

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES
 150 N. 18th Avenue, Suite 450, Phoenix, Arizona 85007
RENEWAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE
 A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution			
Physical Address (optional)		City	State
Mailing Address		City	State
Telephone number	Fax number	E-mail address (optional)	
Health care institution class or subclass:	License Number	Expiration Date	

II. OWNER INFORMATION (Name of Corporation or LLC, etc.)

Owner 's name		
Address		
City		Zip code
Telephone number		Fax number
The owner is a: (check one)	<input type="checkbox"/> Proprietary (For Profit)	<input type="checkbox"/> Non-proprietary (Non-Profit)
The owner is a: (check one)	<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Partnership
<input type="checkbox"/> Limited liability company	<input type="checkbox"/> Corporation	<input type="checkbox"/> Governmental Agency

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:

If the owner is a partnership, the name of each partner;
 If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
 If the owner is a corporation, the name and title of each corporate officer; or
 If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name	Title
Name	Title
Name	Title
Name	Title

B. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended since the last application was submitted?
 Yes No.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended since the last application was submitted?
 Yes No.

- D. If either of the previous questions is answered yes, include on a separate sheet of paper for each yes answer:
1. The reason for the denial, suspension, or revocation;
 2. The date of the denial, suspension, or revocation;
 3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER (Facility Administrator)

Name	Title
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. § 36-422(B) the application must be signed, as follows:

- (1) If an individual, by the owner of the institution;
- (2) If a partnership or corporation, by two of the partners or corporate officers; or
- (3) If a governmental unit, the head of the governmental department having jurisdiction.

Signature	Date	Signature	Date
Title		Title	

VI. TIME FRAME

Pursuant to A.R.S. § 41-1075 The applicant agrees to extend the substantive review time frame if necessary. This will not exceed 25% of the overall time frame.

Provider Signature: _____ Representative of DHS: _____

For DHS use only: Correct application fee enclosed: _____ Yes _____ No _____ Check #: _____