* *Please save the document in your computer, using Adobe Reader type the info, and then email to us*

☐ $ 175.00 (renew)

LICENSE DATA SHEET:

AHCA site user: _____

Password: _____

(existing Registry only)

www.pnsystem.com

305.818.5940

info@pnsystem.com

REQUIRED:

The biennial licensure fee (**$2000.00**)

* *do not print or scan the form please*

* *Type the data using **ADOBE READER**, please use proper capitalization*

Proof of Level 2 screening within the previous 5 years for the Administrator and/or Chief Financial Officer

A. Provider Information – please complete the following for the home health agency name and location.

License # (for renewal & change of ownership applications) _____

National Provider Identifier (NPI) (if applicable) _____

* *do not not print or scan the form please* * *please use proper capitalization*

Name of Nurse Registry _____

Street Address _____

City _____ County _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

E-mail Address _____

Provider Website _____ *(existing agencies only, if applicable)*

Federal Employer Identification Number (EIN) _____

Ownership Names: _____ SS # : _____ % ownership:

_____ SS # : _____ % ownership:

_____ SS # : _____ % ownership:

Administrator: _____ Prof. License: _____ SS #: _____
* *must qualify*

Home Address: _____ Date Last Criminal Background _____

Email: _____ Phone: _____ DOB: _____

☐ Full Time ☐ Part Time

Alt. Administrator: _____ Prof. License: _____ SS#: _____
* *must qualify*

Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ Phone: _____ DOB: _____

RN in Charge: _____ Prof.License: _____ SS#: _____
* *must qualify*

Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ Phone: _____ DOB: _____

RN SV: _____ email: _____

* *RN Backup for the Emergency Plan*

CFO: _____ SS #: _____ ☐ Full Time ☐ Part Time

Home Address: _____ Date Last Criminal Background: _____

Email: _____ Phone: _____ DOB: _____

* *Please save the document in your computer, using Adobe Reader type the info, and then email to us*

CHAP Certified Consultant

PN SYSTEM OVER 30 YEARS UNMATCHED SERVICE

ACHC CERTIFIED CONSULTANT

Hours Operations: _____ to _____

**** Please save the document in your computer, using Adobe Reader type the info, and then email to us***

Owners Information:

	Name	DOB	Title	Personal Address / email address	Telephone	Corporation Begin Date
1						
2						
3						
4						
5						

(Title: President, Vice-President, Secretary, CFO)

Counties License: ☐ Miami Dade ☐ Monroe

Other: _____

_____

(use AHCA areas counties)

For License REVEW:

Emai: ☐ Emergency Plan current year submission or previous year approval letter

Bank routing number: _____

(existing, renew Registry only)

Account Number: _____

Submitted by (Name): _____ (DO NOT SIGN)

**** Please save the document in your computer, using Adobe Reader type the info, and then email to us***

Email form