# Pain Management Registration Application

Florida HEALTH
Medical Quality Assurance

Department of Health
Office Surgery Registration and Inspection Program
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://www.floridahealth.gov/licensing-and-regulation/office-surgery-registration/index.html
Email: PMC_OSR@flhealth.gov
Phone: (850) 245-4131
Fax: 850-488-0596

# Pain Management Clinic Information

Sections (s.) 458.3265 and 459.0137, Florida Statutes (F.S.), provide that any publicly or privately owned facility that advertises in any medium for any type of pain management services or where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisopropol for the treatment of chronic nonmalignant pain must register with the Department of Health. **A business is exempt from registration if:**

- It is licensed as a facility under chapter (ch.) 395, F.S.
- The majority of physicians providing services in the clinic primarily provide surgical services.
- It is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded 50 million dollars.
- It is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.
- It does not prescribe controlled substances for the treatment of pain.
- It is owned by a corporate entity exempt from federal taxation under 26 United States Code, § 501 (c)(3).
- It is wholly owned and operated by one or more board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists.
- It is wholly owned and operated by one or more board-certified medical specialists who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who are also board-certified in pain medicine by a board approved by the American Association of Medical Specialties or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes.

***If the clinic falls into one of the above exemption categories, do not submit this application, and instead submit the "Application for Exemption from Pain Management Clinic Registration."***

**Each location must be registered separately regardless of whether the pain management clinic is operated under the same business name or management as another pain management clinic.**

Pain management clinics **must** designate a physician responsible for complying with all requirements related to registration and operation of the pain management clinic. The **"designated physician"** must be a medical doctor licensed under ch. 458, F.S. or an osteopathic physician licensed under ch. 459, F.S., who holds a full, active and unencumbered license. Each pain management clinic **must** notify the department of any change in designated physician within ten days. Failure to do so may result in a summary suspension of the pain management clinic's registration certificate as described in s. 456.073(8), F.S. or s. 120.60(6), F.S.

Each physician practicing in a pain management clinic must advise the Board of Medicine in writing, within ten calendar days after beginning or ending their practice at a pain management clinic.

**The designated physician must practice in the registered pain management clinic for which they are responsible.**

The pain management clinic must be inspected by the department annually unless it is accredited by a nationally recognized accrediting agency approved by the Board of Medicine or Board of Osteopathic Medicine.

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**Pain Management Clinic Registration Program**
**P.O. Box 6330**
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**Do Not Write in this Space**
**For Revenue Receipting Only**

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| Select One Pain Management Clinic Registration Type: | Sections to Complete | Fee | Effective Date (MM/DD/YYYY) |
|---|---|---|---|
| ☐ Initial Registration | Full application | $150.00 | |
| ☐ Change of Ownership | Full application | $150.00 | |
| ☐ Change of Location | Full application | $150.00 | |
| ☐ Change in Pain Management Clinic Name | Full application | $25.00 | |
| ☐ Request to Withdraw or Close Registration | Section 1 | No Fee | |
| ☐ New Designated Physician | Sections 1 & 6 | No Fee | |
| ☐ Change from Accreditation by National and Board-approved Organizations to Inspection | Sections 1 & 7 | No Fee | |
| ☐ Change from Inspection to Accreditation by National and Board-approved Organizations | Sections 1 & 7 | No Fee | |

**Registration #** *(only required for facilities with an existing registration):* _____

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees are non-refundable.

## 1. BUSINESS INFORMATION

**Corporate or Legal Name of Pain Management Clinic:** _____

**Doing Business As (D/B/A):** _____

**Federal Employer Identification # (FEIN):** _____

_____ _____ _____
**Mailing Address** Suite No. City

_____ _____ _____ _____
State ZIP Telephone (Input without dashes) Fax Number (Input without dashes)

_____ _____ _____
**Pain Management Clinic Physical Location** Suite No. City

_____ _____ _____
State ZIP **Email Address ***

_____ _____
Office Manger **Email Address ***

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Corporate Name: _____

## 2. OWNERSHIP INFORMATION

A. Is the pain management clinic wholly owned by a physician licensed under ch. 458 or 459, F.S. or a group of physicians, each of which is licensed under ch. 458 or 459, F.S.; or is a health care clinic licensed under Part X of ch. 400, F.S.? ☐ Yes ☐ No

B. Has this pain management clinic ever been licensed with the Agency for Health Care Administration (AHCA) under ch. 400, F.S.? ☐ Yes ☐ No

**If "Yes,"** provide the license #:_____

C. Is this pain management clinic exempt from licensure with AHCA? ☐ Yes ☐ No

D. Has this pain management clinic ever been registered with the Department of Health? ☐ Yes ☐ No

**If "Yes,"** provide the registration/license #:_____

E. Is the applicant owned by or with any contractual or employment relationship with a physician whose Drug Enforcement Administration (DEA) number has ever been revoked? ☐ Yes ☐ No

F. Is the applicant owned by or with any contractual or employment relationship with a physician whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction? ☐ Yes ☐ No

G. Is the applicant owned by or with any contractual or employment relationship with a physician who has been convicted of or pleaded guilty or nolo 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 s. 893.03, F.S., in this state, or in the United States? ☐ Yes ☐ No

**If you responded "Yes" to E, F, or G, you must provide the following:**

☐ **A self-explanation** on separate sheet providing accurate details, including the name of the involved party.

☐ Copies of **supporting documentation**.

## 3. BUSINESS HOURS

| Weekday | Opening Time | Closing Time |
|---|---|---|
| Monday | ☐AM ☐PM | ☐AM ☐PM |
| Tuesday | ☐AM ☐PM | ☐AM ☐PM |
| Wednesday | ☐AM ☐PM | ☐AM ☐PM |
| Thursday | ☐AM ☐PM | ☐AM ☐PM |
| Friday | ☐AM ☐PM | ☐AM ☐PM |
| Saturday | ☐AM ☐PM | ☐AM ☐PM |
| Sunday | ☐AM ☐PM | ☐AM ☐PM |

## 4. DESIGNATED PHYSICIAN CLINIC HOURS *(Must be physically present in clinic.)*

| Weekday | Shift Start Time | Shift End Time |
|---|---|---|
| Monday | ☐AM ☐PM | ☐AM ☐PM |
| Tuesday | ☐AM ☐PM | ☐AM ☐PM |
| Wednesday | ☐AM ☐PM | ☐AM ☐PM |
| Thursday | ☐AM ☐PM | ☐AM ☐PM |
| Friday | ☐AM ☐PM | ☐AM ☐PM |
| Saturday | ☐AM ☐PM | ☐AM ☐PM |
| Sunday | ☐AM ☐PM | ☐AM ☐PM |

Corporate Name: _____

## 5. PAIN MANAGEMENT CLINIC PERSONNEL

List the names and addresses of any and all pain management clinic owner(s)/principal(s), officer(s), agent(s), managing employee(s), and affiliated person(s). "License #" refers to a health care license issued by the Department of Health. Attach additional copies of this page if necessary.

**Owner(s)/Principal(s)**

| Name | License # | Address | Telephone # |
|---|---|---|---|
| | | | |
| | | | |

**Officer(s)**

| Name | License # | Address | Telephone # |
|---|---|---|---|
| | | | |
| | | | |

**Agent(s)**

| Name | License # | Address | Telephone # |
|---|---|---|---|
| | | | |
| | | | |

**Managing Employee(s)**

| Name | License # | Address | Telephone # |
|---|---|---|---|
| | | | |
| | | | |

**Practicing Physician(s)**

| Name | License # | Address | Telephone # |
|---|---|---|---|
| | | | |
| | | | |

## 6. DESIGNATED PHYSICIAN (responsible for ensuring compliance with the laws and rules governing office surgeries)

A. Provide information about the Designated Physician.

**Physician Name:** _____
Last/Surname First Middle

**Physician Florida License #:** _____ **Physician Telephone #:** _____

**Mailing Address:** _____ _____ _____ _____ _____
Street Suite No. City State ZIP

**Physician Email Address*:** _____

* Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

B. List all other pain management clinics, as defined by statute, currently supervised by this designated physician. Attach additional sheets if necessary.

| Name of Pain Management Clinic | Address (street, city, ZIP) | Pain Management Clinic Registration # |
|---|---|---|
| | | |
| | | |
| | | |

## 7. ACCREDITATION OR INSPECTION

All pain management clinics required to be registered pursuant to s. 458.3265(3) or s. 459.0137(3), F.S., are to be inspected annually by the Department of Health unless accredited by a nationally recognized accrediting agency recognized by the Board of Medicine or the Board of Osteopathic Medicine. Select the appropriate inspection or accrediting agency:

☐ Inspection by the Department of Health

☐ Board-approved Accrediting Organization: _____
Organization Name

☐ Clinics accredited with a nationally recognized accrediting agency **must submit a copy of their accreditation certificate.**

## 8. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 2.**

a. If "Yes" to 1, for the felonies of the first or second degree (or the equivalent level of felony in another state or jurisdiction), has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

b. If "Yes" to 1, for the felonies of the third degree (or the equivalent level of felony in another state or jurisdiction), has it been more than ten 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 s. 893.13(6)(a), F.S. or similar felony offense committed in another state or jurisdiction. ☐ Yes ☐ No

c. If "Yes" to 1, for the felonies of the third degree (or the equivalent level of felony in another state or jurisdiction) under s. 893.13(6)(a), F.S. or a similar felony offense committed in another state or jurisdiction has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

d. 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? ☐ Yes ☐ No

2. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 3.**

   a. If "Yes" to 2, is the date of application more than 15 years after the sentence and any subsequent period of probation? ☐ Yes ☐ No

3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 4.**

   a. If "Yes" to 3, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been reinstated and 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 been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 5.**

   a. If "Yes" to 4, 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

   b. If "Yes" to 4, did the termination occur at least 20 years prior to 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 the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If "Yes" to 5, is the applicant, principal, officer, agent, managing employee, or affiliated person of the applicant listed because the individual defaulted or is delinquent on a student loan? ☐ Yes ☐ No

   b. If "Yes" to 5.a., is the student loan default or delinquency the only reason the individual is listed on the LEIE? ☐ Yes ☐ No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

☐ **A written self-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.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

**Documents must be sent to the board office at PMC_OSR@flhealth.gov, or mailed to:**

Department of Health
Pain Management Clinic Registration Program
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Corporate Name: _____

## 9. DESIGNATED PHYSICIAN SIGNATURE

I hereby state that I and the clinic meet all requirements of s. 458.3265 or s. 459.0137, F.S. I agree to notify the Department of Health in writing within ten days of any changes to the registration information. All information provided herein is true and correct.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

Florida law requires me to immediately inform the department of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Designated Physician Name _____

Designated Physician Signature _____ Date _____
*You may print this application and sign it or sign digitally.* MM/DD/YYYY