DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

APPLICATION FOR NURSE STAFFING AGENCY LICENSE

Thank you for your desire to provide Nurse Staffing Agency services in the District of Columbia. Please review the instructions carefully and be sure to submit all of the required documents. If you require any assistance with this process, contact DC Health at (202)724-8800.

Applying for: ☐ **Initial License** ☐ **Renewal**

*** Has there been any change in office location since last renewal?** ☐ No ☐ Yes

LICENSURE FEE

Initial License Fee: $1,000 **Renewal Fee: $500** **Renewal Late Fee: $100** **Duplicate Fee: $50**

PAYMENT INSTRUCTIONS

Payable by: **Check or Money Order to DC Treasurer**

Mail to: **Intermediate Care Facilities**
P.O. Box 37804
Washington, D.C. 20013

Walk-in Address: **Department of Health**
Health Regulation and Licensing Administration
899 North Capitol Street, NE, 1st Floor
Washington, D.C. 20002

ATTACHMENTS

Submit <u>all of the</u> following documents along with a signed and notarized copy of your application. Incomplete applications will impact the determination for licensure.

- **Disclosure of Ownership and Control Interest Form**

- **Clean Hands Self-Certification Form**

- **Certificate of Good Standing and Certificate of Trade Name Registration**

  Copy of Certificate of Good Standing as a corporation from the Department of Consumer and Regulatory Affairs, Corporation Division

  If the impending licensee is not the agency identified on the Certificate of Good Standing and is a derivative of a parent company ("do business as [d/b/a]"), please include the Certificate of Trade Name Registration from Department of Consumer and Regulatory Affairs, Corporation Division

- **Insurance Verification**

  Copy of insurance certificate with the D.C. Department of Health, Health Regulation and Licensing Administration added as a certificate holder

  *As a requirement for renewal, the Intermediate Care Facilities Division (ICFD) must receive proof of insurance directly from the insurance company. We are **NOT** accepting copies from the licensee unless they are accompanied by a receipt of payment for coverage. All agencies must request that the Department of Health, Health Regulation and Licensing Administration be listed as a certificate holder on the insurance to make sure that we are notified if any changes occur during your coverage period.*

- **Agencies located within the District of Columbia**

  Certificate of Occupancy issued by the District of Columbia Government for premises in which the office is located

- **Agencies located outside of the District of Columbia**

  Copy of each document certifying the responsible jurisdiction's approval of the use of that location or premises as a Nurse Staffing Agency, including all approvals related to zoning, building and fire codes

- **Policies and Procedures for Initial and Renewal applications**

  Copy of NSA's policies and procedures

  Please note: In order to prevent the disclosure of proprietary information, please place a disclaimer on any information that you consider proprietary.

DEMOGRAPHIC INFORMATION

Agency Name: ____

Alternative/DBA Name**:** ____
[If applicable]

License number: ____
[Please note: This license shall not be valid for use by any other person or persons or at any place other than that designated in the license (Title 22, DCMR, Chapter 49 § 4901.6)]

Owner/Operator of Nurse Staffing Agency

Name: ____

Title: ____

Telephone Number: _______________ **Email Address:** ____________________________

Address: ____

____

Contact Person for this Application: ______________________________

Title: ____

Telephone Number: _______________ **Email Address:** ____________________________

Address: ____

____

Supervising Registered Nurse

Name: ____

Professional Title: ____

DC License Number: ____

Telephone Number: _______________ **Email Address:** ____________________________

Address: ____

____

Registered Business Office ***[Required for all applicants]***

Name of Registered Agent: ____

Telephone Number: _______________ **Email Address:** ____________________________

Location Address: ____

____

OFFICE LOCATION

Operational Office

Telephone Number: _______________ **Email Address:** ______________________________

Address: ____

____

DESCRIPTION OF SERVICES PROVIDED

Total Number of staff employed at time of application: ____________________________________

_______ **RN** _______ **LPN** _______ **Certified Nurse Aide** _______ **Home Health Aide**

_______ **Medication Aide-Certified**

***Number of employees deployed to*:**

- **Hospitals:** ____
- **Assisted Living Residences:** _____________________________
- **Nursing Homes:** __________________________________
- **Private Homes:** _________________________ **Current Patient Census**____________
- **Other:** ____
  ____

***Total Number of Contracts annually*:** ____

***Name of Current Contracted Facilities/Entities*:**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

***Please include additional pages if more space is required.**

COMPLIANCE QUESTIONS

A. **Has another entity suspended, revoked or placed conditions on your license, certification or accreditation as a NSA?** ☐ No ☐ Yes

If yes, please submit an explanation: ____

____

____

B. **Are you currently being, or have you been (since your last renewal), investigated by any authority for any violation of state, federal, or local law?** ☐ No ☐ Yes

If yes, please submit an explanation: ____
____
____

AFFIDAVIT

Note: This application must be signed and notarized.

I hereby swear that the statements in this application and its attachments are true and correct, and understand that providing false or misleading information may result in a fine, denial, suspension, or revocation of this license.

____
(Signature of Applicant)

____
(Title)

Sworn to (or affirmed) and subscribed before me this ____________ day of __________________, ___________

By ______________________________
(Name of Applicant)

____
(Signature of Notary Public)

____
(Notary Public Seal)

Personally Known or Produced Identification ___________________

Type of Identification Produced ______________________________

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov/ .