Mobile Health Evaluation and Screening Provider Registration Form

In accordance with Minnesota Statutes, 13.41, ALL DATA SUBMITTED ON THIS REGISTRATION FORM SHALL BE CLASSIFIED PUBLIC INFORMATION UPON ISSUANCE OF A REGISTRATION CERTIFICATE.

Please answer all questions completely and accurately to avoid unnecessary delay. A mobile health evaluation and screening provider shall register with the commissioner of Health and file the anticipated locations of practice, schedules, and routes annually no later than JANUARY 15.

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby registers to be a Mobile Health Evaluation and Screening Provider subject to the provisions of Minnesota Statutes, Section 144.077.

A. Identification

1. Business Name_____

   Business Street Address_____

   Business City/State/Zip_____

2. Telephone Number_____

   After Hours Number_____

   Fax Number_____

3. Name of county in which business is located_____

B. Ownership

1. Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

   Ownership Code_____

GOVERNMENTAL NONFEDERAL	NONGOVERNMENTAL NONPROFIT	NONGOVERNMENTAL FOR PROFIT	OTHER
11. State 12. County 13. City 14. City-County 15. Hospital District or Authority	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust	27. Tribal

2. Give the name of the corporation, association, governmental unit, person or partners legally responsible for the operation of this service.

   _____

   Name and Mailing Address of Owners of Business _____

   _____

   Federal ID #_____State Tax ID #_____

3. If a corporation, give the date and place of incorporation_____
   Attach a Certificate of Authority to do business in Minnesota if incorporated in another state.

4. President_____

5. Agent(s) _____
   (Individual(s) authorized to transact business with the Department of Health and upon whom all notices and orders shall be served. Include address if different than service address. Please attach another sheet of paper if necessary).

   Address _____ City_____ State _____ Zip_____

C. Supervising Minnesota Licensed Physician

1. Name_____

   Address_____

   City/State/Zip_____

   Phone Number_____

D. Attach a list of the anticipated locations of practice, schedules and routes.

E. Annual Registration

To the best of my knowledge, I certify that the information provided on this form is accurate and complete.

Signature of Authorized Agent: _____

Name (please print or type): _____

Title: _____

Date: _____

NOTE: If you have questions concerning this registration form, please call 651-201-4101 or email health.fpc-licensing@state.mn.us.

Minnesota Department of Health
Heath Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
www.health.state.mn.us

10/18 - FPC999

To obtain this information in a different format, call: 651-201-4101.