

II. MANAGEMENT AND PERSONNEL OF INSTITUTION

Institution conducted 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 non-profit.

C. Give exact name or Individual, Partnership or Organization conducting Institution:

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

- E. List Name and Address of Officers (with title):
- 1. _____
 - 2. _____
 - 3. _____
 - 4. _____
 - 5. _____
 - 6. _____
 - 7. _____
 - 8. _____
 - 9. _____
 - 10. _____

(Attach an extra sheet if space is not sufficient)

F. Give Name and Title of Administrator or Superintendent:

Email Address:

Would you like to receive your licensure packet via e-mail? Yes No

G. List all voting members of the governing authority.

State Law requires all non-profit hospitals and hospitals owned by political subdivisions of the State to have at least forty percent (40%) of their boards composed of equal portions of consumer representatives from each of the following four categories: small business (S), organized labor (L), elderly persons (E), and persons whose income is less than the national median income (I). Members may represent only one consumer category. Please identify consumer representatives on the facility's board. In addition, identify all members who are women (W), members of a racial minority (R), or who are handicapped (H).

	Name/Address	Consumer Category (S, L, E, I)	Other Identification (W, R, H)
1.	_____	_____	_____

2.	_____	_____	_____

3.	_____	_____	_____

4.	_____	_____	_____

5.	_____	_____	_____

6.	_____	_____	_____

7.	_____	_____	_____

8.	_____	_____	_____

9.	_____	_____	_____

10.	_____	_____	_____

11.	_____	_____	_____

	Name/Address	Consumer Category (S, L, E, I)	Other Identification (W, R, H)
12.	_____	_____	_____

13.	_____	_____	_____

14.	_____	_____	_____

15.	_____	_____	_____

16.	_____	_____	_____

17.	_____	_____	_____

18.	_____	_____	_____

19.	_____	_____	_____

20.	_____	_____	_____

(Attach an extra sheet if space is not sufficient)

III. CLASSIFICATION OF HOSPITAL

Type of institution: (Check one)

- General Chronic Disease (Long Term) Mental Orthopedic
 Tuberculosis Rehabilitation Other (Specify): Critical Access

IV. PHYSICAL PLANT AND BED CAPACITY

A. Ownership of Building: _____

B. No. Stories: _____ Type Construction: _____ Age: _____

C. Legal bed capacity requested: _____ CON Approved # Beds _____

(Note: Hospitals may not admit more inpatients than the number of beds for which they are licensed).

D. Number of Beds by Type:

- | | | | |
|-------------------|-------|-----------------|-------|
| Medical-Surgical: | _____ | Rehabilitation: | _____ |
| ICU-CCU: | _____ | SNF (Medicare): | _____ |
| Psychiatric: | _____ | SNF/NF: | _____ |
| Obstetric: | _____ | NF: | _____ |
| Pediatric: | _____ | | |
| PICU: | _____ | | |
| NICU: | _____ | | |
| Swing: | _____ | | |
| Burn: | _____ | | |

V. LICENSURE FEE

License Fee, computed according to the following table, in the amount of \$_____ is attached to this application. (Check, Draft, or Money Order is to be made payable to West Virginia Division of Health - OHFLAC. DO NOT send cash through the mail.)

Bed Capacity	Fee
05 - 49	\$1,018.57
50 - 99	\$1,524.74
100 - 199	\$2,032.25
200 or more	\$2,544.21

VI. GENERAL

A. If applicable, provide the date and category of the most recent JCAHO Accreditation.

B. Additional information and/or remarks: _____

VII. APPLICANT

A. Signature of Individual Applicant: _____

Title or Position: _____

B. If other than Individual or Administrative Officer:

Name

Address

1. _____

2. _____

VIII. 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 hospital, therein contained, are correct and true of his/her own knowledge.

(Signature of Individual Applicant)

Subscribed and sworn to before me this _____ day of _____, 20__

Notary Public

My commission expires _____.