



## 2011 APPLICATION FOR PAIN MANAGEMENT CLINIC LICENSE

- |                                                               |                                                                        |
|---------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> License Application                  | <input type="checkbox"/> Change of Property Ownership or Owner Address |
| <input type="checkbox"/> Clinic Relocation                    | <input type="checkbox"/> Change in Clinic Name or Clinic Ownership     |
| <input type="checkbox"/> Registering New Designated Physician | <input type="checkbox"/> Other: _____                                  |

**\*NOTE – This application must be typed and all sections completed. Any incomplete sections will delay processing and will cause the application to be returned or denied. It is recommended that you fully read the Hillsborough County Pain Management Clinic Ordinance 10-8E, as amended, prior to submitting this application. A copy of the ordinance can be found by accessing the Hillsborough County Consumer Protection Agency website at [www.hillsboroughcounty.org/consumerprotection/](http://www.hillsboroughcounty.org/consumerprotection/). If you have any questions, you may also contact the Consumer Protection Agency at (813) 903-3430.**

### **SECTION A: CLINIC OFFICE INFORMATION:**

1. Corporate or Legal Name of Pain Management Clinic: \_\_\_\_\_
2. Fictitious Name or Doing Business As: \_\_\_\_\_
3. Clinic Physical Address: \_\_\_\_\_
4. Clinic Hours of Operation: \_\_\_\_\_
5. Mailing Address: \_\_\_\_\_
6. Clinic Telephone Number: \_\_\_\_\_ Clinic Fax Number: \_\_\_\_\_
7. Clinic email address and website address: \_\_\_\_\_
8. Federal Tax Identification Number (FEID#): \_\_\_\_\_
9. Name of designated Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
10. Florida Department of Health Pain Management Clinic Registration number: \_\_\_\_\_
11. Is the clinic fully owned by a licensed physician under Florida Statutes Ch. 458 or 459? Yes  No   
If no, a copy of the Health Care Clinic License issued by AHCA must be included with this application.
12. Are controlled substances dispensed at the clinic site? Yes  No
13. Are controlled substances prescribed at the clinic site? Yes  No

**SECTION B: CLINIC OWNER(S) INFORMATION:** (attach a separate sheet if necessary)

1. Full Legal Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Telephone Numbers: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_  
(Cellular) \_\_\_\_\_ (Facsimile) \_\_\_\_\_
4. Has the owner or operator of the clinic had a license or permit denied or revoked related to the ownership or management of a medical clinic that provided pain management services for chronic non-malignant pain in another jurisdiction? Yes  No

If Yes, provide the jurisdiction where the license was denied or revoked, the date when the license was denied or revoked and the clinic name on the line below.

\_\_\_\_\_

**SECTION C: PROPERTY OWNER(S) INFORMATION:** (attach a separate sheet if necessary)

1. Full Legal Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Telephone Numbers: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_  
(Cellular) \_\_\_\_\_ (Facsimile) \_\_\_\_\_

**SECTION D: DESIGNATED PHYSICIAN INFORMATION:**

1. Designated Physician (DP) Full Legal Name: \_\_\_\_\_
2. Physician's Mailing Address (if different from clinic): \_\_\_\_\_
3. Florida Medical License Number and license term: \_\_\_\_\_
4. Physician DEA Number: \_\_\_\_\_
5. List of all pain management clinics currently supervised by RP or where RP practices.

Name of Clinic and Address and Phone Number	Clinic Owner Name	Hours in Attendance

6. Do any other physicians practice or work at the clinic? Yes  No

If yes, complete Section G of this application for each additional physician.

**SECTION E: CLINIC EMPLOYEE INFORMATION:**

1. Have any of the persons associated with the management or operation of the clinic, whether paid or unpaid, part-time or full time, including but not limited to owners, operators, employees, physicians or volunteers, been arrested for an offense that constitutes a felony for receipt, possession, delivery, distribution, selling, manufacturing or purchasing of illicit drugs, including any controlled substance listed in Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V of Florida Statutes Section 893.03, or any other state, or the United States?

Yes  No

If yes, please provide additional information below.

<b>Name of Employee</b>	<b>Date of Arrest</b>	<b>Location of Alleged Crime (County, State)</b>	<b>Case Number</b>	<b>If finalized, the Result of Case (i.e., guilty, not guilty, adjudication withheld, dismissed, etc.)</b>

**SECTION F: PHYSICIAN INFORMATION**

2. Have any of the physicians or other licensed health care practitioners working at the clinic had any disciplinary action initiated against them at any time since their license was issued?

Yes  No

If yes, please provide additional information below.

<b>Name of Employee</b>	<b>Case Initiation Date</b>	<b>Location (City, State)</b>	<b>Case Number</b>	<b>Final Result (i.e., fine, suspension, educational courses, etc.)</b>

\* Information in Sections E and F must be updated within thirty (30) days after either (1) the arrest as described in Section E above of any person associated with the management or operation of the clinic or (2) receipt of disciplinary action as described in Section F above against any physician or other licensed health care practitioner.

**SECTION G: ADDITIONAL PHYSICIAN INFORMATION:**

1. Physician Full Legal Name: \_\_\_\_\_
2. Physician's Mailing Address: \_\_\_\_\_
3. Florida Medical License Number and license term: \_\_\_\_\_
4. Physician DEA Number: \_\_\_\_\_
5. List of all pain management clinics where physician currently practices.

Name of Clinic and Address and Phone Number	Clinic Owner Name	Hours in Attendance

1. Physician Full Legal Name: \_\_\_\_\_
2. Physician's Mailing Address: \_\_\_\_\_
3. Florida Medical License Number and license term: \_\_\_\_\_
4. Physician DEA Number: \_\_\_\_\_
5. List of all pain management clinics where physician currently practices.

Name of Clinic and Address and Phone Number	Clinic Owner Name	Hours in Attendance

**SECTION H: REQUIRED ATTACHMENTS:**

1. **A copy of the Pain Management Clinic license issued by the Florida Department of Health.**
2. **A copy of a current valid Hillsborough County business tax receipt required pursuant to Florida Statute Chapter 205.**
3. **Complete Section I: Clinic Employee List and provide a copy of a FL driver's license or government issued I.D. and a set of fingerprints for every employee. Responsible physician and owner must be included.**
4. **A floor plan of the clinic showing all areas, including the location of controlled substances.**
5. **A copy of property ownership records or the lease agreement, if the property is being leased.**
6. **Check or money order in the amount of \$1,500.00 payable to: Hillsborough County BOCC  
Send payment and completed application to:**

**Consumer Protection Agency  
1101 East 139<sup>th</sup> Avenue  
Tampa, FL 33613-3420**



**SECTION J: DESIGNATED PHYSICIAN AUTHORIZATION AND CERTIFICATION:**

Pursuant to Hillsborough County Ordinance 10-8E, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. I also understand and agree that I may be asked to provide additional information once my application has been reviewed as a requirement to the issuance of a clinic license. Once a license has been issued, I agree to provide any supplemental information that may be requested by the Consumer Protection Agency and to update Consumer Protection Agency within ten (10) days of any changes to the information in this application. I also understand that I have been appointed as the designated physician for the clinic on this application. I understand that, as designated physician, I am responsible for complying with all requirements related to registration and operation of the clinic as well as providing my DEA number to the Consumer Protection Agency. I understand that I must have a full, active and unencumbered license under Florida Statutes Chapters 456 or 459 and shall practice at the clinic location for which I have assumed responsibility.

**Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.**

\_\_\_\_\_  
Designated Physician Signature  
(before a notary)

\_\_\_\_\_  
Print Name

**Notary Certification:**

Sworn to (or affirmed) and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
\_\_\_\_\_, who is personally known to me or who has produced \_\_\_\_\_  
\_\_\_\_\_ as identification and did take an oath.

\_\_\_\_\_  
Notary Signature

Printed Notary Information:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_

Seal:

**SECTION K: CLINIC OWNER AUTHORIZATION AND CERTIFICATION:**

Pursuant to Hillsborough County Ordinance 10-8E, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. I also understand and agree that I may be asked to provide additional information once my application has been reviewed as a requirement to the issuance of a clinic license. Once a license has been issued, I agree to provide any supplemental information that may be requested by the Consumer Protection Agency and to update Consumer Protection Agency within ten (10) days of any changes to the information in this application.

**Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.**

\_\_\_\_\_  
Clinic Owner Signature (before a notary)

\_\_\_\_\_  
Print Name

**Notary Certification:**

Sworn to (or affirmed) and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
\_\_\_\_\_, who is personally known to me or who has produced \_\_\_\_\_  
\_\_\_\_\_ as identification and did take an oath.

\_\_\_\_\_  
Notary Signature

Printed Notary Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Seal: