State of Illinois
Illinois Department of Public Health

Application for Hospital Licensure

CONFIDENTIAL NATURE OF INFORMATION - As required by law, the information given in this application will be considered confidential and will not be disclosed publicly by the Department in such manner as to identify individuals or hospitals, except in a proceeding involving the question of licensure or revocation or in other circumstances as may be approved by the Hospital Licensing Board.

GENERAL INSTRUCTIONS

A. All items of information on the Application for Hospital Licensure form must be filled in when a hospital makes its initial application for license.

B. Prepare the application form in duplicate; send the original to the Illinois Dept. of Public Health, 525 West Jefferson Street, Fourth Floor, Springfield, Illinois 62761-0001; and keep a copy for the hospital files.

C. Please complete using PDF writer or print and complete with typewriter or print legibly with permanent type ink.

D. The applicant should feel free to provide additional information on an attached sheet. This should be done whenever the space on the form is inadequate to give a complete answer.

E. This application *must* be executed and verified by the individual owner or by two officers in the case of a hospital-owned corporation, association, or governmental unit or agency.

F. There is no license fee.

G. This initial application is the only one required of the hospital. Annual re-application is not required. However, if the hospital's location, ownership changes, or a change in clinical services results in a change of license category, a re-application is then required . Refer to Section 250.110a.

H. Separate applications are required for hospitals operated on separate premises, even though operated under the same ownership and/or management.

I. Separate applications are required for each individual hospital, even though ownership is the same.

Additional instruction for completing the application for hospital license

Section 250.210 The Governing Board

This section of the hospital licensing requirements states that the hospital governing board be formally organized in accordance with a written constitution and by-laws.

Please include a copy of the hospital's constitution and by-laws as part of this application.

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Definitions

1. Definition of Hospital. For the purposes of this application, the term hospital means any institution, place, building or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment and/or care of two or more unrelated persons admitted for overnight stay or longer in order to obtain medical, including obstetric, psychiatric and nursing, care of illness, disease, injury, infirmity or deformity. All places where pregnant females are received, cared for or treated during delivery shall be considered to be a hospital within the meaning of this act irrespective of the number of patients received or the duration of their stay. The term hospital includes general and specialized hospitals, tuberculosis sanitaria, and includes maternity homes, lying-in homes and homes for unwed mothers in which care is given during delivery.

2. Bed complement. Give the present number of beds actually set up for in-patient care, including children's cribs. (Exclude bassinets in maternity department nurseries, but count those in pediatric departments and in premature nurseries if not located in the maternity department. Exclude labor and recovery beds.)

3. Bed capacity. Based only on space designed as patient rooms, whether or not beds are installed; compute the “normal” bed count on the basis of a minimum of 100 square feet of floor area per bed in private rooms, 80 square feet per bed in semi-private and ward rooms, 50 square feet per pediatric crib or bed, 30 square feet per bassinet in pediatric departments. There shall be a minimum of 30 square feet of floor area for each bassinet and three feet between bassinets in a nursery. In Special Care and Observation Nurseries, the floor area per bassinet shall be determined by the program but not be less than 40 square feet. The should be 80 to 100 square feet of space fo each infant cared for in the Level III or Intensive Care area.

4. Emergency capacity. Number of beds that can reasonably be added to the bed complement in periods of unusually high occupancy.

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DEPARTMENT USE ONLY
Hospital ID Number

In accordance with requirements of the Hospital Licensing Act (III.Rev.Stat. 1961, Chap 111 1/2, Secs. 142-157) and the regulations issued pursuant thereto, application is hereby made for a license to establish, conduct and/or maintain a hospital.

I. NAME AND LOCATION OF HOSPITAL

Exact legal name _____

Street and number _____

City _____ Zip Code _____

Township _____ County _____

Is the hospital located outside the corporate limits of the city? ☐ Yes ☐ No

Main phone number for public use _____

Administration phone number for IDPH use _____

Administration fax number for IDPH use _____

II. OWNERSHIP AND ADMINISTRATION

Type of control (check one only)

GOVERNMENTAL

○ Federal ○ State ○ County ○ Township
○ City ○ Hospital district ○ Sanitarium district

NOT FOR PROFIT CORPORATION

○ Church operated or affiliated ○ Other non-profit

PROPRIETARY

○ Individual ○ Partnership ○ Corporation

OTHER (explain) _____

Date incorporated under the laws of the State of Illinois _____

Established by * _____ Year Opened _____

Now owned by* _____ Date ownership effective _____

Operated by* _____

(*NAME OF AGENCY, ORGANIZATION, ASSOCIATION, CORPORATION, OR INDIVIDUAL)

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II. OWNERSHIP AND ADMINISTRATION (continued)

Official name of governing body _____

(e.g. BOARD OF TRUSTEES, BOARD OF DIRECTORS, ETC.)

Officers of the governing body (Governmental and non-profit hospitals list officers of governing body. Proprietary hospitals list names and address of individual owner, partners or officers of corporation.)

President _____ Address _____

Vice President _____ Address _____

Secretary _____ Address _____

Treasurer _____ Address _____

Person in charge of hospital

Name _____ Title _____

Date appointed to this position _____ ☐ Full time ☐ Part time

If part time, what other position or employment _____

_____

Applicants (who are not individuals or sole proprietorships) provide the name and address of registered agent or person designated to receive service of process in Illinois.

Name _____

Address _____

City _____ State _____ Zip Code _____

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II. OWNERSHIP AND ADMINISTRATION (continued)

Number of beds for patients (exclude beds in emergency departments, labor and recover rooms, etc.)

	NUMBER OF BEDS
Total bed complements	_____
Bed capacity.....	_____
Emergency capacity.....	_____
Total adult certified beds.....	_____
Extended Care Facilities certified beds (hospital licensed).....	_____
Extended Care Facilities certified beds (nursing home licensed).....	_____

Bed complement (breakdown of total bed complement) by clinical service

	BEDS
Internal Medicine	_____
General surgical	_____
Gynecological and obstetrics	_____
Intensive care	_____
Acute Mental Illness	_____
Neonatal Intensive Care Level II	_____
Neonatal Intensive Care Level III	_____
Pediatrics	_____
Long Term Care	_____
Restorative/Rehabilitation	_____
Other	_____ Total _____

Number of bassinets in maternity department nurseries _____

Are any patient beds located in rooms below ground level? ☐ Yes ☐ No How many beds? _____

Number of patient care days (exclusive of newborn) rendered in last calendar or fiscal year _____

Number of patients discharged and those who died (exclusive of newborn) in same period _____

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III. MEDICAL STAFF

Is the medical staff organized with written by-laws, officers, regular meetings, and written minutes? ☐ Yes ☐ No

Is the medical staff "closed" (i.e. restricted to active staff only) or open? _____ (i.e. both active and courtesy groups?)

To what staff group do dentists belong? _____

Chief of Staff _____ Illinois license no. _____

IV. DEPARTMENTS AND SERVICES

A. Nursing Department

Name of person in charge _____ Title _____

Current Illinois registration number _____

B. Dietary Department

Name of person in charge _____ ☐ Full Time ☐ Part Time

Has the hospital arranged for the service of a consultant dietician if no full -time or part-time dietician is employed?

☐ Yes ☐ No

C. Radiological Department

Is radiological service provided in the hospital? ☐ Yes ☐ No

If not, name hospital, clinic or other facility providing this service _____

Types of service provided

Diagnostic

Radiographic ☐ Yes ☐ No

Regular No. of radiographis units _____ MA rating of each radiographic unit _____

Portable No. of radiographis units _____ MA rating of each radiographic unit _____

Dental No. of radiographis units _____ MA rating of each radiographic unit _____

Other No. of radiographis units _____ MA rating of each radiographic unit _____

Fluoroscopic ☐ Yes ☐ No

Radioactive isotopes ☐ Yes ☐ No

Interventional ☐ Yes ☐ No

Is it hospital policy to make x-ray film of the chest as a routine admission procedure? ☐ Yes ☐ No

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IV. DEPARTMENTS AND SERVICES (continued)

C. Radiological Department (continued)

Therapeutic

Deep therapy	☐ Yes ☐ No	KVP rating of unit	_____
Intermediate	☐ Yes ☐ No	KVP rating of unit	_____
Superficial	☐ Yes ☐ No	KVP rating of unit	_____
Radium (radon) therapy	☐ Yes ☐ No		
Radioactive isotopes	☐ Yes ☐ No		

Name of physician in charge of service _____

Is he/she Board certified? ☐ Yes ☐ No Current Illinois registration number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week ____ days per month ____ ☐ On call

If hospital is not served by a full-time radiologist, or regularly visited by a part-time radiologist, is the radiological service supervised by a member of the medical staff?

☐ Yes ☐ No

Name _____ Illinois license number _____

D. Clinical Laboratory Department

Is laboratory service provided in the hospital? ☐ Yes ☐ No CLIA # _____

If not, name hospital, clinic or other facility providing this service _____

Check types of services provided

☐ Tissue Pathology	☐ Histocompatibiliy	☐ Photography	☐ Basal metabolism
☐ Clinical Pathology	☐ Blood bank	☐ Autopsy	☐ Hematology
☐ Radiobioassay	☐ Diagnostic Immunology	☐ Microbiology	☐ Chemistry
☐ Immunohematology	☐ Clinical Cytogenetics		

☐ Other (specify) _____

Name of physician in charge of service _____

Is he/she Board certified? ☐ Yes ☐ No Illinios license number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week ____ days per month ____ ☐ On call

If hospital is not served by a full-time pathologist, or regularly visited by a pathologist, is the clinical laboratory service supervised by a member of the medical staff?

☐ Yes ☐ No

Name _____

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IV. DEPARTMENTS AND SERVICES (continued)

E. Anesthesiology Department

Name of physician in charge of service _____

Is he/she Board certified? ☐ Yes ☐ No Illinios license number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

If the hospital is not organized under Anesthesia Service, is the anesthesia department supervised by a member of the medical staff:

☐ Yes ☐ No

Name _____ Iliniois License number _____

Who usually gives the anesthetic? ☐ M.D. ☐ Nurse Anesthetist ☐ Other, specify _____

Is the person who usually gives the anesthetic a hospital employee? ☐ Yes ☐ No

F. Outpatient Department

If the hospital has an organized out-patient department, please list the organized clinics conducted (e.g. STD, cancer, pre-natal, orthopedic etc).

_____ _____ _____

_____ _____ _____

If the hospital has no organzied out-patient department, check types of services provided for out-patients:

☐ Laboratory examinations
☐ x-ray examinations
☐ x-ray or radium therapy
☐ Emergency services
☐ Outpatient surgical services
☐ Other _____

G. Medical Department

Is there an organized medical department? ☐ Yes ☐ No

Name of physician in charge of service _____

Is he/she Board certified? ☐ Yes ☐ No Illinios license number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

H. Surgical Department

Is there an organized surgical department? ☐ Yes ☐ No

Name of chief surgeon _____

Is he/she Board certified? ☐ Yes ☐ No Illinios license number _____

Does this person devote full time to surgery? ☐ Yes ☐ No

If no, indicate ☐ Part time days per week _____ days per month _____ ☐ On call

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IV. DEPARTMENTS AND SERVICES (continued)

I. Restorative and Rehabilitation Department

Is there a restoration and rehabilitation department? ☐ Yes ☐ No

Check types of services provided

☐ Physical therapy ☐ Vocational counseling ☐ Dietary
☐ Occupational therapy ☐ Therapeutic recreation ☐ Psychology
☐ Speech pathology ☐ Social services
☐ Other (specify) _____

Name of person in charge of services _____

Professional specialty _____ Illinois License number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

J. Pathology Department

Is there an organized pathology department? ☐ Yes ☐ No
Is there a tissue committe of the medical staff? ☐ Yes ☐ No
Are anatomical pathological services provided in the hospital? ☐ Yes ☐ No

If not, name hospital, clinic or other facility providing this service _____

_____

Name of pathologist in charge of services _____

Is he/she Board certified? ☐ Yes ☐ No Illinois License number _____

Indicate basis of employment:

☐ Full time ☐ Regular part time ☐ Regular consultative (consultative visits at least semi monthly)
☐ Other _____

K. Intensive Care Department

Is there an organized intensive care department? ☐ Yes ☐ No

Name of person in charge _____

Illinios license number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

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L. Dental Department

Is there an organized dental department? ☐ Yes ☐ No

Name of dentist in charge of services _____

Illinois License number _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

M. Social Services Department

Is there an organized social services department? ☐ Yes ☐ No

Name of person in charge _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

N. Medical Records

Is there an organized medical records department? ☐ Yes ☐ No

Name of person in charge _____

Is he/she (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

Is there a medical records committee? ☐ Yes ☐ No

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PERSONNEL BY DEPARTMENTS

Please indicate the anticipated total number of full time employeees (FTE) to be employed at the hospital per Department. Place an X in the appropriate category (employed or contractual) for the Deparment. If this application is for an existing licensed hospital then identify the total FTE on the last day of the most recent pay period. Include only paid employees. If one employee serves in more than one positon, include them in both departments.

DEPARTMENT		Employed Staff	Contractual	Total FTE
A. Administration				
B. Business Office and Records				
C. Medical Records and Library				
D. Anesthesiology	Anesthesiologist Nurse Anesthetist			
E. Nursing	R.N. L.P.N. Others			
F. Nursing Education	Administrative Instructors			
G. X-ray and Radiology	Radiologists Technicians Others			
H. Clinical Laboratory	Pathologists Technicians Others			
I. Dietary	Supervisory Cooks and Bakers Others			
J. Pharmacy	Pharmacist Technicians Others			
K. Medical Social Service				
L. Restorative and Rehabilitation	PT OT PTA OTA SP Other			

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PERSONNEL BY DEPARTMENTS (continued)

DEPARTMENT		Employed Staff	Contractual	Total FTE
M. Housekeeping				
N. Plant Operations Maintenance and Repair				
O. Laundry				
P. Professional Services	Physicians - Surgeons			
	Residents			
	Interns			
Q. Dental				
R. Other Departments*				
	Total			

* If the hospital has other organized departments or other employees, please list and designate the department or the employee's job title.

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PHYSICAL PLANT

Physical Plant	Original Building	Additions			
		1	2	3	4
A. Year Built					
B. Number of stories (exclude Basement)					
C. Sprinkler System	☐ Full	☐ Full	☐ Full	☐ Full	☐ Full
	☐ Partial	☐ Partial	☐ Partial	☐ Partial	☐ Partial
	☐ Non	☐ None	☐ None	☐ None	☐ None
D. Number of beds on each floor					

Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____
Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____
Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____
Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____
Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____
Floor Name _____	# of beds _____	Floor Name _____	# of beds _____	Floor Name _____	# of beds _____

E. Name of person in charge of physical plant: ______________________________

F. New additions and remodeling

1. Is the hospital building a new addition or making remodeling changes at the present time? ☐ Yes ☐ No
   If so, please describe

   ____

   ____

2. How will this affect bed complement? ______________________________

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ACCREDITATION

A. Is the hospital fully approved by the Joint Commission of Accreditation of Hospitals (JCAHO)/American Osteopathic Association (AOA)? ☐ Yes ☐ No

B. If no, has the hospital requested appraisal by the JCAHO/AOA? ☐ Yes ☐ No

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Information supplied by

Name and title _____

Date _____

CONFIDENTIAL INFORMATION - This informtion will be considered confidential and will not be disclosed publicly by the Department in such a manner as to identify individuals or hospitals.

VERIFICATION

STATE OF _____

County of _____ } **S. S.**

_____ And _____

being by me duly sworn on _____ oath, deposes and says that _____ have/has read the foregoing application and know(s) the contents thereof; that the statements concerning the above named hospital, therein contained, are correct and true of _____ own knowledge, and further gives reasonable assurance of the ability and intention of said hospital to comply with the regulations promulated under the Hospital Licensing Act.

(An application on behalf of a corporation, association or a governmental unit of agnecy shall be made and verified by any two officers thereof.)

Signed _____

Title _____

Signed _____

Title _____

Signed and sworn (or attested) to before me this _____ day of _____ 20_____

_____
NOTARY PUBLIC

My commission expires _____ 20_____

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APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility applications:

- Ambulatory Surgical Treatment Center
- Home Health Agency
- Hospice Program
- Hospital

Section 10-65 (c) of the Illinois Administrative Procedure Act, 5ILCS 100/10-65(c), was amended by P.A/ 87-823 and required individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR) ☐ Yes ☐ No

The following question must be answered only if the applicant is an individual (sole proprietor):

I hereby certify, under pendalty of perjury, that ☐ I am ☐ I am not (check one) more than 30 days delinquent in complying with a child support order.

SIgned _____

Date _____

FAILURE TO SO CERTIFY MAY RESULT IN A DENIAL OF THE LICENSE; AND MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT (5ILCS 100/10-65 (c)).