



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243  
[www.tennessee.gov](http://www.tennessee.gov)

TENNESSEE BOARD OF MEDICAL EXAMINERS  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

APPLICATION FOR SITE SURVEY AND CERTIFICATION  
OF OFFICE BASED SURGICAL SUITE – MD

All Application Fees Are Non-Refundable

**NOTICE: A PHYSICIAN OFFICE AT WHICH LEVEL III SURGICAL PROCEDURES ARE PERFORMED IN AN OFFICE-BASED SURGICAL SUITE AS OF OCTOBER 1, 2007 MUST SUBMIT AN APPLICATION FOR A SITE SURVEY AND CERTIFICATION AND REMIT PAYMENT OF THE OFFICE-BASED SURGERY FEE TO THE DEPARTMENT OF HEALTH.**

Level III surgical procedures require sedation which is defined as the use of a general anesthesia, deep sedation, or major conduction anesthesia and pre-operative sedation. This includes the use of: (a) General Anesthesia: loss of consciousness and loss of vital reflexes with probable requirement of external support of pulmonary or cardiac functions; and/or (b) Major Conduction Anesthesia (epidural, spinal, caudal); and/or (c) The use of nitrous oxide in conjunction with other types of sedatives.

APPLICATION INSTRUCTIONS

1. A physician office surgical suite is **required** to be certified by the Board in order to perform office-based surgery. The **Responsible Physician** (the physician in whose name the surgical suite certification will be issued for the office) must complete the Application for Site Survey and Certification of Office Based Surgical Suite. Attachments listed below as required **must** be included. Be sure that it has been signed and notarized.
  - a) Written verification of hospital staff privileges from a hospital within an acceptable distance (within thirty miles or thirty minutes) of the surgical suite where you have staff privileges to perform Level II surgeries.
  - b) Copy of board specialty certification or a copy of the letter stating eligibility and the date to sit for the exam.
  - c) Written verification of medical malpractice coverage.
  - d) Architectural drawings for: 1) Life Safety Features; 2) Mechanical; and, 3) Electrical.
2. Please complete Attachment 1 for **each** physician that will be performing Level III procedures in the office-based surgery suite with attachments listed below as required.

- a) Written verification of hospital staff privileges from a hospital within an acceptable distance from the surgical suite where you have staff privileges to perform Level III surgeries.
  - b) Copy of board specialty certification or a copy of the letter stating eligibility and the date to sit for the exam.
  - c) Written verification of medical malpractice coverage.
3. State law requires that no more than three (3) patients in a physician's office undergoing Level III office-based surgery may be incapable of self-preservation at the same time. The board has promulgated rules requiring physician offices that perform office-based surgery to adopt bylaws that put in place a management system and documentation that will insure that no more than three (3) patients that are in surgery or recovery are incapable of self-preservation at the same time. **Please attach your office based surgery suite's by-laws and documentation of the management system with your application for surgical suite certification.**
  4. Send the completed application with a check or money order made payable to the **TENNESSEE DEPARTMENT OF HEALTH** for the appropriate certification fee indicated on the front of the application to:

Board of Medical Examiners  
665 Mainstream Drive  
Nashville, Tennessee 37243
  5. When the completed application is received and reviewed, the Board of Medical Examiners will transmit it to the Department of Health, Division of Healthcare Facilities (HCF) for the purposes of conducting the survey. After the survey is completed, HCF will transmit the results to the Board of Medical Examiners who will make the final determination on the certification of the surgical suite for office-based surgery.
  6. The initial certification will be for one year. Annual renewal of the certification is required.



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APPLICATION FOR SITE SURVEY AND CERTIFICATION  
OF OFFICE BASED SURGICAL SUITE – MD

A physician office surgical suite is required to be certified by the Board in order to perform Level III surgical procedures. Please provide the name and address of the facility to be certified and the name of the **responsible physician** in whose name the surgical suite certification can be issued for the office.

Name and address of the facility to be certified:

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Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Name of **Responsible Physician**: \_\_\_\_\_ TN License Number: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Please provide a list of **all** Level III Procedures you, the **responsible physician** plans on performing at this Office Based Surgical Suite.

Level III Procedures: \_\_\_\_\_

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Identify each hospital where you have privileges to perform the above identified procedures. Please provide written verification. At least one hospital where you have hospital staff privileges to perform Level III surgical procedures must be within an acceptable distance (at least thirty miles or thirty minutes) from the surgical suite.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you board certified? \_\_\_\_\_ (Please provide copy of board certification or board edibility)  
Yes No

Are you board eligible? \_\_\_\_\_ If board eligible, date scheduled to take the exam: \_\_\_\_\_  
Yes No

Does he/she have medical malpractice coverage? \_\_\_\_\_ (Please provide written verification  
Yes No of malpractice coverage)

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Applicant: Fill out the following Affidavit in the Presence of a Notary Public

**Affidavit and Release**

**This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

Affix Seal Here

My Commission expires: \_\_\_\_\_  
**DATE**

