Application for a License to Operate a Freestanding Outpatient Surgical Center

In accordance with Minnesota Statutes, Section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), **all data submitted on this license application shall be classified public information upon issuance of a license.**

Answer all questions completely and accurately to avoid unnecessary delay. Mail the completed application, fee payment, and applicable supporting documents to MDH (see last page for mailing address). Renewal license applications should be submitted 30 days prior to the expiration date of the current license.

Incomplete application will be communicated to the provider via email.

The undersigned hereby makes application to operate a Freestanding Outpatient Surgical Center subject to the provisions of Minnesota Statutes 144.55 (https://www.revisor.mn.gov/statutes/cite/144.55), and the rules adopted thereunder.

Application Type

Check one option (see Appendix A for documents to attach)

☐ Initial License

☐ Change of Ownership. Proposed effective date: _____

☐ License Renewal

Facility Identification

Outpatient Surgical Name (doing business as): _____

Address: _____

City/State/Zip: _____

☐ Check here if mailing address is the same as above.

Complete if different: _____

Health Facility Identification (HFID) number: _____

Telephone number: _____

Fax number (if applicable): _____

☐ Check here if new telephone and/or fax number.

Business hours (days & times): _____

Name of county in which the surgical center is located: _____

Agent/Administrator's Name: _____

_____

- Direct Email Address: _____
- Direct Phone Number: _____

Name and title of person in charge in the absence of the Administrator: _____

Name of person responsible for completing application: _____

Email to receive correspondences from MDH: _____

☐ Check here if email is the same as the Administrator.

Are you currently a Medicare certified Ambulatory Surgical Center?

☐ Yes, insert CMS Certification Number (CCN): _____

☐ No

If you are not Medicare certified, do you plan to become certified within the next 12 months?

☐ Yes

☐ No

Personnel

Provide the following information.

(MN Rule 4675.040 (https://www.revisor.mn.gov/rules/4675.0400/)

Physician Services – Name of Medical Director as it appears with the MN Board of Medical Practice, Credential Search (https://bmp.hlb.state.mn.us/#/onlineEntitySearch).

Name: _____

License #: _____

Expiration date: _____

Number of Physicians: _____

Number of Physician Assistants: _____

Number of Dentists: _____

Anesthesia Services

Name Director: _____

License #: _____

Expiration date: _____

Number of Anesthesiologists: _____

Nursing Services – Name and license number of Clinical Nurse Supervisor (registered nurse) as it appears with the MN Board of Nursing, Find a Licensee (https://mbn.hlb.state.mn.us/#/services/onlineEntitySearch).

Name: _____

License #: _____

Expiration date: _____

Number of employees in the following categories.

Registered Nurses: _____

Licensed Practical Nurses: _____

Nursing Assistants: _____

Operating Room Assistants: _____

Ownership

Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

Ownership Code_____

Governmental Non-Federal	Governmental Non-Profit	Non-Governmental For-Profit	Other
11. State 12. County 13. City 14. City – County 15. Hospital district of Authority	20. Church-related 21. Nonprofit Corporation 22.Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust 30. Housing and Redevelopment Employment	27. Tribal

Provide the legal entity name that is responsible for the operation of this facility, as it appears on file with the Office of the Minnesota Secretary of State (https://mblsportal.sos.state.mn.us/Business/Search):

Legal Entity Name: _____

- Federal EIN #: _____
- State Tax ID #: _____

President/Owner Representative Name: _____

- Address: _____

City/State/Zip: _____

Ownership Information Sheet

Provide the legal names, titles and addresses of all officers, directors, owners, and managerial employees, and the percent of ownership if applicable. For additional space, use Appendix B.

Name	Title (President, Director, Partner, Stockholder, Etc.)	Address (Street, City, State, Zip Code)	Percentage Of Ownership (If For Profit)

Utilization Data

Provide utilization data for July 1 (previous year) through June 30 (current year).

MN Rule 4675.0400, clause F (https://www.revisor.mn.gov/rules/4675.0400/#rule.4675.0400.F)

Beginning date (mm/dd/yyyy): _____

End date (mm/dd/yyyy): _____

Number of surgical procedures: _____

List five (5) most common operations performed:

_____

_____

_____

_____

_____

Written Agreements

Name of emergency transfer hospital: _____

Name of emergency ambulance service: _____

Evidence of Compliance with Worker's Compensation

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

☐ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b) (https://www.revisor.mn.gov/statutes/cite/60A.06). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of renewal license.

☐ **Self-insured workers' compensation (including its Attachment "A")**. This type of coverage is generally held by large organizations. The certificate is issued from the commissioner of commerce permitting an organization to self-insure pursuant to Minn. Stat. 79A (https://www.revisor.mn.gov/statutes/cite/79A) and Minn. Rules 2780 (https://www.revisor.mn.gov/rules/2780/). Questions regarding self-insurance should be directed to the Minnesota Department of Commerce.

☐ Written confirmation from your Third-Party Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government Entity/Political Subdivision** pursuant to Minn. Statute 176.181, Subd. 2 (https://www.revisor.mn.gov/statutes/cite/176.181). The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

Fees

All applications must be accompanied by the appropriate nonrefundable fee based on the following fee schedule set by Minnesota Statute 144.122, clause (d) (https://www.revisor.mn.gov/statutes/cite/144.122).

Outpatient Surgical Center fee: $1,966.00

Adverse Health Care Events Reporting fee: $2,200.00

Total fee is **$4,166.00**

Affirmation and License Fee

☐ I certify that the information provided on this form is accurate and complete.

☐ I have enclosed the appropriate evidence of compliance with Workers' Compensation Coverage Provisions.

☐ Enclosed is the renewal licensee fee made payable to the **Minnesota Department of Health**.

In accordance with MN Statute 144.52 Application (https://www.revisor.mn.gov/statutes/cite/144.52), the law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures**. All other applications require one (1) signature.

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

If you have questions concerning this license application, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.

Mailing Address
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

07/01/2025

To obtain this information in a different format, call: 651-201-4200.

Appendix A: Application Type

Submit the following documents based on the application type.

Initial License

Required documents for an initial license include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Organizational chart demonstrating relationship of owners to licensee.

Renewal

Required documents for license renewal include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.

Change of Ownership

Required documents for change of ownership include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Organizational charts demonstrating relationship of owners to licensee, both pre-sale and post-sale.
- Bill of Sale

Appendix B: Ownership Information Sheet

Provide the legal names, titles and addresses of all officers, directors, owners, and managerial employees, and the percent of ownership if applicable.

Name	Title (President, Director, Partner, Stockholder, Etc.)	Address (Street, City, State, Zip Code)	Percentage Of Ownership (If For Profit)