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

Exception Application

OSDH ASSIGNED PROJECT NUMBER: _____
(Will be assigned after the first fee submittal)
PROPOSED OR ASSIGNED PROJECT NAME: (6 Words or Less): _____

SUBMITTAL REQUIREMENTS

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

UPLOADING PROCESS AND COMMUNICATION:

- An e-mail will be sent with instructions on formatting documents. All uploaded documents not meeting the requirements will be required to be resubmitted. Submittals will be reviewed in the order approved.
- 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	PROPOSED NEW OR RELOCATED FACILITY
LICENSED NAME (Parent facility if project affects satellite or hospital campus.)	PROPOSED LICENSED NAME
STREET ADDRESS & SUITE #	STREET ADDRESS & SUITE #
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
LICENSE #	CERTIFICATE OF NEED NUMBER (Skilled Nursing OAC 675 Only)

PROJECT REPRESENTATIVES:

LICENSEE/APPLICANT'S REPRESENTATIVE	ARCHITECT'S REPRESENTATIVE (If Applicable)
NAME	NAME
TITLE	TITLE
FIRM/FACILITY	FIRM
ADDRESS	ADDRESS
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
TELEPHONE	TELEPHONE
EMAIL ADDRESS	EMAIL ADDRESS

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/CONTRUCTION 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:

- The fee is $500 for each request.
- Submit a separate application and fee for each requested exception or waiver.

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.

SCOPE OF REQUEST

FGI Guideline Reference:

☐ 2018 edition of the FGI Guidelines for Design and Construction of Hospitals

☐ 2018 edition of the FGI Guidelines for Design and Construction of Outpatient Facilities

- Specific Reference number: _____
- No waivers will be permitted, except for those referencing the Facility Guidelines Institute (FGI).

Describe the proposed alternative to meeting the requirement.

Provide a detailed explanation of how the "FGI Guideline creates an unreasonable hardship or describe any proposed improvements or compensating features that offer greater or equivalent outcomes to the FGI Guidelines."

REPRESENTATIVES:

FACILITY	DESIGN PROFESSIONAL
NAME:	NAME:
TITLE:	TITLE:
FIRM/FACILITY:	FIRM:
ADDRESS:	ADDRESS:
CITY, STATE & ZIP CODE:	CITY, STATE & ZIP CODE:
TELEPHONE:	TELEPHONE:
EMAIL ADDRESS:	EMAIL ADDRESS:
DATE:	DATE:
SIGNATURE:	SIGNATURE:

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