Oklahoma State Department of Health
Protective Health Services, Medical Facilities
123 Robert S. Kerr, Suite 1702, Oklahoma City, OK 73102-6406
Phone: (405) 426-8620
Email: planreview@health.ok.gov

Self-Certification Review Application

For questions about how to fill out the application or what a term may mean, reference the Instruction Guide and the Glossary below.

OSDH ASSIGNED PROJECT NUMBER: _____
(Will be assigned after the first fee submittal.)

PROPOSED PROJECT NAME (6 Words or Less): _____

SUBMITTAL REQUIREMENTS:

- Each submittal must include a hard copy application with the fee attached.

UPLOADING PROCESS AND COMMUNICATION:

- Once your application is approved, you will receive a link to the OSDH Box account. Drag and drop the files into the designated folder. After the upload is complete, email planreview@health.ok.gov. Access will be removed once the upload is approved.
- The project will be placed in a queue for review in the order that the upload is approved. When the submittal process is complete, the review period begins according to the OSDH Self-Certification process.
- To ensure a timely acknowledgment and/or reply to questions/concerns, refrain from emailing OSDH Plan Review team members directly. All emails must be sent to planreview@health.ok.gov and include the project number and "Attn: [Enter the Appropriate OSDH Contact Name Here]."
- Each submitted document must include the assigned OSDH project number.

FACILITY INFORMATION:

EXISTING LICENSED FACILITY
LICENSED NAME (Parent facility if project affects satellite or hospital campus.)
STREET ADDRESS & SUITE #
CITY, STATE & ZIP CODE
LICENSE #

BED COUNT/NUMBER OF PARTICIPANTS OR RESIDENTS CHANGING:

FACILITY WITH LICENSED BEDS Applicable Yes ☐ No ☐		ADULT DAYCARE Applicable Yes ☐ No ☐		RESIDENTIAL CARE HOME Applicable Yes ☐ No ☐	
CURRENT LICENSED BED COUNT:	NUMBER	CURRENT NUMBER OF PARTICIPANTS:	NUMBER	CURRENT NUMBER OF RESIDENTS:	NUMBER
ADDITIONAL BEDS REQUESTED:	NUMBER	ADDITIONAL PARTICIPANTS REQUESTED:	NUMBER	ADDITIONAL RESIDENTS REQUESTED:	NUMBER
TOTAL:	NUMBER	TOTAL:	NUMBER	TOTAL:	NUMBER

DOCUMENTATION FORMAT:

- The following are the document requirements for uploading:
  - File Naming Convention:
    - Project #-Project Name-Type of document-Stage-Submittal-Phase-Date
  - All Documents
    - Format: Documents must be in PDF
    - Text:
      - Copyable
      - Searchable
    - Page Quality:
      - Straight and clear pages
      - No streaks
      - Contrast: High
  - Plans
    - Complete Sets
    - No combined with any other documents
    - Drawing Layers:
      - Flattened
    - Bookmarks: Include
      - sheet number and title
    - Page Orientation:
      - Landscape
    - Sheet Order:
      - Consistent with the cover sheet index
    - Security:
      - Documents must be unsecured to allow plan reviewers to add marks, notes and/or comments

PROJECT FACILITY TYPE:

MEDICAL FACILITIES	HUMAN RESOUCE DEVLOPMENT SERVICES (HRDS)
☐ Hospital (OAC:667)	☐ Skilled Nursing (OAC:675)
☐ Acute Care	☐ IID/ICF (OAC:675)
☐ Psychiatric Hospital	☐ Continuum Care and Assisted Living Facility (OAC:663)
☐ Rehabilitation Hospital	
☐ Long Term Acute Care (LTAC)	
☐ Hospital Outpatient Department (HOD)	
☐ Rural Emergency Hospital (REH)	
☐ Ambulatory Surgical Center (ASC) (OAC:615)	If other specify below:
☐ Hospice Inpatient Freestanding Facility (OAC:661)	

PROJECT/CONSTRUCTION SCOPE: (Licensed facilities only.)

☐ New Facility
☐ Existing Building with New License
☐ Building Addition to Existing Facility
☐ Renovations to Existing Facility
☐ Change of Use or Occupancy Classification in Licensed Facility
☐ Equipment Upgrade/Replacement
☐ Add Satellite to Hospital
☐ Relocation of Existing Facility/Department

FEE AMOUNT:

- Self-Certification Submission:
  - Hospitals/ASCs $1,000.00
  - Applicable LTC Facilities $500.00

FEE AND APPLICATION PROCESSING OPTIONS:

- **Mail to:** Oklahoma State Department of Health
  Financial Management – Receipting Unit
  PO Box 268823
  Oklahoma City, OK 73126-8823
- **Important Notes: In Person:**
  - Submit the fee to the cashier located in the OSDH Vital Records Office breezeway, immediately east of the Strata Tower. The cashier is available Monday through Friday from 2:00 PM to 4:00 PM, except on state holidays.
  - Applications will not be accepted by anyone other than the cashier.
- **Important Notes:**
  - Fees received without a submittal will not be accepted.
  - Plan Review/Medical Facilities staff will not accept any fees.
  - Fees must be paid by check or money order, payable to the Oklahoma State Department of Health.

COMMUNICATION AUTHORIZATION:

- The facility must provide below the organizations authorized to discuss this project. Communicate any changes in the list via e-mail to planreview@health.ok.gov.

ARCHITECTURAL RERESENTATIVE	CONSULTING ENGINEER RERESENTATIVE	FACILITY RERESENTATIVE
NAME	NAME	CONTACT NAME
DATE OF AUTHORIZATION	DATE OF AUTHORIZATION	DATE OF AUTHORIZATION
EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)	EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)	EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)
E-Mail Address	E-Mail Address	E-Mail Address

PROJECT REPRESENTATIVES ATTESTATION:

- The facility and architect attest that the plans comply and acknowledge no comments will be provided by a plan reviewer. Submit final, signed, and sealed construction documents along with a Project Narrative/Functional Program to Box. Available for Hospitals, Ambulatory Surgery Centers, Skilled Nursing, and Assisted Living Centers involving patient care. Refer to the Self-Certification Chapter in each Administrative Code for additional minimum requirements.
- The Architect hereby attests that:
    - The project architect or engineer attesting the application has held a license to practice architecture or engineering for at least five (5) years prior to the submittal of the application, is licensed to practice in Oklahoma.

ARCHITECT
NAME
FIRM
STREET ADDRESS & SUITE #
CITY, STATE & ZIP CODE
LICENSE #

INITIAL LICENSE DATE:
LAST REAUTHORIZATION DATE:
SIGNATURE:

- The Licensing facility also hereby attests that:
    - The project involves any portion of the hospital where patients are intended to be examined or treated and the total cost of design and construction is fifteen million dollars ($15,000,000.00) or less; or
    - The project involves only portions of the hospital where patients are not intended to be examined or treated; and
    - The hospital owner/operator acknowledges that the Department retains the authority to:
        - Perform audits of the self-certification review program and select projects at random for review.
        - Review final construction documents:
        - Conduct on-site inspections of the project:
        - Withdraw approval based on the failure of the hospital or project architect or engineer to comply with the requirements of this Chapter; and
    - The hospital agrees to make changes required by the Department to bring the construction project into compliance with this Chapter

LICENSES REPRESTATIVE
NAME
FACILITY NAME
STREET ADDRESS & SUITE #
CITY, STATE & ZIP CODE
LICENSE #
SIGNATURE: