Registration Application to Operate a Mobile Health Evaluation and Screening Provider

In accordance with Minnesota Statutes, Section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), **all data submitted on this license application shall be classified public information upon issuance of a license.**

Answer all questions completely and accurately to avoid unnecessary delay. Mail the completed application, and applicable supporting documents to MDH (see last page for mailing address). Renewal registration applications should be submitted 30 days prior to January 15th.

Incomplete applications will be communicated to the provider via email.

The undersigned hereby makes application to operate a Mobile Health Evaluation and Screening Provider subject to the provisions of Minnesota Statutes 144.077 (https://www.revisor.mn.gov/statutes/cite/144.077).

Application Type (check one)

☐ Initial Registration

☐ Registration Renewal

Provider Identification

Mobile Health Evaluation & Screening Provider Name (doing business as): _____

_____

Address: _____

City/State/Zip: _____

☐ Check here if mailing address is the same as above.

Complete if different: _____

Health Facility Identification (HFID) number: _____

Telephone number: _____

Fax number (if applicable): _____

☐ Check here if new telephone and/or fax number.

Business hours (days & times): _____

Agent/Administrator's Name: _____

- Direct Email Address: _____
- Direct Phone Number: _____

Name of person responsible for completing application: _____

Email to receive correspondences from MDH: _____

☐ Check here if email is the same as the Administrator.

Supervising Minnesota Licensed Physician

Provide the following information. Name of licensed physician as it appears with the MN Board of Medical Practice, Credential Search (https://bmp.hlb.state.mn.us/#/onlineEntitySearch).

Name: _____

Address: _____

City/State/Zip: _____

Phone number: _____

Minnesota License #: _____

Ownership

Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

Ownership Code: _____

Governmental Non-Federal	Governmental Non-Profit	Non-Governmental For-Profit	Other
11. State 12. County 13. City 14. City – County 15. Hospital district of Authority	20. Church-related 21. Nonprofit Corporation 22.Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust 30. Housing and Redevelopment Employment	27. Tribal

Provide the legal entity name that is responsible for the operation of this facility, as it appears on file with the Office of the Minnesota Secretary of State (https://mblsportal.sos.state.mn.us/Business/Search): _____

_____

_____

Federal EIN #: _____

State Tax ID #: _____

President/Owner Representative: _____

- Address: _____
- City/State/Zip: _____

Ownership Information Sheet

Provide the legal names, titles and addresses of all officers, directors, owners, and managerial employees, and the percent of ownership if applicable. For additional space, use Appendix B.

Name	Title (President, Director, Partner, Stockholder, Etc.)	Address (Street, City, State, Zip Code)	Percentage Of Ownership (If For Profit)

List of Anticipated Locations of Practice, Schedules, and Routes

Practice	Schedules	Routes

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

If you have questions concerning this license application, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.

Mailing Address
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

11/02/2023

To obtain this information in a different format, call: 651-201-4200.