High Prescribing Health Clinic
APPLICATION

IMPORTANT INFORMATION:

- This application is for the registration of High Prescribing Health Clinics which employs a physician who prescribes more than 20 prescriptions of Class II and Class III controlled substances for treatment of pain in a single day.

- Return the completed form, with required attachments, to the following address:

  Pinellas County Consumer Protection
  14250 49th St. N., Suite 1000, Rm. 2
  Clearwater, FL 33762

- Renewal/transfer application and any required attachments (see page 2), MUST be received by no later than 30 days before current license expires**.**

- PLEASE MAKE SURE THAT YOUR APPLICATION IS FILLED OUT ACCURATELY AND COMPLETELY AS INFORMATION WILL BE VERIFIED.

- **For additional information, please visit our website at: www.pinellascounty.org/consumer or call us at (727) 464-6200.**

PINELLAS COUNTY HIGH PRESCRIBING HEALTH CLINIC APPLICATION

Pinellas County Code, Chapter 86 requires that anyone operating a High Prescribing Health Clinic within Pinellas County must submit an application to Pinellas County Consumer Protection.

You must type or legibly complete (print) the application form and submit it with all required attachments.

Questions about this application can be addressed to: Pinellas County Consumer Protection at 14250 49th St. N., Suite 1000, Rm. 2, Clearwater, FL 33762, (727) 464-6200.

Florida Statutes, Section 458 and 459 and 893 should also be read and understood before operating a High Prescribing Health Clinic. Nothing in Pinellas County Code, Chapter 86 relieves any individual or organization from compliance with State law.

REQUIRED ATTACHMENTS:

- ☐ Proof that the applicant has registered with the State Department of Health as a Pain Management Clinic (Please provide a copy of your valid State of Florida Pain Management Registration Certificate), if applicable.
- ☐ Listing of all persons and employees associated with the operation of the High Prescribing Health Clinic. This list is to include, but not limited to all owners, operators, physicians, physicians' assistants, medical assistants, receptionist, clerical staff and other authorized agents. (Page 5)
- ☐ Only for physicians, physicians assistants, medical director, office managers, and owners, a fingerprint card completed at the Pinellas County Sheriff's Office within the last six months must be included. Please contact that office at (727) 464-6032 to verify fees and business hours before visiting location.
- ☐ Photocopy of current Driver's License for each person listed in this application.
- ☐ Floor Plan of the High Prescribing Health Clinic. If any Class II or Class III controlled substances are kept or dispensed on-site, the floor plan should show the location and method of security for these controlled substances (ie; safe, lock box, etc)
- ☐ Non-Refundable Application fee of $250.00 by check or money order payable to Board of County Commissioners.
- ☐ Annual Permit fee of $1,500.00 by check or money order payable to Board of County Commissioners.
- ☐ Signed Authorizations and Certifications by Clinic Owner and Medical Director listed in application. (see page 6-7)

A. **THIS APPLICATION IS FOR**:

☐ Renewal license

☐ Transfer of an existing license to the applicant from the following licensee:

_____

(Attach notarized affidavit from current license holder consenting to the transfer.)

☐ New license

B. **CLINIC INFORMATION**:

1. Clinic's Legal Name: _____
2. Additional Name(s) used: _____
3. Physical address of clinic: _____
4. Telephone Number: _____ Fax: _____
5. E-Mail Address (if applicable): _____
6. Florida Department of Health Pain Clinic Registration Number: _____
7. Name, Title, Mailing Address, Email Address & Telephone number of individual to receive all official notices:

_____

_____

C. **CLINIC OWNER'S INFORMATION**:

1: Name _____
2. Date of Birth: _____
3. Driver's License Number:_____State : _____
4. Address:

_____

5. Telephone Number: _____ Fax: _____
6. E-Mail Address (if applicable): _____

D. **MEDICAL DIRECTOR'S INFORMATION**:

1. Physician's Name:_____
2. Date of Birth: _____
3. Driver's License Number: _____ State: _____
4. Address: _____
5. Telephone Number: _____
6. E-mail Address (if applicable): _____
7. State of Florida Medical License Number: _____
8. DEA License Number: _____

IN THE PAST FIVE (5) YEARS, HAS THE APPLICANT OR ANY PERSON LISTED IN THIS APPLICATION BEEN CONVICTED, ENTERED A PLEA OR HAD ADJUDICATION WITHHELD FOR ANY DRUG RELATED FELONY?

Yes ☐ No ☐ If yes, please provided details and attach an additional sheet if necessary?

_____

_____

DOES THE APPLICANT OR ANY PERSON LISTED IN THIS APPLICATION HAVE ANY PENDING CRIMINAL CHARGES?

Yes ☐ No ☐ If yes, please provided details and attach an additional sheet if necessary?

_____

_____

ARE ANY CLASS II OR CLASS III CONTROLLED SUBSTANCES DISPENSED AT THE PRACTICE/CLINIC?

Yes ☐ No ☐ If yes, under what authority?_____

HAS ANY PHYSICIAN EMPLOYED, CONTRACTED OR TREATING PATIENTS AT THIS OFFICE HAD HIS OR HER LICENSE TO PRACTICE MEDICINE SUSPENDED, REVOKED, OR ENCUMBERED IN ANY WAY AT ANYTIME IN THEIR CAREER?

Yes ☐ No ☐ If yes, please provided details and attach an additional sheet if necessary?

_____

_____

CLINIC NAME: _____

List Each Employee/Associated Persons of the High Prescribing Health Clinic:

(You may make copies of this form if additional are needed)

Last Name: _____ First Name: _____MI: ___

DOB: _____ FL Driver's License #: _____

Title: _____

Home Address: _____

Telephone: _____

Last Name: _____ First Name: _____MI: ___

DOB: _____ FL Driver's License #: _____

Title: _____

Home Address: _____

Telephone: _____

Last Name: _____ First Name: _____MI: ___

DOB: _____ FL Driver's License #: _____

Title: _____

Home Address: _____

Telephone: _____

Last Name: _____ First Name: _____MI: ___

DOB: _____ FL Driver's License #: _____

Title: _____

Home Address: _____

Telephone: _____

AUTHORIZATION AND CERTIFICATION: (CLINIC OWNER)

I own _____ ,
(Name of Clinic)

Located at: _____ .
(*Street Address) (City) (Zip Code)*

I have never had a registration issed under either F.S. 458.309 or F.S. 459.005 suspended or revoked.

I have an active Drug Enforcement Administration (DEA) registration, and I have never had a DEA number revoked.

I have never had a license to prescribe, dispense, or administer a controlled substance denied, revoked, voluntarily relinquished, or otherwise encumbered due to final disciplinary action of the state or by any jurisdiction.

I have not been convicted of or plead guilty or no 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 Section 893.03 of the Florida Statutes, or of any state or the United States in the past five years.

I agree to immediately inform the Pinellas County Consumer Protection should I cease to be affiliated with the clinic, or if I no longer practice at this clinic location.

I have a full, active and unencumbered medical license under Florida Statutes Chapter 456 or 459 and I shall practice at the clinic location identified above.

Pursuant to Pinellas County Prescription Management Ordinance, Section 86, I authorize any law enforcement or code enforcement officer of the department designated by the County Administrator who is authorized by the head of that department access to inspect this facility registered under this Ordinance for proof of registration, at any reasonable hour, without notice.

I certify that the foregoing statements are all true and correct; that I have withheld no information that would affect the review or granting of this license; and that I as permitee will own, operate, and exercise control over the proposed or existing high prescribing health clinic, and in the manner described herein.

I also understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of their official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 837.06, s. 775.082 or s.775.083, Florida Statutes.

_____ _____

Applicant/Clinic Owner Signature Title / Position

_____

Date

AUTHORIZATION AND CERTIFICATION: (MEDICAL DIRECTOR)

I am employed by/ contracted by _____ ,
(Name of Clinic)

Located at: _____ .
(*Street Address) (City) (Zip Code)*

I have never had a registration issed under either F.S. 458.309 or F.S. 459.005 suspended or revoked.

I have an active Drug Enforcement Administration (DEA) registration, and I have never had a DEA number revoked.

I have never had a license to prescribe, dispense, or administer a controlled substance denied, revoked, voluntarily relinquished, or otherwise encumbered due to final disciplinary action of the state or by any jurisdiction.

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I certify that the foregoing statements are all true and correct; that I have withheld no information that would affect the review or granting of this license; and that I as Medical Director will operate, and exercise control over the proposed or existing high prescribing health clinic, and in the manner described herein.

I also understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of their official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 837.06, s. 775.082 or s.775.083, Florida Statutes.

_____ _____

Medical Director Signature Title / Position

_____

Date