



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
PROVIDER APPLICATION

STATE BOARD OF EMBALMERS
 AND FUNERAL DIRECTORS
 3605 MISSOURI BOULEVARD
 P.O. BOX 423
 JEFFERSON CITY, MO 65102
 TELEPHONE (573) 751-0813
 FAX (573) 751-1155 TTY (800) 735-2966
 WEBSITE: <http://pr.mo.gov/embalmers.asp>
 EMAIL: embalm@pr.mo.gov

FOR BOARD USE ONLY	
LICENSE #	ISSUE DATE
FEE RECEIVED	DATE DEPOSITED
CHECK NO.	INITIALS
PRE-LICENSE NUMBER	

INSTRUCTIONS

Use this form to apply for licensure as a preneed provider. Mail completed form to: Missouri State Board of Embalmers and Funeral Directors, P.O. Box 423, Jefferson City, Missouri 65102. **Please attach additional sheets where applicable.**

TYPE OF LICENSE: Please check the box that applies

- Preneed Provider who is a Missouri licensed funeral establishment.** Fee: \$100 Application fee + \$14 Highway Patrol Background Check. Highway Patrol Background Check Fee must be submitted for all individuals listed in Section A, additional background check fees may be required.
- Preneed Provider not a Missouri licensed funeral establishment.** Fee: \$200.00 + \$14 Highway Patrol Background Check. Highway Patrol Background Check Fee must be submitted for all individuals listed in Section A, additional background check fees may be required.
- Amended Application** Fee: \$25 Application fee + \$14 Highway Patrol Background Check. Highway Patrol Background Check Fee must be submitted for all individuals listed in Section A, additional background check fees may be required.

1. NAME OF PRENEED PROVIDER 2. TELEPHONE NUMBER 3. FAX NUMBER

4. WILL THE APPLICANT DO BUSINESS UNDER ANOTHER NAME? IF SO, LIST D/B/A NAME (must be registered with Missouri Secretary of State). 5. E-MAIL

6. PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP)

7. MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP CODE)

8. TYPE OF ENTITY (PLEASE CHECK)
 SOLE PROPRIETORSHIP CORPORATION PARTNERSHIP (PLEASE LIST PARTNERS BELOW) LLC OTHER _____

9. REGISTERED AGENT OR OWNER'S NAME SOCIAL SECURITY NUMBER AND MISSOURI STATE TAX ID NUMBER (REQUIRED)

10. BY CHECKING THIS BOX YOU ARE INDICATING THE ENTITY AND DOING BUSINESS AS (DBA) NAMES FOR THIS PHYSICAL ADDRESS **HAVE BEEN** REGISTERED WITH THE SECRETARY OF STATE.

SECTION A: OWNERSHIP INFORMATION

List each officer, director, or manager. Also list any shareholders or owners with 10% or greater ownership interest in preneed provider.

NAME	TITLE	CONTACT TELEPHONE NO.	CONTACT ADDRESS	SOCIAL SECURITY NUMBER	DATE OF BIRTH

The corporate applicant hereby certifies to the board that each of its officers, directors, managers and controlling shareholders would be eligible for licensure under section 333.330. **If the no box is checked please attach a sheet of explanation.** YES NO

SECTION B: Identify the name and address of each seller authorized by the provider to sell preneed contracts in which the provider is designated or obligated as the provider. (Please do not list each individual person, list the firm(s) authorized to sell preneed contracts for your establishment.)

PRENEED SELLER'S NAME	ADDRESS	PRENEED SELLER REG. NO. (if applicable)

SECTION C: Background Information	Yes	No									
1. Has the applicant ever applied for licensure in this or any other state or territory before making this application? Include all.	<input type="checkbox"/>	<input type="checkbox"/>									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">What State</th> <th style="width: 30%;">Date Applied</th> <th style="width: 40%;">Type of License</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	What State	Date Applied	Type of License								
What State	Date Applied	Type of License									
2. Has the applicant ever been denied a professional license, certification, registration or permit? If yes, attach a full explanation.	<input type="checkbox"/>	<input type="checkbox"/>									
3. Has the applicant ever had any professional license, certification, registration or permit revoked, suspended, placed on probation, censured, reprimanded, fined or otherwise subjected to any type of disciplinary action? If yes, attach a full explanation.	<input type="checkbox"/>	<input type="checkbox"/>									
4. Is the applicant presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold or have applied for? If yes, attach a full explanation.	<input type="checkbox"/>	<input type="checkbox"/>									
5. Has the applicant ever voluntarily surrendered or resigned any professional license, certification, registration or permit? If yes, attach a full explanation.	<input type="checkbox"/>	<input type="checkbox"/>									
6. Has the applicant ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime whether or not sentence was imposed (include SIS), or are such actions currently pending (excluding traffic violations)? If yes, attach a full explanation and provide certified court documents (i.e. Docket Sheet, Information or Indictment, and Final Disposition).	<input type="checkbox"/>	<input type="checkbox"/>									
7. Has the applicant ever been convicted, adjudged guilty by a court, pled guilty or nolo contendere to any traffic offense resulting from or related to the use of drugs, alcohol, whether or not sentence was imposed (includes SIS), or are such actions currently pending? If yes, attach a full explanation and provide certified court documents (i.e. Docket Sheet, Information or Indictment, and Final Disposition).	<input type="checkbox"/>	<input type="checkbox"/>									
8. Has the applicant ever been adjudged mentally incompetent by a state or federal court? If yes, attach a full explanation and provide certified court documents (i.e. Docket sheet, Complaint, and Final Disposition).	<input type="checkbox"/>	<input type="checkbox"/>									
9. Is the applicant now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, attach a full explanation and provide discharge summary or other official documentation that shows your diagnosis, prognosis and treatment plan.	<input type="checkbox"/>	<input type="checkbox"/>									

SECTION D: DESIGNATION OF CUSTODIAN	
Pursuant to § 333.315.1(3), RSMo, identify the name and address of a custodian of records responsible for maintaining the books and records of the provider relating to preneed contracts.	
NAME OF CUSTODIAN	TELEPHONE NUMBER/FAX NUMBER/E-MAIL
ADDRESS OF CUSTODIAN	LOCATION OF BOOKS & RECORDS (MUST BE A MISSOURI ADDRESS)

SECTION E
Pursuant to Section 324.010 RSMo: <input type="checkbox"/> CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX. <i>False statements are subject to criminal penalties and/or license discipline.</i> If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

SECTION F: CONSENT TO INSPECTION, EXAMINATION AND AUDIT BOOKS AND RECORDS
As required by 333.315.2(5) RSMo, I hereby authorize and instruct the custodian(s) named herein to file with the state board, a written consent authorizing the state board to inspect or order an investigation, examination, or audit of the provider's books and records which contain information concerning preneed contracts sold for or on behalf of a seller or in which the applicant is named as a provider.

SECTION G: AFFIDAVIT: MUST BE COMPLETED AND NOTARIZED
I, _____, being first duly sworn and upon my oath do hereby state the foregoing application has
PRINT NAME
been completed on behalf of the applicant truthfully and completely, without omission, and that all answers, statements, designations and consents are true and accurate to the best of my knowledge and belief. I, the undersigned, have personally reviewed the information contained herein and hereby submit this application for a preneed provider license to the State Board of Embalmers and Funeral Directors on behalf of the above-named applicant. I am authorized to submit this application.
I affirm that I made this affidavit knowingly, and understand that any false statement or material omission herein subjects me to criminal penalties for making a false affidavit under section 575.050, RSMo AND MAY RESULT IN DENIAL OF THIS APPLICATION UNDER Sections 333.330.2(3) and (12).

NOTARY SECTION	SIGNATURE AND TITLE	NOTARY PUBLIC SEAL/STAMP
	PLEASE PRINT NAME	
STATE OF	COUNTY	
MISSOURI		
Subscribed and sworn to (or affirmed) before me this _____ day of _____, 20 ____.		
NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	
NOTARY PUBLIC PRINTED NAME		