

Medical Office Certification

Corporate Name : _____

Fictitious Name (DBA): _____

Address: _____

Select one of the following:

I hereby certify that the above referenced clinic/facility/office is a pain management clinic; therefore, it is required to register with the Florida Department of Health pursuant to section 458.3265 or 459.0137, Florida Statutes, as amended.

I hereby certify that the above referenced clinic/facility/office is **not** a pain management clinic; therefore, it is **not** required to register with the Florida Department of Health pursuant to section 458.3265 or 459.0137, Florida Statutes, as amended.

Printed Applicant Name

Applicant Title

Applicant Signature

Date

Subscribed and sworn to before me this _____ day of _____, 20_____.

Signature of Notary

Printed name or stamp of Notary

_____ Personally known to me.

_____ Produced identification: _____