License Data Sheet

Nurse Registry • AHCA licensure (initial / renewal)

www.pnsystem.com
305.818.5940
info@pnsystem.com

Service: ☐ $245.00 Initial license ☐ $175.00 Renewal

AHCA user and password: existing registries only.

AHCA Site User: _____

AHCA Password: _____

Do not print or scan this form. Save it to your computer, type the information using Adobe Reader, and email it to us. Use proper capitalization (e.g., Ana Montanez).
Required: the biennial licensure fee ($2,000.00).

A PROVIDER INFORMATION

Nurse registry name and location

License #: _____ *(for renewal and change of ownership applications)*

NPI: _____

Name of Nurse Registry: _____

DBA (if applicable): _____

Street Address: _____

City: _____ **County:** _____ **State:** _____ **ZIP:** _____

Only if applicable, must match Sunbiz information

Mailing Address (if different): _____

Mailing City, State, ZIP: _____

Telephone: _____

Fax: _____

Email: _____

Website: _____

Tax ID (EIN): _____

B OWNERSHIP

Owner 1: _____ **SS #:** _____ **% Ownership:** _____

Owner 2: _____ **SS #:** _____ **% Ownership:** _____

Owner 3: _____ **SS #:** _____ **% Ownership:** _____

Owner 4: _____ **SS #:** _____ **% Ownership:** _____

Owner 5: _____ **SS #:** _____ **% Ownership:** _____

C KEY PERSONNEL

Administrator ** must qualify*

Name: _____ **Prof. License #:** _____ **SS #:** _____

Home Address: _____ **Last Criminal Background:** _____

Email: _____ **Phone:** _____ **DOB:** _____

☐ Full Time ☐ Part Time

Alt. Administrator ** must qualify*

Name: _____ **Prof. License #:** _____ **SS #:** _____

Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ **Phone:** _____ **DOB:** _____

RN in Charge ** must qualify*

Name: _____ **Prof. License #:** _____ **SS #:** _____

Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ **Phone:** _____ **DOB:** _____

RN Supervisor ** RN backup for the Emergency Plan*

Name: _____ **Email:** _____

CFO (owner)

Name: _____ **SS #:** _____ ☐ Full Time ☐ Part Time

Home Address: _____ **Last Criminal Background:** _____

Email: _____ **Phone:** _____ **DOB:** _____

** Must qualify – Administrator: physician, RN, or a person with at least 1 year of supervisory experience in a nurse registry, home health agency, hospital or ALF.*

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D STAFF

Enter the total number of staff in each category: W-2 employees and 1099 independent contractors.

PERSONNEL	EMPLOYEES (W-2) (total of staff)	INDEPENDENT CONTRACTORS (1099) (total of staff)
Registered Nurse (RN)		
Licensed Practical Nurse (LPN)		
Certified Nursing Assistant (CNA)		
Home Health Aide (HHA)		
Homemaker		
Companion / Sitter		
Other		

E OPERATIONS

Hours of Operation: _____ to _____

F OWNERS / CORPORATION INFORMATION

Title: President, Vice-President, Secretary, CFO

#	Name	DOB	Title	Personal Address / Email	Telephone	Begin Date
1						
2						
3						
4						
5						

G BANK AND COUNTIES

Bank Routing #: _____

Account #: _____

Submitted by (Name): _____

Do not sign.

Counties Licensed:

☐ Miami-Dade ☐ Monroe

Other: _____

Use AHCA area counties.

FOR RENEWAL, email:
(See documents needed page attached)

☐ Emergency Plan current-year submission or previous-year approval letter
☐ License worksheet completed

Email Form