APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R2/6-06)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)
Form Approved By State Board Of Accounts-2006

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____ **Date Rejected** _____

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)***_____
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			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		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			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 # _____ ☐ Radiology ☐ Counseling

☐ Family Planning ☐ Pharmacy ☐ Other (List): _____

2. Surgical Services: ☐ Gynecology ☐ Other (List):_____

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): _____

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic ☐ Moderate/Conscious Sedation ☐

F. Type of Entity:

For Profit	**Non-Profit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ 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

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:	
Signature of the Clinic Administrator:	
Printed Name and Title:	
Date of Signature:	

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

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

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

2. Any supporting attachments; and

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

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236