



INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR REGISTRATION

Please read these instructions before completing the application (Form A-1 and A-2). The information in this application is required pursuant to Sections 4999.1 and 4999.2 of the California Business and Professions Code. All items in this application are mandatory rather than voluntary. Failure to provide any of the required information will result in the application being considered incomplete. The information provided will be used to determine qualification for registration as a telephone medical advice service. Please provide the following information on the application (Form A-1 Pages 1 and 2, and Form A-2).

1. BUSINESS ENTITY INFORMATION:

- **NAME OF BUSINESS:** Enter the exact name under which business will be conducted. The name used should also be the same name as used on your invoices and advertisements.
- **AREA CODE & PHONE NUMBER:** Please enter your telephone number (including area code).
- **FEIN (Federal Employer Identification Number):** Partnerships, please enter the FEIN of your business.
- **ADDRESS OF RECORD:** **Enter the address where the business is located**, including the number and street, suite or unit number, city, state, and zip code (nine digit number if it is available). This is where all correspondence will be mailed.
- **MAILING ADDRESS:** Complete **only** if different from the Address of Record (provided in #2). Enter the address, including the number and street/or post office box, suite or unit number, city, state, and zip code (nine digit number if it is available).
- **CORPORATE NAME:** Enter the name of your corporation as filed with the California Secretary of State's Office. This item does not apply to businesses owned by individuals or partnerships.
- **CORPORATE HEADQUARTERS ADDRESS:** Enter the corporate headquarter's address, if different from the Address of Record and Mailing Address. Enter the address, including the number and street/or post office box, suite or unit number, city, state, and zip code (nine digit number if it is available).
- **AGENT FOR SERVICE OF PROCESS:** Enter the designated agent for service of process in California by entering the individual's name, telephone number, and California address. This person must reside in California.

2. HEALTH CARE PROFESSIONAL EMPLOYEES PROVIDING TELEPHONE MEDICAL ADVICE:

- Use the Provider List, Form A-2, to provide the requested information for all employees providing telephone medical advice on behalf of your business. You are required to update your list on a quarterly basis.

3. ADDITIONAL BUSINESS INFORMATION:

- **Ownership Type:** Check the box that best describes the ownership type of your business.

4. **OWNER(S) AND/OR RESPONSIBLE PERSON(S) CERTIFICATION:**

Use the list below to assist you in determining which owner(s) and/or responsible persons need to be listed for your business and what identifying information is needed. Each owner/responsible person must provide responses to all information requested including their signature and date signed. If there are more than three (3) owners and/or responsible persons in your business, please photocopy the certification page and use it to record their information as well.

- **SOLE PROPRIETOR:** If an individual owns the business, list the owner's name, social security number (SSN), area code and telephone number, and address.
- **PARTNERSHIP:** If the business is owned by a partnership, list the partners' names, federal employer identification number (FEIN), area code and telephone numbers, and addresses of all partners of the business. In addition, each partner must enter a response to the administrative and conviction questions.
- **CORPORATION:** If a corporation owns the business, list the names, area code and telephone numbers, and addresses of the President or Secretary of the business. In addition, each officer must enter a response to the administrative and conviction questions. The signature shall be accompanied by a resolution or other written communication identifying the individual whose signature is on the form as owner, partner, president, or secretary.
- **GOVERNMENTAL ENTITY:** If the business is owned by a government agency, please identify the responsible persons for the telephone medical advice services program. List the responsible persons' names, FEINs or SSNs, telephone numbers, and addresses.
- **LIMITED LIABILITY COMPANY:** List the names, FEIN, telephone numbers, and addresses of the members of the company. In addition, all members must respond to the administrative and conviction questions. If there is not enough space to enter all the members, please photocopy the certification page and provide the information.
- **OTHER AUTHORIZED SIGNORS:** Quarterly Reports must be signed by an authorized person. If you would like someone other than the owner, partner, president or secretary to become an authorized signor, please make sure they have completed section 4 on the Application for Registration.

INSTRUCTIONS RE: ADMINISTRATIVE ACTIONS or CONVICTIONS: You are required to disclose any actions and/or convictions by a state or government agency that was ever taken against any owner(s) members, and/or responsible person(s) within your business. You are also required to list any conviction that has been set aside, dismissed, or expunged, or where a stay of execution has been issued. Please list the violation(s) and location, date, penalty and/or disposition. In addition, please provide documentation to substantiate the manner in which the violation was resolved.

Mail to the Telephone Medical Advice Services Bureau the completed application, Forms A-1 and A-2, along with the application processing and registration fee of \$7,500 made payable to the Department of Consumer Affairs.

All items on this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being considered incomplete. The information provided will be used to determine qualification for registration, per Business and Professions Code 4999 et seq. which authorizes the collection of this information. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Chief of the Telephone Medical Advice Services Bureau at 1625 North Market Boulevard, Suite N-112, Sacramento, CA 95834, (916) 574-7992, is the custodian of records.

Section 30 of the Business and Professions Code and Public Law 94-455 authorizes collection of your FEIN (for partnerships) or your SSN (for sole proprietorships). Corporations are exempt. Disclosure of your SSN/FEIN is mandatory and will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose it, you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.



APPLICATION FOR REGISTRATION

Fee \$7,500

<i>For Department Use Only</i>	
Receipt Number	_____
Date Received	_____
Registration Number	_____
Date Issued	_____

1. Read the attached instructions.
2. Remit fees by check or money order made payable to the Department of Consumer Affairs.
3. Submit completed application and fees to the Telephone Medical Advice Services Bureau at the above address.
4. All information is mandatory and required under California Business and Professions Code and California Code of Regulations.

Please type or print legibly in ink

1. BUSINESS ENTITY INFORMATION:		
Name of Business:	Area Code & Phone Number:	FEIN:
Address of Record (physical location):		
Mailing Address (If different than Address of Record):		
Corporate Name (If different):		
Corporate Headquarters Address (If different than the Address of Record and the Mailing Address):		
Name of Agent for Service of Process, Telephone Number and Address (must be located in California):		
2. HEALTH CARE PROFESSIONAL EMPLOYEES PROVIDING TELEPHONE MEDICAL ADVICE:		
To satisfy the requirements of Sections 4999.1 and 4999.2 of the Business and Professions Code, you must complete Form A-2, Provider List, and attach it to this application.		
3. ADDITIONAL BUSINESS INFORMATION:		
Ownership Type:		
<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Other _____	<input type="checkbox"/> Governmental Entity
(must specify)		

4. OWNER(S) AND/OR RESPONSIBLE PERSON(S) CERTIFICATION:

Person 1:

Name & Title:	SSN:	Area Code & Phone Number:
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Address:	City	State	Zip Code
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• Have you ever had any state license, certificate or registration revoked, suspended or denied or otherwise been the subject of disciplinary action by any government agency? If answer is "yes," see instructions.
Yes No

• Have you ever been convicted of a felony or misdemeanor, other than minor traffic violations? This includes convictions that may have been expunged pursuant to Penal Code 1203.4. If answer is "yes," see instructions.
Yes No

I certify under penalty of perjury under the laws of the State of California that all statements made in this application and any supporting documents pertaining to this application are true and correct.

Signature: _____ *Dated:* _____

Person 2:

Name & Title:	SSN:	Area Code & Phone Number:
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Address:	City	State	Zip Code
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• Have you ever had any state license, certificate or registration revoked, suspended or denied or otherwise been the subject of disciplinary action by any government agency? If answer is "yes," see instructions.
Yes No

• Have you ever been convicted of a felony or misdemeanor, other than minor traffic violations? This includes convictions that may have been expunged pursuant to Penal Code 1203.4. If answer is "yes," see instructions.
Yes No

I certify under penalty of perjury under the laws of the State of California that all statements made in this application and any supporting documents pertaining to this application are true and correct.

Signature: _____ *Dated:* _____

Person 3:

Name & Title:	SSN:	Area Code & Phone Number:
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Address:	City	State	Zip Code
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• Have you ever had any state license, certificate or registration revoked, suspended or denied or otherwise been the subject of disciplinary action by any government agency? If answer is "yes," see instructions.
Yes No

• Have you ever been convicted of a felony or misdemeanor, other than minor traffic violations? This includes convictions that may have been expunged pursuant to Penal Code 1203.4. If answer is "yes," see instructions.
Yes No

I certify under penalty of perjury under the laws of the State of California that all statements made in this application and any supporting documents pertaining to this application are true and correct.

Signature: _____ *Dated:* _____