

Health Care Facility Renewal Application

As defined in section 3701-83-04 of the Ohio Administrative Code

506642 JAN 22 2015

Facility ID #

0288 AS

Please print legibly in ink or type

1. Facility Name <i>Arterm</i>		
2. Address <i>12000 Shaker Blvd.</i>		Suite
3. City <i>Cleveland</i>	4. Zip <i>44120</i>	5. County <i>Cuyahoga</i>
6. Phone Number <i>(216) 991-4000</i>		7. Fax Number <i>(216) 991-4571</i>
8. E-mail Address <i>info@arterm.org</i>		

Mailing address, if different from above

9. Name		
10. Address		Suite
11. City	12. State	13. Zip

14. Renewal application type


- ☒ Ambulatory surgical facility
☐ Freestanding dialysis center

- ☐ Freestanding birthing center
☐ Freestanding inpatient rehabilitation facility

15. Has there been a change in this facility's capacity?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain	
16. Has there been a change or update to this facility's most recent accreditation status report or findings?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
If yes, explain and provide a copy of the most recent accreditation inspection report and findings, unless the department has been previously notified. Explanation: <i>Re-accreditation, attached</i>	
17. Has there been a change in ownership?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
18. Has there been a change of onsite administrator?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, name	
19. Has there been a change of medical director or individual responsible for the provision of health care services?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, name	
License/certification #	

Expires 3/31/2015

<p>20. If the owner(s), administrator or medical director has changed, has the new individual(s) been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?</p> <p>If yes, provide the individual's name and give a full explanation stating the charge(s), date(s) and disposition on a separate page.</p>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<p>21. Has the 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?</p> <p>If yes, provide the individual's name and list the name(s) and address(es) of the facilities on a separate page.</p>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes

<p>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 change occurs.</p> <p>I certify that I am an owner of the facility or the authorized representative of the owner.</p>	
<p>Print/type owner's or representative's name</p> <p><i>Heather Harrington</i></p>	<p>Title</p> <p><i>Director of Clinic Operations</i></p>
<p>Signature</p> 	<p>Date</p> <p><i>1/20/15</i></p>