State of Florida
Department of Business and Professional Regulation
Division of Drugs, Devices, and Cosmetics

Application for Permit as a Health Care Clinic Establishment
Form No.: DBPR-DDC-224

APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.

APPLICATION	APPLICATION REQUIREMENTS
Application for Permit as a Health Care Clinic Establishment	☐ Submit fee of $255.00, made payable by cashier's check, corporate or business check, or money order, to the Florida Department of Business and Professional Regulation. ☐ If you answer "Yes" to any question in Section IV, be sure to provide a detailed explanation along with any relevant documentation. ☐ Sign and date the Affidavit section of the application.
	Submit the completed application with enclosures to: Department of Business and Professional Regulation 1940 North Monroe Street Tallahassee, FL 32399

PLEASE NOTE:
Telephone, email, and fax contact information is used to quickly resolve questions with applications. If such information is not provided, questions regarding applications will be mailed to the application contact's mailing address and may take longer to resolve.

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If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Division of Drugs, Devices and Cosmetics, at **850.717.1800.** ***For additional information see the instructions at the beginning of this application.***

Section I – Application Type

CHECK ONE OF THE APPLICATION TYPES
☐ New Application [3360/1020]
☐ New Application due to Change in Ownership. If checked, provide legal documentation for the change of ownership (i.e. Bill of Sale, stock transfer, merger). [3360/1020]
Current Permit Number: _____

Section II – Applicant Information

APPLICANT INFORMATION
TAXPAYER IDENTIFICATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER
This is a unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification. When the number is used for identification rather than employment tax reporting, it is usually referred to as a Taxpayer Identification Number (TIN), and when used for the purposes of reporting employment taxes, it is usually referred to as the Federal Employer Identification Number (FEIN).
Applicant's TIN/FEIN:
FULL LEGAL NAME
The "full legal name" is the complete name of the business entity that will be operating the establishment. This is generally the name that is on the documents that establish the existence or formation of the business entity. For example, a corporation's full legal name would normally be the name that is found in the corporation's articles of incorporation.
Applicant's Full Legal Name:
FICTITIOUS, TRADE, OR BUSINESS NAME
If the applicant intends to operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above – e.g. fictitious, trade, or business name (also commonly referred to as a "dba", "D/B/A", or "doing business as" name – this name must be registered with the Florida Department of State, Division of Corporations. This is the name that will appear on the permit issued to the applicant by the department and must be the name that the applicant uses on operational documents for permitted activities.
☐ The applicant WILL NOT operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above.
☐ The applicant WILL operate the permitted establishment under the following fictitious, trade, or business name: _____
The fictitious, trade, or business name listed directly above, is registered with the Florida Department of State, Division of Corporations and the applicant has been issued the following registration number: _____.

APPLICANT'S MAILING ADDRESS		
Street Address or P.O. Box:		
City:	State:	Zip Code (+4 optional):

PHYSICAL ADDRESS OF ESTABLISHMENT TO BE PERMITTED (only if different from mailing address) Check ☐ if not applicable		
Street Address:		
City:	State:	Zip Code (+4 optional):
County (if Florida address):	Country:	
E-Mail Address:	Phone Number:	Fax Number:

APPLICATION CONTACT			
The application contact is the person that the department will contact if there are questions regarding the responses provided on, or the documentation submitted with, the application. The application contact is also the person that will receive all official communication from the department regarding the application.			
Last/Surname:	First:	Middle:	Suffix:
Address:			
City:	State:	Zip Code (+4 optional):	
Telephone Number:	Fax Number:		
E-Mail Address:			

DESIGNATED QUALIFYING PRACTITIONER			
The designated qualifying practitioner is the person that the department will contact regarding legal and or regulatory issues related to the purchase, recordkeeping, storage, and handling of prescription drugs. The department will contact this person at times outside of the regular business hours listed below. The contact information provided should be sufficient for the department to actually reach and communicate with the designated qualifying practitioner.			
Last/Surname:	First:	Middle:	Suffix:
Street Address:			
City:	State:	Zip Code (+4 optional):	
Telephone Number:	E-Mail Address:		
License # With Prefix:	Expiration Date: ___ / _____ / _____	Issuing regulatory board (e.g.: Florida Board of Medicine):	
Is qualified practitioner authorized under the appropriate practice act to prescribe and administer prescription drugs? If no, please explain. Explanation Attached? ☐ Yes ☐ No ☐ N/A			☐ Yes ☐ No

Qualifying Practitioner Affidavit:

I UNDERSTAND that as the qualifying practitioner I will be responsible for complying with all legal and regulatory requirements related to the purchase, recordkeeping, storage, and handling of the prescription drugs.

I UNDERSTAND that my name, the establishment address, and my license number will be used on all distribution documents for prescription drugs purchased or returned by the health care clinic establishment.

I UNDERSTAND that a violation of Chapter 499, Florida Statutes, by the health care clinic establishment or me as the qualifying practitioner constitutes grounds for discipline of my health care practitioner license by the appropriate regulatory board.

Signature of Designated Qualifying Practitioner:	Date:

OPERATING HOURS

List Operating Hours – minimum 10 total per week (M-F) between 8:00 a.m. and 5:00 p.m., Eastern Standard Time, and at least 2 consecutive hours on at least 1 day: REMEMBER to circle "a.m." or "p.m." for each time indicated below.

Mon ____:____ a.m./p.m. to ____:____ a.m./p.m.	Fri ____:____ a.m./p.m. to ____:____ a.m./p.m.
Tue ____:____ a.m./p.m. to ____:____ a.m./p.m.	Sat ____:____ a.m./p.m. to ____:____ a.m./p.m.
Wed ____:____ a.m./p.m. to ____:____ a.m./p.m.	Sun ____:____ a.m./p.m. to ____:____ a.m./p.m.
Thu ____:____ a.m./p.m. to ____:____ a.m./p.m.	

Section III – Ownership Information

TYPE OF OWNERSHIP

☐ Publicly Held Corporation	☐ Closely Held Corporation	☐ Limited Liability Company
☐ Charitable Organization—501(c)(3)	☐ Sole Proprietorship	☐ Government
☐ Partnership – General	☐ Professional Corporation or Association	☐ Professional Limited Liability Company
☐ Partnership – Other, Including Limited Liability Partnership and Limited Partnership	☐ Other:_____	

List the state of incorporation or state of organization (except Partnership – General or Sole Proprietorship). Business entities organized under non-U.S. laws list the country of organization.
☐ N/A (Partnership – General or Sole Proprietorship)

State or Country:

List name and address of the applicant's registered agent for service of process in Florida (except Sole Proprietorship or Partnership – General) and provide documentation, such as a print out from the Florida Department of State, Division of Corporations' webpage, that the applicant's registered agent is registered with the Florida Department of State, Division of Corporations. ☐ N/A (Partnership – General or Sole Proprietorship)		
Name:		
Address:		
City:	State:	Zip Code (+4 optional):

List the name, position/title, social security number, date of birth and address of each owner, partner, member, manager, officer, director, chief executive, or other person who directly or indirectly controls the operation of the business entity, as applicable. For example, corporations would list officers and directors, limited liability companies would list members and managers, etc.				
1.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:

List the name, social security number, date of birth and address of each person who owns 10 percent or more of the outstanding stock or equity interest in the business entity.				
1.	Name:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:

2.	Name:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:

List all trade or business names used by the applicant. Use additional sheet(s) if necessary. If the applicant does not use other trade or business names check this box ☐ and write N/A on the lines below.

Section IV – Background Questions

BACKGROUND QUESTIONS			
1.	☐ Yes If yes, explain in detail in Section V	☐ No	Has the applicant **or** designated qualifying practitioner been fined or disciplined by a regulatory agency in any state (Including Florida) for any offense that would constitute a violation of Chapters 456, 465, 474, 499, or 893, F.S., related to the distribution, possession, administration, or dispensing of prescription drugs?
2.	☐ Yes If yes, explain in detail in Section V	☐ No	Has the applicant **or** designated qualifying practitioner ever entered a plea to, been convicted or found guilty of, any felony under a federal, state (including Florida), or local law related to the distribution, possession, administration or dispensing of prescription drugs? Include all cases where a guilty, nolo contendere or no contest plea was entered, whether or not adjudication was withheld.
3.	☐ Yes If yes, explain in detail in Section V	☐ No	Has the applicant **or** designated qualifying practitioner had any current or previous permit or license suspended or revoked which was issued by a federal, state, or local government agency relating to the manufacturing, distributing, prescribing, dispensing, or administration of prescription drugs?
4.	☐ Yes If yes, explain in detail in Section V	☐ No	Has the applicant **or** designated qualifying practitioner been denied a permit or license in any state (including Florida) related to an activity regulated under Chapters 465, 499, or 893, F.S.?

If you answered "YES" to any questions in Section IV, you must provide detailed explanations in Section V, including requirements for submitting supporting legal documents. If needed, explain on separate sheet(s).

Section V – Explanation(s) for "Yes" response(s) to background question(s) in Section IV

EXPLANATION(S)

Section VI – Other Permits or Licenses

PERMITS OR LICENSES			
1.	Are there any other permits or licenses issued by any agency of the State of Florida that authorize the purchase or possession of prescription drugs at the applicant's establishment or address? (If no, please check this box ☐ and write "N/A" in the lines below).		☐ Yes ☐ No
1a.	Permit/License Name	Permit/License Type	Permit/License Number

Section VII – Affidavit

AFFIDAVIT	
Pursuant to s. 559.79, F.S., each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the applicant, or owner or chief executive of the applicant without the need for witnesses unless otherwise required by law. Pursuant to s. 559.791, F.S., any license issued by the Department of Business and Professional Regulation which is issued or renewed in response to an application upon which the person signing under oath or affirmation has falsely sworn to a material statement, including, but not limited to, the names and addresses of the owners or managers of the licensee or applicant, shall be subject to denial of the application or suspension or revocation of the license, and the person falsely swearing shall be subject to any other penalties provided by law. I UNDERSTAND THAT THE ISSUANCE OF A PERMIT BY THE DEPARTMENT ONLY AUTHORIZES THE APPLICANT TO CONDUCT REGULATED ACTIVITIES IN THE STATE OF FLORIDA UNDER THE NAME IN WHICH THE PERMIT IS ISSUED. IF THE PERMIT IS ISSUED IN THE NAME OF A DBA OR D/B/A THE APPLICANT MAY ONLY CONDUCT BUSINESS IN FLORIDA IN THE NAME OF THE DBA OR D/B/A. I FURTHER UNDERSTAND THAT PROVIDING ADDITIONAL DBA OR D/B/A NAMES TO THE DEPARTMENT AS PART OF THE APPLICATION PROCESS IS NOT, UPON LICENSURE, AN AUTHORIZATION TO CONDUCT BUSINESS IN FLORIDA UNDER THE NAME OF THOSE ADDITIONAL DBA'S OR D/B/A'S. I certify that I am empowered to execute this application as required by s. 559.79, F.S. I understand that my signature on this application has the same legal effect as if made under oath. To the best of my knowledge, all information contained on this application is true and correct. I understand the falsification of any information on this application may result in administrative action, including a fine, suspension, or revocation of the license.	
Signature of Applicant, Owner or Chief Executive:	Date:
Print Name:	Title:

Mail completed application to:
Department of Business and Professional Regulation
1940 North Monroe Street
Tallahassee, FL 32399