HLS/Cons-110 Nov 16, 2011

Wyoming Department of Health Aging Division - Healthcare Licensing and Surveys 6101 Yellowstone Rd, Ste 186C Cheyenne, WY 82002

Telephone: (307) 777-7123 Fax: (307) 777-7127

Healthcare Licensing and Surveys Use Only
Project No.:

E-mail: WDH-OHLS@wyo.gov - Website: www.health.wyo.gov/ohls

Healthcare Facility Final Plan Review Application and Project Information Form

The following information is requested to assist in the project review. Please complete this form as accurately as possible and return it to Healthcare Licensing and Surveys at the above address, along with your final plans.

LICENSURE INFORMATION:

If the facility is currently licensed,			If the facility is to be newly licensed,				
complete the information requested below: Existing Licensed Facility			complete the information requested below: Proposed New or Relocated Facility				
Name:	Existing L	icensed Facility		Name:	Troposed New Or F	Relocated Facility	
Street				Street			
& Suite #:				& Suite #:			
City/Town				City/Town			
Zip Code:				Zip Code:			
PROJECT TYPE:							
New Facility* Add Outpatient Satellite to Hospital* Relocate Satellite to Hospital* Renovation to Existing Facility (If a relocation of services plans with information on the displaced services must also be submitted.) Other							
BED CHANGES: # Increase: # Decrease: No Change							
* Is this project located on the premises of another separately licensed entity?							
Yes No If yes, indicate the name of the other licensee:							
* Will the proposed facility site share functional areas or services with another entity (licensed or unlicensed)?							
Yes No If yes, explain the functional program:							
Licensee/Applicant's Contact Person:			Architect's Contact Person:				
Name:				Name:			
Address:				Address:			
City/State/Zip:				City/State/Z	ip:		
Telephone:			Telephone:				
Fax:				Fax:			
E-Mail:				E-Mail:			
Signature of Applicant:				Date signed:			