

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION

MEDICARE AND HOSPITAL PROGRAM

408 Leon Sullivan Way

CHARLESTON, WEST VIRGINIA 25301-1713

APPLICATION FOR BIRTHING CENTER LICENSE

INSTRUCTIONS:

Please read carefully and complete this application in accordance with instructions (use typewriter or print legibly with permanent type ink.)

▪ Application for a birthing center license may be made by an individual owner or administrative officer. An application on behalf of a corporation or government unit shall be made by any two officers thereof or by its managing agents on whom rests responsibility for maintaining approved standards for the facility.

▪ The application shall be verified before an officer of the State authorized to administer oaths, by the individual, or by a member of the firm or association or an officer of the corporation making this application.

▪ This application must be accompanied by a check or money order payable to the West Virginia Department of Health and Human Resources in the amount of ten dollars (\$10.00).

I. NAME AND LOCATION

Name of Facility: _____

Address: _____

Telephone Number: _____

The birthing center has implemented a paternity program pursuant to section thirteen [' 16-2E-13].

YES _____

NO _____

Comments: _____

II. MANAGEMENT AND PERSONNEL OF INSTITUTION

Facility Operated by: (Check One)

- A. Public: County County and City Municipal
- B. Private: Individual Partnership Corporation
- Association Church Other

(If by any other than individual or partnership, state whether profit or not-profit):

C. Exact Name of Individual, Partnership or Organization Operating Facility:

D. Name of Governing Body: (Board of Directors, Trustees, etc.)

E. Name and Address of Officers (with titles) and Members of Governing Board:

	Name	Address
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

F. Name and Title of Administrator or Director:

(Attach an extra sheet if space is not sufficient.)

G. Name of Physician(s) Participating in Development and Review of Policies and Procedures:

H. Name of Physician(s) Available by Telephone 24 Hours a Day:

III. APPLICANT

_____, 19____

A. Signature of Individual/Administrative Officer:

Title or Position: _____

B. If other than Individual/Administrative Officer:

Name

Address

1. _____

2. _____

VERIFICATION

STATE OF WEST VIRGINIA

County of _____)

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof; that the statements concerning the above named birthing center, therein contained, are correct and true of his/her own knowledge.

(Signature of Individual Applicant)

Subscribed and sworn to before me this

_____ day of _____, 19____

Notary Public

My Commission expires _____