miamidade.gov

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 PERSONAL INJURY PROTECTION MEDICAL PROVIDER

1. Legal Name of Provider: ______________________________

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

2. Physical Address: ______________________________

3. Mailing Address: ______________________________

4. Phone Number: ______________ Fax Number: ______________ website address ______________________

5. Name of designated Contact Person: ______________________________Title: ______________

6. Contact Phone Number: ______________________ **Contact Email** ______________________

7. Property Owner: ______________________________

8. Property Owner Address: ______________________________ Phone Number: ______________

9. Florida Department of Health or Florida Agency for Health Care Administration Registration number: ______________

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

DESIGNATED PHYSICIAN INFORMATION: This individual must complete and submit the Designated Physician Affidavit (attached)

NOTE: A Designated Physician is responsible for complying with all requirements related to registration and operation of the PIP Medical Provider. This Designated Physician must have a clear and active license under Chapter 458, 459, 460 or 466, Florida Statutes. If this physician ceases to be affiliated with the PIP Medical Provider, you must inform the Consumer Protection Division that another physician has been so designated within fifteen (15) days.

1. Designated Physician (DP) Full Legal Name: ___ ______________________________

2. Physician's Mailing Address (if different from clinic): ______________________________

3. Florida Medical License Number and license term: ______________________________

4. Physician DEA Number: ______________________________

5. Hours in Attendance at the Provider ______________________________

6. **Check one:** ☐ Employee of the Clinic ☐ Under contract with the Clinic

7. 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

List of All Owners and Other Persons Associated with the Provider **(photocopy this sheet to add additional persons)**

(provide a photocopy of a current Florida driver license for each person listed below)

Name	Title	Date of Birth	Home Address	Telephone Number

1. Is this person an owner or shareholder? **Yes** ☐ **No** ☐
   If yes, please provide the percentage of ownership: _______________%

2. Is this person licensed by the Florida Department of Health, Agency for Healthcare Administration or another agency? **Yes** ☐ **No** ☐
   If yes, please provide a copy of the person's license. License #: ______________________________

3. Has this person ever been convicted, plead guilty or nolo contendere of a criminal misdemeanor or felony? **Yes** ☐ **No** ☐
   If yes, please provide a listing of each misdemeanor and/or felony, along with location and date of conviction/plea.

Name	Title	Date of Birth	Home Address	Telephone Number

1. Is this person an owner or shareholder? **Yes** ☐ **No** ☐
   If yes, please provide the percentage of ownership: _______________%

2. Is this person licensed by the Florida Department of Health, Agency for Healthcare Administration or another agency? **Yes** ☐ **No** ☐
   If yes, please provide a copy of the person's license. License #: ______________________________

3. Has this person ever been convicted, plead guilty or nolo contendere of a criminal misdemeanor or felony? **Yes** ☐ **No** ☐
   If yes, please provide a listing of each misdemeanor and/or felony, along with location and date of conviction/plea.

Name	Title	Date of Birth	Home Address	Telephone Number

1. Is this person an owner or shareholder? **Yes** ☐ **No** ☐
   If yes, please provide the percentage of ownership: _______________%

2. Is this person licensed by the Florida Department of Health, Agency for Healthcare Administration or another agency? **Yes** ☐ **No** ☐
   If yes, please provide a copy of the person's license. License #: ______________________________

3. Has this person ever been convicted, plead guilty or nolo contendere of a criminal misdemeanor or felony? **Yes** ☐ **No** ☐
   If yes, please provide a listing of each misdemeanor and/or felony, along with location and date of conviction/plea.

Name	Title	Date of Birth	Home Address	Telephone Number

1. Is this person an owner or shareholder? **Yes** ☐ **No** ☐
   If yes, please provide the percentage of ownership: _______________%

2. Is this person licensed by the Florida Department of Health, Agency for Healthcare Administration or another agency? **Yes** ☐ **No** ☐
   If yes, please provide a copy of the person's license. License #: ______________________________

3. Has this person ever been convicted, plead guilty or nolo contendere of a criminal misdemeanor or felony? **Yes** ☐ **No** ☐
   If yes, please provide a listing of each misdemeanor and/or felony, along with location and date of conviction/plea.

Clinic Name: ____

CLINIC OWNER AFFIDAVIT: *(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 Personal Injury Protection Medical Provider Registration.

I authorize any law enforcement, code enforcement officer or any other person authorized to enforce ordinance violations in Miami Dade County, access to this facility 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 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 Personal Injury Protection Medical Provider Registration. Once a registration has been issued, I agree to provide any supplemental information that may be requested, and to update Miami-Dade County within fifteen (15) days of any changes to the information in this application.

______________________________ ______________________________

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: _________________________

Clinic Name: ____

DESIGNATED PHYSICIAN AFFIDAVIT:

I, ______________________________________, the undersigned, under penalties of perjury, declare that I have read the foregoing application and verify that the information relating to the Designated Physician 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 Personal Injury Protection Medical Provider Registration.

I hereby declare that as the Designated Physician I understand that I am responsible for complying with all requirements related to registration and operation of the Personal Injury Protection Medical Provider. I currently possess a clear and active license under Chapter 458, 459, 460 or 466, Florida Statutes. Should I ceases to be affiliated with this Personal Injury Protection Medical Provider, I will inform the Miami-Dade County, Consumer Protection Division within fifteen (15) days.

I also understand and agree that I may be asked to provide additional information once the application has been reviewed, as a requirement to the issuance of the registration. Once a registration has been issued, I agree to provide any supplemental information that may be requested, and to update Miami-Dade County within fifteen (15) days of any changes to the information in this application.

____
Physician 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: _________________________

REQUIRED ATTACHMENTS:

1. A copy of a FL driver's license or government issued I.D. for each owner, and all other persons identified in the application.

2. A copy of each active State of Florida license for persons listed on the application including:

   a. **Medicine pursuant to Chapter 458, F.S.**
   b. **Osteopathic Medicine pursuant to Chapter 459, F.S.**
   c. **Chiropractic Medicine pursuant to Chapter 460, F.S.**
   d. **Dentistry pursuant to Chapter 466, F.S.**
   e. **Physical Therapy pursuant to Chapter 486, F.S.**
   f. **Acupuncture pursuant to Chapter 457, F. S.**
   g. **Massage Therapy pursuant to Chapter 480**

3. If applicable, a copy of the Health Care Clinic License or Exemption issued by the Florida Agency for Health Care Administration or Florida Department of Health.

4. A copy of a current valid Miami-Dade County local business tax receipt.

5. A copy of a current valid local Municipal business tax receipt (*unless located in Unincorporated Miami-Dade County*).

6. **A copy of the Certificate of Occupancy issued by Miami-Dade County, or Municipality in which the provider is located.**

7. **A floor plan of the provider showing all areas, including the location of controlled substances.**

8. A sworn and notarized Owner Affidavit for each owner (form attached).

9. A sworn and notarized Designated Physician Affidavit (form attached).

10. Check or money order for the registration fee, made payable to: "MIAMI DADE COUNTY - CP"

-Renewal Applications Need Only Include the Underlined Items-

Completed application package and payment must be submitted to:

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