

**Maryland Department of Health**  
**Office of Health Care Quality**  
**Application for a Surgical Abortion Facility License**

**Instructions**

The Maryland Department of Health has designated the Office of Health Care Quality (OHCQ) as the state agency that licenses and oversees surgical abortion facilities. A Maryland license permits the provider to operate a business in Maryland. Prior to operating a surgical abortion facility in Maryland, the facility must first obtain a surgical abortion facility license from OHCQ. To apply for a license, submit this completed application and the required attachments through the link on the OHCQ website. There is no fee to apply for a license. Approved applicants generally receive a license within 6 - 10 weeks after the application is complete.

**Required Attachments:**

1. Policies and procedures as required in COMAR 10.12.01.16.
2. Letter of Good Standing: The applicant must obtain an official letter of good standing from the Maryland’s Department of State Assessments and Taxation (SDAT) Business Express. Search for the name of your business, click on the business name, and then click on “Order Document” in the lower right-hand corner of the page.  
<https://egov.maryland.gov/businessexpress/entitysearch>
3. Workers’ Compensation: Attach a copy of your 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 must submit a Letter of Exemption.
  - c. For more information, contact the Maryland Workers’ Compensation Commission at [https://www.wcc.state.md.us/Gen\\_Info/ICR.html](https://www.wcc.state.md.us/Gen_Info/ICR.html), call 410-864-5293 or email [wccinsur@wcc.state.md.us](mailto:wccinsur@wcc.state.md.us).

**A. General Information**

Legal Name of Surgical Abortion Facility:

Doing Business As or Trade Name:

Street Address:

City, State, Zip Code:

County:

Mailing Address (if different from above):

Mailing Address City, State, Zip Code:

Mailing Address County:

Primary Agency Phone:

After Hours Emergency Phone:
Business Fax Number:
Business Website, if applicable:
Business Email:
Name of Primary Contact:
Title of Primary Contact:
Business Email of Primary Contact:
Business Phone of Primary Contact:
<b>B. Ownership: Complete the section that is applicable</b>
<b>Sole Proprietorship - Skip this section if applicant is not a sole proprietorship</b>
Name of Sole Proprietor:
Title:
Street Address:
City, State, and Zip Code:
Business Email:
Business Phone:
Business Fax:
<b>Limited Liability Company (LLC) - Skip this section if applicant is not an LLC</b>
<b>Non-Maryland LLC:</b> 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?
Type of Limited Liability Company: <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit
Location of Principal Office: Street Address:
City, State and Zip Code:
County:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent (Member 1):
Street Address:
City, State, and Zip Code:
County:
Business Email:
Business Phone:
Business Fax:
Name of Member 2:
Street Address for Member 2:
Phone Number for Member 2:
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:
If there are additional members, provide the information in Section D.
<b>Partnership - Skip this section if applicant is not a partnership</b>
Type of Partnership: <input type="checkbox"/> Limited <input type="checkbox"/> General
Is the partnership for profit or non-profit? <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit
Street Address of Principal Office:
City, State, and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent (Limited Partnership) or Name of Partner 1 (General Partnership):
Resident Agent Title:
Percent Owned:
Street Address:
City, State, and Zip Code:
County:
Business Email:
Business Phone:
Business Fax:
Below list all partners owning more than 25 percent of the applicant.
Name of Partner 2:
Title of Partner 2:
Street Address for Partner 2:
City, State, Zip Code for Partner 2:
Percent Owned for Partner 2:
Business Email for Partner 2:
Business Phone Number for Partner 2:
Business Fax Number for Partner 2:
Name of Partner 3:
Title of Partner 3:
Street Address for Partner 3:
City, State, Zip Code for Partner 3:

Percent Owned for Partner 3:
Business Email for Partner 3:
Business Phone Number for Partner 3:
Business Fax Number for Partner 3:
Name of Partner 4:
Title of Partner 4:
Street Address for Partner 4:
City, State, Zip Code for Partner 4:
Percent Owned for Partner 4:
Business Email for Partner 4:
Business Phone Number for Partner 4:
Business Fax Number for Partner 4:
<b>Corporation, if applicable</b>
Type of Corporation: <input type="checkbox"/> Stock Corporation <input type="checkbox"/> Tax Exempt Nonstock Corporation <input type="checkbox"/> Close Corporation
Type of Corporation: <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit
Date of Charter:
Date of Articles of Incorporation:
FEIN Number:
<b>Non-Maryland Corporation:</b> 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?
Street Address of the Principal Office:
City, State, Zip Code:
County:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Resident Agent Title:
Percent Owned:
Street Address:
City, State, Zip Code:
County:
Business Email:
Business Phone:
Business Fax:
<b>For Stock Corporation, Close Corporation, and Tax Exempt Nonstock Corporation Only</b>
Name of Director:
Business Email of Director:

Street Address of Director:
City, State, Zip Code of Director:
Phone Number of Director:
Business Fax of Director:
Name of President:
Business Email of President:
Street Address of President:
City, State, Zip Code of President:
Phone Number of President:
Business Fax of President:
Percent Owned of President:
Name of Secretary:
Business Email of Secretary:
Street Address of Secretary:
City, State, Zip Code of Secretary:
Phone Number of Secretary:
Business Fax of Secretary:
Percent Owned of Secretary:
Full Name of Treasurer:
Business Email of Treasurer:
Street Address of Treasurer:
City, State, Zip Code of Treasurer:
Phone Number of Treasurer:
Business Fax of Treasurer:
Percent Owned of Treasurer:
List the full name, business email address, and business phone number for each member of the Board of Directors. Do not include the Director, President, Secretary, and Treasurer that are listed above.
Full Name of Board of Directors Member 1:
Business Email for Board of Directors Member 1:
Phone Number for Board of Directors Member 1:
Full Name of Board of Directors Member 2:
Business Email for Board of Directors Member 2:
Phone Number for Board of Directors Member 2:
Full Name of Board of Directors Member 3:
Business Email for Board of Directors Member 3:
Phone Number for Board of Directors Member 3:
Full Name of Board of Directors Member 4:
Business Email for Board of Directors Member 4:
Phone Number for Board of Directors Member 4:

Full Name of Board of Directors Member 5:
Business Email for Board of Directors Member 5:
Phone Number for Board of Directors Member 5:
<b>For Stock Corporation and Close Corporation Only</b>
List the full name and address of all stockholders who own more than 25 percent interest in the applicant.
Stakeholders Name 1:
Stakeholder 1 Address:
Stakeholders Name 2:
Stakeholder 2 Address:
Stakeholders Name 3:
Stakeholder 3 Address:
Stakeholders Name 4:
Stakeholder 4 Address:
Stakeholders Name 5:
Stakeholder 5 Address:
<b>D. Disclosures</b>
<p>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 (OHCQ)? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please list the name and type of facility in Section E.</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please list the name and type of facility in Section E.</p> <p>3. Has the parent company, owner, or officer had a license revoked, suspended, or denied by the Maryland Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please list the name and type of license in Section E.</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please include details of the conviction in Section E.</p> <p>5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include the details of the conviction in Section E.</p>

**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 this surgical abortion facility is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements in 10.12.01.

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

The signature of each applicant is required below.

Print Full Name of Applicant 1:

Title of Applicant 1:

Signature of Applicant 1:

Date of Signature of Applicant 1:

Print Full Name of Applicant 2:

Title of Applicant 2:

Signature of Applicant 2:

Date of Signature of Applicant 2: