Department of Regulatory and Economic Resources
Business Affairs Division
Office of Consumer Protection
601 NW 1st Court, 18th Floor
Miami, Florida 33136

Tel: 786-469-2300 ☏ Fax: 786-469-2311 ☏ email: license@miamidade.gov

NEW/RENEWAL APPLICATION FOR PAIN MANAGEMENT CLINIC REGISTRATION

Legal Name of Pain Clinic: _____

Check one of the following: ☐ Corporation ☐ Partnership ☐ LLC ☐ Sole Proprietor ☐ Fictitious Name ☐ Other _____

Clinic Physical Address: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____ website address _____

Name of designated Contact Person: _____

Contact Phone Number: _____ **Contact Email** _____

Florida Department of Health Pain Management Clinic Registration number: _____

Federal Tax Identification Number (FEID#): _____

Yes ☐ **No** ☐ The clinic is fully owned by a duly licensed medical or osteopathic physician or group of medical or osteopathic physicians, or is licensed as a health care clinic under Part X of Chapter 400 of Florida Statutes. License # _____

Yes ☐ **No** ☐ Controlled substances are dispensed at the clinic site

Yes ☐ **No** ☐ Controlled substances are prescribed at the clinic site

DESIGNATED PHYSICIAN INFORMATION:

NOTE: A Designated Physician is responsible for complying with all requirements related to registration and operation of the clinic. This Designated Physician must have a clear and active license under Chapter 458 (medical) of Florida Statutes or under Chapter 459 (osteopathic) of Florida Statutes, and active DEA registration; and shall practice at this clinic location. If this physician ceases to be affiliated with the clinic, you must inform Consumer Protection that another physician has been so designated within ten (10) days.

Designated Physician (DP) Full Legal Name: _____

Physician's Mailing Address (if different from clinic): _____

Florida Medical License Number and license term: _____

Physician DEA Number: _____ **ONLY** Last four numbers of Social Security: ☐☐☐☐

Hours in Attendance at Clinic _____

Check one: ☐ Employee of the Clinic ☐ Under contract with the Clinic

Has this physician had any disciplinary action initiated against them by the Department of Health? **Yes** ☐ **No** ☐
If yes, please provide additional information below.

Name	Case Initiation Date	Location	Case Number	Final Result

❖ **This individual must complete and submit the Designated Physician Affidavit (attached)**

ADDITIONAL PHYSICIAN INFORMATION: **(if more than 2 physicians, photocopy this page to continue to add more)**

List all physicians that are employed by or have a contractual relationship with the clinic, or otherwise see patients at the clinic.

Physician's Full Legal Name: _____

Address: _____

Phone Numbers: (Home) _____ (Business) _____ (Cellular) _____

Florida Medical License Number and license term: _____

Physician DEA Number: _____ 6. **ONLY** Last four numbers of Social Security: ☐☐☐☐

Hours in Attendance at Clinic _____

Check one: ☐ Employee of the Clinic ☐ Under contract with the Clinic

Has this physician had any disciplinary action initiated against them by the Department of Health? **Yes** ☐ **No** ☐
If yes, please provide additional information below.

Name	Case Initiation Date	Location	Case Number	Final Result

❖ **This individual must complete and submit the Physician Affidavit (attached)**

Physician's Full Legal Name: _____

Address: _____

Phone Numbers: (Home) _____ (Business) _____ (Cellular) _____

Florida Medical License Number and license term: _____

Physician DEA Number: _____ 6. **ONLY** Last four numbers of Social Security: ☐☐☐☐

Hours in Attendance at Clinic _____

Check one: ☐ Employee of the Clinic ☐ Under contract with the Clinic

Has this physician had any disciplinary action initiated against them by the Department of Health? **Yes** ☐ **No** ☐
If yes, please provide additional information below.

Name	Case Initiation Date	Location	Case Number	Final Result

❖ **This individual must complete and submit the Physician Affidavit (attached)**

Clinic Employee List **(photocopy this page to add additional employees)**

Employee Name	Employee Title	Date of Birth	Home Address	Telephone Number

CLINIC OWNER(S) INFORMATION: **(if more than 1 owner, photocopy this page to continue to add more)**

Owner's Full Legal Name: _____
(Including date of birth and last four numbers of Social Security for each owner or corporate officer).

Date of birth: _____ Last four numbers of Social Security:_____

Address: _____

Phone Numbers: (Home) _____ (Business) _____ (Cellular) _____

Florida Medical License Number and license term: _____

Physician DEA Number: _____

Yes ☐ **No** ☐ I have had a license or permit denied, suspended or revoked related to the ownership or management of a medical clinic that provided pain management services in another jurisdiction. ***If yes, provide details on separate sheet***.

Yes ☐ **No** ☐ I have had a Drug Enforcement Administration number revoked. ***If yes, provide details on separate sheet***.

Yes ☐ **No** ☐ I have had a license to prescribe, dispense, or administer a controlled substance denied by this or another jurisdiction. ***If yes, provide details on separate sheet***.

Yes ☐ **No** ☐ I have been convicted of or plead guilty or nolo 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 Florida Statutes, or of any State or the United States. ***If yes, provide details on separate sheet***.

Have you had any disciplinary action initiated against you by the Department of Health? **Yes** ☐ **No** ☐
If yes, please provide additional information below.

Name	Case Initiation Date	Location	Case Number	Final Result

Do you have an ownership interest(s) in a pharmacy(s) and/or other pain clinic(s*).* **Yes** ☐ **No** ☐
If yes, please provide additional information below.

Name of Pharmacy or Clinic	Address	% Ownership

- **Complete and submit the Attestation on the following page**

CLINIC OWNER ATTESTATION: *(Each owner must complete a separate attestation)*

I, _____, the undersigned, under penalties of perjury, declare that I have read the foregoing application and verify that the facts stated in it are true and complete. I will abide by the provisions of the Code of Miami-Dade County and all other applicable laws. I acknowledge that omissions or false statements will be grounds for suspension, revocation or non-issuance of a Pain Clinic Registration.

I hereby declare that the Pain Clinic identified in this application is in good standing with the State of Florida, Department of Health (DOH), and has not received notification of a pending investigation by the Department of Health. Furthermore, I hereby declare that this Pain Clinic has not received a probable cause finding as a result of a DOH investigation, that this Pain Clinic's DOH registration is not currently suspended, and that this Pain Clinic has not received notice of any deficiencies from its most recent DOH inspection.

I authorize any law enforcement, code enforcement Officer or any other person authorized to enforce ordinance violations in Miami Dade County, access to this clinic at any reasonable time without prior notice, to determine proof of registration and/or compliance with local, state or federal law. I understand that civil penalties may be imposed for violations of the provisions of the Miami-Dade County Code.

I agree to authorize Miami-Dade County to conduct a criminal background check. I also understand and agree that I may be asked to provide additional information once my application has been reviewed as a 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, and to update Miami-Dade County within ten (10) days of any changes to the information in this application.

_____ _____

Clinic Owner Signature (before a notary)

Print Name

Notary Certification:

Sworn to (or affirmed) and subscribed before me this _____day of _____, 20___, by_____, who is personally known to me or who has produced _____ as identification and did take an oath.

_____

Notary Signature

Print Notary Information:

Name: _____

Address: _____

City/State/Zip: _____

Pain Clinic Requirements:

1. **Signed, completed application.**
2. A copy of the Pain Management Clinic license issued by the Florida Department of Health.
3. **A copy of a current valid Miami-Dade County local business tax receipt.**
4. **A copy of a current valid local Municipal business tax receipt (unless located in Unincorporated Miami-Dade County.**
5. A copy of the Certificate of Occupancy issued by Miami-Dade County, or Municipality in which the clinic is located.
6. A copy of a FL driver's license or government issued I.D. for each owner and each physician identified in the application.
7. **A copy of each physician's active State of Florida medical license.**
8. A sworn and notarized Owner Attestation for each owner.
9. A sworn and notarized Designated Physician Affidavit (form attached).
10. A sworn and notarized Physician Affidavit (form attached), for each physician identified in the application (who has not completed a Designated Physician affidavit).
11. A floor plan of the clinic showing all areas, including the location of controlled substances.
12. **A copy of property ownership records or the lease agreement, if the property is being leased.**
13. Reminder: All fees are non-refundable.
14. Check or money order for the registration fee in the amount of **$370.00**, plus an additional **$25.00** for each owner and physician background check payable to: **MIAMI-DADE COUNTY-CP**
15. **For renewal registrations: Please enclose #1,3,4,7,and 12, along with your payment #14.**

All initial registrations must be presented in person at:

Department of Regulatory and Economic Resources
Business Affairs
Consumer Protection
601 NW 1st Court, 18th Floor
Miami, FL 33136