Maryland Department of Health
Office of Health Care Quality
Application for a Major Medical Equipment Provider License

Instructions

Applying for a License

Major medical equipment includes all cardiac catheterization equipment necessary to perform heart catheterization; CT scanner; lithotripter; radiation therapy equipment, including a linear accelerator; and an MRI machine.

A facility operating major medical equipment must obtain a license from the Office of Health Care Quality (OHCQ) prior to operating. The first step in becoming licensed as a facility operating major medical equipment provider (MME) 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.

Exception to License Requirement: A facility operating major medical equipment that is engaged exclusively in biomedical research is not required to be licensed as an MME if charges for any health care service provided with the equipment will not be paid by any patient or third-party payor; and the capital costs associated with the equipment and any related construction or renovation are not included in patient charges. COMAR 10.05.03.02.

Required Attachments:

1. Documentation that the Maryland Health Care Commission has determined that the MME has either received a certificate of need or is exempt from the certificate of need requirement. COMAR 10.05.01.04.
2. Qualifications of the licensed physician who will supervise the use of the major medical equipment.
3. Written description of the quality assurance program. COMAR 10.05.01.08.
4. 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.
5. 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.

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; verification that the required equipment is in place; interview of staff, and review of documentation.

OHCQ Determination of License Application

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

- **License Approval:** 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 MME. 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 with conditions to operate an MME.
    - **License with Conditions:** In certain circumstances, OHCQ may issue a license with conditions. COMAR 10.05.01.04.
- **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 10.05.01.04 and COMAR 10.05.03.03. 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 MME:
Doing Business As or Trade Name:
FEIN Number:
Street Address:
City, State, Zip Code:
County:
Business Phone:
After Hours Emergency Phone:
Business Email:
Fax Number:
Provider Website:
Name of Administrator:

Administrator's Business Email:
Administrator's Business Phone:
Name of Medical Director:
Medical Director's Business Email:
Medical Director's Business Phone:
Name of Primary Contact:
Title of Primary Contact:
Business Email of Primary Contact:
Business Phone of Primary Contact:
Name of Secondary Contact:
Title of Secondary Contact:
Business Email of Secondary Contact:
Business Phone of Secondary Contact:
List the normal business hours below:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:
B. Required Information for Equipment
Complete a section for each piece of major medical equipment. Attach the qualifications of the licensed physician who will supervise the use of the equipment.
Services: Select which services provided
Equipment 1: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:
Equipment 2: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:
Equipment 3: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:

Equipment 4: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:
Equipment 5: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:
Equipment 6: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:
Equipment 7: ☐ Cardiac cath ☐ CT ☐ Lithotriptor ☐ Radiation therapy ☐ MRI Manufacturer: Model: If the equipment is not at the business address in Section A, list the address where the equipment is located:

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, and 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 of Maryland (including in Washington DC, Puerto Rico, Guam, and the U.S. Virgin Islands), or in another country, state where the LLC was formed.
Name of Limited Liability Company:
Street Address of Principal Office:
City, State and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:

City, State, and 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 of Member 1:
Street Address for Member 1:
Phone Number for Member 1:
Full Name of Member 2:
Street Address of Member 2:
Phone Number of Member 2:
Full Name of Member 3:
Street Address of Member 3:
Phone Number of Member 3:
Full Name of Member 4:
Street Address of Member 4:
Phone Number of Member 4:
Full Name of Member 5:
Street Address of Member 5:
Phone Number of Member 5:
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, and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Below list all partners directly or indirectly owning 2 percent or more of the applicant.
Full Name of Partner 1:
Street Address for Partner 1:
Phone Number for Partner 1:
Full Name of Partner 2:
Street Address for Partner 2:
Phone Number for Partner 2:
Full Name of Partner 3:
Street Address for Partner 3:
Phone Number for Partner 3:
Full Name of Partner 4:

Street Address for Partner 4:
Phone Number for Partner 4:
Full Name of Partner 5:
Street Address for Partner 5:
Phone Number for Partner 5:
Corporation, if applicable
Type of Corporation: ☐ Stock Corporation ☐ Tax Exempt 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 the State of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands) or in another country, where was the corporation formed?
Name of Corporation:
Street Address of the Principal Office:
City, State, Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, 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 of Director:
Street Address of Director:
Phone Number of Director:
Full Name of President:
Street Address of President:
Phone Number of President:
Full Name of Secretary:
Street Address of Secretary:
Phone Number of Secretary:
Full Name of Treasurer:
Street Address of Treasurer:
Phone Number of Treasurer:

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 of Owner 1:
Street Address for Owner 1:
Phone Number for Owner 1:
Full Name of Owner 2:
Street Address for Owner 2:
Phone Number for Owner 2:
Full Name of Owner 3:
Street Address for Owner 3:
Phone Number for Owner 3:
Full Name of Owner 4:
Street Address for Owner 4:
Phone Number for Owner 4:
Full Name of Owner 5:
Street Address for Owner 5:
Phone Number for Owner 5:

D. Disclosures

1. Does the parent company, owner, 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? ☐ Yes ☐ No If you answered yes, please list the name and type of facility in Section E.

2. Has the parent company, owner, agent, officer, or managerial staff 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 parent company, owner, or officer had a license revoked, suspended, or denied by the Maryland Department of Health? ☐ Yes ☐ No If you answered yes, please list the name and type of license in Section E.

4. 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 are answered yes, please include details of the conviction in Section E.

5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony or a crime involving moral turpitude? ☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section E.

6. If the applicant is a corporation, has an owner, director, or officer whose conduct caused the revocation of a prior license; or who held the same or similar position in another corporate entity that had its license revoked? ☐ Yes ☐ No If you answered yes, please include the details of the revocation in Section E.

7. If the applicant is an individual, has the individual's conduct caused the revocation of a prior license; or who held a position as owner, director, or officer in a corporate entity which had its license revoked; or an individual or corporate applicant that has consented to surrender a license as a result of a license revocation action? ☐ Yes ☐ No If you answered yes, please include the details of the revocation in Section E.

E. Additional Information

Use this space to clarify any of your responses. Attach additional sheets, 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 agency 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 facility is in compliance with all applicable federal, State, and local laws.

Corporation or Association: An officer of the corporation or association shall apply for a license on behalf of the entity and shall sign below.

Sole Proprietorship, LLC, and Partnership: The signature of an owner, member, or partner, is required below.

Full Name of Applicant:
Title of Applicant:
Signature of Applicant:
Date of Signature of Applicant: