NATIONAL URGENT CARE CENTER ACCREDITATION

2813 S. Hiawassee 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 <u>one</u>):

☐ 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 <u>all</u> 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
Total				

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

   *Are you applying for the Early Survey Program ☐ Yes ☐ No
   (see the brochure and/or the NUCCA Handbook for Urgent Care Center Accreditation for more information about the Early Survey Program)?

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 Fees

1 clinic	$1,950
2-5 clinics	$1,050 per location
6-10 clinics	$710 per location
11 -15 clinics	$640 per location
16-20 clinics	$445 per location
21 or more clinics	Call or email National Urgent Care Center Accreditation for pricing

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, meals, tolls, parking fees, etc. 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.

The on-site review will take place within six weeks from receipt of your application (depending on reviewer availability). The Accreditation Coordinator will coordinate with the clinic and the reviewer to schedule which locations will be reviewed and the dates of each review to ensure a smooth review process.

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 lists medical practices that have been awarded Accreditation on the website and displays a photo (when provided by the Applicant or taken by the surveyor), http://ucaccreditation.org/find-an-accredited-center.html. 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 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 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.) which will be invoiced to the clinic after the completion of the on-site review(s).

Medical Director (Print name) _____

Medical Director Signature _____

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)

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

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

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