

# Transient Accommodation License Application



## Items Needed to Complete Your Application

- This application for the license, completed and signed.
- Licensing fees.

The Department of Health will conduct an on-site survey prior to issuing an initial transient accommodation license or reinstating an invalid license; the inspection will be announced or an unannounced on-site surveys during routine business hours.

For the complete process of licensing see the [Transient Accommodations Licensing Process](https://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/TransientAccommodations) (<https://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/TransientAccommodations>). Each license shall be issued only for the premises and persons named in the application.

## Contact Us

Contact the Transient Accommodation Program at 360-236-3393 or [housing@doh.wa.gov](mailto:housing@doh.wa.gov).

## Definitions

The term "**transient accommodation**" means any facility such as a hotel, motel, condominium, resort, or any other facility or place offering three or more lodging units to travelers and transient guests.

The term "**Licensee**" means the **person** to whom the department issues the transient accommodation license.

The term "**person**" means any individual, firm, partnership, corporation, company, association or joint stock association, and the legal successor thereof.

The term "**department**" is the Washington State Department of Health.

The term "**lodging unit**" means one self-contained unit designated by number, letter, or some other method of identification.

## Self-Inspection Form

Review the form. By signing the application you are certifying that you have received and reviewed the items of inspection.

## More Resources

For laws and rules, and other program services, see [Transient Accommodations Resource Book](https://www.doh.wa.gov/portals/1/Documents/Pubs/505019.pdf) (<https://www.doh.wa.gov/portals/1/Documents/Pubs/505019.pdf>).

# Transient Accommodation License Application



**Application Type:**  New  Change of Ownership  Amended  Expired/Re-Licensure

## Section 1 - Facility Primary Contact Information

Facility Name:

Facility Address:

City:

State: WA

Zip Code:

County:

Primary Facility Onsite Contact Person:

Title:

Primary Facility Phone:

Cell Phone:

(All electronic communication from our office will be sent to this email.)

Facility Email:

Website:

(All mailed communication from our office will be sent to this address.)

Facility Mailing Address:

City:

State:

Zip:

## Section 2 – Licensee Information

**Business Type:**  Limited Liability  Corporation  Non-Profit  Sole Proprietor  Association  
 Tribal Government Association  State Government Agency  Limited Liability Partnership  Partnership

Business/Owner Name:

UBI Number:

Business/Owner Mailing Address:

City:

State:

Zip Code:

County:

Primary Business/Owner Contact:

Phone:

Cell Phone:

Email:

Emergency Contact:

Phone:

Title:

Alternate Contact:

Phone:

Title:

## Section 3 – Facility Information

**Facility Type:**  Hotel  Motel  Bed and Breakfast  Inn  Resort  Retreat  Hostel  Shelter

Number of Rooms:

Year Round Facility

Seasonal Facility

If **Seasonal**, Operation Start Date:

If **Seasonal**, Operation End Date:

Facility access available during normal business hours?  Yes  No

If no, person to contact for access? Name:

Phone:

## Section 4 - Change of Ownership (if applicable)

Previous Facility Name:

Previous License Number:

Previous Owner Name:

Phone:

Effective Date of Ownership: \_\_\_\_\_

## Section 5 - Required Documents Checklist

Original Application with Signature

[Licensing Fees](#)

([www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/TransientAccommodations/LicenseRequirements/Fees](http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/TransientAccommodations/LicenseRequirements/Fees))

**Note:** Application will be considered incomplete and may delay licensing if any of the above items are not included.

## Section 6 - Signature

This Certifies that I have reviewed and agree to comply with the laws, regulations and requirements as stated in **RCW 70.62** and **WAC 246.360** and the Self Inspection Form enclosed. I certify that the information herein submitted is true to the best of my knowledge.

Print Name:

Signature:

Date:

## Submitting Your Application

Mail your application and fees to: Department of Health, Revenue Section, P.O. Box 1099, Olympia, WA 98507-1099

Make check or money order payable to: Department of Health

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To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).