ALLIED HEALTH:

HEALTH CARE STAFF AGENCIES & NURSING REFERRAL SERVICE AGENCIES

APPLICATION FOR LICENSURE

FOR OFFICE USE ONLY			
INITIALS	DATE	AMOUNT PAID	CHECK NUMBER
DATE OF CHECK	BANK		

1. GENERAL INFORMATION

CHECK TYPE OF LICENSE

	AGENCY TYPE	CODE OF MARYLAND REGULATIONS (COMAR)	LICENSE DURATION
◯	Nursing Referral Service Agency	10.07.07	3 years
◯	Health Care Staff Agency **(There are no fees effective 8.29.16)**	10.07.03	1 year

CHECK TYPE OF APPLICATION

◯ Initial ◯ Renewal ◯ Other Changes (specify)

LEGAL AGENCY NAME			TRADING NAME (DBA)		
E-MAIL ADDRESS			PHONE NUMBER	FAX NUMBER	
BUSINESS ADDRESS (physical location)			MAILING ADDRESS (if different)		
NUMBER, STREET			NUMBER, STREET		
CITY	STATE	ZIP	CITY	STATE	ZIP
COUNTY			LICENSE NUMBER (if applicable)		
NAME OF RESPONSIBLE PARTY (Last, First, Middle Initial)			AFTER HOURS/EMERGENCY CONTACT NUMBER		

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

2. FEES

There are **no licensing fees** associated with Allied Health: Health Care Staff Agencies & Nursing Referral Service Agencies effective 8/29/16.

3. OWNERSHIP (Type of business organization of disclosing entity)

◯ SOLE PROPRIETORSHIP ◯ PARTNERSHIP ◯ CORPORATION

NAME	ADDRESS

NAME(S), TITLE(S), AND ADDRESS(ES) OF PARTNER(S) AND PERCENTAGE OWNED IF 2% OR MORE
(Attach additional pages if needed.)

NAME AND TITLE	ADDRESS	PERCENTAGE OWNED

IF CORPORATION: DATE OF CHARTER	DATE OF INCORPORATION	FEIN NUMBER

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER	
ADDRESS (number, street)	CITY	STATE	ZIP

4. BACKGROUND

1. Has any owner, officer, director, agency, or managerial staff had a license revoked, suspended, or denied by the DHMH within the last five years? ◯ No ◯ Yes (explain)

2. Does the parent company, owner, agent, officer, or managerial staff own or operate a health care facility/agency licensed or surveyed by the OHCQ? ◯ No ◯ Yes (explain)

3. The agency hereby attests that it is in compliance with The Civil Rights Act of 1964; The Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990; and The Drug Free Workplace Act of 1988. ◯ Yes ◯ No (explain)

4. Have the owners, officers, directors, agents, or managerial staff been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? ◯ No ◯ Yes

5. WORKERS' COMPENSATION

Do you have any employees? ◯ Yes ◯ No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER	BINDER NUMBER	
INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (refer to the instruction guide for details).

6. HEALTH CARE STAFF AGENCIES

IDENTIFY ALL HEALTHCARE FACILITIES STAFF WILL BE REFERRED TO

7. AFFIDAVIT

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Code of Maryland Regulations (COMAR) checked below.

I further certify that I will notify the OHCQ if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

If the program is going to be in more than one applicant's name, each applicant's signature is required.

Governing Regulations:

◯ Nursing Referral Service Agency – COMAR 10.07.07
◯ Health Care Staff Agencies – COMAR 10.07.03

SIGNATURE OF APPLICANT	TITLE	DATE
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8. ADDENDUM - VERIFICATION FORM

LICENSED NAME	LICENSE NUMBER (if applicable)

Individuals providing services in the State of Maryland must be licensed/certified with the State. Complete this form by listing the required information. It is the responsibility of the responsible party to verify the status of each employee. (Attach additional pages if needed.)

STAFF NAME	POSITION (RN, LPN, GNA)	LICENSE NUMBER	EXPIRATION DATE	VERIFICATION DATE	NAME OF PERSON VERIFYING INFO

SIGNATURE OF VERIFYING PARTY	DATE