State of Illinois
Illinois Department of Labor

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

Type of Application (check one)

☐ New ☐ Renewal

License Number: ____________

Type of Application (check one)

☐ Primary Location ☐ Additional Loc.

Date Received:

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

Expiration:

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: ____________

Fee Received:

☐ 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

Check No:

File No:

Proof of general and professional liability Insurance in the amount of $3,000,000 aggregate and $1,000,000 per incident. Proof of Worker's Compensation Policies for all nurses and certified nursing aides employed, assigned and referred by a nurse agency to a healthcare facility. Policies must be attached.

Professional Liability Carrier (Insurance Company name): ____________

Name of Insurance Agency: ____________ Telephone # ____________

Policy Number: ____________ Policy Term dates: From ____________ To ____________

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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:

RNs ________ LPNs ________ CNAs ________

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 RNwho oversees the assignments:		
Hiring/Firing of RNs, LPNs, and CNAs:		
Verifying Licensure of CertificationStatus:		
Evaluating Performance of RNs, LPNs and CNAs:		
Conducting Personal Interview of Applicant:		
Responding to Complaints from HealthCare Facilities:		
Recruitment of RNs, LPNs,and CNAs:		
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: ____________

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

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

Owner Name: ____________________

Residence Address: ____________________

City: ____________ State: ____ Zip Code: ____________ % of Stock Owned: ________

List Board of Directors:

Director Name: ____________________

Residence Address: ____________________

City: ____________ State: ____ Zip Code: ____________

List of Additional Partners:

Partner Name: ____________________

Residence Address: ____________________

City: ____________ State: ____ Zip Code: ____________

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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 # __________

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 is 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

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