

Request for Temporary Beds

INSTRUCTIONS FOR APPLICATION:

- _____ 1. **Regulations:** Review 12VAC5-220-100 and 12VAC5-371-45 (if your facility is a nursing home) or 12VAC5-410-110 (if your facility is a hospital).
- _____ 2. **Application:** Be sure that all information is completed on the application.
- _____ 3. **Attachments:** While an attachment is not required, requesters are welcome to attach documentation to support the request for temporary beds.

An incomplete application will delay the processing of your application. Documents submitted with an application are the property of Virginia Department of Health Office of Licensure and Certification (OLC) and cannot be returned.

The completed application may be faxed to the OLC at **(804) 527-4502** or be emailed to OLC-inquiries@vdh.virginia.gov. It may also be mail to the OLC at:

**Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233**

Questions regarding the application can be directed to the OLC at OLC-inquiries@vdh.virginia.gov or by calling (804) 367-2102.

Doc. Number	Rev. Number	Eff. Date	Page Number
OLC-1009-F	1.00.00	June 1, 2022	1 of 4

Request for Temporary Beds

FACILITY INFORMATION.	
1. Facility Name	
2. License Number	3. Facility Type Hospital Nursing Home
4. Administrator/Chief Executive Officer Name (or designee)	
5. Telephone Number	6. Email
7. Number and Type of Temporary Beds Requested <input type="checkbox"/> Adult medical/surgical beds <input type="checkbox"/> Pediatric medical/surgical beds <input type="checkbox"/> Adult intensive care unit (ICU) beds <input type="checkbox"/> Pediatric ICU beds <input type="checkbox"/> Long-term care beds	

LOCATION INFORMATION. Attach additional pages if needed.
8. What is the address of the location(s) where the temporary beds will be located?
9. Is any location identified above a temporary structure or satellite location? If yes, please indicate which location.
10. Identify the specific location within building or structure where the temporary beds will be located.

Doc. Number	Rev. Number	Eff. Date	Page Number
OLC-1009-F	1.00.00	June 1, 2022	2 of 4

LIFE SAFETY CODE. Attach additional pages if needed.

11. Do the locations identified in Question 10 meet life safety code requirements for the type of patients or residents expected to occupy those temporary beds?

Yes

No

12. If the response to Question 11 is "No," explain what action the facility will take to meet life safety code requirements.

USAGE AND STAFFING. Attach additional pages if needed.

13. What is the planned use of the temporary beds?

14. Describe in detail the plans for staffing the temporary beds.

15. Describe the efforts the facility is undertaking or will undertake to reduce or eliminate the number of temporary beds needed.

Doc. Number	Rev. Number	Eff. Date	Page Number
OLC-1009-F	1.00.00	June 1, 2022	3 of 4

AFFIRMATION.

I certify on behalf of _____ that all of the information submitted with this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is cause for denial, rescission of modification of any resulting approval for temporary beds.

I acknowledge and understand on behalf of _____ that it is not authorized to add temporary beds unless its application for temporary beds has been granted.

I acknowledge and understand on behalf of _____ that the State Health Commissioner may attach conditions to the approval for temporary beds that, in the sole judgment of the State Health Commissioner, protects the health, safety, or welfare of the public and patients or residents.

I acknowledge and understand on behalf of _____ that it must notify the OLC in writing within 24 hours of opening a temporary bed and within 24 hours of closing a temporary bed.

I acknowledge and understand on behalf of _____ that it is not authorized to operate temporary beds more than 30 days after the expiration of the State Health Commissioner's determination regarding a public health emergency arising from a hospital or nursing evacuation causing a bed shortage or after the expiration of an emergency order of the State Board of Health or the State Health Commissioner for the purpose of suppressing dangers to public life and health.

I have carefully read the laws and regulations related to the type of licensed facility on whose behalf I am submitting this application. _____ agrees to abide by and remain current with the laws and regulations administered by the Board of Health and State Health Commissioner.

Signature

Date

Printed Name

Title

Doc. Number	Rev. Number	Eff. Date	Page Number
OLC-1009-F	1.00.00	June 1, 2022	4 of 4