



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

APPLICATION FOR BIRTH CENTER LICENSURE

Name of Entity \_\_\_\_\_

D/B/A \_\_\_\_\_

Street Address \_\_\_\_\_

City, County, State, Zip Code \_\_\_\_\_

Telephone No. (\_\_\_\_\_) \_\_\_\_\_ Fax No. (\_\_\_\_\_) \_\_\_\_\_

Administrator \_\_\_\_\_ Effective Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

**PAYMENT**

The fee for a regular license is \$70. A check or money order payable to the "Commonwealth of Pennsylvania" for the amount of the licensure fee must accompany this application. Currency is NOT acceptable.

**DECLARATION**

I understand that the license will be issued to me on the condition that I will conduct the above named facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health, Title VI of the Civil Rights Act of 1964; and the Pennsylvania Human Relations Act, and I hereby declare that the information given in this application is true to the best of my knowledge and belief.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**NOTE: If operated by a corporation, attach a copy of the Articles of Incorporation and list of corporate officers with application, and report changes of corporate officers as the occur. If fictitious name is used for facility, attach a copy of state approval to use fictitious name with initial application.**