



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF HEALTH CARE FACILITIES  
227 FRENCH LANDING, SUITE 501  
HERITAGE PLACE METROCENTER  
NASHVILLE, TENNESSEE 37243  
(615) 741-7221

**PRESCRIBED CHILD CARE CENTER  
RENEWAL APPLICATION**

*All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at [www.state.tn.us/health](http://www.state.tn.us/health). Please check this website periodically for updates.*

Name of the Facility/Agency \_\_\_\_\_

Facility License Number \_\_\_\_\_

**Location of the Facility:**

Street \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

Twenty-four (24) Hour Emergency Phone Number (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Administrator \_\_\_\_\_

**Mailing address if different from the Facility location address:**

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Ownership of Building:**

Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**OWNERSHIP OF BUSINESS:**

1. a. Check the type of Legal Entity:  
\_\_\_\_\_ Individual \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ Limited Liability Company  
\_\_\_\_\_ Church Related \_\_\_\_\_ Government/County \_\_\_\_\_ Other
- b. Check One: \_\_\_\_\_ For Profit \_\_\_\_\_ Non-profit
- c. Legal Entity checked in 1.a:  
Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
- | Name  | Address | City, State, Zip |
|-------|---------|------------------|
| _____ | _____   | _____            |
| _____ | _____   | _____            |
| _____ | _____   | _____            |
- (If additional space is needed, please use a separate sheet)*
2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date \_\_\_\_\_
- b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date \_\_\_\_\_
3. a. Is this facility chain affiliated? Yes \_\_\_\_\_ No \_\_\_\_\_
- b. If yes, list name, address and phone number of the parent company.  
Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. a. If a corporation, is there a holding company/parent corporation? Yes \_\_\_\_\_ No \_\_\_\_\_
- b. If yes, list the name, address and phone number of the holding company/parent corporation.  
Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes \_\_\_\_\_ No \_\_\_\_\_

b. If yes, list names and addresses of all such facilities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. a. Do you have a contract with a management firm to operate this facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify dates: From \_\_\_\_\_ To \_\_\_\_\_

b. If yes, specify name of firm: \_\_\_\_\_

Street \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION.  
FEES ARE NON-REFUNDABLE.**

**VERIFICATION BY NOTARY PUBLIC:**

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) §68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA §71-6-103 to report incidents of abuse or neglect.

\_\_\_\_\_  
Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of \_\_\_\_\_

The above named applicant (print name) \_\_\_\_\_, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof; that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this \_\_\_\_\_ day of \_\_\_\_\_  
Month Year

Notary Public: \_\_\_\_\_

My commission expires: \_\_\_\_\_