Health Care Facility Renewal Application

Ohio Department of Health - Office of Health Assurance and Licensing
Section 3701-83-04 of the Ohio Administrative Code

Facility ID #
0288AS

Facility Name PRETERM		
Address 12000 SHAKER BOULEVARD		
Address2		
City CLEVELAND	**Zip** 44120	**County** CUYAHOGA
Phone Number (216)991-4000	**Fax Number** (216)373-0307	
E-mail Address info@preterm.org		

☑ **Ambulatory surgical facility**

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

Operating Rooms 0
Procedure Rooms 0
Total Licensed Capacity 5

Mailing address, if different from above

Has there been a change in this facility's capacity?	☒ No ☐ Yes
If yes, has a change of ownership application been submitted to our office?	
If yes, explain N/A	

Transfer Agreement

Is Ambulatory Surgical Facility a provider-based entity of a hospital? ☒ No ☐ Yes
Do you have a transfer agreement with a local hospital (within 30 miles) ? ☐ No ☒ Yes
Effective Date of Transfer Agreement with local hospital: 09/01/2017

Hospital Name: University Hospitals of Cleveland
Hospital Address: 11100 Euclid Avenue
City: Cleveland
State: Ohio
Zip: 44106

Business Entity Type

This business is a/an
☐ Limited Liability Company ☐ Individual ☐ Partnership
☑ Corporation ☐ Association ☐ Government
☐ Other:

Business Entity Type Details

Business Entity Legal Name (Legal name as registered with the Secretary of State):
Preterm-Cleveland

Address 12000 Shaker Blvd
City Cleveland
State OH
Zip 44120
Phone (216)472-3217

Statutory agent's name (As Registered with the Secretary of State)
Chrisse France

Address Preterm
Phone (216)472-3217
Business Activity health care
Tax Status Not for profit
Date Incorporated or Registered 06/01/1973
Secretary of State Charter/Registration/Entity Number 440144

Officers

Salutation:
First Name:
Middle Initial:
Last Name:
Title:
Address:
City:
State:
Zip:
Email:
Phone:
Fax:

Owners

Owner Type: Business Entity Owner
Start Date:
End Date:
Corporation Name: PRETERM-CLEVELAND
Title:
Address:
City:
State:
Zip:
Email:
Phone:
Fax:
Percentage: 0%

Is your facility accredited? ☐ No ☒ Yes

If yes, has there been a change or update to this facility's most recent accreditation status report or findings? ☒ No ☐ Yes

If report changed, explain and provide a copy of the most recent accreditation inspection report and findings, unless the department has been previously notified.

Explanation:
N/A

Has there been a change in ownership? ☒ No ☐ Yes

If yes, has a change of ownership application been submitted to our office?	☐ No	☐ Yes
Has there been a change of onsite administrator?	☒ No	☐ Yes
If yes, name N/A **Medical Director License #:** 35-076274		
If the administrator has changed, has the new administrator 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? **If yes, explain** N/A	☐ No	☐ Yes
Has the new administrator 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
Has there been a change of medical director or individual responsible for the provision of health care services?	☐ No	☒ Yes
If yes, name Mitchell Reider MD **License/certification #** 35-076274		
If the medical director has changed, has the new medical director 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? **If yes, explain** N/A	☒ No	☐ Yes
Has the new 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

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.

I certify that I am an owner of the facility or the authorized representative of the owner.

Print/type owner's or representative's name	Title
Chrisse France	executive director
Signature	**Date**
(EIDC Online Submission)	3/23/2018 4:54:43PM

ODH USE ONLY

Date received	Receipt number	Tracking number	Fee amount	Renewal year

		106746		2018 - 2019

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Ohio Department of Health - Division of Quality Assurance

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(Addendum page)

New Administrator's Affiliations:

New Medical Director's Affiliations:

Accreditation Inspection Information:

Means of Inspection being sent to ODH:	
Date Sent:	
Date of Inspection:	
Provider or Accreditation Number:	
Number of Inspection Documents Sent/Attached:	0

Supporting Documentation:

Document Type: fire inspection
Method of Delivery Type: Upload
Sent By: CHRISSE.FRANCE on 3/23/2018 4:54:13 PM
*** Document attached to this Email ***

Document Type: Transfer Agreement
Method of Delivery Type: Upload
Sent By: CHRISSE.FRANCE on 3/23/2018 4:33:53 PM
*** Document attached to this Email ***