



Area of Critical Need Facility Designation Request Application

(Please complete an individual form for each clinic site location requested)

PLEASE TYPE OR PRINT CLEARLY

I. Contact Information:

Name: Last:	First:	Middle:
Email Address:		Telephone Number:

II. Clinic Site Information:

Name of Practice:			
Business Name:			
Owner Name and Title:			
Please Check One: Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr. <input type="checkbox"/>			
Email Address:		Telephone Number:	
Physical Street Address:			
City:	State:	Zip:	County:
Type: of Medical Practice:			

Please submit application electronically to: volunteers@flhealth.gov

FOR DEPARTMENT USE ONLY:	
Date Request Received:	
In a HPSA: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Application Status: In Process <input type="checkbox"/> In Review <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/>	
Business License Submitted: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date of Approval or Denial:	Comments: