APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only
Date Received *(mm/dd/yyyy)*____________ **Date Approved** *(mm/dd/yyyy)*____________ **Date Rejected** *(mm/dd/yyyy)*____________

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ **New Facility** ☐ **Renewal** ☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease** (mm/dd/yyyy)**)** ____________________
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4

Telephone Number	Fax Number	
( )	( )	Abortion Clinic e-mail address:____________________ Internet Web Address:____________________

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state		
Street Address *(number and street)*		P.O. Box
City	State	ZIP Code+4

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
( )	( )		

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☐ Laboratory: CLIA Certificate Number ________________ ☐ Radiology ☐ Counseling

☐ Family Planning ☐ Pharmacy ☐ Other *(List)*: ________________________________

2. Abortion Services: ☐ Drug Induced Only ☐ Surgical Only ☐ Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☐ Registered Nurses: ☐ Licensed Practical Nurses: ☐ Licensed Social Workers: ☐

Other *(List title and number, do not use acronyms)*: ____

E. Number of Procedure Rooms Utilizing:

Minimal Sedation ☐ Moderate Sedation ☐

F. Type of Entity:

For Profit

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* ________________________

Non-Profit

- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* ________________________

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* ________________

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO		
Vice-President / Vice-Chairperson / COO		
Treasurer / CFO		
Secretary		

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ **YES** ☐ **NO**

Has any principal or clinic staff member been convicted of a felony? ☐ **YES** ☐ **NO**

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ **YES** ☐ **NO**

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	
Date of Signature *(mm/dd/yyyy)*:	
Signature of the Clinic Administrator:	
Printed Name and Title:	
Date of Signature *(mm/dd/yyyy)*:	

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204