|  |
| --- |
|  **Section 1: Licensing Action ( Required)**  |
|  [ ] **Initial License** | [ ]  **Legal Name Change** | [ ]  **Relocation** | [ ]  Other: Enter text. |
|  [ ] **License Renewal** | [ ]  **DBA Name Change** | [ ]  **Mailing Address Change** |  |
|  [ ] **Voluntary Closure** | [ ]  **Ownership Change** | [ ]  **Corporate Address Change** |   |
|  **License Number:** Enter text.  |  **Expiration Date**: Enter text. |
|  **Total Fee Amount Included:** Enter text |  **Check/Money Order #:** Enter text. |
| **State ID #: NS** Enter text. |
| ***\*Check & Payment Transmittal Form must be submitted to LDH Licensing Fee, PO Box 734350, Dallas, TX 75373*** |

|  |
| --- |
|  **Section 2: Nurse Staffing Agencies Information ( Required)** |
| **Agency Legal Entity Name as it is registered with the IRS: (Must submit IRS documentation showing legal name & EIN):**  |
| **EIN#:**Enter text. |
| **Agency DBA Name (if applicable):** Enter text. |
| **Geographical Street Address:** Enter text. |
| **City:** Enter text.  | **Parish/County:** Enter text. | **Zip:** Enter text. |
| **Main Phone # (not voice mail) that can be reached during business hours:** Enter text. | **Main Fax #:** Enter text. |
| **Mailing Address:** Enter text. | **Street:** Enter text. |
| **City/State/Zip:**  Enter text. |  |
| **Accrediting Organization (if Applicable)**Enter Text. | **Accrediting Organization Expiration**Enter Text |

|  |
| --- |
|  **Section 3: Registered Agent** |
| **Agency Name:** Enter text. |
| **Agent:** Enter text. |
| **Address:** Enter text. |
| **City:** Enter text. | **State:** Enter text. | **Zip:** Enter text. |
| **Phone #:** Enter text. |
| **Email Address:** Enter text. |

|  |
| --- |
|  **Section 4: Contact Information ( Required )** |
| **Administrator/Director** |  **Nursing Manager/Supervisor** | **Designated Contact Person** |
| **Name:** Enter text. | **Name:** Enter text. | **Name:** Enter text. |
| **Phone:** Enter text. | **Phone:** Enter text. | **Phone:** Enter text. |
| **Email:** Enter text. | **Email:** Enter text. | **Email:** Enter text. |

|  |
| --- |
|  **Section 5: Service Type ( Required )** |
| [ ] **Registered Nurse**  |
| [ ] **Licensed Practical Nurse**  |
| [ ] **Certified Nursing Assistant**  |

|  |
| --- |
|  **Section 6: Hours of Operation**  |
|  **Required for Initials** **Has this information changed since the initial/renewal** [ ] **No (Skip to next section)** [ ] **Yes (complete this section)** |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  Enter Text AM toEnter Text PM | Enter text.AM to Enter text. PM | Enter text.AM toEnter text.PM | Enter text.AM to Enter text.PM | Enter text.AM toEnter text.PM | Enter text.AM toEnter text.PM | Enter text.AM toEnter text.PM |

|  |
| --- |
|  **Section 7: Type of Ownership (Must Be Completed For Initials & Changes in Ownership)** |
|  **Has this information changed since initial/renewal application: No (skip to next section) Yes (complete this section)** |
|  **Non-Profit** **(Must submit evidence of non-profit status)** |  **For Profit** | **Government****(Must submit evidence of government status)** |
| [ ] **Individual / Sole Proprietor** | [ ] **Individual / Sole Proprietor** | [ ] **Federal Facility** |
| [ ] **Corporation** | [ ] **Corporation** | [ ] **Hospital Service District** |
| [ ] **Limited Liability Corporation** | [ ] **Limited Liability Company** | [ ] **State Facility** |
| [ ] **Partnership** | [ ] **Partnership** | [ ] **Combination Gov-N-Profit** |
| [ ] **Religious Affiliation** | [ ] **Group Practice** | [ ] **Parish (specify)** |
| [ ] **Unincorporated Association** | [ ] **Other:** | [ ] **Other:** Enter text. |
| [ ] **Other:** Enter text. |  |  |

|  |
| --- |
| **Section 8: Ownership Structure (Must Be Completed For Initials & Changes in Ownership)****For other: Has this information changed since the initial/renewal application:** **Please include all persons or entities with 5% or greater direct and/or indirect ownership or membership** |
| **All Owners’ Names With 5% or greater direct or indirect ownership** | **Percentage** | **Tax ID Number/Social Security #** | **Address, phone #, fax #, Email Address** |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
|  **Section 9: Branch Offices and Satellites**  |
|  ***INDICATE THE NAME, ADDRESS, CITY, STATE, ZIP, PARISH, AND TELEPHONE NUMBER OF EACH OFF-SITE CAMPUS*** |
| **Branch Name**  | **Geographical Address** **(Street,City,State,& Zip Code)** | **Parish/County** | **Telephone Number** | **License Number** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Section : Payment Information (Must Be Completed If There Is a Fee Associated with This Action)** |
| Mail Payment & Payment Transmittal Form To | Email License Application To |
|  [ ] LDH Licensing Fee  PO Box 734350 Dallas, TX 75373-4350 |  [ ]  HSS.LA.NSA@la.gov |

|  |
| --- |
|  **Section 10 : Attestation & Signature** |
| **I understand that if the agency license is granted with this application action, it is granted for two years and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Louisiana Department of Health, Health Standards Section, in writing of any changes in the information provided in this application in a separate packet. I attest that the Nurse Staffing Agency currently complies with the requirements of the Nurse Staffing Agency licensing standards LAC 48:I.Chapter 77**. **I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health.**  |
| **Authorized Representative’s Printed Name & Title:** |
| **Authorized Representative’s Signature** | **Date:** |