

Provisional Provisional

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|-----------|-------|----------------|---|
| State ID: | 00000 | Facility Name: | - |
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Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

JOINT ANNUAL REPORT OF AMBULATORY SURGICAL TREATMENT CENTERS 2016

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| State ID: | 00000 | Facility Name: | - | | 2016 | |
| Schedule A - Identification | | | | | | |
| Complete ALL fields. | | | | | | |
| Do not use all UPPER case letters when filling out the schedules. | | | | | | |
| <p>According to the Department of Health Rules and Regulations Section 1200-8-10-.11(1), "a yearly statistical report, the 'Joint Annual Report of Ambulatory Surgical Treatment Centers', shall be submitted to the Department." Please read all information carefully before completing your Joint Annual Report with data for the year specified above. Please complete all items, using 0 (zero) when appropriate and checking all appropriate checkboxes. Check all computations, especially where a total is required. Any items which appear to be inconsistent will be queried.</p> <p>Facilities will be reported to the Board for Licensing Health Care Facilities for failure to timely file a report or respond to queries.</p> | | | | | | |
| Facility | State ID | | License Number | - | | |
| | Facility Name | - | | | | |
| | Did the facility name change during the reporting period? | | | | Yes/No | |
| | If Yes, Prior Name | | | | | |
| | Street | - | | | | |
| | City | - | County | - | | |
| | State | - | Zip Code (5 digit) | - | | |
| | Phone Number (10 digits) | | | | | |
| | Mailing Address same as Street Address? If Yes, proceed to next section. | | | | Yes/No | - |
| | Mailing Address | | | | | |
| | City | | | | | |
| | State | | Zip Code (5 digit) | | | |
| Preparer | Name | | | | | |
| | Title | | | | | |
| | Phone Number (10 digit) | | | | | |
| | Email Address | | | | | |
| Adminis- tration | Name of Administrator | | | | | |
| | Name of Medical Director | | | | | |
| Reporting Period | The reporting period is July 1 2015 through June 30 2016. | | | | Yes/No | - |
| | If unable to report based on above dates, provide beginning and ending dates (used for all utilization and financial data): | Beginning (mm/dd/yyyy)--use slashes between numbers | | | | |
| | | Ending (mm/dd/yyyy)--use slashes between numbers | | | | |
| | Number of days in reporting period: | | | | 0 | |

2016 Joint Annual Report of Ambulatory Surgical Treatment Centers

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|--|--------|--|---|------------------------|--|------|
| State ID: | 00000 | Facility Name: | - | | | 2016 |
| Schedule B - Certifications, Accreditation, and Memberships | | | | | | |
| Do not use all UPPER case letters when filling out the schedules. | | | | | | |
| Certifications | Yes/No | - | Participation in TennCare | Provider Number: | | |
| | Yes/No | - | Participation in Medicare | Provider Number: | | |
| Accreditation | Yes/No | - | The Joint Commission (TJC) | Approval Date (year) | | |
| | | | | Expiration date (year) | | |
| | Yes/No | - | Accreditation Association for Ambulatory Health Care (AAAHC) | Approval Date (year) | | |
| | | | | Expiration date (year) | | |
| | Yes/No | - | American College of Surgeons Commission on Cancer (ACoS-Coc) | Approval Date (year) | | |
| | | | | Expiration date (year) | | |
| | Yes/No | - | American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) | Approval Date (year) | | |
| Expiration date (year) | | | | | | |
| Yes/No | - | American Osteopathic Association (AOA) | Approval Date (year) | | | |
| | | | Expiration date (year) | | | |
| Yes/No | - | Other, specify: | | | | |
| Memberships | Yes/No | - | Federation of Ambulatory Surgery Centers (FASC) | | | |
| | Yes/No | - | Freestanding Ambulatory Surgery Center Association of Tennessee (FASCA of TN) | | | |
| | Yes/No | - | Tennessee Hospital Association (THA) | | | |
| | Yes/No | - | Other, specify: | | | |

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| State ID: | 00000 | Facility Name: | - | 2016 |
| Schedule C - Classification | | | | |
| Do not use all UPPER case letters when filling out the schedules. | | | | |
| Select one item in each category that best describes your facility. | | | | |
| Classification of Facility | - | Surgical Clinic (includes ASCs, ASTCs) | | |
| | - | EENT Clinic (Eye, Ear, Nose and Throat) | | |
| | - | Dental Clinic | | |
| | - | Maternity Clinic | | |
| | - | Plastic Surgery Clinic | | |
| | - | Other, specify: | | |
| Type of Facility | - | Free Standing | | |
| | - | Hospital Based, specify | | |
| | - | Hospital Affiliated, specify | | |
| | - | Other, specify: | | |

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|--|---------------------------|---|---|------|
| State ID: | 00000 | Facility Name: | - | 2016 |
| Schedule C - Classification | | | | |
| Do not use all UPPER case letters when filling out the schedules. | | | | |
| Select one item in each category that best describes your facility. | | | | |
| Type of Owner (select only one) | - | (For Profit) Proprietorship – a business owned by one person. | | |
| | - | (For Profit) Partnership – an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under 61-1-202, predecessor law, or comparable law of another jurisdiction. TCA Title 61 Chapter 1. | | |
| | - | (For Profit) Limited Partnership (LP) – a partnership formed by two or more persons under the law of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2. | | |
| | - | (For Profit) Limited Liability Partnership (LLP) – is governed by TCA § 61-1-106(C). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state. | | |
| | - | (For Profit) Limited Liability Company (LLC) – established by the “The Tennessee Limited Liability Company Act” found in the TCA § 48-201-101 through § 48-248-606. | | |
| | - | (For Profit) Corporation – defined by the Tennessee Business Corporation Act codified in TCA Title 48 Chapters 11-27. | | |
| | - | (Not For Profit) Non-Religious Corporation or Association – defined by the “Tennessee Nonprofit Corporation Act” codified in TCA Title 48 Chapters 51-68. | | |
| | - | (Not For Profit) Religious Corporation or Association – either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67. | | |
| | - | (Not For Profit) Limited Liability Company (LLC) – a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15). | | |
| | - | (Government) City | | |
| | - | (Government) County | | |
| | - | (Government) State | | |
| | - | (Government) Federal | | |
| - | Other Government, specify | | | |

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Schedule D - Availability and Utilization of Services

Do not use all UPPER case letters when filling out the schedules.

Provide the following to cover the entire reporting period.

| Availability of Rooms | Licensed Rooms | Number of Rooms | ***Unduplicated Patients |
|-----------------------|-----------------------------------|-----------------|--------------------------|
| | *Operating Rooms | | |
| | **Procedure Rooms | | |
| | Total (System Calculation) | 0 | 0 |

*Operating Room - A room where general and/or Monitored Anesthesia Care (MAC) (the ability to administer general anesthesia) is employed. Any level of sedation or anesthesia can be utilized in Operating Rooms as the anesthesia equipment is present in the room.

**Procedure Room - A room where local and/or intravenous sedation is employed.

***Unduplicated patients - Patient can be counted only once during the reporting period regardless of how many services are received.

The Total unduplicated number of patients served should agree with **Total Patients Served and **Total Tennessee and Non-Tennessee Residents (Schedule E).

Cases - One visit to an Operating Room or Procedure Room by one patient, regardless of the number of surgeries or procedures performed during that visit.

Check the "Yes/No" column for each of the services the facility offers. Indicate the number of operating room cases and procedure room cases for each service during the reporting period.

| Utilization of Services | Is your facility a single or multi specialty facility? | | - | | |
|---------------------------------|--|--------|----------------------|----------------------|----------------------------|
| | Type of Service | Yes/No | Operating Room Cases | Procedure Room Cases | Total Cases (System Calc.) |
| Dental/Oral Surgery | - | | | | 0 |
| Endoscopy | - | | | | 0 |
| General Surgery | - | | | | 0 |
| Gynecology | - | | | | 0 |
| Infertility | - | | | | 0 |
| Neurology | - | | | | 0 |
| Obstetrics | - | | | | 0 |
| Ophthalmology | - | | | | 0 |
| Orthopedics | - | | | | 0 |
| Otolaryngology | - | | | | 0 |
| Pain Management | - | | | | 0 |
| Plastic Surgery | - | | | | 0 |
| Podiatry | - | | | | 0 |
| Pulmonary | - | | | | 0 |
| Radiological/Oncology Treatment | - | | | | 0 |
| Urology | - | | | | 0 |
| Vascular | - | | | | 0 |

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|---|------------------------------------|----------------|-----------------|------------|--|-------------------|------------|
| State ID: | 00000 | Facility Name: | - | | | 2016 | |
| Schedule D - Availability and Utilization of Services | | | | | | | |
| Do not use all UPPER case letters when filling out the schedules. | | | | | | | |
| Provide the following to cover the entire reporting period. | | | | | | | |
| Utilization of Services | Other(1), specify: | | - | | | 0 | |
| | Other(2), specify: | | - | | | 0 | |
| | Other(3), specify: | | - | | | 0 | |
| | Total | | | 0 | 0 | 0 | |
| | % Capacity | | | | | | |
| Note: % Capacity is auto calculated per Certificate of Need Standards and Criteria for ASTC | | | | | | | |
| % Capacity Procedure Rooms (PR) = (Total PR Cases/Total PR Rooms) / 2667 | | | | | | | |
| % Capacity Operating Rooms (OR) = (Total OR Cases/Total OR Rooms) / 1263 | | | | | | | |
| Number of patients transferred to a hospital for admission | | | | | | | |
| Average number of patients in overnight observation setting per month | | | | | | | |
| Availability and Utilization of Equipment | Type of Equipment on Site | Yes/ No | Number of Units | | If Mobile****, number of days per week | Fixed plus Mobile | |
| | | | Fixed | Mobile**** | | Patients | Procedures |
| | Computerized Tomography (CT/CAT) | - | | | | | |
| | Ultrafast CT | - | | | | | |
| | Linear Accelerator | - | | | | | |
| | Lithotripter | - | | | | | |
| | Magnetic Resonance Imaging (MRI) | - | | | | | |
| | Upright MRI | - | | | | | |
| | Mammography | - | | | | | |
| | Megavoltage Radiation | - | | | | | |
| | Positron Emission Tomography (PET) | - | | | | | |
| | Ultrasound | - | | | | | |
| X-ray | - | | | | | | |
| **** Mobile units: units coming to the ASTC facility for the diagnosis and treatment of ASTC patients on site | | | | | | | |

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| Schedule E - Patient Characteristics | | | | | | | |
| Do not enter zero. Blank fields will represent zero patients. | | | | | | | |
| Number of patients served during this reporting period by Age, Gender and Race | Age | Gender | | **Total Unduplicated Patients Served | Race | | |
| | | Female | Male | | White | Black | Other |
| | 17 and under | | | 0 | | | |
| | 18-64 | | | 0 | | | |
| | 65-84 | | | 0 | | | |
| 85 and older | | | 0 | | | | |
| Total Patients | 0 | 0 | 0 | 0 | 0 | 0 | |

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| State ID: | 00000 | Facility Name: | - | | | 2016 |
| Schedule E - Patient Characteristics | | | | | | |
| Do not enter zero. Blank fields will represent zero patients. | | | | | | |
| Patient Origin Tennessee Counties | Please enter the number of patients from each county who received services during the reporting period. | | | | | |
| | County | Number of Patients | County | Number of Patients | County | Number of Patients |
| | 01 Anderson | | 33 Hamilton | | 65 Morgan | |
| | 02 Bedford | | 34 Hancock | | 66 Obion | |
| | 03 Benton | | 35 Hardeman | | 67 Overton | |
| | 04 Bledsoe | | 36 Hardin | | 68 Perry | |
| | 05 Blount | | 37 Hawkins | | 69 Pickett | |
| | 06 Bradley | | 38 Haywood | | 70 Polk | |
| | 07 Campbell | | 39 Henderson | | 71 Putnam | |
| | 08 Cannon | | 40 Henry | | 72 Rhea | |
| | 09 Carroll | | 41 Hickman | | 73 Roane | |
| | 10 Carter | | 42 Houston | | 74 Robertson | |
| | 11 Cheatham | | 43 Humphreys | | 75 Rutherford | |
| | 12 Chester | | 44 Jackson | | 76 Scott | |
| | 13 Claiborne | | 45 Jefferson | | 77 Sequatchie | |
| | 14 Clay | | 46 Johnson | | 78 Sevier | |
| | 15 Cocke | | 47 Knox | | 79 Shelby | |
| | 16 Coffee | | 48 Lake | | 80 Smith | |
| | 17 Crockett | | 49 Lauderdale | | 81 Stewart | |
| | 18 Cumberland | | 50 Lawrence | | 82 Sullivan | |
| | 19 Davidson | | 51 Lewis | | 83 Sumner | |
| | 20 Decatur | | 52 Lincoln | | 84 Tipton | |
| | 21 DeKalb | | 53 Loudon | | 85 Trousdale | |
| | 22 Dickson | | 54 McMinn | | 86 Unicoi | |
| | 23 Dyer | | 55 McNairy | | 87 Union | |
| | 24 Fayette | | 56 Macon | | 88 Van Buren | |
| | 25 Fentress | | 57 Madison | | 89 Warren | |
| | 26 Franklin | | 58 Marion | | 90 Washington | |
| | 27 Gibson | | 59 Marshall | | 91 Wayne | |
| | 28 Giles | | 60 Maury | | 92 Weakley | |
| | 29 Grainger | | 61 Meigs | | 93 White | |
| | 30 Greene | | 62 Monroe | | 94 Williamson | |
| | 31 Grundy | | 63 Montgomery | | 95 Wilson | |
| 32 Hamblen | | 64 Moore | | 96 Unknown | | |
| Total Tennessee Patients | | | | | 0 | |

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| State ID: | 00000 | Facility Name: | - | | | 2016 |
| Schedule E - Patient Characteristics | | | | | | |
| Do not enter zero. Blank fields will represent zero patients. | | | | | | |
| Patient Origin | 01 Alabama | | 18 Kentucky | | 34 North Carolina | |
| | 04 Arkansas | | 25 Mississippi | | 47 Virginia | |
| Out of State | 11 Georgia | | 26 Missouri | | 55 Other States/ Countries | |
| | Total Patients from Other States and Countries | | | | | 0 |
| **Total Tennessee and Other States/Countries Unduplicated Patients | | | | | | 0 |
| ** Total Tennessee and Other States/Countries Undup. Patients should match **Total Unduplicated Patients from the Utilization of Services section (Schedule D) and from the **Total Undup. Patients Served section (Schedule E) | | | | | | |

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|---|---|--|-----------------------|-------|-----------------------|--------|---------------------|-----|
| State ID: | 00000 | Facility Name: | - | | | | 2016 | |
| Schedule F - Financial Data | | | | | | | | |
| Complete ALL fields. Round figures to the nearest dollar. | | | | | | | | |
| Expenses | Type of Expenses | | | | | Amount | | |
| | (Exclude all depreciation and round figures to the nearest dollar) | | | | | | | |
| | Payroll: Include salaries for all full-time and part-time personnel who are included in Schedule G. | | | | | | | |
| | Fringe Benefits: Social security, group insurance, retirement benefit, etc. | | | | | | | |
| | Other Operating Expenses: Expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.), and all other operating expenses. | | | | | | | |
| | Non-operating Expenses: Expenses for interest, taxes, real estate lease expenses, and other non-operating expenses. | | | | | | | |
| | Total | | | | | \$0 | | |
| Depreciation | Depreciation recorded this year on all capital (buildings, equipment, etc.) rounded to nearest dollar. | | | | | | | |
| Complete ALL fields. Do not include revenue related losses. Round figures to the nearest dollar. | | | | | | | | |
| Patient Revenue | Source | | Gross Patient Charges | Minus | Adjustment to Charges | Equal | Net Patient Revenue | |
| | Government | Medicare | | - | | = | \$0 | |
| | | Medicaid/TennCare | | - | | = | \$0 | |
| | | Cover Tennessee | | - | | = | \$0 | |
| | | Other Government | | - | | = | \$0 | |
| | | Total Government: | | \$0 | - | \$0 | = | \$0 |
| | Non-Government | Self-Pay | | - | | = | \$0 | |
| | | Insurance | | - | | = | \$0 | |
| | | Other Non-Government | | - | | = | \$0 | |
| | | Total Non-Government: | | \$0 | - | \$0 | = | \$0 |
| | Total Patient Revenue: Total Government + Total Non-Government | | | \$0 | - | \$0 | = | \$0 |
| | Non-Patient Revenue | All Other Revenue | | | | | | |
| | Total Revenue | Grand Total Revenue: Total Government Net Patient Revenue + Total Non-Government Net Patient Revenue + All Other Revenue | | | | | \$0 | |

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| State ID: | 00000 | Facility Name: | - | 2016 |
| Schedule F - Financial Data | | | | |
| Complete ALL fields. Round figures to the nearest dollar. | | | | |
| Non-Government Adjustment to Charges | Bad Debts – Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay. | | | |
| | Charity Care – Services provided to medically needy persons for which the facility does not expect payment | | | |
| | Other – Any other adjustments that are not appropriately reported in either Bad Debt or Charity | | | |
| | Total Non-Government Adjustments | | | \$0 |

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Schedule G - Personnel

**Do not enter zero. Blank fields will represent zero employees.
Please do not use all UPPER case letters when filling out the schedules.**

Please indicate the number of personnel on the last day of the reporting period. Record zero where appropriate. Leave the item blank if the value is unknown. Full Time Equivalent (FTE) = number of hours worked by part-time employees per week/40 hours per week. For example, three Registered Nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. For two medical records employees, one working 10 hours per week and the other working 15 hours per week, the FTE would be (10+15)/40=.63

| Type of Employee | Employee | | Employee Pool/ Consultant/Contract | |
|--|-----------|---------------------|---------------------------------------|---------------------|
| | Full-Time | Part-Time In FTE | Full-Time | Part-Time In FTE |
| Administrator | | | | |
| Business Office (Manager & Staff) | | | | |
| Receptionist/Secretary/Frontdesk/Clerical | | | | |
| Housekeeping | | | | |
| Scheduler | | | | |
| Medical Director | | | | |
| Physicians (MD or DO) | | | | |
| Dentists | | | | |
| Physicist/Dosimetrist | | | | |
| Financial/Billing Personnel | | | | |
| Nursing (RN, LPN & Ancillary Nursing) | | | | |
| Certified Registered Nurse Anesthetists (CRNA) | | | | |
| Operating Room Technicians | | | | |
| Radiology Technicians | | | | |
| Scrub Technicians | | | | |
| Surgical Technicians | | | | |
| Medical Records | | | | |
| Other (1), Specify: | | | | |
| Other (2), Specify: | | | | |
| Other (3), Specify: | | | | |
| Total | 0 | 0.00 | 0 | 0.00 |

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| State ID: | 00000 | Facility Name: | - | | | | 2016 | | |
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| Schedule G - Personnel | | | | | | | | | |
| Do not enter zero. Blank fields will represent zero employees. Please do not use all UPPER case letters when filling out the schedules. | | | | | | | | | |
| Please indicate below the number of personnel during the reporting period. | | | | | | | | | |
| Nurses | Nurse Type | Highest Education Level | Number Currently Employed | Number of Budgeted Vacancies | Average # Weeks Required to Recruit Staff | Number Added in the Past 12 Months | Number Eliminated in the Past 12 Months | | |
| | | | | | | | Clinical | Admin. | |
| | Registered | Diploma | | | | | | | |
| | | Associate | | | | | | | |
| | | Bachelors | | | | | | | |
| | | Masters | | | | | | | |
| | | Doctorate | | | | | | | |
| | | Total | | 0 | 0 | | 0 | 0 | 0 |
| | Advanced Practice | Nurse Practitioner | | | | | | | |
| | | Clinical Nurse | | | | | | | |
| | | Certified Registered Nurse Anesthetist | | | | | | | |
| | | Total | | 0 | 0 | | 0 | 0 | 0 |
| Other Nurses | Other Nursing Staff | | Number Currently Employed | Number of Budgeted Vacancies | Average # Weeks Required to Recruit Staff | Number Added in the Past 12 Months | Number Eliminated in the Past 12 Months | | |
| | Licensed Practical Nurses | | | | | | | | |
| | Certified Nurses Aides | | | | | | | | |
| Other (1) | | | | | | | | | |
| Other (2) | | | | | | | | | |

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| Schedule G - Personnel | | | | | | |
| Do not enter zero. Blank fields will represent zero employees. Please do not use all UPPER case letters when filling out the schedules. | | | | | | |
| Contract Nursing Personnel | Yes/No | - | Does your organization use contract nursing personnel? If yes, indicate the number of contract personnel in the following categories. | | | |
| | Type | Number Currently Contracted | Number of Budgeted Vacancies | Average # Weeks Required to Recruit Staff | Number Added in the Past 12 Months | Number Eliminated in the Past 12 Months |
| | Registered Nurses | | | | | |
| | Licensed Practical Nurses | | | | | |
| | Certified Nurses Aides | | | | | |

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Schedule H - Medical Staff

**Do not enter zero. Blank fields will represent zero medical staff.
Please do not use all UPPER case letters when filling out the schedules.**

Include all medical staff with privileges to practice at the facility, whether considered active or associate.
Active: employed and practicing at the facility.
Associate: has privileges to practice at the facility but is not employed at the facility.

| | Specialty | Number of Medical Staff | Number of Medical Staff who are Board Certified | |
|---|---------------|-------------------------|---|--|
| | Medical Staff | Abdominal Surgery | | |
| Anesthesiology | | | | |
| Cardiovascular Surgery | | | | |
| Certified Registered Nurse Anesthetist (CRNA) | | | | |
| Colon and Rectal Surgery | | | | |
| Dental/Oral Surgery | | | | |
| Gastroenterology | | | | |
| General Surgery | | | | |
| Gynecology | | | | |
| Head and Neck Surgery | | | | |
| Neurological Surgery | | | | |
| Obstetrics | | | | |
| Oncology | | | | |
| Ophthalmology | | | | |
| Orthopedic Surgery | | | | |
| Otolaryngology | | | | |
| Pain Management | | | | |
| Pathology | | | | |
| Pediatric Dentistry | | | | |
| Pediatric Surgery | | | | |
| Physical Medicine/Rehabilitation | | | | |
| Plastic Surgery | | | | |
| Podiatry | | | | |
| Radiology | | | | |
| Radiation Oncology | | | | |
| Thoracic Surgery | | | | |
| Urological Surgery | | | | |
| Vascular | | | | |
| Other (1), specify: | | | | |
| Other (2), specify: | | | | |
| Other (3), specify: | | | | |
| Total | | 0 | 0 | |

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| State ID: | 00000 | Facility Name: | - | 2016 |
| Administrator Declaration | | | | |
| - | Have you Saved and Renamed the report with your State ID and Facility name as instructed? Example: "12345 ABC Surgery Center" | | | |
| - | Have you <u>Checked</u> and <u>Corrected</u> all Errors on the Error Tab? | | | |
| Administrator's Declaration | - | I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete. | | |
| Date (mm/dd/yyyy) (use slashes) | | | | |