

**Maryland Department of Health
Office of Health Care Quality
Application for Nursing Referral Service Agency License**

Instructions

Applying for a License

Prior to operating a nursing referral service agency in Maryland, the agency must first obtain a nursing referral service agency license from the Office of Health Care Quality (OHCQ). COMAR 10.07.07.03. To apply for a license, complete this application. The application must be typed. Handwritten applications 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. Policies and procedures as required in [COMAR 10.07.07.04](#).
2. 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.
3. 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.

Change of Ownership

A licensee may not, under any circumstances, transfer or reassign its nursing referral service agency license to another person. [COMAR 10.07.07.06](#). If the ownership is changing, the new owner must submit an initial license application and receive a new license prior to operating the agency.

If the agency ceases to operate for any reason, the license is void and the licensee shall immediately return the license to OHCQ. [COMAR 10.07.07.06](#).

Determination of the Request for a License

Once your license application is complete, OHCQ will make one of the following determinations regarding your application:

- **License Approval:** After OHCQ determines that the applicant is in compliance with all licensure requirements, a license is issued to the applicant.

- **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 the Department has received all the required application materials. 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

Type of Application: Initial Change of Ownership

Legal Name of Business

Doing Business As or Trade Name

Street Address

City

State

Zip Code

County

Business Phone

After Hours Emergency Phone

Fax Number

Business Email

Business Website

Name of Primary Contact for Application

Title of Primary Contact

Business Email

Business Phone

Name of Director of Nursing

Title of Director of Nursing

Business Email

Business Phone

B. Description of Services

What type of services will the applicant provide?

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	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	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 each member.		
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	Zip Code
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Business Email of Principal Office	Business Phone	Business Fax
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Name of Resident Agent

Street Address

City	State	Zip Code
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Business Email	Business Phone	Business Fax
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Enter the full name, street address, city, state, zip code, and business phone number for each partner.

Full Name	Street Address	Phone Number
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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	Zip Code
Business Email	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	Street Address	Phone Number

D. Disclosures

1. Does the parent company, owner, or officer currently own or operate a health care facility or agency? 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? 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 to provide care to third parties revoked, suspended, or denied? 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 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? Yes _____ No _____ If you answered 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 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 applicant is in compliance with all applicable federal, State, and local laws and regulations, including the State administrative and procedural requirements governing nursing referral service agencies in [COMAR 10.07.07](#).

I understand that a licensee may not, under any circumstances, transfer or reassign its nursing referral service agency license to another person. I understand that if the agency ceases to operate for any reason, the license is void and the licensee shall immediately return the license to OHCQ. See [COMAR 10.07.07.06](#).

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

Full Name of Applicant	Title of Applicant
Signature of Applicant	Date