Application for License to Operate an Abortion Facility

FOR ADMINISTRATIVE USE ONLY Date Received_____

Amount Received_____

I. IDENTIFICATION

Facility Name _____

Address _____

City/County/Zip _____

Telephone number _____Fax#:_____

Director _____

E-mail Address:_____

Date operation began at current address _____

Date operation began under current owner_____

II. OWNERSHIP

Name and address of direct owner:

_____

_____

_____

NOTE: Provide the following supporting documentation as an attachment to this application:

- The of name, mailing address, email address and phone number each person or legal entity having an ownership interest in the facility.
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation in addition to the information requested below.
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

Parent Corporation
(If Applicable)

_____

_____

_____

Management Company
(If Applicable)

_____

_____

_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time.

I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel.

I agree to provide written agreements with a Kentucky-licensed, acute care hospital and a local ambulance service with this application as required by KRS 216B.0435(4) and 902 KAR 20:360.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

An incomplete application or failure to submit the licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that as a condition precedent to provisional licensure or renewal, this facility shall be in compliance with all applicable state and federal statutes and administrative regulations.

_____	_____	_____
Signature of Authorized Representative	Title	Date

The annual licensure fee for an abortion facility is $155.00.

Make check payable to Kentucky State Treasurer. **DO NOT SEND CASH.**

Return application, agreements, and fee to:

Division of Health Care
275 East Main Street, 5E-A
Frankfort, Kentucky 40621