Application for Hospital Licensure
BED CAPACITY/SERVICES
DIRECTIONS

1. Please refer to Hospital Licensure Regulations 105 CMR 130.020 regarding definitions of services.

2. Complete one form for each campus and one form for the total beds at all campuses.
   For each category of service: identify the unit, building, wing, floor and **campus**, (if there is more than one). Identify the number of beds **on each unit**, in addition to the total number of beds within the service. If beds are out of service, identify the location (unit), the number of beds, and the exact date the beds were taken out of service. Identify the reason the beds are out of service in the comment section.

3. For Pediatric Services, please circle the level of the Pediatric Service (Level I or Level II). Additionally, please identify any specialty services (e.g., rehabilitation).

4. For Psychiatric Services, please identify adult and Pediatric Psychiatric Service beds.

5. For Intensive Care Units, please identify any specialty care units (e.g., transplantation).

6. Complete information for Skilled Nursing and/or Intermediate Care Facility Services **only if those services were licensed prior to April 21, 1988.** Please note that Long Term Care beds licensed since April 21, 1988 are separately licensed as a Long Term Care Facility and **are not included** on this hospital license form.

APPLICATION for HOSPITAL LICENSURE
Bed Capacity/Services

SERVICES *See 105 CMR 130.020*	TOTAL NUMBER OF BEDS **PER SERVICE**	NUMBER OF BEDS **PER UNIT**	LOCATION (BLDG./WING, FLOOR, UNIT, CAMPUS – If applicable)	(If applicable) NUMBER OF BEDS TEMPORARILY OUT-OF-SERVICE (INCLUDED IN LICENSED BED CAPACITY) (Identify month/day/year out-of-service)	COMMENTS
MEDICAL/SURGICAL SERVICE					
INTENSIVE CARE UNIT					
CORONARY CARE UNIT					
BURN UNIT					
PEDIATRIC SERVICE: LEVEL I OR LEVEL II					
PEDIATRIC INTENSIVE CARE UNIT: LEVEL III					

APPLICATION for HOSPITAL LICENSURE
Bed Capacity/Services

SERVICES *See 105 CMR 130.020*	TOTAL NUMBER OF BEDS **PER SERVICE**	NUMBER OF BEDS **PER UNIT**	LOCATION (BLDG./WING, FLOOR, UNIT, CAMPUS – If applicable)	(If applicable) NUMBER OF BEDS TEMPORARILY OUT-OF-SERVICE (INCLUDED IN LICENSED BED CAPACITY) (Identify month/day/year out-of-service)	COMMENTS
MATERNAL SERVICE: ANTEPARTUM POSTPARTUM LDRP (LABOR-DELIVERY-RECOVERY-POST-PARTUM)					
NEONATAL INTENSIVE CARE UNIT: LEVEL III					
PSYCHIATRIC SERVICE					
SUBSTANCE ABUSE SERVICE					
CHRONIC CARE SERVICE					
REHABILITATION SERVICE					

IDENTIFY THE TOTAL LICENSED INPATIENT BED CAPACITY: BEDS _____

SKILLED NURSING FACILITY SERVICE **(only if licensed prior to 4/21/88)**					
INTERMEDIATE CARE FACILITY SERVICE **(only if licensed prior to 4/21/88)**					

APPLICATION for HOSPITAL LICENSURE
Bed Capacity/Services

NEWBORN SERVICES *See 105 CMR 130.601*	TOTAL NUMBER OF BASSINETS	LOCATION (BLDG./WING, FLOOR, UNIT, CAMPUS – If applicable)	NUMBER OF BASSINETS PER NURSERY	(If applicable) NUMBER OF BASSINETS TEMPORARILY OUT-OF-SERVICE (INCLUDED IN LICENSED BASSINET CAPACITY) (Identify month/day/year out-of-service)	COMMENTS
LEVEL I: WELL INFANT NURSERY					
LEVEL IB: CONTINUING CARE NURSERY (CCN)					
LEVEL IIA: SPECIAL CARE NURSERY (SCN)					
LEVEL IIB: SPECIAL CARE NURSERY (SCN)					

TOTAL BASSINETS: WELL/INFANT _____ TOTAL CCN _____ TOTAL SCN _____

	Service Provided		NUMBER OF STATIONS/BEDS	LOCATION (BLDG./WING, FLOOR, UNIT, CAMPUS – If applicable)	COMMENTS
CHRONIC DIALYSIS SERVICE	Yes	No			
AMBULATORY CARE SERVICE	Yes	No			
EMERGENCY SERVICE	Yes	No			
BIRTH CENTER SERVICE (FREESTANDING)	Yes	No			
HOSPICE SERVICE	Yes	No			
PRIMARY STROKE SERVICE	Yes	No			
CARDIAC CATHETERIZATION SERVICE	Yes	No			
HEMATOPOIETIC PROGENITOR/STEM CELL SERVICE	Yes	No			
DESIGNATED TRAUMA CENTER	Yes	No			
MEDICAL CONTROL SERVICE	Yes	No			

APPLICATION for HOSPITAL LICENSURE
Bed Capacity/Service

Please complete and sign or identify N/A

Name of Satellite	Street Address	Floor/Suite	City/Town	Zip Code	Type of Services (check appropriate column below) Inpatient	Outpatient	Type of Satellite Services (e.g., Medical, Rehab., Psych.)

I attest that the above is an accurate listing of the bed capacity and services at:

Facility Name:_____

Administrator:_____ Date: _____