Supplemental Nursing Services Agency – Closure

Complete all the following information.

Health Facility Identification Number (HFID): _____

Agency's Doing Business As (DBA) name: _____

Address: _____

City/State/Zip Code: _____

Name of Administrator: _____

Email of Administrator: _____

Effective Date of Closure: _____

Reason(s) for the closure: _____

_____

_____

Next Steps

- Email completed form to Health.HRD-FEDLCR@state.mn.us.

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Administrator/Authorized Agent: _____

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

04/24/2025

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