

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 <input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership <input checked="" type="checkbox"/> Initial/Replacing existing facility, ID# 1081AS	2. Date of operation or projected opening date or date of change of ownership. upon approval of ASF License
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3. Licensure Type only one

<input checked="" type="checkbox"/> Ambulatory surgical facility # of operating rooms <input type="text" value="1"/> <i>> same</i> # of procedure rooms <input type="text"/>	<input type="checkbox"/> Freestanding dialysis center # of hemodialysis stations <input type="text"/> # of peritoneal stations <input type="text"/> # of training stations <input type="text"/>
<input type="checkbox"/> Freestanding inpatient rehabilitation facility # of patient care beds <input type="text"/>	<input type="checkbox"/> Freestanding birthing center # of birthing rooms <input type="text"/>

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

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

9. Mailing address, if different from above

Name		
Address		
City	State	Zip

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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
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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 <u>Cuyahoga Falls</u>	State <u>OH</u>	Zip <u>44223</u>	21. Phone number <u>330-923-4009</u>
22. Business Activity			
23. This business is a <input checked="" type="checkbox"/> For profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> 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

DR. DAVID BURKONS MD

32. License/Certification #

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?

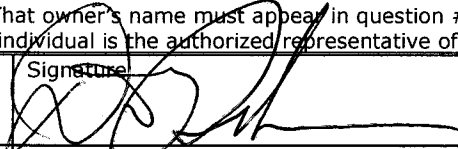
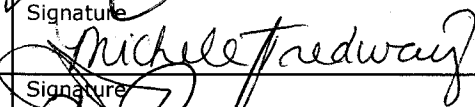

No Yes If "yes", provide in writing the individual's name(s) and address(es) of the facilities.

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		12/22/14
Print/Type medical director's name	Signature	Date
DR. DAVID BURKONS, MD		12/22/14

Ohio Department of Health ~ DQA/BIOS - Licensure Program ~ 246 N. High Street ~ 3rd Floor ~ Columbus, OH 43215 ~ (614) 466-7713

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