Delaware Health and Social Services
Division of Health Care Quality
Office of Health Facilities Licensing & Certification

Registration for Office Based Surgery Facilities

Facility Name: _____

Facility Address: _____

_____

_____ DE _____
City State Zip Code

Facility Contact: _____

Contact E-mail: _____

Phone Numbers: _____ _____ _____
Facility Phone Number Contact Phone Number Contact Fax Number

Medical Director Name: _____

Medical Director E-mail: _____ Medical Director Phone: _____

Office Manager Name: _____

Office Manager E-mail: _____ Office Manager Phone: _____

I hereby acknowledge that the above facility performs office based surgery as defined in 16 Del. C § 122 (3) (y & z).

First Date of Operation as a Facility that Performs Office Based Surgery: _____

Signature: _____ **Date:** _____

Print Name: _____

All facilities that perform office based surgery must obtain accreditation from an accreditation organization approved by the Department of Health and Social Services.

The following accreditation organizations are approved by DHSS:

- **The Joint Commission (TJC)**
- **Accreditation Association for Ambulatory Health Care (AAAHC)**
- **Healthcare Facilities Accreditation Program (HFAP)**
- **American Association of Accreditation of Ambulatory Surgery Facilities (AAAASF)**
- **Delaware Board of Dentistry and Dental Hygiene Anesthesia Advisory Committee**

Attach the most current copy of the certificate from the accreditation organization, or evidence that the facility has applied for accreditation. All facilities must provide proof of accreditation to the Department within 12 months of the first day of operation of such facility.

Accrediting Organization: _____

Date Accreditation Expires: _____

Name of Person Completing This Form: _____ _____
Name Title

Signature: _____ Date: _____

Complete and Return Registration to:

Office of Health Facilities Licensing and Certification
261 Chapman Road
Suite 200
Newark, DE 19702