Change of Registered Agent and/or Registered Office Out-of-State Telehealth Provider

Completed forms must be sent to:
Telehealth
4052 Bald Cypress Way, Bin C-11
Tallahassee, FL 32399-1708
Email: MQA.Telehealth@flhealth.gov

OUT-OF-STATE TELEHEALTH PROVIDER INFORMATION:

Name: _____
Last/Surname First Middle

Address: _____ _____
Street/P.O. Box Apt. No.

_____ _____ _____
City State ZIP

Out-of-State Telehealth Registration Number: _____

REGISTERED AGENT INFORMATION:

The agent must be registered with the **Florida Department of State, Division of Corporations**, and the agent's name must appear on the Registered Agent Name List maintained by the Division of Corporations.

The name and street address of the registered agent you have designated to receive service of process is required by section 456.47(4)(b), F.S, and this information must be updated if there is a change in the registered agent and/or the registered office.

Name of Registered Agent: _____

Physical Address: _____ _____
Street (cannot be a P.O. Box) Apt. No.

_____ **Florida** _____
City State ZIP

I acknowledge this document is being submitted to notify the Department of Health of a change of registered agent and/or registered office.

Out-of-State Telehealth Provider's Signature: _____ **Date:** _____
You may print out the form and sign it or sign digitally. MM/DD/YYYY