Health Care Facility Licensure Application

As defined in section 3702.30 of the ORC and 3701-83-04 of the OAC

161074 OCT 24

300.00

ODH Use Only
ID # 1014AS
OHL # 41596

Please Print Legibly in Ink or Type

1. Application Type	2. Date of operation or projected opening date or date of change of ownership.
[X] Initial [ ] Change of Ownership	12/1/11

3. Licensure Type - √ only one

[X] **Ambulatory surgical facility**
# of operating rooms 3
# of procedure rooms 3
Is this facility located in a building that houses in-patient care? [X] No [ ] Yes

[ ] **Freestanding dialysis center**
# of hemodialysis stations
# of peritoneal stations

[ ] **Freestanding inpatient rehabilitation facility**
# of patient care beds

[ ] **Freestanding birthing center**
# of birthing rooms

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4. Facility name (DBA) Planned Parenthood Bedford Heights Regional Med Center	Telephone number 440, 232-9732
6. Previous facility name, if applicable	
7. Address 25350 Rockside Rd.	
City Bedford Heights	Zip 44146
County Cuyahoga (BJ)	
8. E-mail address r.dawson@ppneo.org	

9. Mailing address, if different from above

Name		
Address		
City	State	Zip

10. Days and hours of operation for this facility

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.		10:00	8:30	8:30	8:30	8:30	
P.M.		4:00	4:00	4:00	4:00	4:00	

NOV -8 PM 2:

OHIO DEPARTMENT OF HEALTH
DOA BIOS

11. Is this health care facility accredited or certified? ☐ No ☒ Yes

If yes, type Planned Parenthood Federation of America.

If yes, enclose a copy the current accreditation inspection report with this application.

12. This business is a/an ☐ Individual ☐ Partnership ☐ Limited Liability Company ☒ Corporation ☐ Association ☐ Other: _____

Individual owner: Skip questions 19 through 29 **only**.

More than one owner, partnership, corporation, limited liability company or association, skip questions 13 through 18 **only**.

13. Owner's name		
14. Address		
City	State	Zip
15. Phone number	16. Owner's occupation	

17. Owner's business address, if different from question #7

Address			
City	State	Zip	18. Phone number ( )

Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other

19. Business entity name: Planned Parenthood of Northeast Ohio			
20. Address: 444 West Exchange St.			
City: Akron	State: OH	Zip: 44302	21. Phone number: (330) 535-2674
22. Business Activity: Health Care			
23. This business is a ☐ For profit ☒ Not for Profit ☐ Government	24. Date of incorporated or registration: 7/2/07	25. Charter/registration number: 352111 Fed TIN: 34-1015976 DOC # 200718300224	

26. List the **name of each person** who has an ownership interest of 5% or more in the business (attach additional sheets if necessary). N/A

Name: Tara Broderick, President & CEO (Non-profit 501(c)3)	Name:
Name:	Name:
Name:	Name:

Board of Directors officers

27. Officers' names, titles, addresses and phone numbers

Title	Name	Address	Phone Number
Chairman	Adarsh Krishen MD	844 Merriman Rd, Akron OH 44303	(330) 208-0070
Vice Chairman	Gayle Noble	2159 Larch Drive, Wooster OH 44691	(330) 263-9988
Treasurer	Ymatzy DeLeon-Mettee	806 Stonehaven Cal, Hudson OH 44236	(330) 556-4355
Secretary	Christie Lucco	1487 Felton Rd. South Euclid OH 44121	216) 291-4280

28. Statutory agent's name	Address	Phone Number
Kathy Godshall Buckingham Doolittle & Burroughs LLP	191 Nationwide Blvd. #300 Columbus OH 43215	( )

29. If state agency or local government, the name, address and phone number of individual authorized to enter into agreement on behalf of state agency or local government. ☐ **Not Applicable**

Name	Address	Phone Number
N/A		( )

30. On-site administrator's name: Regan Clawson

31. Medical director's name or individual responsible for the provision of health care services	32. License/Certification #
Sarah K Smith, MD	35.092297

33. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04(A)(1)(c) of the OAC within five years prior to the date of this application?

☐ No ☒ Yes *If "yes", provide in writing the individual's name(s) and address(es) of the facilities.*

34. Has the owner(s), administrator or medical director been convicted of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he/she is to carry out?

☒ No ☐ Yes *If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).*

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the occurrence of the change.

Any owner named herein may sign the application. That owner's name must appear in question #13 or #26. If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

Print/Type owner's/representative's name & title	Signature	Date
Tara Broderick President/CEO	Tara Broderick	10/6/11
Print/Type administrator's name	Signature	Date
Regan Clawson		10/6/11
Print/Type medical director's name	Signature	Date
Sarah K Smith, MD		10/6/11