



**Bureau of Community Program Licensure and Certification  
Mothers' Milk Bank Program  
555 Walnut St., 7th floor  
Harrisburg, PA 17101  
Phone: (717) 783-1379  
Email: [RA-DHMILKBANK@pa.gov](mailto:RA-DHMILKBANK@pa.gov)**

**Instructions for Completion of Department of Health Mothers' Milk Bank Application**

**It is important that you fill out the application completely, including signatures where required. If you fail to submit all requested information, the application materials will be mailed back to you.**

**Please submit the application fee in the form of a certified check or money order with your application.**

**To prevent a delay in processing your application, please check to make sure all of the following are provided:**

- Completed application.**
- Supplemental information needed to complete the application.**
- Signature of applicant.**
- Application fee made out to the Commonwealth of Pennsylvania.**



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**Mothers' Milk Bank Program**  
 555 Walnut St., 7<sup>th</sup> floor  
 Harrisburg, PA 17101  
 Phone:

Department of Health Use Only
ID#:
Application status:
Fee received:
Other:

**APPLICATION FOR MOTHERS' MILK BANK LICENSURE**  
**Act 7 of 2020**

Licensure Application:  <input type="checkbox"/> Initial application <input type="checkbox"/> Renewal application  The application for licensure shall be accompanied by a single certified check or money order made payable to "Commonwealth of Pennsylvania."	License Fee Schedule:  \$1,000 - Initial license \$ 250 - Bi-annual license
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I. MILK BANK INFORMATION					
Name of milk bank:			Point of contact if not the managing director:		
Telephone number:			Email address:		
Street address:			Mailing address (if different):		
City	State	Zip code	City	State	Zip code
<b>II. THE ARTICLES OF INCORPORATION, CERTIFICATE OF REGISTRATION, CERTIFICATE OF INCORPORATION, CHARTER, CERTIFICATE OF ORGANIZATION, OR OTHER ARTICLES, STATEMENTS OR DOCUMENTS ESTABLISHING THE LEGAL EXISTENCE OF THE BUSINESS ENTITY THAT WILL HOLD THE LICENSE. THIS SUBMISSION SHALL INCLUDE APPLICABLE PENNSYLVANIA DEPARTMENT OF STATE FILINGS AND APPROVALS. FOR FOREIGN ENTITIES, PROVIDE A COPY OF THE APPLICABLE PENNSYLVANIA DEPARTMENT OF STATE FILINGS AND APPROVALS TO CONDUCT BUSINESS IN PENNSYLVANIA. (Provide in a separate attachment)</b>					
III. MANAGING DIRECTOR INFORMATION					
Managing director name:			Degree:		
Telephone number:			Email address:		

Street address:			Mailing address (if different):		
City	State	Zip code	City	State	Zip code
<b>IV. MEDICAL DIRECTOR INFORMATION</b> <b>(Copies of current medical license from Pa. or from the state the milk bank is located in and CV are attached.)</b>					
Medical director name:			Degree:		
Telephone number:			Email address:		
Street address:			Mailing address (if different):		
City	State	Zip code	City	State	Zip code
<b>V. TECHNICAL OR SUPERVISORY STAFF INFORMATION</b> <b>(Information may be provided in a clearly identified separate attachment.)</b>					
Name:			Title:		
Experience:			Education:		
Name:			Title:		
Experience			Education:		
Name:			Title:		
Experience:			Education:		
Name:			Title:		
Experience			Education:		
Name:			Title:		
Experience:			Education:		

Name:	Title:
Experience	Education:
<b>VI. DESCRIPTION OF THE PHYSICAL FACILITIES, LOCATIONS, EQUIPMENT, SOURCES OF MATERIALS, AND METHODS OF PROCESSING, STORAGE AND DISTRIBUTION OF DONOR MILK</b> (Information shall be provided in a clearly identified separate attachment.)	
<b>VII. DESCRIPTION OF EACH TECHNICAL PROCEDURE USED IN THE ROUTINE OPERATION OF THE MILK BANK</b> (Information shall be provided in a clearly identified separate attachment.)	
<b>VIII. IDENTIFY ANY RELATIONSHIPS WITH DISPENSARIES OR SATELLITE MILK DEPOTS</b> (If additional space is needed, provide the information on a clearly identified separate attachment.)	
Dispensary name:	Dispensary name:
Point of contact:	Point of contact:
Address:	Address:
Telephone number:	Telephone number:
Email address:	Email address:
Comments:	Comments:
Satellite milk depot name:	Satellite milk depot name:
Point of contact:	Point of contract:
Address:	Address:
Telephone number:	Telephone number:
Email address:	Email address:
Comments:	Comments:
<b>IX. ACCREDITATION INFORMATION</b>	
Is the milk bank certified as a member in good standing of a Department of Health approved association?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide a copy of most recent certification.
If yes, list the name of the accrediting organization:	Note the date of the last survey:
Does the milk bank have a valid license or accreditation from another state?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, list the other states along with the license number or accreditation information:

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**CERTIFICATION BY APPLICANT**

I have read the Pennsylvania Mothers' Milk Bank Act (Act 7 of 2020), and I certify that this milk bank meets these standards. I realize I will be liable for fine and/or sanctions specified in the act if I fail to correct violations of these standards as cited by the Department of Health. The undersigned hereby affirms that the foregoing information is true and correct to the best of my knowledge, information and belief, and this affirmation is made subject to the penalties prescribed by 18 PA. C.S. § 4904 (relating to unsworn falsification to authorities).

Person(s) liable (Print)	Title
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Signature of applicant	Date
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