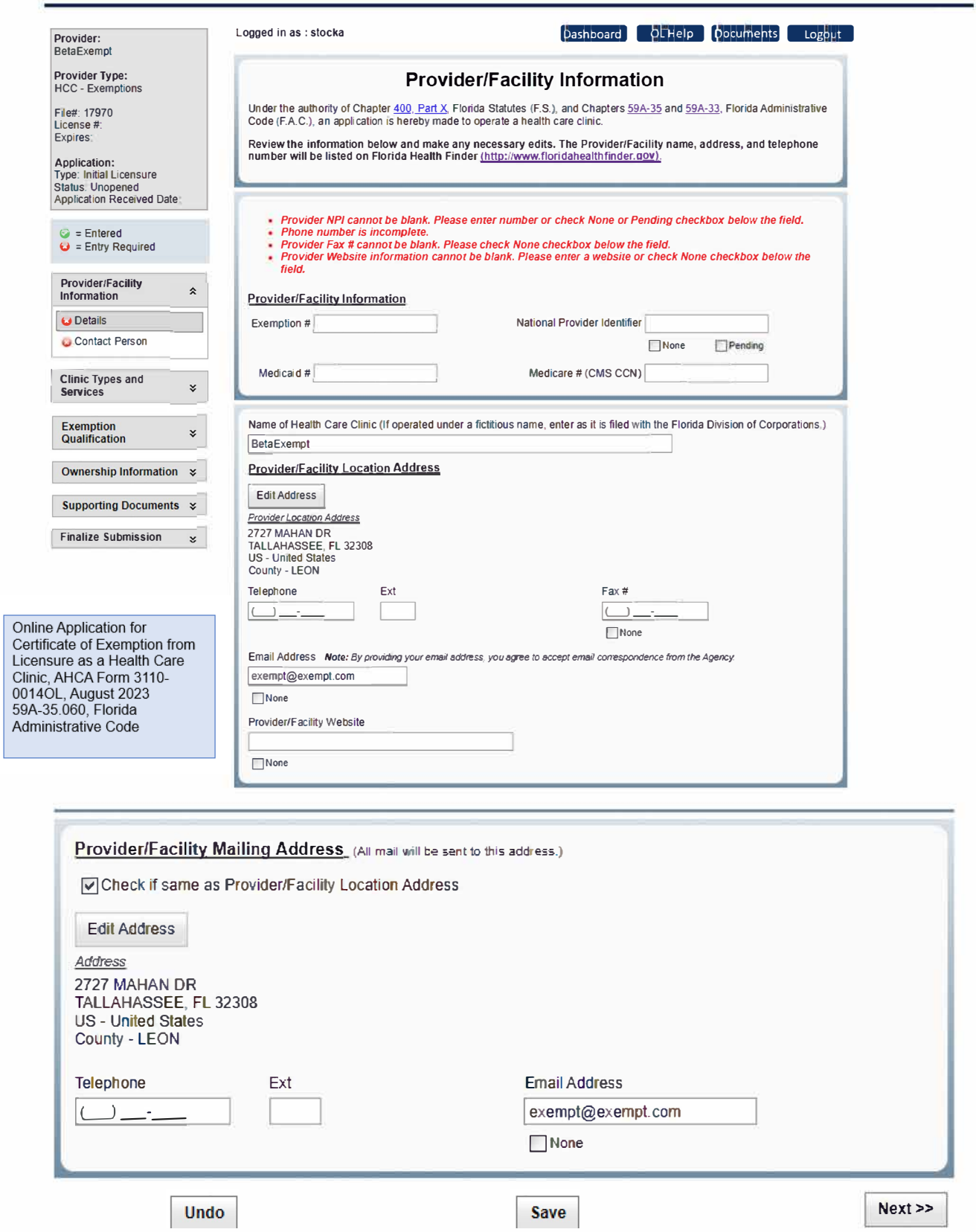
Provider:
BetaExempt
Provider Type:
HCC - Exemptions
File#: 17970
License #:
Expires:
Application:
Type: Initial Licensure
Status: Unopened
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Details
Contact Person
Clinic Types and Services
Exemption Qualification
Ownership Information
Supporting Documents
Finalize Submission
Logged in as : stocka
Dashboard
OL Help
Documents
Logout
Provider/Facility Information
Under the authority of Chapter 400, Part X, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-33, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care clinic.
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 NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.
Phone number is incomplete.
Provider Fax # cannot be blank. Please check None checkbox below the field.
Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.
Provider/Facility Information
Exemption #
National Provider Identifier
None
Pending
Medicaid #
Medicare # (CMS CCN)
Name of Health Care Clinic (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)
BetaExempt
Provider/Facility Location Address
Edit 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
exempt@exempt.com
None
Provider/Facility Website
None
Online Application for Certificate of Exemption from Licensure as a Health Care Clinic, AHCA Form 3110-0014OL, August 2023 59A-35.060, Florida Administrative Code
Provider/Facility Mailing Address (All mail will be sent to this address.)
Check if same as Provider/Facility Location Address
Edit Address
Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON
Telephone
Ext
Email Address
exempt@exempt.com
None
Undo
Save
Next >>

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

Telephone (___) ___-____ | Ext | Fax # (___) ___-____

☐ None

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

☐ None

Undo | Save | << Back | Next >>

Clinic Types

- *Select at least one Reimbursement.*
- *Select at least one Designation.*

Reimbursements

Check all that apply:

- [ ] Medicare and/or Medicaid
- [ ] Commercial Insurance Plans (HMO, PPO, EPO, etc.)
- [ ] Automobile Personal Injury Protection (PIP) Insurance
- [ ] Individuals pay for services by cash, check, credit card, or debit card
- [ ] Other payer source not listed above
- [ ] None apply

Designations

Check all that apply:

- [ ] Urgent Care Center [Refer to definition in section 395.002, F.S.]
- [ ] Pain Management Clinic [Refer to sections 458.3265 and 459.0137, F.S.]
- [ ] Office Surgery Center [Refer to sections 458.328 and 459.0138, F.S.]
- [ ] None apply

Undo | Save | << Back | Next >>

Service Providers Employed By/Contracting With the Clinic

- *At least one service provider must be selected*

Service Provider

- [ ] Acupuncturist
- [ ] Advanced Practice Registered Nurse
- [ ] Athletic Trainer
- [ ] Audiologist
- [ ] Autonomous APRN
- [ ] Behavior Analyst (BACB certified)
- [ ] Certified Nursing Assistant
- [ ] Chiropractic Physician
- [ ] Clinical Laboratory Personnel
- [ ] Clinical Social Worker
- [ ] Dentist
- [ ] Dietitian/Nutritionist/Nutrition Counselor
- [ ] Electrologist
- [ ] Hearing Aid Specialist
- [ ] Licensed Practical Nurse
- [ ] Marriage & Family Therapist
- [ ] Massage Therapist
- [ ] Mental Health Counselor
- [ ] Midwife
- [ ] Naturopathic Physician
- [ ] Occupational Therapist
- [ ] Optician
- [ ] Optometrist
- [ ] Orthotist/Prosthetist/Pedorthist
- [ ] Pharmacist
- [ ] Physical Therapist
- [ ] Physician
- [ ] Physician Assistant
- [ ] Podiatric Physician
- [ ] Psychologist/School Psychologist
- [ ] Radiological Personnel
- [ ] Registered Nurse
- [ ] Respiratory Therapist
- [ ] Speech-Language Pathologist

- [ ] Other 1
- [ ] Other 2

Undo | Save | << Back | Next >>

Qualifications for Exemption from Clinic Licensure

Select the exemption type you are seeking for your facility.

Note: Documentation specific to the selected exemption is required and must be submitted with the application. Lack of documentation will deem your application incomplete.

- *An Exemption Qualification must be selected.*

◯ A. Entities licensed or registered by the state as defined in section 400.9905(4)(a), F.S.

◯ B. Entities that own, directly or indirectly, entities that are licensed or registered by the state as defined in section 400.9905(4)(b), F.S.

◯ C. Entities that are owned, directly or indirectly, by an entity licensed or registered by the state as defined in section 400.9905(4)(c), F.S.

◯ D. Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state as defined in section 400.9905(4)(d), F.S.

◯ E. An entity that is exempt from federal taxation under 26 U.S.C. section 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. section 409 that has a board of trustees at least two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof. (health departments, clinics and federal health care facilities). [section 400.9905(4)(e), F.S.]

◯ F. A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by section 627.419, F.S., that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician. [section 400.9905(4)(f), F.S.]

◯ G. A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or section 464.012, F.S., and that is wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in section 456.053(3)(b), F.S. which provides only services authorized pursuant to section 456.053(3)(b), F.S. may be supervised by a licensee specified in section 456.053(3)(b), F.S. [section 400.9905(4)(g), F.S.]

◯ H. Clinical facilities affiliated with an accredited medical school as defined in section 400.9905(4)(h), F.S.

◯ I. Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459, F.S. or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459, F.S. which are owned by a corporation whose shares are publicly traded on a recognized stock exchange. [section 400.9905(4)(i), F.S.]

◯ J. Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education as defined in section 400.9905 (4)(j), F.S.

◯ K. Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services as defined in section 400.9905 (4)(k), F.S.

◯ L. Orthotic, prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt under paragraph (a) or paragraph (k) and that are a publicly traded corporation or are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange. [section 400.9905 (4)(l), F.S.]

◯ M. Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners and supervised by Florida health care practitioner as defined in section 400.9905 (4)(m), F.S.

◯ N. Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459, F.S. where the billing for medical services is under a single tax identification number as defined in section 400.9905 (4)(n), F.S. The entity and the health care clinics owned or operated by the entity has not received payment for health care services under personal injury protection insurance coverage for the preceding year.

◯ O. Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in section. 628.703, F.S., with an entity issued a certificate of authority under chapter 624 or chapter 641 which has $1 billion or more in total annual sales in this state. [section 400.9905(4)(o), F.S.]

◯ P. Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part. [section 400.9905(4)(p), F.S.]

◯ Q. Entities that are Medicaid providers. [section 400.9905(4)(q), F.S.]

Supervisor Practitioner

Please provide the requested information for the individual who be the supervising practitioner pursuant to sections 400.9905(4)(f), (g), (m), (p), F.S.

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

Undo | Save | << Back | Next >>

Owner Information

- *Individual information is incomplete*
- *Phone number is incomplete.*
- *Owner Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *If Owner does not have Fax number then please select the None check box below the field.*
- *Owner mailing address line 1 must not be blank. Owner mailing address city must not be blank. Owner mailing address zip must not be blank.*

Description of owner (select only one option below)

(•) For Profit ( ) Not for Profit ( ) Public

Ownership Types

Individual

Individual Licensee Details

Licensee Name

First Name | Middle Name | Last Name | Suffix

Tax ID | Type

Mailing Address

Edit Address

Address

Telephone | Ext | Fax # | Email Address

(___) ___-____ | | (___) ___-____ |

[ ] None | [ ] None

Undo | Save | << Back | Next >>

Ownership Interests

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add Controlling Interests. Select 'Next' to proceed.*

To **add** a ownership interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Ownership Interest - Individual' or 'New Ownership Interest - Entity' .

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

Undo | Save | << Back | Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapter 400, Part X F.S. and Chapters 59A-35 and 59A-33, 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.

- ***Please select an 'Exemption Type' to see which Supporting Documents are required for your application submission.***

Required for all exemptions : Documentation of schedule of charges of the medical services offered to patients

☐ 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.

Browse...

Required for exemptions A - D : Copy of the qualifying facility license, registration, or certification

☐ 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.

Browse...

Required for exemptions B - D : Ownership documents or a diagram or organizational chart showing the parent, subsidiary, or common ownership, which qualifies the entity for the exemption

☐ 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.

Browse...

Required for exemption E, if applicable : Copy of the I.R.S. letter granting the tax exemption

☐ 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.

Browse...

Required for exemption E, if applicable : A letter describing the ownership structure, listing the Florida practitioner names, their Florida license, and indicating if the facility provides physical therapy services under physician orders

☐ 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.

Browse...

Required for exemption E, if applicable : A letter on official letterhead and signed by an authorized representative of the university or community college confirming that the entity is applying for an exemption

☐ 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.

Browse...

Required for exemption E, if applicable : A letter on official letterhead and signed by an authorized representative of a federal or state government office confirming that the entity is applying for an exemption

☐ 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.

Browse...

Required for exemptions F - G : Copy of the health care practitioner(s) license(s) from the Florida Department of Health and any other specialty certifications necessary for supervision of the services provided

☐ 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.

Browse...

Required for exemptions F – G, if applicable : Documentation demonstrating the relationship between the licensed practitioner owner and the family member(s) owner [i.e. copy of birth certificate, marriage certificate]

☐ 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.

Browse...

Required for exemptions F - G : Documentation confirming the ownership of the entity

☐ 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.

Browse...

Required for exemption H : A letter on official letterhead and signed by an authorized representative of the medical school, confirming that training for medical students, residents or fellows is provided at this facility

☐ 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.

Browse...

Required for exemption I : A letter on official letterhead and signed by an authorized representative of the facility attesting that the facility provides only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459, F.S.

☐ 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.

Browse...

Required for exemption I, if applicable : Documentation demonstrating that the entity is owned by a corporation whose shares are publicly traded on a recognized stock exchange

☐ 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.

Browse...

Required for exemption J : A letter on official letterhead and signed by an authorized representative of the college of chiropractic medicine attesting that the facility is affiliated with the college and confirming that training is provided for chiropractic students

☐ 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.

Browse...

Required for exemption J : Documentation demonstrating that the college is accredited by the Council on Chiropractic Education

☐ 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.

Browse...

Required for exemption K : Provide a list of locations, licensed under chapter 395, F.S., where the entity provides licensed practitioners to staff emergency departments or to deliver anesthesia services

☐ 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.

Browse...

Required for exemption K : Documentation demonstrating that the entity derives at least 90 percent of their gross annual revenues from the provision of such services

☐ 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.

Browse...

Required for exemption L : Documentation demonstrating that the entity is a publicly traded corporation or is wholly owned, directly or indirectly, by a publicly traded corporation

☐ 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.

Browse...

Required for exemption M : Documentation showing that the corporation has $250 million or more in total annual sales of health care services provided by licensed health care practitioners

☐ 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.

Browse...

Required for exemption M : A copy of the contract or agreement between the entity and the supervising health care practitioner accepting responsibility for supervising the business activities of the entity and for the entity's compliance with state law for purposes of this part

☐ 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.

Browse...

Required for exemption M : A copy of health care practitioner supervisor's license from the Florida Department of Health

☐ 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.

Browse...

Required for exemption N : A complete list of the names and contact information of all officers and directors of the corporation

☐ 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.

Browse...

Required for exemption N : The name, residence address, business address, and medical license number of each licensed Florida health care practitioner employed by the entity

☐ 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.

Browse...

Required for exemption N : A listing of health care services to be provided by the entity at the clinics owned or operated by the entity

☐ 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.

Browse...

Required for exemption N : A certified statement prepared by an independent certified public accountant, which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services under personal injury protection insurance coverage for the preceding year

☐ 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.

Browse...

Required for exemption O : Name and FEIN of the related mutual insurance holding company

☐ 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.

Browse...

Required for exemption O : Copy of the certificate of authority issued under chapter 624 or 641, F.S. to the related entity

☐ 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.

Browse...

Required for exemption O : Documentation showing the entity, which was issued the certificate of authority, has $1 billion or more in total annual sales in this state

☐ 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.

Browse...

Required for exemption O : Ownership documents or a diagram or organizational chart demonstrating the common ownership which qualifies the applicant entity for the exemption

☐ 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.

Browse...

Required for exemption O : Ownership documents or a diagram or organizational chart demonstrating the common ownership which qualifies the applicant entity for the exemption

☐ 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.

Browse...

Required for exemption P : Documentation demonstrating the parent entity provides behavioral health care services in at least five other states and, together with its affiliates, has $90 million or more in total annual revenues associated with the provision of behavioral health care services

☐ 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.

Browse...

Required for exemption P : Ownership documents or a diagram or organizational chart showing the direct or indirect ownership which qualifies the entity for the exemption

☐ 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.

Browse...

Required for exemption Q : Copy of the entity's original Medicaid enrollment letter (the applicant must be a currently active Medicaid provider and the name, street address and FEIN provided on the application must match the current information in the Medicaid data base, FLMMIS)

☐ 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.

Browse...

Undo | Save | << Back | Next >>

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.

1. Provider/Facility Information
   a. *Details*
   b. *Contact Person*

2. Clinic Types and Services
   a. *Clinic Types*
   b. *Service Providers*

3. Exemption Qualification
   a. *Exemption Qualification*
   b. Supervisor Practitioner

4. Ownership Information
   a. *Owner Information*
   b. Ownership Interests

5. Supporting Documents
   a. *Supporting Documents*

I **ANGEL STOCK**, 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.

ANGEL STOCK	**ANALYST**	**09/22/2023**
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree

Amounts Due Upon Submission of Application

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

Submit Application