



# APPLICATION CHECKLIST

## Emergency Services Exemption Request

Applicants **must** include the following information as stated in section 395.1041(3)(d)3, F.S., and rule 59A-3.255(4), F.A.C. Applications must be received **at least 45 days prior to** the proposed effective date for initial exemptions or **at least 60 days prior to** the expiration of the current license (with renewal application) if conditions which led to the exemption have not changed. Each hospital shall immediately report any change in the conditions which led to the granting of an exemption.

All forms listed below may be obtained from the website: <http://ahca.myflorida.com/HQALicensureforms>. Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

### A. General Instructions:

- Type or print in ink.
- Submit a separate Emergency Services Exemption Request, AHCA Form 3000-1 for each service exemption requested.
- Attach additional pages if necessary.
- Complete all sections.
- Sign and date the form. (If an incomplete form is submitted, the exemption request will be denied.)
- Submit the completed form as an attachment to an appropriately completed hospital licensing application (AHCA Form 3130-8001).

### B. Section specific instructions

- Section 1 Identify the hospital and the type of exemption requested.
- Section 2 Mark the appropriate service category. If more than one, complete a separate form for each.
- Section 3 List all professionals at your hospital that are credentialed to perform the service for which you are requesting an exemption. Attach a copy of the hospital bylaws concerning medical staff privileges.
- Section 4 Enter the number of patients for each situation for the past 12 complete months.
- Section 5 List all hospitals within 50 miles that have the capability to provide the service on a 24 hour per day, 7 day per week basis, related to the exemption request. A useful tool is Facility/Provider Locator by Proximity available on [www.floridahealthfinder.gov](http://www.floridahealthfinder.gov).
- Section 6 Document all attempts made by your hospital to enter into agreements with other hospitals or physicians to provide the service on a 24 hour per day, 7 day per week basis. Attach copies of all documentation to support your initiatives. Document all efforts that have taken place in the past 12 months to recruit additional physicians. Include all other information that you feel is pertinent to why your hospital cannot provide the service 24 hours per day, 7 days per week
- Section 7 Signature of the Chief Executive Officer.



# APPLICATION

## Emergency Services Exemption Request

Attach to AHCA Form 3130-8001, Health Care Licensing Application, Hospitals

### 1. Provider Information

License #
Name of Hospital (include fictitious name, if applicable)
This exemption application is for: <input type="checkbox"/> Full exemption. Requesting 24/7 exemption from providing call coverage. <input type="checkbox"/> Partial exemption. Requesting an exemption from providing call coverage ____ days per month

### 2. Service Category for Which Exemption is Requested (select only one)

<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Oral/Maxillofacial Surgery	<input type="checkbox"/> Pulmonary Medicine
<input type="checkbox"/> Burns	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Radiology
<input type="checkbox"/> Cardiology	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Neurology	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> Cardiovascular Surgery	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Urology
<input type="checkbox"/> Colon/Rectal Surgery	<input type="checkbox"/> Hematology	<input type="checkbox"/> Obstetrics	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Hyperbaric Medicine	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Psychiatry	

### 3. Professionals Credentialed to Provide the Service

Name	License Number	Specialty	Credentials	Privileges

### 4. Statistical Data Relating to the Service for Which Exemption is Requested

NOTE: The statistical data provided must be specific to the service category for which the exemption is requested

	For the past 12 months beginning _____ to _____
	Number of patients presenting at the hospital's emergency department and receiving services that required the specialized services of the on-call physician credentialed to provide this service.
	Number of patients presenting at the hospital's emergency department and transferred to another facility
	Number of patients diverted to other hospitals for emergency treatment
	Number of patients receiving services on an inpatient basis
	Estimated number of emergency department procedures to be performed during the next 12 months that will require the specialized services of the on-call physician credentialed to provide this service.

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**5. Other Hospitals with the Same Service Capability within a 50 Mile Radius**

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Distance (Miles)	Name of Other Hospital

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**6. Supporting Facts**

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**7. Signature of Affirmation**

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I, \_\_\_\_\_ hereby affirm that the information provided on this form is true and correct to the best of my knowledge and belief. I understand that any false statements are subject to punishment pursuant to s. 837.06, F.S.

\_\_\_\_\_  
Signature of Chief Executive Officer

\_\_\_\_\_  
Date