State of Illinois
Illinois Department of Labor

Nurse Agency Application

Illinois Department of Labor
115 S LaSalle St, 37th Floor
Chicago, Illinois 60603
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): _____

Fee Received:

☐ 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

Check 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.

File No:

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 _____

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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