License Application
STROKE CENTER AFFIDAVIT

Name, address and contact information of hospital attesting by affidavit that the hospital meets the criteria to be a stroke center as specified in 59A-3.246(4)(b) Florida Administrative Code (F.A.C.).

Provider Information			
Name of Hospital:			License #:
Street Address:			Telephone Number:
City:	County:	State:	Zip:

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital meets the said criteria for a state recognized stroke center. Check applicable item(s) below:

☐ **Acute Stroke Ready Center**

☐ This facility meets the criteria as specified in 59A-3.246(4)(c), Florida Administrative Code.

☐ This facility is certified as an acute stroke ready center by a nationally recognized accrediting organization. A copy of the certificate is attached.

☐ **Primary Stroke Center**

☐ This facility meets the criteria as specified in 59A-3.246(4)(d), Florida Administrative Code.

☐ This facility is certified as a primary stroke center by a nationally recognized accrediting organization. A copy of the certificate is attached.

☐ **Comprehensive Stroke Center**

☐ This facility meets the criteria as specified in 59A-3.246(4)(e), Florida Administrative Code.

☐ This facility is certified as a comprehensive stroke center by a nationally recognized accrediting organization. A copy of the certificate is attached.

Hospital Chief Executive Officer (CEO)

Print Name: _____, who is a resident of

_____ County, State of _____,

Dated this _____ day of _____ (month), _____ (year)

Signature: _____

Hospital Chief Executive Officer (CEO)

Sworn to and subscribed before me, this _____day of _____.
(Month/Year)

This individual is personally known to me or produced the following identification:

_____

_____
Notary Public (Type or Print Name)

_____
Notary Public (Signature)

_____
My Commission Expires

Notary State Seal:

Return completed AHCA forms 3130-8001 and 3130-8009 to:

Agency for Health Care Administration
Hospital and Outpatient Services Unit, MS # 31
2727 Mahan Drive
Tallahassee, FL 32308