Health Standards Section
License Application
PAIN MANAGEMENT CLINIC

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* (Specify) ____________________

LICENSE NUMBER ________________ *EXPIRATION DATE* ________________

TOTAL FEE AMOUNT INCLUDED ________ *CHECK / MONEY ORDER #* ____________________

**Check & Payment Transmittal Form must be submitted to LDH Licensing Fee, PO BOX 734350, Dallas, TX 75373-4350*

☐ **check if any change has occurred since last application** **STATE ID #PM___ ___ ___ ___ ___ ___ ___**

I. *FACILITY (DBA) NAME* ____

GEOGRAPHICAL ADDRESS ____

CITY / STATE / ZIP ____

TELEPHONE NUMBER (____) ____________ *FAX NUMBER* (___) ____________ *EMAIL ADDRESS* ____________________

II. MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)* ____

CITY / STATE / ZIP ____

III. ADMINISTRATOR: ________________________ **MEDICAL DIRECTOR:** ________________________

IV. TYPE OF OWNERSHIP:

NON- PROFIT

☐ *INDIVIDUAL/SOLE PROPRIETOR*

☐ *CORPORATION*

☐ *PARTNERSHIP*

☐ *RELIGIOUS AFFILIATION*

☐ *UNINCORPORATED ASSOCIATION*

☐ *OTHER (Specify):* ______________

FOR – PROFIT

☐ *INDIVIDUAL/SOLE PROPRIETOR*

☐ *CORPORATION*

☐ *PARTNERSHIP*

☐ *GROUP PRACTICE*

☐ *OTHER (Specify):* ______________

V. *ENTITY / CORPORATION NAME* ____

MAILING ADDRESS (IF DIFFERENT) ____

CITY / STATE / ZIP ____

TELEPHONE NUMBER (_____) ________________ *FAX NUMBER* (____) ____________________

VI. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER	ADDRESS	TELEPHONE #

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://ldh.la.gov/

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VII. ***If the disclosing entity is a corporation, list name, address and telephone number of the President.***

NAME	*ADDRESS*	*TELEPHONE NUMBER*

VIII. ***Are any owners of the disclosing entity also owners of other licensed health care facilities?*** ☐***Yes*** ☐***No***
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.

NAME	*ADDRESS*	*PROVIDER NUMBER*

IX. Were you in operation prior to June 15, 2005? ☐***Yes*** ☐***No***

If you answer yes, submit proof of operation (this proof shall be an occupational license or certificate of operation issued by local governmental authorities, in addition to verifying information that indicates the facility held itself out to the public as an urgent care facility.)

X. ***Has there been a change of ownership or control within the last year?*** ☐***Yes*** ☐***No If yes, give date: ___________________***

XI. ***PROGRAM OPERATION INFORMATION:***
DAYS OF OPERATION ____ HOURS OF OPERATION _____________________________

Is this a change since last application? ☐***Yes*** ☐***No***

XII. LA CDS#: ______________________ US DEA CS Registration #: ________________________________

ATTESTATION:

- ***I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.***
- ***Emergency Preparedness Attestation: I certify that I am in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning emergency preparedness.***

____

AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

____ ____________________________

AUTHORIZED REPRESENTATIVE SIGNATURE ***DATE***