



Nurse Agency Application

Illinois Department of Labor
160 North LaSalle, Suite C-1300
Chicago, Illinois 60601-3150
Tel # (312) 793-1804
Fax# (312) 814-1210
DOL.NurseAgency@illinois.gov

Print Form

Type of Application (check one)

New Renewal

License Number:

Type of Application (check one)

Primary Location Additional Loc.

Application is hereby made on behalf of: Corporation Sole Proprietor Partners LLC LLP

Business Name and Address under which business will operate:

Business Name: _____

Business Address: _____

County: _____ City: _____ State: _____ Zip Code: _____

Telephone # _____ Email: _____ FEIN: _____

if Address is new, Date Moved: _____

Has this Nurse Agency ever been licensed under another name? Yes No

Please provide name(s): _____

Franchise Date Purchased: _____

President Sole Owner Partner

Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # _____ Fax # _____

Have you, as Principal Officer, ever been convicted of a felony? Yes No

Proof of professional liability Insurance in the amount of \$1,000,000 aggregate and \$500,000 per incident Insurance Policy must be attached!

Professional Liability Carrier (Insurance Company name): _____

Name of Insurance Agency: _____ Telephone # _____

Policy Term dates: From _____ To _____

Policy Number: _____

Date Received:

Expiration:

Fee Received:

Check No:

File No:



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List the number of employees reported on your last quarterly UI3-40 form, or if this is a new application, list the anticipated referrals for the next quarter:

RN's _____ LPN's _____ CNA's _____

Provide the following personnel responsible for:

Responsibility	Name	Title (License # if applicable)
Assignments or referrals to Health Care Facilities:	_____	_____
If individual listed above is not RN, list RN who oversees the assignments:	_____	_____
Hiring/Firing for RN's, LPN's, and CNA's:	_____	_____
Verifying Licensure of Certification Status:	_____	_____
Evaluating Performance of RN's, LPN's and CNA's:	_____	_____
Conducting Personal Interview of Applicant:	_____	_____
Responding to Complaints from Health Care Facilities:	_____	_____
Recruitment of RN's, LPN's, and CNA's:	_____	_____
Signing of Payroll Checks:	_____	_____
Acquiring Line of Credit:	_____	_____
Signing of Insurance:	_____	_____

Supervising Registered Nurse (RN): _____ Date Appointed: _____

A current copy of BOTH the registered nurse's license and verification from the Illinois Department of Professional Regulations must be attached.

Person who is to have management of the Nurse Agency: _____

Type of Facilities/Clients Served (check all that apply):

- Hospitals Kidney Disease Treatment Centers
 Nursing Homes Health Maintenance Organization Ambulatory Surgical Treatment Centers

List two most recent health care facilities to which you have made referrals:

Name of facility: _____

Contact Person: _____ Telephone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Name of facility: _____

Contact Person: _____ Telephone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____



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List Corporate Officers (excluding the President):

Officer Title: _____

Officer Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Add another Officer

Remove Last Officer

If not completed for corporation, application will not be processed.

List Officers, Directors and Shareholders owning more than 5% of the corporation stock.

Owner Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____ % of Stock Owned: _____

Add another Owner

Remove Last Owner

List Board of Directors:

Director Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Add another Director

Remove Last Director

List of Additional Partners:

Partner Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Add another Partner

Remove Last Partner



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List any other business owned or operated in whole or in part:

- Private Employment Agency Home Health Care Agency Other (please specify)

Name of Agency: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Telephone # _____

Add another Agency

Remove Last Agency

Statement of Financial Solvency:

For the purpose of meeting the requirements of the Nurse Agency Licensing Act (225 ILCS 510/1-15), the Nurse Agency Applicant hereby states and declares:

1. That within the last seven (7) years the Nurse Agency and/or its owners have not been adjudged insolvent or bankrupt in a State or Federal court; and
2. That a court proceeding to make a judgment of bankruptcy or insolvency with respect to the Nurse Agency and/or its owners is not pending in a State or Federal court.
3. That the Nurse Agency and/or its owners are able to pay any and all debts as they become due and owing.

In addition, the Nurse Agency agrees to inform the Director of the Illinois Department of Labor prior to a court proceeding to make a judgment of insolvency or bankruptcy, which will be instituted with respect to the Nurse Agency or its owners.

- Sole Owner Partner Authorized Corporate Officer Manager

Title of Signer: _____

Signature _____ Printed Name _____ Date _____



Nurse Agency Application

The undersigned certifies that he/she has read and understands the contents of this application and shall abide by all terms and conditions stated in any part of the form (instructions, filing requirement and licensing information) and that the undersigned is AN OWNER OR MANAGER of the business and is sufficiently familiar with the ownership, management, control and other aspects of the business to accurately and completely fill out the form. Further, the undersigned swears or affirms that the information provided is true and current at the time of the signing and that the person signing is authorized to do so.

The undersigned also certifies that the Nurse Agency is in compliance with State and Federal laws relating to employee compensation, social security taxes, State and Federal income taxes, worker's compensation, unemployment taxes and State and Federal overtime compensation laws.

- Sole Owner Partner Authorized Corporate Officer Manager

Title of Signer: _____

Signature Printed Name Date

Subscribed and sworn to before me this _____ day of _____, _____

Notary Public