



**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION AND LICENSING ADMINISTRATION**



**NURSE STAFFING AGENCY  
RENEWAL CHECKLIST**

The following documents are required to complete the renewal process:

- 1) Completed, signed, dated Application
- 2) License Fee
- 3) Copy of Certificate of Good Standing from the District of Columbia. This document can be obtained from the Department of Consumer and Regulatory affairs.
- 4) \*Copy of each document certifying the responsible jurisdiction's approval of the use of that location or premises as a Nurse Staffing Agency. (Agencies located outside of the District of Columbia)

**Special Note:**

As a requirement for renewal, The Board of Nursing must receive proof of insurance directly from the insurance company. We are not accepting copies from the licensee unless they are accompanied by a receipt of payment for coverage. All agencies must request that the Department of Health be listed as a certificate holder on the insurance to make sure that we are notified if any changes occur during your coverage period.



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
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APPLICATION FOR RENEWAL  
NURSE STAFFING AGENCY LICENSE

LICENSURE FEE

RENEWAL FEE: \$500

LATE FEE: \$100

PAYMENT INSTRUCTIONS

PAYABLE BY: Check or Money Order to DC Treasurer

MAIL TO:  
Intermediate Care Facilities  
P.O. Box 37804  
Washington, D.C. 20013

DEMOGRAPHIC INFORMATION

Please complete all sections of the application. Incomplete applications can delay the process.

Agency name: \_\_\_\_\_

License no. \_\_\_\_\_

[Please note: This license shall not be valid for use by any other person or persons or at any place other than that designated in the license Title 22, DCMR, Chapter 49, § 4901.6.]

Please keep this contact information current. This is the person that we will contact prior to and after the issuance of your licensure.

Contact Person

Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Supervising Registered Nurse

Name: \_\_\_\_\_

Professional Title/DC License Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Owner/Operator of Nurse Staffing Agency**

Name: \_\_\_\_\_  
Professional Title/DC License Number, if applicable: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**AGENCIES LOCATED OUTSIDE OF THE DISTRICT OF COLUMBIA**

**\*Registered Business Office:**

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**\*Operations Headquarters:**

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Send updated copy of each document certifying the responsible jurisdiction’s approval of the use of that location or premises as a Nurse Staffing Agency, including all approvals related to zoning, building and fire codes

**AGENCIES LOCATED WITHIN THE DISTRICT OF COLUMBIA**

**DC Operations Headquarters:**

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Certificate of Occupancy # \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

Send updated Certificate of Occupancy issued by the District of Columbia Government for premises in which the office is located

**Registered Agent within the District of Columbia**

Registered Agent: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Address: \_\_\_\_\_

**REPORT FRAUD, WASTE, AND ABUSE:** To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General’s hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at [hotline.oig@dc.gov](mailto:hotline.oig@dc.gov), or by TTY at 711. For additional information, visit the Office of the Inspector General’s website at [oig.dc.gov](http://oig.dc.gov).

# Compliance Questions

## **A. Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.**

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke the License** which you are now renewing, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. **Official Code § D.C. Official Code § 47-2862 (2001)**.

**As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:** Yes \_\_\_ No \_\_\_

*IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.*

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);  No  Yes
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);  No  Yes
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);  No  Yes
4. Past due taxes;  No  Yes
5. Past due District of Columbia Water and Sewer Authority service fees  No  Yes
6. Failure to file District tax returns  No  Yes

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

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**B. Has another entity suspended, revoked or placed conditions on your license, certification or accreditation as a NSA?**  No  Yes If yes, please submit an explanation

**C. Are you currently being or have been (since your last renewal) investigated by any authority for any violation of state, federal, or local law?**  No  Yes If yes, please submit an explanation

**D. Have you removed a nurse licensed in DC from your registry as the result of a complaint regarding practice or substance abuse?**  No  Yes If yes, please submit name(s) and license number (s) or social security number(s) and the results of your investigation (if not reported previously)

**E. Have you made any significant amendments to your Policies and Procedures?**  No  Yes If yes, please submit an explanation

## ATTESTATION

*I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE