

Provider:
Test Forensic Tox

Provider Type:
Forensic Toxicology Laboratory

File#: 37980071
License #: 56
Expires: 10/30/2023

Logged in as : happyfeet20

Dashboard

OL Help

Documents

Logout

Provider/Facility Information

Under the authority of Chapter [408, Part II](#), Section [112.0455](#), and Section [440.102](#), Florida Statutes (F.S.), and Chapters [59A-35](#), [59A-24](#), Florida Administrative Code (F.A.C.), an application is hereby made to operate a Forensic Toxicology Laboratory as indicated below.

Pursuant to section [408.806\(1\)\(a\) and \(b\)](#), F.S., an application for licensure must include: the name, address and social security number of the applicant, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory. The Agency for Health Care Administration (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (<http://www.floridahealthfinder.gov>).

- **Provider Fax # cannot be blank. Please check None checkbox below the field.**
- **Provider Email cannot be blank. Please enter an email or check None checkbox below the field.**
- **Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.**
- **Provider Mailing Email cannot be blank. Please check None checkbox below the field.**

Provider/Facility Information

License #

Name of Forensic Toxicology Laboratory (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

Provider/Facility Location Address

Provider Location Address

2727 Mahan Dr
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone

Ext

Fax #

None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

None

Provider/Facility Website

None

Provider/Facility Mailing Address (All mail will be sent to this address.)

Check if same as Provider/Facility Location Address

Address

2727 Mahan Dr
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone

Ext

Email Address

None

= Entered
 = Entry Required

Provider/Facility Information

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Days and Hours of Operation

Accreditation / Certification

Proficiency Testing Provider Information

Specimen Type

Equipment

Collection Stations

Supporting Documents

Finalize Submission

Health Care Licensing Online
Application
Forensic Toxicology Laboratory
AHCA Form 3170-5001 OL,
August 2023
59A-35.060, Florida
Administrative Code

Provider/Facility Information

- *Contact first name must not be blank.*
- *Contact last name must not be blank.*
- *Phone number is incomplete.*
- *If there is no Fax # please check the None check box below it.*
- *If there is no Email address please check the None check box below it.*

Provider/Facility Contact Person for this Application

First Name	Middle Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone	Ext	Fax #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
		<input type="checkbox"/> None	
Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)			
<input type="text"/>			
<input type="checkbox"/> None			

Licensee Information

- Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.
- If Licensee does not have Fax number then please select the None check box below the field.

Description of Licensee (select only one option below) 

For Profit Not for Profit Public

Ownership Types

Individual 

Individual Licensee Details

Licensee Name

First Name


LOUIE

Middle Name

Last Name

DUCK

Suffix

Tax ID 

XXX-XX-3033

Type

SSN 

Mailing Address

[Edit Address](#)

Address

301 OAK ST
MELBOURNE, FL 32951-2035
US - United States
County - BREVARD

Telephone

(303) 030-3030

Ext

Fax #

() -

None

Email Address

None

Controlling Interests of Licensee

Changes have been saved.

Controlling Interests, as defined in section [408.803\(7\)](#), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter [651](#), F.S. To verify who must be screened, visit the [Background Screening](#) site.

Yes No

To **add** a controlling interest -

Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

To **edit** an existing controlling interest -

Select "Edit/View" and edit as needed.

To **remove** an existing controlling interest -

Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			<u>Full Name of Individual/Entity</u>	<u>Type</u>	<u>Tax ID</u>	<u>Effective Date</u>	<u>End Date</u>	<u>%</u>
Remove	Edit/View	(+)	LOUIE DUCK	SSN	XXX-XX-3033	9/1/2023		50.00
Remove	Edit/View	(+)	Sample Company	EIN	02-2020202	9/1/2023		50.00

Total 100.00

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

- *Select either Yes or No option.*

Does a company other than the licensee manage the licensed/registered provider?

Yes No

To **add** a management company -

Utilizing the picklist below, either select an entity that is already associated with this application or select 'New Management Company'.

		<u>Full Name of Entity</u>	<u>Tax ID</u>	<u>Effective Date</u>	<u>End Date</u>
<input type="button" value="Remove"/>	<input type="button" value="Edit/View"/>	(+) Sample Mgmt Co	04-0404040	9/1/2023	

Removed: Added:

Management Company Controlling Interest

Changes have been saved.

Controlling interests, as defined in section [408.803\(7\)](#), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter [651](#), F.S. To verify who must be screened, visit the [Background Screening](#) site.

To **add** a controlling interest -

Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

To **edit** an existing controlling interest -
Select "Edit/View" and edit as needed.

To **remove** an existing controlling interest -

Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			Full Name of Individual/Entity	Type	Tax ID	Effective Date	End Date	%
Remove	Edit/View	(+)	DEWEY DUCK	SSN	XXX-XX-3032	9/1/2023		40.00
Remove	Edit/View	(+)	Sample Company	EIN	02-2020202	9/1/2023		51.00

Total 91.00

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Sample reason

Personnel

Changes have been saved.

A. Provider/Facility Personnel

Personnel

Note: For the administrator, financial officer, director and co-director, if applicable, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit [Background Screening](#) site.

Provide the information for the individual(s) who perform the following roles:

- Co-Director
- Financial Officer
- Laboratory Director

To **add** an individual -

Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To **edit** an existing individual -

Select "Edit/View" and edit as needed.

To **remove** an existing individual -

Select "Remove" and enter the date the individual's relationship with the licensee ended.

		<u>Full Name of Individual</u>	<u>Type</u>	<u>Tax ID</u>	<u>Roles</u>	<u>Effective Date</u>	<u>End Date</u>
Remove	Edit/View	DEWEY DUCK	SSN	XXX-XX-3032	Financial Officer	09/01/2023	
Remove	Edit/View	HUEY DUCK	SSN	XXX-XX-3031	Laboratory Director	09/01/2023	
Remove	Edit/View	SCROOGE MCDUCK Sr	SSN	XXX-XX-4864	(+) Co-Director	09/01/2023	

Removed: (-) Added: (+)

Personnel

- *At least one Certifying Scientist must be listed*
- *At least one Certifying Scientist for Negative Test must be listed*
- *At least one Person Responsible for the day-to-day Supervision of Analysts must be listed*
- *At least one Technical Personnel Performing Toxicology Testing must be listed*

B. Additional Staff

Provide the requested information for individuals holding the following roles:

- CS – Certifying Scientist
- CSNT – Certifying Scientist for Negative Tests
- PRSA – Person Responsible for the day-to-day Supervision of Analysts
- TRPTT – Technical Personnel Performing Toxicology Testing

#	First Name	Last Name	Job Title	FL License / Registration Type	FL License / Registration #	FL License Level	Toxicology Experience (Years)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

[+ Add Rows](#)

Required Disclosure

- *Either Yes or No must be selected.*

Convictions

Pursuant to section [408.809](#), F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections [435.04](#) and [408.809\(4\)](#), F.S., for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section [408.809](#), F.S.?

Yes No

Select an individual from this list

	Full Name of Individual	Type	Tax ID
<input type="button" value="Remove"/>	<input type="button" value="Edit/View"/> (+) LOUIE DUCK	SSN	XXX-XX-3033

Required Disclosure

- *Either Yes or No must be selected.*

Exclusions

Pursuant to section [408.810\(2\)](#), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

Yes No

Select an individual/entity from this list

	Full Name of Individual	Type	Tax ID
<input type="button" value="Remove"/>	<input type="button" value="Edit/View"/> (+) Sample Mgmt Co	EIN	04-0404040

Required Disclosure

- *All questions related to Felonies/Terminations must be answered.*

Felonies/ Terminations

Pursuant to section [408.815\(4\)](#), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

1. Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter [409](#), chapter [817](#), chapter [893](#), [21 U.S.C. ss. 801-970](#), or [42 U.S.C. ss. 1395-1396](#), Medicaid fraud, Medicare fraud or insurance fraud, within the previous 15 years prior to the date of this application?

Yes No

2. Terminated for cause from the Medicare program or a state Medicaid program?

Yes No

If yes, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application?

Yes No

Days and Hours of Operation

- *Either select 24 hour checkbox or enter opening and closing times or select By Appointment option.*

List the regular operating hours. Section [59A-8.003\(9\)\(a\)](#), F.A.C., requires that an agency be open for 8 consecutive hours per day, Monday through Friday between the hours of 7:00 AM and 6:00 PM, excluding legal and religious holidays.

Note: Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine or denial of an application.

Indicate if the regular operating hours are 24 hours / 7 days a week. Otherwise, enter them below.

<u>Day</u>	<u>Opening Time</u>	<u>Closing Time</u>	<u>By Appointment</u>
MONDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FRIDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SATURDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SUNDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Accreditation / Certification

1. Is this laboratory SAMHSA (HHS) certified?

Yes No

If yes, provide the date of last SAMHSA (HHS) inspection.

In lieu of Agency inspection, submit a copy of the most recently completed SAMHSA (HHS) inspection report in the Supporting Documents section of this application.

2. Is this laboratory enrolled in CAP's forensic toxicology accreditation program?

Yes No

Note - Participation in a Proficiency Testing program is not equivalent to accreditation.

If yes, provide the date of last accreditation inspection.

In lieu of Agency inspection, submit a copy of the most recently completed CAP inspection report and proof of non-provisional accreditation for the current year in the Supporting Documents section of this application.

Proficiency Testing Provider Information

• *Select at least one option*

Select the option(s) that apply to this provider:

- SAMHSA(HHS)
 CAP(UDC)

Specimen Type

Select the option(s) that apply to this provider:

- Hair
 Urine
 Blood

Equipment

- *User must enter information in at least 1 row.*

List the major equipment/test systems used by the laboratory, and identify them as being used for initial screening/testing and/or confirmation purposes. Abbreviations are acceptable.

Note - Ancillary equipment such as centrifuges, shakers, rotators, computer equipment, etc., does not need to be included.

#	Equipment	Usage Type	
1	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
2	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
3	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
4	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
5	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
6	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
7	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
8	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
9	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
10	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
11	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
12	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
13	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
14	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation
15	<input type="text"/>	<input type="checkbox"/> Initial Screening/Testing	<input type="checkbox"/> Confirmation

[+ Add Rows](#)

Collection Stations

- *At least one collection station must be added*

List all locations in Florida for which the laboratory accepts drug free workplace specimens.

To **add** a collection station, select 'Add Location'.

		Facility Name	Street Address
<input type="button" value="Remove"/>	<input type="button" value="Edit/View"/>	(+) Sample Location	2726 MAHAN DR, TALLAHASSEE, LEON, FL 32308

Removed: Added:

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters [408 Part II](#) and Sections [112.0455](#) and [440.102](#), Florida Statutes (F.S.) and Chapters [59A-35](#) and [59A-24](#), Florida Administrative Code (F.A.C)

The following file types are suggested for uploading and submitting electronic documents to the Agency:
.DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are **NOT** permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS.
The upload and submission process will fail if any of these unpermitted file types are selected.

Laboratory Director Qualification Documentation

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Accreditation Documentation

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

SAMHSA (HHS) Inspection Report

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Approved Repayment Plan

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Additional Documentation

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

- An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below, or from the Applications Components list to the left, and provide the missing information.

- | | |
|--|--|
| <input type="radio"/> 1. Provider/Facility Information
a. Details
b. Contact Person | <input type="radio"/> 7. Days and Hours of Operation
a. Days and Hours of Operation |
| <input checked="" type="radio"/> 2. Licensee Information
a. Licensee Details | <input checked="" type="radio"/> 8. Accreditation / Certification
a. Accreditation / Certification |
| <input type="radio"/> 3. Controlling Interests
a. Controlling Interests | <input type="radio"/> 9. Proficiency Testing Provider Information
a. Proficiency Testing Provider Information |
| <input type="radio"/> 4. Management Company Information
a. Management Company Information
b. Management Company Controlling Interest | <input checked="" type="radio"/> 10. Specimen Type
a. Specimen Type |
| <input type="radio"/> 5. Personnel
a. Administration
b. Additional Staff | <input type="radio"/> 11. Equipment
a. FTL Equipment |
| <input type="radio"/> 6. Required Disclosure
a. Convictions
b. Exclusions
c. Felonies/Terminations | <input checked="" type="radio"/> 12. Collection Stations
a. FTL Collection Stations |
| | <input checked="" type="radio"/> 13. Supporting Documents
a. Supporting Documents |

I **MANDI MANZIE**, attest as follows:

- (1) Pursuant to section [837.06](#), Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.
- (2) Pursuant to section [408.815](#), Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.
- (3) Pursuant to section [408.806](#), Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter [435](#), Florida Statutes.
- (4) Pursuant to section [408.809](#) and [435.05](#), Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter [408, Part II](#) and Chapter [435](#), Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.
- (5) Pursuant to section [435.05](#), Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter [408, Part II](#) or Chapter [435](#), Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.
- (6) Pursuant to section [408.810\(12\)](#), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure, who has a disqualifying offense pursuant to section [408.809](#), Florida Statutes or in a provider that had a license revoked or application denied pursuant to section [408.815](#), Florida Statutes.
- (7) Pursuant to sections [408.810\(14\)](#) and [408.051\(3\)](#), Florida Statutes, the licensee ensures that all patient information stored in an offsite physical or virtual environment, including through a third-party or subcontracted computing facility or an entity providing cloud computing services, is physically maintained in the continental United States or its territories or Canada.
- (8) Pursuant to section [408.810\(15\)](#), Florida Statutes, the licensee ensures that controlling interests of the licensee do not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to section [287.135](#), Florida Statutes.

MANDI MANZIE

09/21/2023

Signature of Licensee or Authorized Representative

Title

Date

I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is \$16,435
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

Selecting the 'Submit Application' you will no longer be able to make changes to your application.