**Bureau of Community Program Licensure and Certification**
**Mothers' Milk Bank Program**
**2525 N 7th Street**
**Harrisburg, PA 17110**
**Phone: 717-783-1379**
**Email:** 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.**

pennsylvania
DEPARTMENT OF HEALTH

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

**Bureau of Community Program Licensure and Certification**
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**Harrisburg, PA 17110**

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

| Licensure application: | License fee schedule: |
|---|---|
| ☐ Initial application<br>☐ Renewal application<br><br>The application for licensure shall be accompanied by a single certified check or money order made payable to "Commonwealth of Pennsylvania." | $1,000 - Initial license<br>$ 250 - Bi-annual license |

| **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 |

**II. SUBMIT 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 this in a separate attachment)**

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

| | |
|---|---|
| Name: | Title: |
| Experience | Education: |
| **VI. DESCRIPTION OF THE PHYSICAL FACILITIES, LOCATIONS, EQUIPMENT, SOURCES OF MATERIALS, AND METHODS OF PROCESSING, STORAGE AND DISTRIBUTION OF DONOR MILK**<br>**Renewals – Complete only if changes were made. (Information shall be provided in a clearly identified separate attachment.)** | |
| | |
| **VII. DESCRIPTION OF EACH TECHNICAL PROCEDURE USED IN THE ROUTINE OPERATION OF THE MILK BANK**<br>**Renewals – Complete only if changes were made. (Information shall be provided in a clearly identified separate attachment.)** | |
| | |
| **VIII. IDENTIFY ANY RELATIONSHIPS WITH DISPENSARIES OR SATELLITE MILK DEPOTS**<br>**(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: |

| IX. ACCREDITATION INFORMATION | |
|---|---|
| Is the milk bank certified as a member in good standing of a Department of Health approved association? | ☐Yes ☐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? | ☐Yes ☐No |
| If yes, list the other states along with the license number or accreditation information: | |
| **X. EXEMPTION TO REMUNERATE DONORS (If applicable)** | |
| Does the milk bank desire an exemption allowing the milk bank to remunerate its donors for value? | ☐Yes ☐No |
| If yes: | |
| Does the milk bank certify it shall operate in accordance with the requirements to receive an exemption pursuant to the Pennsylvania Mothers' Milk Bank Act (Act 7 of 2020)? | ☐Yes ☐No |
| Does the milk bank certify it shall not remunerate a donor without testing for, at a minimum, the following controlled substances: tetrahydrocannabinol, cocaine, opiates, opioids, penylcyclohexyl piperidine, benzodiazepines, amphetamines (or relevant metabolite)? | ☐Yes ☐No |
| Does the milk bank certify it shall not remunerate a donor without obtaining medical verification that the donor's biological infant is achieving adequate growth? | ☐Yes ☐No |
| **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 |
| Signature of applicant | Date |