COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Department of Public Health
Bureau of Health Care Safety and Quality
99 Chauncy Street, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

RECEIVED
APR 2 5 2019
MA Dept of Public Health
99 Chauncy Street
Boston, MA. 02111

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/26/19

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE: HealthQuarters, Inc.
2. NAME OF CLINIC: Same
3. ADDRESS: 100 Cummings Ctr Suite 131-Q (if same, write same) Beverly MA 01915
   Street City or Town Zip Code
4. TELEPHONE: 978 922 4490 EMAIL: [redacted]@healthq.org
5. LICENSE NUMBER: 4WSC Date current license expires: JUNE 21, 2019
6. SERVICES (check all that apply)

Medical ✓	Substance Abuse ____	Dental ____
Surgical ____	Physical Rehabilitation ____	Mental Health ____
Birth Center ____	Mobile Medical ____	Transfusion ____
Pharmacy ____	Limited Services ____	

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Healthquarters, Inc.

Application Date 4/26/19

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: Healthquarters, Inc - Haverhill Clinic

215 Summer St. Suite 16 Haverhill, MA 01830

Street: Suite #/Floor City/Zip Code

Telephone Number: 9785214444 Days and Hours of Operation: M, W, Th: 8:30-4:30 T: 11-7

Services offered: Medical

Department of Public Safety Certificate Issued: N/A Fire Certificate Issued: ✓

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Healthquarters, Inc.

280 Merrimack St. Suite 544 Lawrence MA 01843

Street: Suite #/Floor City/Zip Code

Telephone Number: 9786815258 Days and Hours of Operation: M, TH: 11-7 T, W: 9-5 F: 8:30-4:30

Services offered: Medical

Department of Public Safety Certificate Issued: N/A Fire Certificate Issued: ✓

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: __________

Street: Suite #/Floor City/Zip Code

Telephone Number: __________ Days and Hours of Operation: __________

Services offered: __________

Department of Public Safety Certificate Issued: __________ Fire Certificate Issued: __________

Substance Abuse Certificate Issued: __________

(Attach addendum for additional sites, if applicable)

Clinic Name Healthquarters, Inc.

Application Date 4/26/19

9. Number of patients visits per year: (CY 2018)
   Less than 5,000 ________
   5,000 – 25,000 7636
   25,000 – 100,000 ________
   100,000 - ________

10. I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

    ____
    Federal Identification Number

    Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.

11. Signature and Seal:

    I, ________________________, being first duly sworn on oath depose and say that the statements contained in this license application ... best of my knowledge.*

    ____
    Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

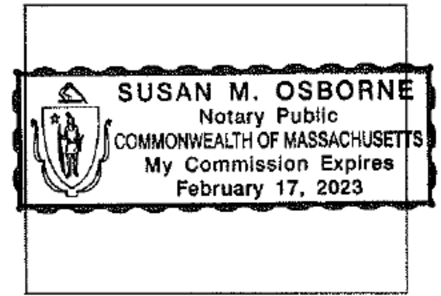
    By: ________________________
    Corporate Officer (if applicable)

Essex MA

Subscribed and sworn to before me on this 19th day of April 20 19.

My commission expires on 2/17/23 20 23.

________________________ (Seal)
Notary Public



*Note: All information contained in this application must be kept current.

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Department of Public Health
Bureau of Health Care Safety and Quality
99 Chauncy Street, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 5/8/17

RECEIVED
MAY 9 - 2017
MA Dept of Public Health
99 Chauncy Street
Boston MA 02111

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE: HealthQuarters, INC.

2. NAME OF CLINIC: Same (if same, write same)

3. ADDRESS: 100 Cummings Center Suite 131-Q Beverly MA 01915
   Street City or Town Zip Code

4. TELEPHONE: (978)522-5609 EMAIL: [redacted]@healthq.org

5. LICENSE NUMBER: 4WSC Date current license expires: JUNE 21, 2017

6. SERVICES (check all that apply)

Medical ✓	Substance Abuse ____	Dental ____
Surgical ____	Physical Rehabilitation ____	Mental Health ____
Birth Center ____	Mobile Medical ____	Transfusion ____
Pharmacy ____	Lithotripsy ____	Limited Services ____

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name HealthQuarters, Inc

Application Date ________

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: HealthQuarters, Inc - Haverhill Clinic

215 Summer Street | Suite 16 | Haverhill MA 01830
Street: | Suite #/Floor | City/Zip Code

Telephone Number: 978 521-4444 Days and Hours of Operation: M,W: 830-430 T: 11-7

Services offered: Medical

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ✓

Substance Abuse Certificate Issued: ________

2. Name of Clinic: HealthQuarters, Inc - Lawrence Clinic

280 Merrimack St. | Suite 501 | Lawrence, MA 01843
Street: | Suite #/Floor | City/Zip Code

Telephone Number: 978 681 5258 Days and Hours of Operation: M,T,W: 9-5 TH: 10-6 F: 830-430 SAT: 8-1

Services offered: Medical

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ✓

Substance Abuse Certificate Issued: ________

3. Name of Clinic: ________

Street: | Suite #/Floor | City/Zip Code

Telephone Number: ________ Days and Hours of Operation: ________

Services offered: ________

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ________

Substance Abuse Certificate Issued: ________

(Attach addendum for additional sites, if applicable)

Clinic Name Heatmquarters, Inc
Application Date 5/8/17

9. Number of patients per year:
Less than 5,000 ________
5,000 – 25,000 ~5,500
25,000 – 100,000 ________
100,000 - ________

10. I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

____
Federal Identification Number

Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.

11. Signature and Seal:

I ________________________, being first duly sworn on oath depose and say that the statements contained in this license application are true, complete and correct to the best of my knowledge.*

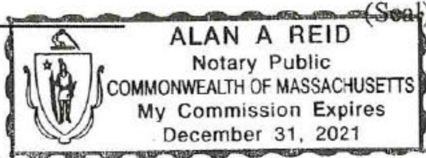
____
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

By: ________________________
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 4th day of May 20 17.

My commission expires on 12/31/21 20 ________.

________________________ (Seal)
Notary Public



*Note: All information contained in this application must be kept current.