# Nursing Pool Registration Application Packet

## Contents:



## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Nursing Pool Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

## Contact us:

360-236-4700

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Washington State Department of Health

# Application Instructions Checklist

Please indicate type of application – new, change of ownership, or change of location.

**New**—First time requesting a Nursing Pool registration.

**Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed agency.

**Change of Location—** Changing the location address. Include your current license number.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **1. Demographic Information:**
**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI #'s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/ Master Business License.

**Mailing Address:** Enter the owner's complete mailing address.

**Phone and Fax Numbers:** Enter the owner's phone and fax number, if you have them.

**Email and Web Address:** Enter the owner's email and agency Web addresses, if you have them.

**Facility/Agency Name:** Enter the agency's name as advertised on signs, brochures or Web site.

**Physical Address:** Enter the agency's physical street location including city, state, zip code and county.

**Phone and Fax Numbers:** Enter the agency's phone and fax number, if you have them.

**Mailing Address:** Enter the agency's mailing address, if different than physical address.

☐ **2. Facility Specific Information:**
**Background Questions:** Check yes or no. If you answer yes, list and explain on a separate sheet of paper.

☐ **3. Contact Information:**
Enter the contact person's name, phone number and email address. This will be the person that the Department can contact for additional information.

☐ **4: Additional Information:**

**Additional Locations:** Provide name and location addresses of any other locations of nursing pools.

**Corporation Information:** Enter date of incorporation, corporate number, and state of corporation.

**Legal Owner:** List the names, addresses, and phone numbers of the corporate officers, partners, etc. Attach additional sheets if you need more space.

**Change of Ownership Information:** If applicable, list the previous legal owner name, previous name of facility, previous registration number, effective date of ownership change and physical address.

**Liability Insurance:**

Please indicate which method your policy reflects and include a copy of your policy:

- Insurance coverage in the amount of one million dollars per occurrence for each person who delivers patient care services for the nursing pool itself and its employees or agents.
- The nursing pool maintains professional and general liability insurance for its own liability in the amount of one million dollars per occurrence for each person who delivers patient care services. It only refers self-employed, independent contractors who must maintain their own professional and general liability insurance coverage in the amount indicated. Written evidence of such insurance shall be maintained by the nursing pool in the independent contractor's personnel file for a minimum of three years.

☐ **5. Quality Assurance Standards Affidavit:**

Must be signed by owner, partner or corporate officer and provide title. Affidavit must be submitted with the application and fee.

Quality Assurance Standards: **WAC 246-845-090** requires all nursing pools to comply with quality assurance standards. This rule also requires the nursing pool maintain evidence of compliance for up to three years be made available upon inspection. The department may request evidence during the application process or during a random audit following registration.

☐ **6. Applicant Confirmation:**

Each owner, partner, or corporate officer is to sign and provide title.

Washington State Department of Health

Date Stamp Here

| Fee |
| --- |
| Click here for current **Fee Link** |
| **All application fees are nonrefundable** |

**Revenue: 0299040000**

# Nursing Pool Registration Application

This is for: ☐ Initial/New Licensure ☐ Change of Ownership ☐ Change of Location

## Check One

☐ Association
☐ Corporation
☐ Federal Government Agency
☐ Limited Liability Company
☐ Limited Liability Partnership
☐ Limited Partnership
☐ Municipality (City)
☐ Municipality (County)
☐ Non-Profit Corporation
☐ Partnership
☐ Sole Proprietor
☐ State Government Agency
☐ Tribal Government Agency
☐ Trust

## 1. Demographic Information

| | | | |
| --- | --- | --- | --- |
| UBI # | | Federal Tax ID (FEIN) # | |
| Legal Owner/Operator Name | | | |
| Mailing Address | | | |
| City | State | Zip Code | County |
| Phone (enter 10 digit #) | | Fax (enter 10 digit #) | |
| Email Address | | Web Address | |

| | | | |
| --- | --- | --- | --- |
| Facility/Agency Name (Business name as advertised on signs or Web site) | | | |
| Physical Address | | | |
| City | State | Zip Code | County |
| Facility Phone (enter 10 digit #) | | Fax (enter 10 digit #) | |
| Mailing Address (If different than physical address) | | | |
| City | State | Zip Code | County |

## 2. Facility Specific Information

| Background Questions | Yes | No |
|---|---|---|
| 1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license? | ☐ | ☐ |
| If yes, list and explain on a sheet of paper. | | |
| 2. Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation? | ☐ | ☐ |
| If yes, list and explain on a sheet of paper. | | |

## 3. Contact Information

| Contact Person | Title |
|---|---|
| Phone (enter 10 digit #) | Email Address |

## 4. Additional Information

Does Nursing Pool operate in any other location(s)? ☐ Yes ☐ No

If **yes**, provide name and location address. Each location is required to obtain separate registration.

| Name | Location |
|---|---|
| | |
| | |
| | |

### Corporate Information

| Date of Incorporation | Corporate Number | State of Corporation |
|---|---|---|
| | | |

### Legal Owner Information–attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

| Name | Address | Phone (enter 10 digit #) | Title |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### Change of Ownership Information

| Previous Name of Legal Owner | | |
|---|---|---|
| Previous Name of Facility | Previous License Number | Effective Date of Change in Ownership |
| Physical Address | | |

**Liability Insurance** (Copy of policy must be attached)

Each nursing pool shall carry professional and general liability insurance in the amount of $1 million dollars per occurrence for each person who delivers patient care services. The policy must show coverage using one of the following methods. **Please indicate which method your policy reflects and include a copy of your policy.**

☐ The nursing pool maintains insurance coverage in the amount indicated for the nursing pool itself and its employees or agents.

☐ The nursing pool maintains professional and general liability insurance for its own liability in the amount indicated. It only refers self-employed, independent contractors who must maintain their own professional and general liability insurance coverage in the amount indicated. Written evidence of such insurance shall be maintained by the nursing pool in the independent contractor's personnel file for a minimum of three years.

## 5. Quality Assurance Standards Attestation

**WAC 246-845-090** requires all nursing pools to comply with quality assurance standards. This rule also requires the nursing pool maintain evidence of compliance for up to three years to be made available upon inspection. The Department of Health may request evidence during the application process or during a random audit following registration.

Must be signed by owner, partner or corporate officer and provide title. Affidavit must be submitted with the application and fee.

This is to certify I have read **WAC 246.845.090** of the Law Relating to Nursing Pools **18.52C RCW** and as a registered nursing pool shall comply with the quality assurance standards as outlined. Evidence of compliance with the standards shall be retained by the nursing pool and will be made available for inspection by the Department of Health.

| Initials of Representative | Date |
|---|---|
| | |

## 6. Applicant Affirmation

Each owner, partner or corporate officer is to sign and provide title.

This is to certify the information provided in this application is true and complete. I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act. To the best of my knowledge all supporting documents are actual and complete. I understand the department may require more information from me prior to making a determination regarding my registration, and may independently validate conviction records with official state and federal databases.

_____ _____

Signature of Authorized Representative | Date

_____ _____

Print Name | Print Title

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# RCW/WAC and Online Web Site Links

## RCW/WAC Links

Nursing Pool Laws, RCW 18.52C

Nursing Pool Rules, WAC 246-845

## On-Line

Nursing Pool Web Page