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APPLICATION FOR PAIN MANAGEMENT CLINIC LICENSE

**Public Safety
Code Enforcement**
330 W. Church St.
P.O. Box 9005, Drawer CS03
Bartow, FL 33831-9005
(863)534-6054
Fax 863-534-6073

NOTE – You must complete all sections of this application. Any incomplete or illegible sections will delay processing and may cause the application to be returned or denied. It is recommended that you fully read the Polk County Pain Management Clinic Ordinance 10-068, prior to submitting this application. A copy of the ordinance can be found by accessing the Polk County Code Enforcement website at www.polkcounty.net/BuildingandCodes/. If you have any questions, you may also contact Code Enforcement at (863) 534-6054.

CLINIC OFFICE INFORMATION:

1. Corporate or Legal Name of Pain Clinic: _____

2. Fictitious Name or Doing Business As: _____

3. Clinic Physical Address: _____

4. Mailing Address: _____

5. Clinic Telephone Number: _____ Clinic Fax Number: _____

6. Clinic email address and website address: _____

7. Federal Tax Identification Number (FEID#): _____

8. Name of designated Contact Person: _____

Mailing Address: _____

Telephone Number: _____

9. Is this clinic required to be registered with the Florida Department of Health pursuant to Florida Statutes 458.309 or 459.005? Yes No

If yes, provide the registration number: _____

10. Are controlled substances dispensed at the clinic site? Yes No

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

1. Full Legal Name: _____

2. Address: _____

3. Telephone Numbers: (Home) _____ (Business) _____

(Cellular) _____ (Facsimile) _____

PROPERTY OWNER(S) INFORMATION: *(Attach a separate sheet if necessary)*

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

PHYSICIAN INFORMATION: – For each designated responsible physician *(Attach a separate sheet if necessary)*.

- 1. Responsible Physician (RP) 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. *(Attach a separate sheet if necessary)*.

Name: _____
Address: _____
Telephone: _____ Fax: _____
Clinic Owner Name: _____
Hours in Attendance: _____

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

If yes, provide the same information for each physician as you provided for the RP, above. *(Attach a separate sheet if necessary)*.

Name: _____
Address: _____
Telephone: _____ Fax: _____
Clinic Owner Name: _____
Hours in Attendance: _____

REQUIRED ATTACHMENTS:

1. Proof that the applicant has registered with the Florida Department of Health as required by Sec. 458.309 or 459.005, Fla. Stat., or any successor state law.
2. Proof of business operation prior to and through June 14, 2010, and a copy of a valid Polk County business tax receipt issued before June 15, 2010.
3. A list of all employees or individuals involved with the management or operation of the clinic, including their title, home address, telephone number, date of birth, a list of all criminal convictions whether misdemeanor or felony, a copy of their FL driver's license or government issued I.D., and a set of fingerprints for each person. Responsible physician and owner must be included.
4. A floor plan of the clinic showing all areas, including the location of controlled substances.
5. Check or money order in the amount of \$1,500.00 payable to: B.o.C.C. Send payments to: Code Enforcement, Drawer CS03 / PO Box 9005, Bartow, FL 33831-9005.

AUTHORIZATION AND CERTIFICATION:

Pursuant to Polk County Ordinance 10-068, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Polk 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 pre-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 Polk County Code Enforcement and to update Polk County Code Enforcement 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 and correct in all aspects and that no information has been withheld that may affect the review of this application or granting of a Pain Management Clinic license.

Applicant Name Printed

Applicant Signature

State of Florida
County of Polk

The foregoing instrument was acknowledged before me this _____ day of _____, 20____. By _____, as _____ (name of person) (type of authority,...e.g. officer, trustee, attorney in fact)

For _____ (name of party on behalf of whom instrument was executed)

_____ Personally known or _____ produced the following type of identification:_____

Notary _____ (Signature of Notary Public)