Health Care Facility Licensure Application

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

300

ODH Use Only
ID #
OHL #

Print Legibly in Ink or Type

1. Application Type	2. Date of operation or projected opening date or date of change of ownership.
☐ Initial ☐ Change of Ownership ☒ Initial/Replacing existing facility, ID# 1081AS	upon approvl of ASF License

3. Licensure Type √ only one

☒ **Ambulatory surgical facility**

\# of operating rooms [1] } same

\# of procedure rooms [ ]

Is this facility located in a building that houses in-patient care? ☒ No ☐ Yes

☐ **Freestanding dialysis center**

\# of hemodialysis stations [ ]

\# of peritoneal stations [ ]

\# of training stations [ ]

☐ **Freestanding inpatient rehabilitation facility**

\# of patient care beds [ ]

☐ **Freestanding birthing center**

\# of birthing rooms [ ]

4. Facility name (DBA)		Telephone number
Northeast Ohio Women's Center		330-923-4009
6. Previous facility name, if applicable		
~~2127 State Rd.~~ (same)		
7. Address		
~~Cuyah~~ 2127 State Rd.		
City	Zip	County
Cuyahoga Falls	44223	Summit
8. E-mail address		
neowc2127@gmail.com		

9. Mailing address, if different from above

Name		
Address		
City	State	Zip

504527 DEC 29 14

504525 per rev doc

10. Days and hours of operation for this facility

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.	12p		12p		12p		
P.M.	5p		5p		5pm		

11. Is this health care facility accredited or certified?	☒ No ☐ Yes
If yes, type	
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 ~~DR. DAVID BURKONS~~		
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 (Legal name as registered with the Secretary of State) Northeast Ohio Women's Center			
20. Address 2127 State Rd.			
City Cuyahoga Falls	State OH	Zip 44223	21. Phone number 330-923-4009
22. Business Activity			

23. This business is a ☒ For profit ☐ Not for Profit ☐ Government	24. Date of incorporated or registration	25. Charter/registration number

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

Name	Name
Name	Name
Name	Name

27. Officers names, titles, addresses and phone numbers

Title	Name	Address	Phone Number
President/OWNER	DR. DAVID BURKONS	1611 S. Green Rd S. Euclid, OH 44121	216-297-2061

28. Statutory agent's name (As Registered with the Secretary of State)	Address	Phone Number
DR. DAVID BURKONS	1611 S. Green Rd. South Euclid, OH 44121	216-297-2061

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

30. On-site administrator's name
Michele Tredway

31. Medical director's name or individual responsible for the provision of health care services	32. License/Certification #
DR. DAVID BURKONS MD	35040676

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. ☒ Affirm

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
DR. DAVID BURKONS, MD - OWNER		12/22/14
Print/Type administrator's name	Signature	Date
Michele Tredway	Michele Tredway	12/22/14
Print/Type medical director's name	Signature	Date
DR DAVID BURKONS, MD		12/22/14