Maryland Department of Health
Office of Health Care Quality
Application for a Cosmetic Surgery Facility License

Instructions

Applying for a License

A person may not establish or operate a cosmetic surgical facility (CSF) without obtaining a license from the Office of Health Care Quality (OHCQ). The first step in becoming licensed as a CSF is to complete this application. The application must be typed. Handwritten applications are not accepted and will be returned to the applicant. Submit the completed application and the required attachments through the "Submit a License Application" link on the OHCQ website. There is no fee to apply for a license.

Required Attachments:

1. Letter of Good Standing: The applicant must obtain an official letter of good standing from the Maryland Department of Assessments and Taxation (SDAT) Business Express. Search for the name of your business, click on the business name, and then click on "Order Documents" in the lower right-hand corner of the page.
2. Workers' Compensation: Attach a copy of the declaration page from your Workers' Compensation coverage.
    a. Corporations and limited liability companies who are not required to carry Workers' Compensation insurance coverage must submit a Certificate of Compliance.
    b. Sole proprietorships and partnerships that do not have any employees and who are not required to have Workers' Compensation insurance coverage must submit a Letter of Exemption.
    c. For more information, visit the Maryland Workers' Compensation Commission website, call 410-864-5293, or email wccinsur@wcc.state.md.us.
3. If applicable, documentation of accreditation by the American Association for Accreditation of Ambulatory Surgical Facilities; the Accreditation Association for Ambulatory Health Care; or The Joint Commission.

On-site Licensure Survey

1. After OHCQ reviews and approves this application and the required attachments, OHCQ will contact the applicant to schedule an on-site licensure survey.
2. OHCQ surveyors will conduct various tasks during the survey, such as a tour of the facility; interview of staff; and review of documentation.

OHCQ Determination of License Application

OHCQ will make one of the following determinations regarding your license application:

- **If the applicant does not yet have accreditation or certification and meets all other licensure requirements:**
    - If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and OHCQ will issue a **Temporary License** for a

period not to exceed one year to operate a CSF. OHCQ may extend the period for a temporary license beyond 1 year for good cause.
    - If there are deficiencies, you will receive a Statement of Deficiencies. You have 10 business days to write a Plan of Correction that describes how you will resolve the deficiencies. After your Plan of Correction is accepted by OHCQ, OHCQ will issue a temporary license for a period not to exceed one year to operate a CSF. OHCQ may extend the period for a **Temporary License** beyond 1 year for good cause.
- **Non-expiring License:**
    - After the CSF is either accredited or certified, a **Non-Expiring License** will be issued.
    - OHCQ shall void a temporary license upon receiving notice that the facility's application for certification or accreditation has been denied.
- **If the applicant is either accredited or certified and meets all other licensure requirements:**
    - If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a license to operate a CSF.
    - If there are deficiencies, you will receive a Statement of Deficiencies. You have 10 business days to write a Plan of Correction that describes how you will resolve the deficiencies. After your Plan of Correction is accepted by OHCQ, you will receive a license to operate a CSF.
- **License Denial:** If you are unable to comply with all of the licensure requirements, then your application will be denied. If the application is denied, the applicant will receive a detailed letter explaining the reason for the denial and your appeal rights.
- **License Application Administratively Closed:** An application is not complete until OHCQ has received all the materials required under COMAR 10.12.03.03. OHCQ will hold an application for 180 days from the date of initial receipt, after which the application will be deemed inactive and administratively closed. An applicant whose application is administratively closed may reapply by submitting a new application.

Withdrawal of Application: An applicant may withdraw their license application at any time by notifying OHCQ in writing. An applicant may reapply by submitting a new application.

A. General Information

Legal Name of CSF			
Doing Business As or Trade Name			FEIN Number
Street Address			
City	State (Select C	Zip Code	County (Select One)
Business Phone	After Hours Emergency Phone		Fax Number
Business Email	Website		

Name of Administrator	Business Email	Business Phone
Name of Medical Director	Business Email	Business Phone

Name of Primary Contact for Application	Title of Primary Contact
Business Email	Business Phone
Name of Secondary Contact for Application	Title of Secondary Contact
Business Email	Business Phone

B. Accreditation and Certification

Are you applying for or have received accreditation? Yes_____ No_____

If yes, which accreditation organization are you using?
_____American Association for Accreditation of Ambulatory Surgical Facilities
_____Accreditation Association for Ambulatory Health Care
_____The Joint Commission

Date Accreditation Effective	If accreditation is pending, enter the submission date of the application

Are you applying for or have become certified to participate in the Medicare Program, as enacted in Title XVIII of the Social Security Act? Yes_____ No_____

Date Certification Effective	If certification is pending, enter the submission date of the application

C. Ownership: Complete the section that is applicable

Sole Proprietorship - Skip this section if applicant is not a sole proprietorship

Name of Sole Proprietor	Title	
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Limited Liability Company (LLC) - Skip this section if applicant is not an LLC

Non-Maryland LLC: If this is an LLC formed in a State or territory outside the State of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands), or in another country, state where the LLC was formed.

Name of Limited Liability Company		
Street Address of Principal Office		
City	State (Select One)	Zip Code

Business Email of Principal Office	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for each member, owner, or investor directly or indirectly owning 2 percent or more of the applicant.

Full Name Street Address Phone Number

Partnership - Skip this section if applicant is not a partnership

Type of Partnership: _____Limited _____General

Name of Partnership		
Street Address of Principal Office		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for each partner, owner, and investor directly or indirectly owning 2 percent or more of the applicant. Full Name Street Address Phone Number
Corporation - Skip this section if applicant is not a corporation
Type: _____Stock Corporation _____Nonstock Corporation _____Close Corporation Is this corporation _____For Profit _____Non-Profit

Date of Charter	Date of Articles of Incorporation

Non-Maryland Corporation: If this is a corporation formed in a State or territory outside of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands) or in another country, state where the corporation was formed.		
Name of Corporation		
Street Address of Principal Office		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for the Director, President, Secretary, and Treasurer.

Full Name	Street Address	Phone Number

Enter the full name, street address, city, state, zip code, and business phone number of every owner and investor directly or indirectly owning 2 percent or more of the applicant.

Full Name	Street Address	Phone Number

D. Disclosures

1. Does the company, individual owner, or any director or officer currently own or operate a health care facility or agency licensed or surveyed by the Maryland Department of Health's Office of Health Care Quality (OHCQ)? Yes_____ No_____ If you answered yes, please list the name and type of facility in Section E.

2. Has the company, individual owner, or any director or officer previously owned or operated a health care facility or agency licensed or surveyed by the Maryland Department of Health's Office of Health Care Quality? Yes_____ No_____ If you answered yes, please list the name and type of facility in Section E.

3. Has the conduct of the company, individual owner, or any director or officer resulted in a license being revoked, suspended, or denied? Yes_____ No_____ If you answered yes, please list the name and type of license in Section E.

4. Has the company, individual owner, or any director or officer held the same or similar position in another corporate entity which had its license revoked, suspended, or denied? Yes_____ No_____ If you answered yes, please list the name and type of license in Section E.

5. Has the company, individual owner, or any director or officer consented to surrender a license as a result of a license revocation action? Yes_____ No_____ If you answered yes, please list the name and type of license in Section E.

6. Has the parent company, owner, or officer been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? Yes_____ No_____ If you answered yes, please include details of the conviction in Section E.

7. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony? Yes_____ No_____ If yes, please include the details of the conviction in Section E.

E. Additional Information

Use this space to clarify any of your responses. Attach additional pages, as needed.

F. Attestation

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 Maryland Department of Health. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in the denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that the applicant hereby attests that it is in compliance with the federal Civil Rights Act of 1964; the Rehabilitation Act of 1973; the American with Disabilities Act of 1990; and the Drug Free Workplace Act of 1988.

I certify that this applicant is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements in COMAR 10.12.03.

I understand that the current license shall become void immediately and the licensee shall return the license to OHCQ if the facility is sold or leased; ceases to operate; moves to a new permanent location; has had its Medicare Program certification or accreditation issued by an accreditation organization denied or revoked; or has its license denied, suspended or revoked.

An authorized individual of a government unit or agency shall apply for a license on behalf of the government unit or agency. An officer of a corporation or association shall apply for a license on behalf of the entity. The owner shall apply on behalf of a sole proprietorship.

The signature of an owner, member, partner, or officer is required below.

Print Full Name of Applicant	Title of Applicant
Signature of Applicant	Date