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: ☐ Initial Licensure ☐ License Renewal ☐ Change of Address	☐ Change of Name ☐ 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:	☐ No ☐ Yes
If Yes, Agency name:	Program/ part:

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Type of Ownership and Control		
For Profit: ☐ Corporation ☐ Partnership ☐ Limited Liability Co. ☐ Individual ☐ Other:	Not for Profit: ☐ Charitable organization ☐ Church ☐ Corporation ☐ Other:	Public: ☐ State ☐ County ☐ City ☐ Multijurisdictional ☐ Other:

Is the abortion facility operated by the owner? ☐ Yes ☐ 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: ☐ CLIA ☐ None	
D. Accreditation: ☐ Yes ☐ None Planned Parenthood: ☐ Accreditation period: Other: Accreditation period:	
E. Number of procedure/treatment rooms:	

Application attachments: Initial applications only

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.

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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