

# NATIONAL URGENT CARE CENTER ACCREDITATION

2813 S. Hiawasse Rd., Suite 206, Orlando, FL 32835-6690

Ph 407-521-5789 Fax 407-521-5790

ucaccreditation.org



Please complete and return the Application for Accreditation with applicable application fee (see fee schedule on last page) to **National Urgent Care Medicine Accreditation**. Retain a copy of the completed document for your files.

Legal Name of Practice \_\_\_\_\_

If the center has a “dba” or is known to the public or patients by a different name than the legal name, indicate the dba here. If none, write N/A.

\_\_\_\_\_

Medical Director (M.D./D.O.) \_\_\_\_\_  
Name

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Web Address \_\_\_\_\_

Practice Administrator/Manager) \_\_\_\_\_  
Name Title

Survey Contact Person \_\_\_\_\_  
Name Title

Contact Email Address \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

If your Urgent Care center is a subunit of a larger organization, or if it is owned, operated, or managed by, or affiliated with another organization, indicate the name and address of the organization

\_\_\_\_\_

**Please indicate which of the following best describes your facility type (please select one):**

- Urgent Care Center
- Occupational Health Center
- Student Health Center
- Community Health Center
- Community Health Center
- Other \_\_\_\_\_

**Indicate below the scope of medicine practiced (please check all that apply);**

- Urgent Care Medicine
- Emergency Medicine
- Sports Medicine
- Occupational Medicine
- Family Practice
- Pediatrics
- Other \_\_\_\_\_

1. List all center locations

Main Site	Street Address & City	Phone #	# of Providers	Date Opened (month/year)

**Additional Locations (if none, write N/A).**

**Attach page with additional addresses if needed.**


2. List, by specialty:

(a) the number of full-time providers

(b) the number of part-time providers

(c) the full-time equivalents (FTEs) of part-time providers who are engaged in providing services at all locations. If more lines are needed, photocopy this page or provide a staff roster with the information requested.

Specialty	(a) Number Full-Time	(b) Number Part-Time	(c) FTEs	Total
<b>Total</b>				

3. If the center is not yet operational, indicate the anticipated date services will begin (month /year) \_\_\_\_\_

4. Medicare provider number \_\_\_\_\_

5. Other Medicare Certifications  Yes  No

If Yes, please specify) \_\_\_\_\_

6. Are diagnostic imaging services provided?  Yes  No

If Yes, specify type:  X ray  CT  MRI  US  Other \_\_\_\_\_

7. Does the center provide occupational health services on a regular basis for employees, employers and workers' compensation carriers?  Yes  No

8. Does the center provide medical care of an urgent nature as the primary focus of its mission?  Yes  No

9. Are there any other special services the center provides that should be considered in planning the survey?  Yes  No

If Yes, explain \_\_\_\_\_

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

10. Has your center ever been previously accredited?  Yes  No

If Yes, please specify the name of the accrediting organization and the dates of Accreditation:

\_\_\_\_\_

11. Is there any physician/practitioner currently in your center whose license has been suspended, revoked or voluntarily surrendered?

Yes  No

12. Is there any physician/practitioner in your center whose license is currently under review by the state medical board?

Yes  No

13. Has your center placed any limitations or conditions on any practitioner's privileges?  Yes  No

14. Are there any litigation/malpractice cases currently pending or settled within the past five years against the center and/or a physician/practitioner?  Yes  No

15. Has the center had any unfair labor practice filings or any other litigation involving the center or its officers?

Yes  No

16. Does the center have a written policy regarding the manner in which you handle non-English speaking patients?

Yes  No

17. Do you utilize any translation services for non-English speaking patients?

Yes  No

If Yes, what service us utilized? \_\_\_\_\_

18. Do you have Policy & Procedures manual?

Yes  No

How did you first learn about National Urgent Care Center Accreditation?

\_\_\_\_\_

How long has your center been considering the Accreditation process?

\_\_\_\_\_

What factors contributed to your desire to accredit your center? Please rank in order of importance, starting with one (1) as most important.

— To reduce malpractice rates

— To potentially increase reimbursement by health insurance carriers, or other third-party payors

— To maintain or obtain HMO/managed care contracts

— To communicate and market your facility's standard of quality to the public

— To obtain educational and consultative guidance

— To meet state (or federal) legislative/regulatory requirements

— To obtain Medicare certification

— Other \_\_\_\_\_

**Accreditation Application Fees**

1 clinic	\$1,800
2-5 clinics	\$3,000 (surveyor will complete a site review at two locations)
6-10 clinics	\$5,000 (surveyor will complete a site review at three locations)
11 -15 clinics	\$7,500 (surveyor will complete a site review at five locations)
16-20 clinics	\$14,000 (surveyor will complete a site review at 10 locations)
21 or more clinics	Call National Urgent Care Center Accreditation for pricing (surveyor will determine the number of clinics to be reviewed based on the total number of clinic locations)

The application fee should accompany this Accreditation Application (this “Application”). The clinic (the “Applicant”) is also responsible for travel expenses for the surveyor (airfare, hotel, car rental and meals, as applicable) [to be invoiced to Applicant after completion of the site review(s)].

*\*\*Applicant has 30 days to request a refund of their application fee (less \$250 processing fee to be retained by National Urgent Care Center Accreditation) if it elects not to seek Accreditation. After 30 days all fees are non-refundable.\*\**

All written or verbal information provided to National Urgent Care Center Accreditation (“NUCCA”) by Applicant regarding this Application, the survey and/or Accreditation process must be accurate, complete, and true. Applicant is subject to the current Accreditation policies and procedures of NUCCA. As an Accredited Center, the Applicant will receive notice regarding changes in NUCCA policies and procedures.

The Applicant agrees to hold NUCCA and its members, officers, directors, governors, examiners, and agents, free and harmless from any damage, expense, complaint, or cause of action whatsoever by reason of any action they, or any of them, may reasonably take in connection with this Application, the investigation of same, the failure of NUCCA to admit the Applicant to the Accreditation process. NUCCA makes no warranties, representations, or guarantees as to Applicant’s ability to obtain Accreditation.

NUCCA will maintain as confidential all information provided and will not disclose such information to any third party except on prior written authorization from the Applicant. If NUCCA and/ or its affiliates or representatives becomes legally compelled by law, process or order of any court or governmental agency or otherwise to disclose Confidential Information, or legal counsel therefore opines in writing that NUCCA or its affiliates or representatives is required to disclose any Confidential Information, NUCCA shall be relieved of its confidentiality obligations under this Section solely as and to the extent that it becomes legally compelled to disclose Confidential Information. As used herein “Confidential Information” shall include (i) all analyses, compilations, studies or other documents prepared by NUCCA or its representatives containing or based in whole or in part on any confidential information furnished by the Applicant, and (ii) all work product of any kind produced by NUCCA or its affiliates in the course of or in connection with the Accreditation.

NUCCA designates medical practices that have been awarded Accreditation in the “Find an Urgent Care Center” database, displays a photo (when provided by the Applicant or taken by the surveyor) on its web site, [ucaccreditation.org](http://ucaccreditation.org), and on its Facebook page, [facebook.com/UrgentCareAccreditation](https://facebook.com/UrgentCareAccreditation). A press release announcing Applicant’s Accreditation is also distributed by NUCCA. The Applicant agrees and permits NUCCA and/or its affiliates to publish such information and Accreditation and/or revocation of any Accreditations.

Applicant agrees to follow NUCCA’s *Self-Assessment Guidelines and Handbook for Urgent Care Center Accreditation*, both of which documents are incorporated into this Application by this reference. Applicant further agrees that the terms and conditions stated in this Application shall govern the relationship between Applicant and NUCCA, including this Accreditation, any additional locations seeking future accreditation, and any future applications for renewal of Accreditation.

This Application is governed by and shall be construed in accordance with the laws of the State of Florida. NUCCA shall at all times be an independent contractor as to Applicant, and shall exercise objectivity in making all Accreditation determinations. In no event will NUCCA's aggregate liability arising out of or related to this Application exceed the Application Fee paid by Applicant.

On behalf of the Applicant, the undersigned certifies that all information submitted is complete and accurate as of the date below. Applicant will notify NUCCA if there are any changes to this information. Applicant understands that the Accreditation application fees are due prior to NUCCA’s on-site survey, and that all fees should be paid to NUCCA. Applicant understands that in addition to the application fee, Applicant is responsible for all travel expenses for the surveyor (for example: airfare, hotel, car rental, meals, etc.).

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Medical Director (Print name)

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Medical Director Signature

**To assist NUCCA in making travel arrangements for the surveyor, please provide the following information:**

Name of closest major airport \_\_\_\_\_ Approx. distance (in miles) from center \_\_\_\_\_

Include a Check or Money Order with your application or Pay by Credit Card:

Account number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVC/CVV2 Number \_\_\_\_\_

Name on card (please print): \_\_\_\_\_

Cardholder signature: \_\_\_\_\_

Billing address: \_\_\_\_\_  
(if different from address on first page)

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**DO NOT WRITE IN THIS SPACE - FOR NUCCA OFFICE USE ONLY**

Date Rec'd \_\_\_\_\_ Check # \_\_\_\_\_ Amount \$ \_\_\_\_\_ Credit Card Auth: \_\_\_\_\_