the option of a non-surgical (medication) abortion using the medication mifepristone.

Ind. Code 16-21-1-9 states that the State Health Commissioner may grant a waiver of a rule for good cause shown, and if the granting of the waiver "will not adversely affect or increase any risk to the health, safety or welfare of existing or potential residents or patients". In connection therewith, and pursuant to IC 16-21-1-9, Whole Woman's Health South Bend requests a waiver of certain abortion licensing requirements itemized below; we respectfully submit that the waiver should be granted, as it will not adversely affect or increase any risk to the health, safety or welfare of existing or potential residents or patients. We also respectfully note that Planned Parenthood of Indiana and Kentucky has previously received a waiver of each of the requirements listed below from the State Health Commissioner for its clinic in Lafayette, based on the same rationale explained below.

As stated above, we will not offer surgical abortions, only non-surgical (medication) abortions, in compliance with all applicable Indiana regulations including the waiting period. Our patients will come to our clinic, take the medication in the presence of a physician, and then leave the clinic shortly after. Another medication is taken by the patient at home, one to two days later, after which the patient is scheduled for a follow up appointment to confirm that the pregnancy is terminated. As there is no surgery, or any procedure at all, performed in connection with a medication abortion, the waiver of the rules itemized below will have no adverse effect or increase in risk to the health, safety or welfare of our patients.

We respectfully request that the State Health Commissioner waive the following rules:

RULE	RATIONALE
410 IAC 26-10-1(b)(5): Observation during Recovery Period LPP-G	There is no recovery period necessary in the provisions of a non-surgical abortion, since there is no surgery from which to recover.
410 IAC 26-11-2(a): Sterilization of Equipment and Supplies LPP requested - Neither approved or denied 410 IAC 26-11-3 Laundry LPP only requested 26-13-3(b)	Non-surgical abortions will be performed by medication, not surgery; no sterile equipment or supplies are required in order to give patient an oral medication. The clinic will use disposable linens and therefore there is no need for the laundry processing requirements to apply.
410 IAC 26-13-1 Anesthesia LLP requested Neither Approved or denied	No anesthesia is used and therefore there is no need for the listed anesthesia services.
410 IAC 26-13-3(b) and (c) Anesthesia and Surgical Services: emergency equipment and supplies LPP requested ISDH ruled NO IV sedation waived not required	There is no procedure performed and no procedure room; there is no recovery needed and no recovery room. Therefore, there is no need for the itemized emergency supplies.
410 IAC 26-17-2(c)(3): Toilet Room LPP same - Approved	The clinic does not have a separate restroom (toilet and hand washing station) in the waiting room. However, there is a patient restroom (toilet and hand washing station) that will also be available to visitors in the waiting room.
410 IAC 26-17-2(c)(4) Drinking Fountain LPP same - Approved	The clinic does not have a water fountain. However, we will provide a water cooler and/or bottled water to patients and visitors.
410 IAC 26-17-2(d)(1) Physical Plant Standards: procedure room size and traffic flow LPP Same - Approved	As noted above, there is no procedure performed and no procedure room used for a non-surgical abortion. Medications may be dispensed in an examination room, which may be less than 120

	square feet. There is no need for procedure rooms to be segregated/ removal from traffic flow as there are no such rooms.
410 IAC 26-17-2(d)(2) Hand Washing Station in Procedure Room LPP - same APPROVED	As noted above, there are no procedure rooms. Hand washing stations are available in the patient restroom.
410 IAC 26-17-2(d)(3) Scrub Facilities LPP Same APPROVED	As noted above, there are no procedures performed for non-surgical abortions, and no procedure rooms. Therefore, scrub facilities are not required near procedure rooms.
410 IAC 26-17-2(d)(4) Recovery Area/ Rooms LPP Same approved	As noted above, there is no procedure performed in a non-surgical abortion and therefore no need for a recovery area or recovery rooms.
410 IAC 26-17-2(d)(6) Toilets LPP Same approved	As described above, there is a patient restroom (toilet and hand washing facilities) in the clinic area, available for use by patients as well as visitors in the waiting area.

We appreciate your timely consideration of our request, and we await your response. If you have any questions, please do not hesitate to contact me at (512) 291-6505 or john@johnbucy.com.

Sincerely,

John H. Bucy, II