2019-2020 Hillsborough County Pain Management Clinic Licensing Application and Important Information

All pain management clinics currently licensed by Hillsborough County must apply for a 2019-2020 license prior to October 1, 2019 at 4 p.m. if the clinic wishes to remain open and operating. All 2018-2019 licenses will expire on November 20, 2019. The Pain Management Clinic Ordinance applies to clinics that operate in unincorporated Hillsborough County and the cities of Temple Terrace and Plant City. The City of Tampa maintains its own ordinance related to Pain Management Clinics.

- **Pain Management Clinic Ordinance –**It is highly recommended that all persons associated with the management or operation of the clinic read and become familiar with the Pain Management Clinic Ordinance, Number 10-8E, as amended. The ordinance can be found on our website.

- **Fees –** Each application for a pain management clinic license shall be accompanied by a nonrefundable application fee in the amount of $500. The additional license fee of $1,500 is due upon issuance of license. Payments can be made by CREDIT or DEBIT CARD online at the following page:

  https://velocitypayment.com/client/bankofamerica/hillsboroughcce/index.htm

  Other methods of payment are Cashier's Check, Money Order, Escrow or Trust Account Checks, made payable to BOCC or "Board of County Commissioners" **NOTE: No Personal Checks Accepted**

  Payments should be mailed to:
  Hillsborough County Citizen Boards Support
  601 E. Kennedy Blvd., 18th Floor, County Center, Tampa, FL, 33602
  For your convenience, a payment drop box is also available in the lobby of the 18th Floor

- **Designation of Physician** – The clinic will be responsible for the designation of a properly licensed physician who will be responsible for complying with all requirements related to the registration and operation of the clinic. Within ten (10) days after termination or absence of a designated physician, the clinic must notify the Consumer and Veterans Services of the identity of another designated physician for the clinic or forfeit the clinic's license.

- **Hours of Operation -** The hours of operation of the clinic shall be limited to 7:00 a.m. to 9:00 p.m., Monday through Saturday.

- **List of Employees/FDLE Backgrounds – "Section G"** of the application be fully completed and list all persons associated with the management or operation clinic.

  Please contact Isaac Ruffin at (813) 274-6779 or RuffinI@HCFLGov.net *to schedule an appointment for your clinic employees to be fingerprinted.*

- **Inspections** – Any time the clinic is open or occupied, the clinic must allow for inspections by a Code Enforcement Officer or any other person authorized to enforce ordinance violations in Hillsborough County. Failure to do so will result in license denial or revocation.

- **Sworn and Notarized Statement** – The applicant must provide a sworn and notarized statement from **both the designated physician and the clinic owner** attesting to the veracity and accuracy of the information provided in the application.

The "2019-2020" Application for Pain Management Clinic License" may be downloaded at:
https://www.hillsboroughcounty.org/en/residents/citizens/consumer-issues/pain-management-clinics.

The application must be **typed** and all sections completed. Any incomplete sections will delay processing and will cause the application to be returned or denied. After completing the application, save it to your computer and submit as an email attachment. The notarized statements can be scanned and submitted by email to Isaac Ruffin at RuffinI@HCFLGov.net The application fee should be mailed or paid the same day as the application.

APPLICATION FOR PAIN MANAGEMENT CLINIC LICENSE

☐ License Renewal – License # _____ ☐ Change of Property Owner or Property Owner Address

☐ Clinic Relocation ☐ Change in Clinic Name or Clinic Ownership

☐ Registering New Designated Physician ☐ Other: _____

SECTION A: CLINIC OFFICE INFORMATION:

1. Corporate or Legal Name of Pain Management Clinic: _____
2. Fictitious Name or Doing Business As: _____
3. Clinic Physical Address: _____
4. Clinic Mailing Address: _____
5. Clinic Days & Hours of Operation: _____
6. Clinic Telephone Number: _____ 7. Federal Tax I.D. Number (FEID#): _____
8. Name of Clinic's Designated Contact: _____

   Designated Contact's Email Address: _____

***NOTE – All correspondence from Hillsborough County regarding the clinic's application and license will be sent to this email address**

9. Florida Department of Health Pain Management Clinic License number: _____
10. Agency for Health Care Administration Health Care Clinic License Number: HCC_____ or Exempt ☐
11. Hillsborough County Business Tax Receipt Account Number: _____
12. Does any person listed on Section G, Clinic Employee List, have a financial interest or employment relationship with any pharmacy? Yes ☐ No ☐

    If yes, indicate the name of the employee and the name and address of the pharmacy below.

    _____

SECTION B: CLINIC OWNER(S) INFORMATION:

(If the clinic is owned by more than one individual, attach a separate sheet to this application with the same information)

1. Full Legal Name: _____
2. Clinic Owner Address:_____
3. Clinic Owner Email Address: _____
4. Telephone Numbers: (Home) _____ (Cellular) _____
5. Does the clinic owner own a pain management clinic in another jurisdiction?

   If yes, indicate the name and address of the clinic(s) below.

   _____

SECTION C: PROPERTY OWNER(S) INFORMATION:

1. Full Legal Name: _____

2. Address: _____

3. Telephone Numbers: (Business) _____ (Cellular) _____

SECTION D: DESIGNATED PHYSICIAN (DP) INFORMATION:

1. Designated Physician Full Legal Name: _____

2. Designated Physician Email Address: _____

3. Florida Medical License Number: _____ 4. Designated Physician DEA Number: _____

5. List of ALL pain management clinics currently supervised by DP or where DP practices:
Include the clinic name and address as well as the clinic owner's name and the hours the DP works at the clinic.

_____

_____

_____

6. a. Has the designated physician ever had disciplinary action taken against his/her license? Yes ☐ No ☐
b. Has the designated physician ever had any administrative complaints filed against him/her? Yes ☐ No ☐
c. Are you aware that you must update the Consumer and Veterans Services within thirty (30) days if either 6a or 6b occurs? Yes ☐ No ☐

SECTION E: ADDITIONAL PHYSICIAN INFORMATION:

1. Do any other physicians practice or work at the clinic? Yes ☐ No ☐
If Yes, complete Section E for each additional physician.
If No, skip to Section F.

1. Physician Full Legal Name: _____

2. Physician Email Address: _____

3. Florida Medical License Number: _____ 4. Physician DEA Number: _____

5. List of ALL pain management clinics currently supervised by physician or where physician practices:
Include the clinic name and address as well as the clinic owner's name and the hours the DP works at the clinic.

_____

_____

_____

6. a. Has the physician ever had disciplinary action taken against his/her license? Yes ☐ No ☐
b. Has the physician ever had any administrative complaints filed against him/her? Yes ☐ No ☐
c. Are you aware that you must update the Consumer and Veterans Services within thirty (30) days if either 6a or 6b occurs? Yes ☐ No ☐

SECTION F: REQUIRED ATTACHMENTS:

1. A floor plan or the pain management clinic showing the location and size of the waiting area, location and size of the patient rooms and location of any type of diagnostic equipment. In addition, if any controlled substances are dispensed at the site or are stored at the site, the location and method of security for any controlled substances must be shown. If the floor plan is the same as was what was provided in previous Hillsborough County Pain Management Clinic Applications, the clinic is not required to submit this attachment.
2. A copy of property ownership records or the lease agreement if the property is being leased. If the lease agreement and property owner information are the same as was what was provided in previous Hillsborough County Pain Management Clinic Applications, the clinic is not required to submit this attachment.
3. **Check or money order in the amount of $500 payable to: Hillsborough County BOCC**

Send the completed application to:

Consumer and Veterans Services
Attn: Regulatory Compliance
2709 East Hanna Avenue
Tampa, FL 33610

Send your payment to:

Hillsborough County Citizen Boards Support
601 E. Kennedy Blvd., 18th Floor, County Center, Tampa, FL, 33602
For your convenience, a payment drop box is also available in the lobby of the 18th Floor

Clinic Name: _____

Section G:
Clinic Employee List

Date:_____

Employee Name	Employee Title	Date of Birth	Home Address	Telephone Number	Check Yes or No For Each			Driver's License Number
					Arrest	Drug Arrest	Criminal Conviction	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	

SECTION H: DESIGNATED PHYSICIAN AUTHORIZATION AND CERTIFICATION:

Pursuant to Hillsborough County Ordinance 10-8E, as amended, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. 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 by the Consumer and Veterans Services Department and, with the exception of changes of information under Sections 6(A)(4)(F) & (G), to update the Consumer and Veterans Services Department within ten (10) days of any changes to the information in this application. With respect to Sections 6(A)(4)(F) & (G), I agree to update the Consumer and Veterans Services Department within thirty (30) days of any change in information. I also understand that I have been appointed as the designated physician for the clinic on this application. I understand that, as designated physician, I am responsible for complying with all requirements related to registration and operation of the clinic as well as providing my DEA number to the Consumer and Veterans Services Department. I understand that I must have a full, active and unencumbered license under Florida Statutes Chapters 456 or 459 and shall practice at the clinic location for which I have assumed responsibility.

Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.

_____ _____

Designated 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.

_____ Seal:

Notary Signature

SECTION I: CLINIC OWNER AUTHORIZATION AND CERTIFICATION:

Pursuant to Hillsborough County Ordinance 10-8E, as amended, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. 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 by the Consumer and Veterans Services Department and, with the exception of changes of information under Sections 6(A)(4)(F) & (G), to update the Consumer and Veterans Services Department within ten (10) days of any changes to the information in this application. With respect to Sections 6(A)(4)(F) & (G), I agree to update the Consumer and Veterans Services Department within thirty (30) days of any change in information.

Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.

_____ _____

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.

_____ Seal:

Notary Signature