LICENSURE APPLICATION
for
HOSPITALS AND INSTITUTIONAL GENERAL INFIRMARIES

REGULATION 60-16

Return all documentation to:

Email address (preferred method):
HTL@dph.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
P.O. Box 2046
West Columbia, SC 29171

For additional questions, contact us at: 803-545-4370.

3292-ENG-DPH (07/2025)

INSTRUCTIONS FOR COMPLETING 3292-ENG-DPH

Application must be complete and legible. Any missing information may result in delays in processing this application. An application cannot be processed without payment.

Purpose:

Application to apply for licensure as a Hospital and/or Institutional General Infirmary per Regulation 61-16.

Instructions:

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed facility. An application cannot be processed without payment. Any missing information may result in delays in processing the application.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the facility must appear exactly as it did the prior year. Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part D.

Part A: Facility Information

- Facility Information: Please complete the applicant information for the facility.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- CEO: Please complete each field.
- Food Service Areas: Please list all restaurants and/or food kiosks in the facility. If more than 10 =m attach an 8.5 x 11 sheet with additional names)

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate thefacility at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
    - For partnerships, you must provide the name of each partner;
    - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
    - For a corporation, you must provide the name and title of each corporate officer.
- If this is an LLC or Corporation list all persons/entities who have ownership interest in the entity applying for licensure.

Part C: Licensure Changes

- For Facility Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For changes in Capacity, complete Section 3.

Part D: Emergency Services

- For Type of Service, complete Section 1.
- For Change in Emergency Services, complete Section 2.

Part E: Verification

- The application shall be signed by the following:
    - If an individual partnership, ***the owner(s)***
    - If a corporation, ***two*** of its ***officers*** if a corporation
    - If governmental unit, the ***head of the governmental department*** having jurisdiction

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Hospitals and Institutional General Infirmaries
Regulation 60-16

Reason for Application			
☐ Initial	☐ Renewal		☐ Change Request
	License Number:	Expiration Date:	

Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Emergency Number:			

Type of Hospital:	
Specialty Type:	Other:
Are you certified to perform abortions ☐ YES ☐ NO	**If yes, a request to licensing must be on file.**

Number of beds to be licensed			
General Beds:	Psychiatric Beds:	Rehabilitation Beds:	Substance abuse beds:
Do you operate a swing bed unit? ☐ YES ☐ NO		If yes, number of swing beds:	

Perinatal Services	
Does your hospital provide perinatal (obstetrics and newborn) services? ☐ YES ☐ NO	If yes, indicate designation level: ☐ I; ☐ II; ☐ III; ☐ IV; ☐Regional Perinatal Center
If licensed as level II, III, IV, or RPC please indicate the number of licensed intermediate and intensive bassinets: Intermediate Bassinets: _____ Intensive Bassinets: _____	

Food Service Areas (Initial Application Only)	
Number of Kitchens:	
Certified Food Protection Manager (must attach a copy of the certification)	
Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Contact Person and Correspondence Mailing Address: *(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)*		
Name:		Title:
Address:		
City:	State:	Zip:
Telephone Number:		
Primary Email Address:		

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Chief Executive Officer	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Emergency Events Person Contact	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Part B. Operation and Ownership Disclosure			
Licensee Information: *(name of the person[s] or legal entity licensed to operate the business at that site as indicated in Part A)* ***This can be found on your current license OR your documentation from the Secretary of State.***			
Licensee Name:			
Mailing Address:			
City:	State:	Zip:	
Telephone Number:	Fax Number:		
Name of Presiding Officer of the Register Organization's Governing Body:			
Ownership Type:			
☐ Sole Proprietorship	☐ Corporation	☐ Other:	
☐ Partnership	☐ Limited Liability (LLC)*		
☐ Limited Partnership	☐ Government		

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES			
☐ Change of Location (Complete Section 1)	☐ Change of Licensee Ownership (Complete Section 2)	☐ Change of Licensed Beds (Complete Section 3)	☐ Change of Facility Name (Complete Section 1)
Section 1 (FACILITY INFORMATION)			
PRIOR TO CHANGE			
Current License Number:			
Current Facility Number:			
Current Facility Address:			
City:	Zip:	County:	
Facility Telephone Number:		Fax Number:	
AFTER CHANGE			
New Facility Name:			
New Facility Address:			
City:	Zip:	County:	
New Facility Telephone Number:		Fax Number:	

Section 2 (LEGAL IDENTITY OF OWNERSHIP) *Application must be completed by new owner, as licenses are not transferable.*		
PRIOR TO CHANGE		
Name of Current Owner:		
License Number of Current Owner:		
Address of Current Owner:		
City:	Zip:	County:
Telephone Number of Current Owner:		
Signature of Current Owner:		Date:
AFTER CHANGE		
Name of New Owner:		
Address of New Owner:		
City:	Zip:	County:
Telephone Number of New Owner:		
Signature of New Owner:		Date:

Section 3 (CHANGE IN LICENSED UNITS)		
License Number:		
Facility Name:		
Facility Address:		
City:	State:	Zip:
Facility Telephone Number:		Fax Number:
☐ Increase	☐ Decrease	
Number of General Beds:	From:	To:
Number of Rehabilitation Beds:	From:	To:
Number of Psychiatric Beds:	From:	To:
Number of Substance Abuse Beds:	From:	To:

For Perinatal Services Only		
☐ Increase from Level ____ to Level ____	☐ Decrease from Level ____ to Level ____	
Number of Intensive Care Bassinets:	From:	To:
Number of Intermediate Bassinets:	From:	To:

Part D: Emergency Services Only	
Section 1: Type of On-Campus Service ☐ I ☐ II ☐ III ☐ IV	

Section 2: Do you operate a Freestanding or Off-Campus Emergency Service? ☐ Yes ☐ No			
If yes, please provide the following information:			
Name of Freestanding:	Type (Off-campus emergency services may be the same type as or a lower-level type than the hospital's on-campus emergency service)	Address (city, state, zip):	County:

Part E: Verification

The application shall be signed by the following:

- If an individual, the ***owner(s)***
- If a limited liability company, the ***head of the limited liability company***
- If a corporation, ***two*** of its ***officers***
- If governmental unit, the ***head of the governmental department*** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 60-16. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 60-16.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Application for Licensure Hospitals and Institutional General Infirmaries
Instructions for Completing 3292-ENG-DPH

PURPOSE: This is an external form used by customers to apply for a health license or service regulated by Healthcare Quality.

AUDIENCE: DPH Customers.

INSTRUCTIONS: Customers will complete this application when applying for a healthcare facility or service regulated by Healthcare Quality. This application is to be used in conjunction with the facility's regulation.

OFFICE MECHANICS & FILING: The completed form will be stored on the Bureau of Operations Support's SharePoint Site / OneDrive. This form is maintained by retention schedule 16327 — Masterfiles. Once the 10-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.