



Virginia Department of Health
Office of Licensure and Certification

Application for Abortion Facility Licensure

Complete all fields. Incomplete or inaccurate applications will be returned. Any changes affecting the accuracy of the information contained herein must be reported in writing immediately to the VDH Office of Licensure and Certification.

Application type:	License year:
Application is for: <input type="checkbox"/> Initial Licensure <input type="checkbox"/> License Renewal <input type="checkbox"/> Change of Address	<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Ownership
All sections of this application must be completed for all application types	

Facility identification			
Name of abortion facility		Main Telephone Number ()	
Street Address		Fax ()	
City	County	State	Zip
Web Address		Federal Employer ID Number:	
Mailing address (if different from above)			
City		State	Zip
Administrator of record, if different than owner/operator			
Name:		Title:	
Telephone Number: ()		Email Address:	

Ownership of the facility			
Owner:		Tel. Number:	
Street Address:		Fax Number:	
City:	County:	State:	Zip:

Is any part or program of the abortion facility licensed by another state agency:	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Agency name:	Program/ part:

VDH/Office of Licensure and Certification Application for Abortion Facility Licensure

Type of Ownership and Control			
<u>For Profit:</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Individual <input type="checkbox"/> Other:	<u>Not for Profit:</u> <input type="checkbox"/> Charitable organization <input type="checkbox"/> Church <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	<u>Public:</u> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Multijurisdictional <input type="checkbox"/> Other:	
Is the abortion facility operated by the owner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete section below:			
Operator Name:			Fax:
Street Address:			
City:	County:	State:	Zip:
Email Address:		Web Address:	

General Information concerning the facility	
A. Ambulance services providing emergency transportation of patients:	
B. Inpatient hospitals for transferring patients needing treatment beyond the scope of the facility:	
C. Certification: <input type="checkbox"/> CLIA <input type="checkbox"/> None	
D. Accreditation: <input type="checkbox"/> Yes <input type="checkbox"/> None	
Planned Parenthood: <input type="checkbox"/>	Accreditation period:
Other:	Accreditation period:
E. Number of procedure/treatment rooms:	

Application attachments: Initial applications only
<ol style="list-style-type: none"> 1. A plan, signed by the facility administrator, describing how the facility will come into full compliance with 12VAC5-412-380 within two years from the date of licensure; 2. The proposed organizational chart; 3. The facility's disaster preparedness plan 4. Patient Rights and Procedures; and 5. The job description, qualifications and specific responsibilities of the Administrator.

**VDH/Office of Licensure and Certification
Application for Abortion Facility Licensure**

AFFIDAVIT

I, _____, hereby swear (or affirm) that the information contained in this application is true and correct, and all federal, state, and local laws and regulations have been complied with.

Signature and Title of Applicant

Date

Return this completed application and a check for \$75.00 to:

**Acute Care Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233**

Questions? Contact the Acute Care Unit at: (804) 367-2107 or OLC-Inquiries@vdh.virginia.gov