FOR OFFICE USE ONLY
Check Amount: _____
Check Number: _____
License Expiration: _____

STATE OF DELAWARE

OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

(302) 292-3930

APPLICATION FOR FREE STANDING BIRTHING CENTER LICENSE

FSBC - _____

CENTER NAME: _____

CENTER ADDRESS: _____

_____

_____ _____ _____
City State Zip Code

ADMINISTRATOR/CEO: _____

CENTER CONTACT: _____

E-MAIL: _____

PHONE NUMBERS: _____ _____ _____
Center Phone Contact Phone Center Fax

NUMBER OF BIRTHING ROOMS: _____

NUMBER OF PHYSICIANS WITH PRIVILEGES: _____

NUMBER OF CERTIFIED NURSE MID-WIVES WITH PRIVILEGES: _____

ALL PHYSICIANS HAVE ADMITTING PRIVILEGES TO AREA HOSPITALS: ☐ YES ☐ NO

ALL CERTIFIED NURSE MID-WIVES HAVE A BACK-UP AGREEMENT WITH A PHYSICIAN: ☐ YES ☐ NO

ACCREDITED: ☐ YES ☐ NO

IF YES, NAME OF ACCREDITING ORGANIZATION AND ACCEDITATION EXPIRATION DATE: _____

_____

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES, ADDRESSES AND PERCENT OF INTEREST OF EACH OFFICER, DIRECTOR, AND OWNER HAVING AN INTERESST IN THE CENTER.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. EMAIL A COPY OF THE ACCREDITATION CERTIFICATE, OFFICIAL ACCREDITATION REPORT, AND PLAN OF CORRECTION TO: AMY-JOY.ANDREWS@DELAWARE.GOV
4. FIRE SAFETY REPORT
5. OTHER

NAME OF PERSON COMPLETING THIS FORM: _____

SIGNATURE: _____ TITLE: _____

DATE: _____

CHECKS SHOULD BE MADE PAYABLE TO: **STATE OF DELAWARE**

INITIAL APPLICATION FEE:	ANNUAL LICENSURE FEE:
$150	$75.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO:
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
261 CHAPMAN ROAD
SUITE 200
NEWARK, DE 19702

FOR OFFICE USE ONLY

Application Reviewed & Approved by: _____ Date: _____

Director/Designee: _____ Date: _____

Type of License: ☐ Annual ☐ Provisional

Licensure Period: _____ to _____

License Sent – Date: _____ Initials: _____

Tracking Update – Date: _____ Initials: _____