Hospital License – Signature of Secondary Authorized Representative

Complete the following information

Hospital Doing Business As (DBA) name: _____

Hospital address: _____

Hospital City and Zip code: _____

Applicant Attestation

In accordance with Minnesota Statutes, section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), all data submitted on this application shall be classified public information upon issuance of a registration.

Under Minnesota Statutes, section 144.52 (https://www.revisor.mn.gov/statutes/cite/144.52), an application on behalf of a corporation or association or governmental unit shall be made by any two officers thereof or by its managing agents.

- I understand there is a nonrefundable license fee.
- I have read and understand Minnesota Statutes, section 144.50 to 144.591 (https://www.revisor.mn.gov/statutes/cite/144.50) and Minnesota Statutes, section 144.651 (https://www.revisor.mn.gov/statutes/cite/144.651), Minnesota Statutes, section 144.1461 (https://www.revisor.mn.gov/statutes/cite/144.1461), and the rules adopted thereunder.
- I certify that the information provided on the hospital application is accurate and complete.

Signature of Secondary Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

04/20/2026

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.