New Jersey Department of Health
Division of Certificate of Need and Licensing
Office of Certificate of Need and Healthcare Facility Licensure

US Postal Service
P. O. Box 358
Trenton, NJ 08625-0358

Overnight Delivery
25 South Stockton Street, 2nd Floor
Trenton, NJ 08608-1832

SURGICAL PRACTICE APPLICATION FOR

☐ **REGISTRATION** ☐ **RENEWAL** ☐ **RELOCATION** ☐ **TRANSFER OF OWNERSHIP**

(Check off appropriate box)

FOR STATE USE ONLY		
Team	☐ Approval ☐ Denial	Amount Received **$**
Facility ID No.		Date Received
Reviewer Signature		Date

SECTION 1

Legal Name of Surgical Practice			**Date Surgical Practice Commenced (or will commence) Operation**
Operating Room Address			Class of Operating Room
City	State	Zip Code	County
Telephone Number	Fax Number	Email Address	
Name of Administrator/Manager			
Emergency Contact			
Emergency Telephone Number	Emergency Fax Number	Emergency Email Address	
Mailing Address (if different from above)			County
City	State		Zip Code

SECTION 2

Name and Title of Individual or Current Registered Agent Upon Whom Orders May be Served *(Must be a NJ Resident)*

Name: _____

Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SURGICAL PRACTICE APPLICATION
(CONTINUED)

Legal Name of Surgical Practice	Date Surgical Practice Commenced (or will commence) Operation

SECTION 3
The New Jersey Board of Medical Examiners Approved Professional Practice Form of this Surgical Practice is:

SECTION 4

OWNERSHIP INFORMATION

- Identify 100% of the ownership of the surgical practice below. Attach additional sheets, if necessary.

Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______
Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______
Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______

SURGICAL PRACTICE APPLICATION
(CONTINUED)

Legal Name of Surgical Practice	**Date Surgical Practice Commenced (or will commence) Operation**

SECTION 4, Continued

OWNERSHIP INFORMATION, Continued

- Identify 100% of the ownership of the surgical practice below. Attach additional sheets, if necessary.

Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______
Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______
Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______	Name: ______ N.J. Professional License: ______ N.J. License Number: ______ Address: ______ City: ______ State: ______ Zip Code: ______ SSN/Tax ID: ______ % Ownership: ______

SURGICAL PRACTICE APPLICATION
(CONTINUED)

Legal Name of Surgical Practice	**Date Surgical Practice Commenced (or will commence) Operation**

SECTION 5

1. Have any principals, owners, operators or managers, of the surgical practice ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?

☐Yes ☐No If Yes, indicate whom and give details. (Attach additional sheets if necessary):

2. Have any principals, owners, operators or managers of the surgical practice ever been indicted for or convicted of a felony crime?

☐Yes ☐No If Yes, indicate whom and give details. (Attach additional sheets if necessary):

SECTION 6

Surgical practices are required to report the following information annually upon registration. This section must be completed in order for a registration renewal to be issued.

1. Number of surgical patients served by payment source:

Private Insurance:	_____	Medicaid Participant:	_____
Medically Indigent:	_____	Private Pay:	_____
Medicare Participant:	_____		

2. Number of new surgical patients accepted since last registration:

3. Provide the number of practitioners who are involved in the surgical practice for the following categories:

Surgeons	_____	Anesthesiologists	_____
Physicians (Other)	_____	Physician Assistants	_____
Advanced Practice Nurses	_____	Registered Nurses	_____

SECTION 7

This Surgical Practice is:

☐ Certified by the Centers for Medicare and Medicaid Services

☐ Accredited as an Ambulatory Surgery Facility by _____
(Name of Independent Accreditation Organization)

Certification or Accreditation Expires on: _____
(Date)

Include a copy of the surgical practice's current certification or accreditation with this application.

SURGICAL PRACTICE APPLICATION (CONTINUED)

Legal Name of Surgical Practice	**Date Surgical Practice Commenced (or will commence) Operation**

SECTION 8

The applicant certifies:

1. That all information contained in this application and all attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
2. That the application has been duly authorized by the applicant; and
3. (a) Since _____ the surgical practice has been and will be operated in accordance with applicable federal rules and state requirements; or

   (b) That the new surgical practice will be operated in accordance with applicable federal rules and state requirements when operations at the surgical practice commence on _____.

Name of Authorized Individual Completing Application *(Type)*	Title

Signature	Date