STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)
OFFICE OF HEALTH CARE QUALITY (CHCQ)

Form Approved 3/31/13 DHMH Form AC.APP.1.1

AMBULATORY CARE APPLICATION FOR LICENSURE

SELECT ONE TYPE OF LICENSE (only one agency type may be applied for on each seglication) AGENCY TYPE Ambutatory Surgery Center Antibutatory Surgery Center 10.05 3 years 10.05 10.05 10.05 3 years 10.05 10.05 10.07.18 1 year 10.05 10.07.10 1 year 10.07.11 1 year 10.07.11 1 year 10.07.11 1 year 10.07.15 1 year 10.07.15 1 year 10.07.05 1 year 10	1. GENERA	L INFORMAT	ION								
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3. OWNERSHIP (Type of bush	ness organiz	cation of disclos	sing entity)					
SOLE PROPRIETORSHIP		PARTNERSHIP)	X COR	PORATIO	N		
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NAME AND TITLE			ADDRES	,		PERCENTAGE OWNED		
								
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IF CORPORATION: DATE OF INCORPORATION	14-198	ω	FEIN NUMBER					
NAME OF PRESIDENT			910-576	-1400	CELL NUM	BER		
ADDRESS (number, street) 330 N. HOWAL	d'5+		Balti	more	STATE	21201		
4. BACKGROUND								
Has any owner, officer, dire DHMH within the last five year.				nse revoked, e	suspended	, or denied by the		
2. Does the parent company, facility/agency licensed or s	urveyed by t	he OHCQ? []No ⊠Yes(d LSt. 130	explain) Utime <i>i</i>	ie m	10 21201		
The agency hereby attests 1973; The Americans with D (explain)								
 Have the owners, officers, oprogram under Title 18, 19, 					criminal of	fense involving any		
5. WORKERS' COMPENSAT	ON	•						
Do you have any employees?	X Yes [No "	- 1					
If you answered YES, provide POLICY NUMBER			n insurance into BINDER NUMBE	rmation: R				
INSURANCE COMPANY EFFECTIVE DATE EXPIRATION DATE								
Marsh USIA, Inc. 1-1-2015 1-1-2014								
If you answered NO, additions application (refer to the instruction)	I documenta		Vorkers' Compe	nsation Comm	ission mus	t accompany this		
6. AMBULATORY SURGERY								
DAYS AND HOURS THE OFFICE M SUNDAY	ANAGER IS O MONDAY	N-SITE (In HH:MN TUESDAY	formal) WEDNESDAY	THURSDAY	FRIDA	SATURDAY		
FROM:								
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AC Fax

TO:							
BACK-UP GENERATOR	DAYS OR IS USED						
Yes No		esday 🔲 Wednesday 🔲 Thurs	day 🔲 Friday 🔲 Saturday				
NUMBER OF OPERATIING/PROCEDURE ROOMS NAME OF MEDICAL DIRECTOR							
ACCREDITED	ACCREDITING AGENCY		DATE OF ACCREDITATION				
Yes No]				
If yes provide a copy of letter and/or certificate			}				
DEEMED STATUS	DEEMING AGENCY		DATE OF DEEMED STATUS				
☐ Yes ☐ No							
If yes provide a copy of letter and/or certificate							
IDENTIFY ALL SPECIALTIES PR	ROVIDED	<u> </u>					
☐ Cardiovascular	☐ Neurological	☐ Otolaryngology	Urology				
Colon and Rectal	OB/GYN	Pain Mariagement	Other (specify)				
Endoscopy	Ophthalmology	Plastic Surgery	7				
GI Procedures	Oral	Podlatric					
☐ General	Orthopedic	☐ Thoracic					
Lower Gl Procedures	Other GI Procedures	Upper GI					
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7. BIRTHING CENTER			MMAMAMAAA - 111-71-11-11-11-11-11-11-11-11-11-11-11-				
NAME OF MEDICAL DIRECTOR		NAME OF DIRECTOR OF MIDWIF	ERY SERVICES				
8 COMPREHENSIVE OUT	PATIENT REHABILITATION	FACILITY					
DATE OF ACCREDITATION BY		NAME OF MEDICAL DIRECTOR					
ACCREDITATION OF REHABILI		IAMBIC OF BIEDICAL DIVERTOR					
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Provide a copy of letter and/or ca	rtificate	A 000					
CORE SERVICES PROVIDED Physical Therapy	OTHER SERVICES PR	4	atacad Numa				
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Psychological	Orthotist		piratory Therapist				
Social	Prosthetist	Snee	sch Language Pathologist				
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facility names)			•				
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DHMH Form AC ARP 1 1 (GIST)							

10. HOME HEALTH	AGENCY				· · · · · · · · · · · · · · · · · · ·				
NAME AND ADDRESS OF PARENT AGENCY IF DIFFERENT FROM LICENSED AGENCY									
ACCREDITED ACCREDITING AGENCY DATE OF ACCREDITATION Yes No If yes provide a copy of letter and/or cartificate									
DEEMED STATUS Yes No If yes provide a copy of left and/or certificate	DEEMED STATUS Yes No If yes provide a copy of letter and/or cartificate								
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SKILLED NURSING	<u> </u>	<u> </u>	<u> </u>						
HOME HEALTH AIDES PHYSICAL THERAPY	 		┝┈╠╬	 		<u> </u>			
SPEECH LANGUAGE PATHOLOGY					• • • • • • • • • • • • • • • • • • • •				
OCCUPATIONAL THERAPY					***************************************				
MEDICAL SOCIAL SERVICES					**************************************				
INFUSION SERVICES									
LIST OTHER SERVICES									
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17. AFFIDAVIT			,		
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I hereby swear and affirm	that I am over the age of 21 and	i I am otherwise com	petent to	sign this A	ffidavit.
If the program is going to b	e in more than one applicant's	name, each applicant	t's signat	ure is requ	ilred.
Governing Regulations:					
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