RI Department of Health

Licensing Application

and instructions for

School Based Health Centers

RI General Law Chapter 23-17.10

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of ownership
3. ☐ Change of address
4. ☐ Licensee/Residence Name Change

(Complete the following for either 1, 2, or 3)

Current facility name:_____ License #:_____

Current address:_____

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- There is no fee for this application.
- Sign the completed application and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- **For the affiliated health care facility, you must attach a printed current list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.**

Attachments: Please label and staple each separate attachment and securely affix any and all additional documents and/or approvals to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Medical Director Information: Please provide the name of the Medical Director for this facility. **Note: This section must be completed as a requirement of your license.**	**Name** =_____ **License Number** = _____
License Sub-Type: Please select one.	☐ **Profit** ☐ **Non-Profit**
Affiliated Health Care Facility License: **Note: This is a requirement for licensure.**	RI Licensed Health Care Facility Name: _____ RI License Number: _____

State of Rhode Island and Providence Plantations
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Facility Name: Name of the Facility as known to the public	_____
Facility Contact Information: Please provide the name and telephone number of a person we can contact concerning this Facility.	Name: _____ Phone: ( ) - _____ Fax: ( ) - _____ Wed site/address: _____ Facility e-mail address: _____
Facility Mailing Information: Please provide the mailing & contact information for other communication regarding this Facility. **(Not Published on HEALTH website)**.	Contact name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. Note: Fax and e-mail fields are required. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Governmental Entity

Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____ Contact information (if different from above): _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone: _____ Fax: _____ Email Address: _____
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility control.	Corporation Type _____ Name of Organization _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code_____ Phone: _____ Fax: _____ Email Address: _____
Land/Building Info: If the owner of the land and building is other than the operator of this Facility, please complete the following:	Name: _____ Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip code _____ Phone _____
Compliance with Conditions of Approval: Please check Yes or no.	This facility is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☐ Yes ☐ NO

Acknowledgements

I am aware of Chapter 23-17.10 of the General Laws of Rhode Island, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this Residence.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17.10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any Residence/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator. Please provide below SSN/FEIN for this license: SSN/F.E.I.N. Number: _____
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** _____ _____ **Signature of Authorized Person** **Date of Signature** (MM/DD/YY) _____ **Printed Name of Authorized Person** _____ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.**