License Application
LEVEL II ADULT CARDIOVASCULAR SERVICES

AUTHORITY: Pursuant to subsections 408.0361(2) and (3), Florida Statutes, a provider of Level II adult cardiovascular services shall comply with rules adopted by the Agency that establish licensure standards that govern the provision of Level II adult cardiovascular services.

Provider Information			
License #:	12-month Reporting Period:		
Name of Hospital:		Telephone Number:	
Street Address:			
City:	State:	Zip:	County:

Volume - Information in this section required for Initial Application Only – Not required for Renewal	
Total Number of Adult Cardiac Catheterization Patients / Sessions: Total Number of Therapeutic Catheterization Patients / Sessions:	
Number of Inpatient Sessions:	Number of Outpatient Sessions:
OR	
Total Number of Inpatient Discharges with Principal Diagnosis of Ischemic Heart Disease (ICD-10-CM codes I20 through I25):	

This hospital confirms and will comply with the following:

1. Initial Applicants only: The above named hospital volumes are true, accurate and complete.
2. The above named hospital will fully comply, where applicable, with the guidelines of the American College of Cardiology/American Heart Association for staffing, physician training and experience, operating procedures, equipment and physical plant criteria for a Level II program to ensure quality patient care and safety, except where they are in conflict with Florida law.
3. The above named hospital will fully comply with the physical plant requirements regarding cardiac catheterization laboratories and operating rooms found in section 419.2.1.2, Florida Building Code as applicable.
4. The above named hospital will participate in the American College of Cardiology – National Cardiovascular Data Registry and the Society of Thoracic Surgeons National Database.
5. The above named hospital has a formalized plan to provide services to Medicaid and charity care patients in need of Level II adult cardiovascular services.

_____
Printed or typed name of Chief Executive Officer

_____ _____
Signature of Chief Executive Officer Date

Return completed AHCA forms 3130-8001 and 3130-8011 to:
Agency for Health Care Administration
Hospital and Outpatient Services Unit, MS # 31
2727 Mahan Drive
Tallahassee, FL 32308