



**Commonwealth of Pennsylvania
Department of Health**

Application for Birth Center Licensure

Name of Entity: _____

D/B/A: _____

Street Address: _____

(City) (County) (State) (Zip Code)

Mailing Address: _____

(City) (County) (State) (Zip Code)

Telephone No. () _____ Fax No. () _____

Email Address: _____

Contact Person: _____

Payment

A Check or Money Order Payable to “Commonwealth of Pennsylvania” for the amount of the fee must accompany this application. **Currency is not acceptable.** The regular fee per license is \$70.

Return the completed and signed original application materials and check or money order to:

Pennsylvania Department of Health
Division of Home Health
132 Kline Plaza, Suite A
Harrisburg, PA 17104

IMPORTANT: Please retain a copy of your entire packet for your records.

Affirmation

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.

Authorized Representative's Signature*	Date
Print Name of Authorized Representative*	Date

**Authorized Representative – the individual within the Applicant organization with the legal authority to give assurances, make commitments, enter into contracts, and execute documents on behalf of the Applicant, including this application. The signature of the Authorized Representative certifies that commitments made on this Application will be honored and ensures that the Applicant agrees to conform to applicable law and regulations.*