HIGH PRESCRIBING PHYSICIAN REGISTRATION
IMPORTANT INFORMATION:

- This application is for the registration of prescribers who prescribe 34 or more prescriptions of Class II and Class III narcotics each day.

- This application is also to be used by Pinellas County Pain Management Clinics who are currently registered with Pinellas County.

- Return the completed application, with required attachments, to the following address:

Pinellas County Department of Justice and Consumer Services
631 Chestnut Street
Clearwater, FL 33756

- Permit application and required attachments and fees MUST be received by no later than 4:00 PM on December 30, 2011.

- PLEASE MAKE SURE THAT YOUR APPLICATION IS FILLED OUT ACCURATELY AND COMPLETELY AS INFORMATION WILL BE VERIFIED.

- For additional information, please visit our website at: www.pinellascounty.org/consumer or call us at (727) 464-6200.

PINELLAS COUNTY PAIN MANAGEMENT PERMIT RENEWAL APPLICATION

Pinellas County Code, Chapter 86 requires that anyone operating a Pain Management Clinic within Pinellas County must first apply for and receive a Pinellas County Pain Management Clinic Permit issued by the Pinellas County Department of Justice and Consumer Services.

You must type or legibly complete (print) the application form and submit it with all required attachments and fees. Applicants must submit a $250.00 non-refundable application fee and a $1,500.00 annual permit fee with this application in separate checks or money orders. Checks or money orders should be made payable to the Board of County Commissioners.

Questions about this application can be addressed to: Department of Justice & Consumer Services at 631 Chestnut Street, Clearwater, FL 33756, (727) 464-6200.

Florida Statutes, Section 458 and 459 and 893 should also be read and understood before operating a Pain Management Clinic. Nothing in Pinellas County Code, Chapter 86 relieves any individual or organization from compliance with State law.

A. **CLINIC INFORMATION**:

1. Clinic's Legal Name: ____

2. Additional Name(s) used: __________________________________

3. Physical address of clinic: ____

4. Telephone Number: ( ) ______________ Fax ( ) __________

5. E-Mail Address (if applicable): ____

6: Florida Department of Health Pain Clinic Registration Number: ______________

7. Name, Title, Mailing Address, and Telephone number of individual to receive all official notices:

____

B. **CLINIC OWNER'S INFORMATION**:

1: Name____

2. Date of Birth: ____/____/______

3. Driver's License Number: ____________________ State : _______

4. Address: ____

5. Telephone Number: (_____) __________ Fax: ( ) _______________

5: E-Mail Address (if applicable): ______________________________________

C. **MEDICAL DIRECTOR'S INFORMATION**:

1. Physician's Name:____

2. Date of Birth: ____/___/___

3. Driver's License Number: ___________________ State: ____

4. Address: ____

5. Telephone Number: ( ) ______________

6. E-mail Address (if applicable): _____________________

7. State of Florida Medical License Number: ________________

8. DEA License Number: ____

IN THE PAST FIVE (5) YEARS, HAS THE APPLICANT OR ANY PERSON LISTED IN THIS APPLICATION been convicted, entered a plea or had adjudication withheld for any drug related felony? Yes ____ No _____ If yes, please attach an additional sheet of paper providing details.

DOES THE APPLICANT OR ANY PERSON LISTED IN THIS APPLICATION HAVE ANY PENDING CRIMINAL CHARGES? Yes ____ No ____ if yes, please attach an additional sheet of paper providing details.

ARE ANY CLASS II CONTROLLED SUBSTANCES DISPENSED at the Pain Management Clinic? Yes ______ No _____ if yes, under what authority?

HAS ANY PHYSICIAN EMPLOYED, CONTRACTED OR TREATING PATIENTS AT THIS OFFICE had his or her license to practice medicine suspended, Revoked, or encumbered in any way at anytime in their career? Yes ______ No ______
Details: (Use additional sheets if necessary)

REQUIRED ATTACHMENTS:

- ☐ Proof that the applicant has registered with the State Department of Health as a Pain Management Clinic (Please provide a copy of your valid State of Florida Pain Management Registration Certificate)

- ☐ Listing of all persons and employees associated with the operation of the Pain Management Clinic. This list is to include, but not limited to all owners, operators, physicians, physicians' assistants and other authorized agents. (Page 5)

- ☐ Photocopy of current Driver's License for each person listed in this application

- ☐ Floor Plan of the Pain Management Clinic. If any Class II controlled substances are kept or dispensed on-site, the floor plan should show the location and method of security for these controlled substances (ie; safe, lock box, etc)

- ☐ Non-Refundable Application fee of $250.00 by check or money order payable to Board of County Commissioners

- ☐ Annual Permit Fee of $1,500.00 by check or money order payable to Board of County Commissioners.

- ☐ A fingerprint card completed at the Pinellas County Sheriff's Office - 4801 145th Avenue North, Clearwater, Fl 33760 for each person listed in this application. Business hours are**:** Monday through Friday from 8:00 AM to 4:30 PM (closed for lunch 12:30 PM - 1:30 PM). **Please note**: The Sheriff's Office charges a fee of $5 per fingerprint card payable by check or money order for providing this service.

- ☐ Signed and Notarized Authorizations and Certifications by both Clinic Owner **and** Medical Director listed in application. (see page 6 & 7)

CLINIC NAME: ____

List Each Employee/Associated Persons of the Pain Management Clinic:

(You may make copies of this form if additional are needed)

Last Name: ____________________ First Name: ____________________ MI: ___

DOB: _______________ FL Driver's License #: ____________________

Title: _____________________________________

Home Address: ____

Telephone: (   ) ___________________

Last Name: ____________________ First Name: ____________________ MI: ___

DOB: ______________ FL Driver's License # ____________________

Title: _______________________________________

Home Address: ____

Telephone: (   ) ____________________

Last Name: ____________________ First Name: ____________________ MI: ___

DOB: ________________ FL Driver's License # ____________________

Title: ______________________________________

Home Address: ____

Telephone: (   ) ____________________

Last Name: ____________________ First Name: ____________________ MI: ___

DOB: __________ FL Driver's License # ____________________

Title: __________________________________

Home Address: ____

Telephone: (   ) ____________________

AUTHORIZATION AND CERTIFICATION: (CLINIC OWNER)

"Pursuant to Pinellas County Pain Management Clinic Ordinance, Section 86, I authorize any law enforcement or code enforcement officer of the department designated by the County Administrator who is authorized by the head of that department access to inspect this facility registered under this Ordinance for proof of registration, at any reasonable hour, without notice."

"Having been duly sworn, I certify that I have verified the eligibility to practice medicine in the State of Florida for each physician employed, contracted or otherwise treating patients at the facility named in this application. I, furthermore, agree not to hire or maintain in my employment any physician who is not properly licensed to practice medicine.

"Having been duly sworn, I certify that the foregoing statements are all true and correct; that I have withheld no information that would affect the review or granting of this license; and that I as permitee will own, operate, and exercise control over the proposed or existing pain management clinic, and in the manner described herein."

(Sign before a Notary)

_____________________________ _________________________

Applicant/Clinic Owner Signature Title / Position

Notary certification:
The foregoing instrument was acknowledged 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

Printed Notary Information:
Name: _______________________________________
Address: ______________________________________
City/State/Zip: __________________________________
Telephone: (_____)________________________________

AUTHORIZATION AND CERTIFICATION: (MEDICAL DIRECTOR)

"Pursuant to Pinellas County Pain Management Clinic Ordinance, Section 86, I authorize any law enforcement or code enforcement officer of the department designated by the County Administrator who is authorized by the head of that department access to inspect this facility registered under this Ordinance for proof of registration, at any reasonable hour, without notice."

"Having been duly sworn, I certify that the foregoing statements are all true and correct; that I have withheld no information that would affect the review or granting of this license; and that I as permitee will own, operate, and exercise control over the proposed or existing pain management clinic, and in the manner described herein."

(Sign before a Notary)

_____________________________ _________________________

Medical Director Signature Title / Position

Notary certification:
The foregoing instrument was acknowledged 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

Printed Notary Information:
Name: _______________________________________
Address: ______________________________________
City/State/Zip: __________________________________
Telephone: (_____)________________________________

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.

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

5. 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 Pinellas County, Justice & Consumer Services Department 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 PINELLAS)

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 _________________________, 2011.

____
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__________________________