

**OHIO DEPARTMENT OF HEALTH  
Maternity Licensure Program**

*(Based on Rules from Section 3701-84 of the Ohio Administrative Code)*

**FREESTANDING BIRTHING CENTER REPORT FORM**

**PART I**

**Please return original plus three (3) copies at least two (2) weeks prior to the survey visit.**

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Today's Date: \_\_\_\_\_ Date Facility Opened: \_\_\_\_\_

Birthing Center Name: \_\_\_\_\_

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

County: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Total Number of Birthing Rooms: \_\_\_\_\_ Non-Profit: \_\_\_\_\_

Birth per Annum for Last Five (5) Years:

19 \_\_\_\_\_ 19 \_\_\_\_\_ 19 \_\_\_\_\_ 19 \_\_\_\_\_ 19 \_\_\_\_\_

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I Administrator:

A. Name: \_\_\_\_\_ Signature: \_\_\_\_\_

B. Title: \_\_\_\_\_ Tenure in Position: \_\_\_\_\_

C. Experience, Formal/Continuing Education: \_\_\_\_\_

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II. Director of Patient Services:

- A. Name: \_\_\_\_\_ Signature: \_\_\_\_\_
- B. Title: \_\_\_\_\_ Tenure in Position: \_\_\_\_\_
- C. Experience, Formal/Continuing Education: \_\_\_\_\_  
\_\_\_\_\_

III. Back-up Physician:

- A. Name: \_\_\_\_\_ Signature: \_\_\_\_\_
- B. Title: \_\_\_\_\_ Tenure in Position: \_\_\_\_\_  
License Number: \_\_\_\_\_
- C. Experience, Formal/Continuing Education: \_\_\_\_\_  
\_\_\_\_\_

IV. Back-up Hospital(s):

- A. Name: \_\_\_\_\_
- B. Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_
- C. Distance:
  - 1. Miles: \_\_\_\_\_
  - 2. Travel Time: \_\_\_\_\_

Comments – Use for ODH Staff Only

V. Ambulance Service(s):

A. Name: \_\_\_\_\_

B. Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

C. Distance:

1. Miles: \_\_\_\_\_

2. Travel Times: \_\_\_\_\_

VI. Owner of Birthing Center:

A. Name: \_\_\_\_\_

Name of Birth Center: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

VII. Alterations:

A. Date of last construction, alterations, or renovations of the birthing center facilities:

\_\_\_\_\_

B. Is new construction or any structural change planned within the next year?

\_\_\_\_\_

Comments – For Use by ODH Staff Only

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**PART II**

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Name of Birthing Center: \_\_\_\_\_

Date of Survey: \_\_\_\_\_

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**FACILITIES:**

A. Facility has the following areas: (Check (x) or indicate number as appropriate)

- |     |              |       |  |
|-----|--------------|-------|--|
| 1.  | 83-39(A)(1)  | _____ | Waiting Room                             |
| 2.  | 83-39(A)(1)  | _____ | Play Area                                |
| 3.  | 83-39(A)(2)  | _____ | Number of Exam Rooms                     |
| 4.  | 83-39(A)(3)  | _____ | Family Room                              |
| 5.  | 83-39(A)(3)  | _____ | Conference Room                          |
| 6.  | 83-39(A)(3)  | _____ | Staff Area                               |
| 7.  | 83-39(B)     | _____ | Number of Birthing Rooms                 |
| 8.  | 83-39(C)(1)  | _____ | Patient Toilet Rooms                     |
| 9.  | 83-39(C)(2)  | _____ | Family/Staff Toilet Rooms                |
| 10. | 83-39(C)(10) | _____ | Clean Utility Rooms                      |
| 11. | 83-39(C)(10) | _____ | Dirty Utility Rooms                      |
| 12. | 83-39(C)(10) | _____ | Janitor's Closet                         |
| 13. | 83-39(E)     | _____ | Laundry Room/Service                     |
| 14. | 83-39(F)     | _____ | Sterilization Area/Storage               |
| 15. | 83-39(G)     | _____ | Refreshment Area                         |
| 16. | 83-39(C)(4)  | _____ | Emergency Communication System           |
| 17. | 83-39(C)(5)  | _____ | Telecommunication to Community Resources |
| 18. | 83-39(C)(9)  | _____ | Emergency Lighting                       |
| 19. | 83-40        | _____ | Emergency Cart – Maternal and Neonatal   |
| 20. | 83-41(C)(3)  | _____ | Refrigerator for Biologicals             |
| 21. |              | _____ | Other (specify)                          |

INSURANCE COVERAGE:

A. 83-38(C)(3):

Liability Insurance Coverage for staff: \_\_\_\_\_ Yes \_\_\_\_\_ No

Liability Insurance for Birthing Center: \_\_\_\_\_ Yes \_\_\_\_\_ No

B. 83-38(C)(4)

Have any malpractice claims been filed against the staff/center? \_\_\_\_\_ Yes \_\_\_\_\_ No

C. 83-38(C)(4)

If yes, what is the status of the claim(s)? (provide documentation)

STATISTICS

3701-83-12(B)(12)

Complete Ohio Department of Health Maternity Licensure Program Statistical Report Form for Freestanding Birth Centers.

