STATE OF FLORIDA
DEPARTMENT OF
HEALTH

Request for Access to the Compassionate Use Registry

Mail the completed form and required documentation to:
Florida Department of Health Office of Compassionate Use, 4052 Bald Cypress Way, Bin A06
Tallahassee, FL 32399

Request Type: ☐ **Initial Request** ☐ **Update**

Name of individual to be given access: _____

Organization represented: _____

Mailing address: _____
P.O. Box or Street City State Zip Code

Phone number: _____ E-mail address: _____

Specify the duration of time for which you request access: _____ through _____
date date

Please check that box next to the statement that describes your need for access and provide the information requested:

☐ **Authorized employee of a dispensing organization**

Date of your most recent successful privacy training: _____

☐ **Law enforcement official**

Date of your most recent successful privacy training: _____

☐ **Authorized employee of the department**

Date of your most recent successful privacy training: _____

The undersigned persons certify that the requested access to the Compassionate Use Registry is for lawful purpose and is authorized under section 381.986, Florida Statutes, and Chapter 64-4, F.A.C. The information contained in this application and in any attached exhibits that serves as a basis for access, is true and correct. I understand that knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree punishable as provided in sections 775.082 or 775.083, Florida Statutes.

_____ _____ _____ _____
Signature of Requestor Date Signature of Immediate Supervisor Date

_____
Name of Immediate Supervisor (print or type)

_____
Phone number of Immediate Supervisor

DRAFT