AFFIDAVIT OF PAIN CLINIC PHYSICIAN

BEFORE ME, the undersigned authority personally appeared _____,
(Name of Physician)

who after being duly sworn states as follows:

1. I am employed by / contracted by _____,
(Name of Pain Management Clinic)

Located at: _____.
(*Street Address)* *(City)* *(Zip Code)*

2. I have a full, active and unencumbered medical license under Florida Statutes Chapter 456 or 459 and I shall practice at the clinic location identified above

3. I have never had any disciplinary action taken against me by the Florida Department of Health, or by any medical licensing agency in any jurisdiction.

3. I have an active Drug Enforcement Administration (DEA) registration, and I have never had a DEA number revoked.

4. I have never had a license to prescribe, dispense, or administer a controlled substance denied by any jurisdiction.

6. I have never been convicted of or plead guilty or no contendere to (regardless of adjudication) an offense that constitutes a felony for receipt of illicit and diverted drugs, including a controlled substance listed in Schedule I, Schedule II, Schedule III, Schedule IV or Schedule V of Section 893.03 of the Florida Statutes, or of any state or the United States.

7. I agree to immediately inform the Miami-Dade County, Consumer Protection Division should I cease to be affiliated with the clinic, or if I no longer practice at this clinic location.

FURTHER AFFIANT SAYETH NAUGHT.

_____
Affiant,

STATE OF FLORIDA)
) SS
COUNTY OF MIAMI-DADE)

BEFORE ME, an officer duly authorized to take acknowledgments in the State of Florida, personally appeared

_____ who acknowledged before me that he/she executed the foregoing instrument for

the purposes therein stated on this _____ day of _____, 20__.

_____
Signature of Notary Public

_____
Print, Type, or Stamp Commissioned Name
of Notary Public

My Commission Expires:

Personally Known_____ OR Produced Identification_____
Type of Identification Produced_____