DEPARTMENT OF HEALTH
AMBULATORY SURGICAL TREATMENT CENTER
APPLICATION

AMBULATORY SURGICAL TREATMENT CENTER APPLICATION

To: Health Regulations and Licensing Administration
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

We, (1) Laura Meyers and (2) _____

Resident at (1) [redacted] Washington DC 20007

(2) _____
Street Address City State Zip Code

Officers of the center named below, certifying that we are twenty-one years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a center during the 2016 calendar year subject to the provisions of District of Columbia Law 2-66, and to any regulations and standards adopted thereunder.

Name of ambulatory surgical treatment center: Carol Whitehill Moses Center

Location: 1225 4th St. NE Washington DC 20002 202-763-7404
Street Address City State Tele. Zip Code

Name of person in charge: Laura Meyers

Medical director or principal physician: Dr. Serina Floyd

[redacted]
Street Address City State Zip Code

Name of organization owning and conducting center: Planned Parenthood of Metropolitan Washington DC, Inc.

Type of organization: Non-Profit Corp. ✓, Private Corp. _____
(Attach lists of board officers and members)

Class of institution for which application is made: (Check one)

[ ] General Surgery [ ] Family Planning [X] Other (Specify) Abortion Services

Transfer agreement with a hospital within twenty minutes ambulance time [X] Yes [ ] No

Name of hospital: Washington Hospital Center

Number of surgical procedures performed in the previous fiscal year 0 (2800 projected)

Application and license fee* of ~~2800~~ 1680 drawn payable to: ☐D.C. Treasurer☐is attached to this application. (Fee is not refundable.) There is also attached documentary evidence of financial responsibility on the part of the applicant institution in the sum of not less than One Hundred Thousand Dollars ($100,000.00) per occurrence and Three Hundred Thousand Dollars in the aggregate which become readily available for the benefit of any person who may become aggrieved as the result of the center.

Signatures of Applicants (1) [signature] Title CEO

(2) _____ Title _____

Sworn and subscribed to before me this 6 day of September, 2016

Notary Public for the District of Columbia

My commission expires KAREN KELSEY NOTARY PUBLIC DISTRICT OF COLUMBIA My Commission Expires February 14, 2021

NOTE: THIS FORM FOR APPLICATION OF ASSOCIATION OR OTHER NON-INDIVIDUAL APPLICANT

* Refer to license fees for ambulatory surgical centers for correct fee

District of Columbia: SS
Subscribed and sworn to before me, in my presence,
this 6 day of September, 2016

Karen Kelsey, Notary Public, D.C.
My commission expires February 14, 2021

HEALTH REGULATION AND LICENSING ADMINISTRATION
RECEIPT FORM

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration (HRLA)
Office of Health Professional Boards
899 North Capitol Street, NE, 1st Floor
Washington, DC 20002
Call Center: 1-877-672-2174 (Phone), (202) 724-5145 (Fax)

Date 9/8/16

RECEIVED FROM: Lena Schneider DOB 4/672

FOR: Ambulatory Surgical Treatment Center App BOARD: Facilities

	Criminal Background Check		
	Check or Money Order (ONLY)	MO# / CK# / CC	AMOUNT $ 1680.00
	Clean Hands Form	00019470	
	Copies of Legal Name change Documents		
	Social Security Number		
	Signed Application for Registration		
	Two 2" x 2" Photos	RCD BY: K Jones	
	Copy of current License or I.D.		
	FINES — PAID IN FULL	BALANCE $ 0	

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DOCUMENT COPY

Office of Finance and Treasury
Date: 9/8/2016 3:36 PM
Office: OFT-HRLA Term:DOH-DJXCC9Y1
Batch: 44560 Batch Date: 9/8/2016
Cashier:OFT49
Trans #:22

DEPARTMENT OF HEALTH Rcpt: 02054468
Comment/Document: LENA SCHNEIDER
Payment Total: $1,680.00
Payment Distribution:
4672 HCO (3230) r5450-45300 $1,680.00
CK Tendered: $1,680.00

Thank you for your payment.
Have a nice day!