Updated July 20, 2011

Date Stamp

Indian River County Community Development Department

PAIN MANAGEMENT CLINIC PERMIT APPLICATION UNINCORPORATED COUNTY

Name of pain management clinic:____

Site Address:____

Mailing Address of Applicant____

E-mail Address of Applicant____

Tax Parcel ID# for site:____

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1. Information on clinic owners, officers, supervisors, prescription writers, physicians

Note: Information under B and C below is not required for a "Qualified Pain Management Clinic" (see attached definition)

A. Name of Clinic Owner or Business Entity: ________________ Address:________________ ________________ Phone #:________________ E-mail:________________	Check One: ☐ Single owner or business entity ☐ Multiple owners or business entities If multiple owners or business entities own the clinic, then attach the name and address of each and every owner or business entity
B. Name of clinic business entity officer, manager, or partner: ________________ Address:________________ ________________ Phone #:________________ E-mail:________________	Check One: ☐ Not Applicable ☐ Single officer, manager, or partner ☐ Multiple officers, managers, or partners If multiple officers, managers, or partners, then attach the name and address of each and every officer, manager, or partner
C. Name of person managing or supervising clinic activities: ________________ Address:________________ ________________ Phone #:________________ E-mail:________________	Check One: ☐ Single manager or supervisor ☐ Multiple managers or supervisors If multiple managers or supervisors, then attach the name and address of each and every manager or supervisor

D. Name of person prescribing or administering controlled substances at the clinic: ____________________ Address: ____________________ ____________________ Phone #: ____________________ E-mail: ____________________	Check One: ☐ Single prescription writer or administer ☐ Multiple prescription writers or administers If multiple prescription writers or administers, then attach the name and address of each and every prescription writer or administer

2. Information on the clinic responsible physician:

Note: Information under 2 below is not required for a "Qualified Pain Management Clinic" (see attached definition)

Name: ____________________ Address: ____________________ ____________________ Phone #: ____________________ E-mail: ____________________	Check One: ☐ Single responsible physician or osteopathic physician ☐ Multiple physicians If multiple physicians, then attach the name and address of each and every physician

3. Information on the owner of the clinic site/building:

Note: Information under 3 below is not required for a "Qualified Pain Management Clinic" (see attached definition)

Name: ____________________ Address: ____________________ ____________________ Phone #: ____________________ E-mail: ____________________	Check One: ☐ Single person or entity owns the real property ☐ Multiple persons or entities own the real property If multiple persons or entities own the real property, then attach the name and address of each owner

Applicant name and relationship to the clinic (print): ____________________

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Signature: ____________________ Date: ____________________

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4. Attach the following:

Note: Items D, E, and F below are not required for a "Qualified Pain Management Clinic" (see attached definition)

A. Letter of authorization from real property owner, if other than the applicant.

B. Letter of Authorization from clinic owner, if other than the applicant.

C. Permit fee ($200.00) [Note: no charge for applications submitted on or before July 18, 2011]

D. Proof that the clinic is currently registered as a pain management clinic with the Florida Department of Health, pursuant to sections 458.3265 or 459.0137, Florida Statutes or that the clinic is exempt from registering with the Florida Department of health as provided by law.

E. Proof that any person who will be prescribing or administering controlled substances at the pain management clinic has a valid and current substance registration number issued by the United States Department of Justice, Drug Enforcement Administration, including the controlled substance registration number for each such person.

F. A sworn statement certifying that within the ten (10) years prior to submittal of this application, neither the pain management clinic, nor any person identified in this application, has been found by any county or municipal board, commission or council, or by any state or federal court, or by any state or federal regulatory body, to have acted with respect to controlled substances in violation of applicable law. Use the sworn statement wording below.

G. A sworn statement certifying that the pain management clinic, and every other clinic owned or operated by any person identified in this application, will, during the term of the permit, be operated in compliance with applicable law. Use the sworn statement wording at the bottom of this application form.

H. If the application is for a "Qualified Pain Management Clinic" (see attached definition), then submit proof (such as written verification or confirmation from the State of Florida) that the clinic is exempt from state registration pursuant to Florida Statutes 458.3265(1)2g or h, or 459.0137(1)(a)2g or h.

Term of Permit: two years from the date of issuance. Permit renewal requires filing a new application. Allow at least 20 days for application issuance.

SWORN STATEMENT FOR THIS APPLICATION

STATE OF FLORIDA
COUNTY OF INDIAN RIVER

BEFORE ME, the undersigned authority, personally appeared _____

who, upon oath, states that he/she has read the foregoing _____,

which he/she has executed, and the facts contained therein are true and correct.

(NOTARY SEAL)

_____

Print Name:_____
NOTARY PUBLIC – State of Florida

Personally Known ☐ or Produced Identification ☐

Type of Identification Produced: _____

Definition of "Qualified Pain Management Clinic"

"Qualified pain management clinic" shall mean:

a. A pain management clinic which is wholly owned and operated by one or more board-certified anesthesiologists, physiatrists, or neurologists; or

b. A pain management clinic which 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 Board of medical Specialties or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes.