OFFICE SURGERY REGISTRATION APPLICATION

Please read the laws and rules that pertain to this registration application prior to completing the form. The laws and rules state the minimum requirements for the general standards, policy and procedure manuals, surgical logs, equipment, supplies, accreditation or inspection, definitions of the surgery levels, background and training for physicians, assistants and recovery room personnel. A copy of the laws and rules are available on line at www.doh.state.fl.us/mqa/medical/osr_laws.html. If you have any questions about the information contained in the laws and rules, please contact the Office Surgery Registration and Inspection Program at (850) 245-4131.

The registered physician(s) must notify the Board of Medicine, in writing, of any changes to the registration documentation immediately. This includes changes in accreditation status, accrediting certificates, inspection, staff privileges and/or transfer agreements, ACLS/BLS certification, staff who assist in surgery and/or recovery, staff protocols, facility name and address changes (requires a new application) and any other information required by 64B8-9 F.A.C.

I. Facility Identification

_____ _____
Name of Facility OSR # if available

_____
Street Address City State ZIP Code

_____ _____ _____
Telephone Fax Number Email address

_____ _____
Office Manager Email address

II. Accreditation or Inspection:

All office-based surgery facilities are required by Section 458.309(3) F.S. to be inspected by the Department of Health or be accredited by a nationally recognized accrediting agency. Please check the appropriate inspection or accrediting agency.

____ Inspection by the Department of Health (fee: $1500.00)
(A Department of Health inspector will contact you to make an appointment for the inspection.)

____ AAAASF (American Association for Accreditation of Ambulatory Surgery)

____ AAAHC (Accreditation Association for Ambulatory Health Care)

____ JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

____ Other _____

(If you are accredited with a nationally recognized accrediting agency, submit a copy of your accreditation certificate and a copy of the accreditation survey with the application.)

III. Facility: All questions in this section must be answered or the application will be rejected.

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

☐ Yes ☐ No	**1.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.)
☐ Yes ☐ No	**1a.** If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
☐ Yes ☐ No	**1b.** If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).
☐ Yes ☐ No	**1c.** If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?
☐ Yes ☐ No	**1d.** If "yes" to 1, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).
☐ Yes ☐ No	**2.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?
☐ Yes ☐ No	**2a.** If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?
☐ Yes ☐ No	**3.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)
☐ Yes ☐ No	**3a.** If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with the Florida Medicaid Program for the most recent five years?
☐ Yes ☐ No	**4.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)
☐ Yes ☐ No	**4a.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with a state Medicaid program for the most recent five years?
☐ Yes ☐ No	**4b.** Did the termination occur at least 20 years before the date of this application?
☐ Yes ☐ No	**5.** Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

IV. (1) Physician (Surgeon) Information

_____-_____

Physician Name License Number

_____

Mailing Address City State Zip Code

_____

Telephone Number E-mail Address

Indicate the Level(s) of Surgery that you intend to perform at this facility.

_____ level I _____ Level II _____Level III _____Level II & III

To determine level of surgery please refer to Rule 64B8-9.009 F.A.C.

List the types of procedures that will be performed, by the physician, at this facility.

_____
_____
_____

IV. (2) Physician(Surgeon) Background and Training

Do you hold current certification or are you eligible for certification with a Specialty Board approved by the Florida Board of Medicine?

____ Yes If yes, submit a copy of your certificate or the board eligibility letter with the registration application.

____ No If no, the physician must provide documentation to establish comparable background, training and experience.

IV. (3) List residency, fellowship, background experience and any additional training.	**Specialty**	**Dates of Attendance**

VI (4). Physician (Surgeon) Staff Privileges

Do you have staff privileges to perform the procedures that you intend to perform in the office setting?

____ Yes If so, please submit a letter of good standing and a copy of the delineation of privileges with this registration application. Staff privileges must be within reasonable proximity (30 minutes of transport time).

____ No Submit a copy of a transfer agreement, between the physician and a hospital within 30 minutes of transport time.

Do you hold a current ACLS certification?

____ Yes If yes, submit a copy of the ACLS card with this application

____ No The surgeon is required by Rule 64B8-9.009 F.A.C. to be ACLS certified please obtain ACLS (PALS if appropriate) certification and submit a copy of the ACLS Card to the Board of Medicine. The registration will not be approved until the Board receives this information.

V. Anesthesia Provider

_____
Name of Anesthesia provider. License Number

(If this facility utilizes more than one anesthesia provider, please list name, license number and practitioner code for each individual on a separate page.)

____ MD/DO Anesthesiologist _____PA _____CRNA _____ARNP _____RN (Level II only)

Do you hold a current ACLS or PALS certification? _____Yes _____ No

The physician performing a surgical procedure is required by Rule 64B8-9.009 F.A.C. to be ACLS certified. Please obtain ACLS (PALS if appropriate) certification and submit a copy of the ACLS Card to the Board of Medicine. The registration will not be approved until the Board receives this information

VI. Recovery Personnel

_____
Name of Recovery personnel License Number

_____
Name of Recovery personnel License Number

_____MD/DO Anesthesiologist _____PA _____CRNA _____ARNP _____RN _____ACLS
(Check all that apply)

Recovery personnel are required to be ACLS certified. Rule 64B8-9.009(4)(b)4. F.A.C.

VII. Other Personnel on Surgical Team List any additional personnel who will be assisting in surgery.
One assistant to the surgeon must be BLS certified. Submit a copy of the BLS certification card with the application.

Name	License Number	Practitioner Code (PA, CRNA, ARNP, RN, Surgical Tech, Medical Assistant)	Type of Involvement

VIII. Statement of Physician Submitting Registration

I state that all information provided herein is true and correct and I confirm compliance with Florida Statutes and Chapter 64B8-9 Florida Administrative Code.

Additionally, I agree to immediately notify the Board of Medicine in writing of any changes to the information provided in this registration application.

_____ _____
Signature of Physician (Surgeon) Date

Mailing Instructions:

The original application, with the applicant's original signature and processing fees must be mailed, to the Department of Health; faxed copies are not acceptable.

*Mail registration application(s) and fee of $150.00 to:

Department of Health
P.O. Box 6320
Tallahassee, FL 32314

Note: Post office boxes do not accept overnight or express packages. For faster delivery, Priority Mail (2-3 days) is accepted by post office boxes.

Submit any additional documentation not included in the original application to:

FIorida Board of Medicine
Office Surgery Registration and Inspection Program
4052 Bald Cypress Way
Bin C-03
Tallahassee, FL 32399-3253