Applicant's Name:	Completed by:	Date:

OUTPATIENT SURGERY CENTERS SUPPLEMENTAL APPLICATION

1. Are you doing any bariatrics, cosmetic or refractive laser eye surgery? If 'Yes', please provide details in the Comments Section. ☐ YES ☐ NO

2. Please attach a list of the procedure categories with percentages done at the facility (i.e., orthopedic 10%, minor superficial 30%, cosmetic 5%, etc.).

3. Are beds maintained for overnight occupancy? If 'Yes', please explain in the Comments Section. ☐ YES ☐ NO

4. Are there any licensed hospital beds or is the facility licensed as a surgical hospital? If 'Yes', please explain in the Comments Section. ☐ YES ☐ NO

5. Please check-off the following policies and procedures that are established and adhered to by all staff, including contractors and volunteers. Please explain any 'No' answers in the Comments Section.
   a. Patient selection (candidate selection/appropriateness for setting) ☐ YES ☐ NO
   b. Pre-anesthesia (general anesthesia) evaluation by the anesthesia provider ☐ YES ☐ NO
   c. Informed consent ☐ YES ☐ NO
   d. Minimum monitoring requirements for all types of anesthetics ☐ YES ☐ NO
   e. Discharge criteria (when other than a local anesthetic is administered):
      i. By physician/anesthesiologist ☐ YES ☐ NO
      ii. Discharge criteria is established (alert, vital signs, tolerates fluids, etc.) ☐ YES ☐ NO
      iii. With a responsible adult ☐ YES ☐ NO
   f. Discharge instructions:
      i. Written ☐ YES ☐ NO
      ii. Copy provided to patient (original copy for the medical record) ☐ YES ☐ NO
   g. Patient identification (right patient, right surgical site) ☐ YES ☐ NO
   h. Notifying and documenting patient of abnormal pathology results ☐ YES ☐ NO

6. Please check-off the following policies and procedures that are established. Please explain any 'No' answers in the Comments Section.
   a. Incident/Occurrence criteria ☐ YES ☐ NO
   b. Medical devices involved in patient injuries ☐ YES ☐ NO

7. Do you verify that staff physicians carry $1,000,000/$3,000,000 liability limits? If 'No', what limits do you require? $_____ Each occurrence/$_____ Aggregate ☐ YES ☐ NO

8. Complete the following if you perform bariatrics at your facility:

Type of Procedures:	Number of Procedures Performed in the Past 12 Months:	
a. Roux-en-Y (RYGB)	Open _____	Laparoscopic _____
b. Gastric Banding	Open _____	Laparoscopic _____
c. Vertical Band Gastroplasty (VBG)	Open _____	Laparoscopic _____
d. Biliopancreatic Diversion	Open _____	Laparoscopic _____
e. Other (please describe)	Open _____	Laparoscopic _____
f. Other (please describe)	Open _____	Laparoscopic _____

9. Do you do any pediatric/adolescent patients under 18 years? ☐ YES ☐ NO

10. Is your facility accredited by Surgical Review Corporation? ☐ YES ☐ NO

Comments Section:

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