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.

FORM MUST BE PRINTED AND SIGNED IN THE PRESENCE OF A NOTARY

______________________________	______________________________
Printed Applicant Name	Applicant Title
______________________________	______________________________
Applicant's 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: ___________________________________