



FLORIDA DEPARTMENT OF HEALTH
APPLICATION FOR REGISTRATION
HEALTH CARE SERVICES CLINIC

INSTRUCTIONS: Please type or print all required information and remit the attached form with a check or money order made payable to Florida Department of Health in the amount of the \$155.00 (registration fee of \$150 plus a \$5 unlicensed activity fee required by s. 456.065(3), F.S.). Mail fee and application form to:

Department of Health
Division of Medical Quality Assurance
Post Office Box 6320
Tallahassee, Florida 32314-6320

A “health care services clinic” means a business operating in a single structure or facility, or in a group of adjacent structures or facilities operating under the same business name or management, at which health care services are provided to individuals and which tender charges for reimbursement for such services. Section 456.0375, Florida Statutes, requires every such clinic to register with the Department of Health. Each clinic location must register separately even though operated under the same business name or management.

A clinic is **EXEMPT** from registration only if it meets at least one of the following conditions:

1. The facility is already licensed or registered by the state under one of the following chapters of the Florida Statutes: 390, 394, 395, 397, 400, 463, 465, 466, 478, 480, or 484, OR
2. The clinic is exempt from federal taxation under 26 U.S.C. s. 501(c)(3), OR
3. The clinic provides services by licensed health care practitioners pursuant to chapters 457, 458, 459, 460, 461, 462, 463, 466, 467, 484, 486, 490, 491, or parts I, III, X, XIII, or XIV of chapter 468, or s. 464.012, AND is wholly owned by licensed health care practitioners or the licensed health care practitioner and the spouse, parent, or child of a licensed health care practitioner, AND one of the owners who is a licensed health care practitioner is supervising the services performed and is legally responsible for the clinic’s compliance with all federal and state laws.



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CARE CLINIC
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1. CLINIC INFORMATION (PLEASE TYPE OR PRINT IN BLACK INK)

Full Name of Clinic:		Business Telephone: ()
Location Address:	No. and Street No.	City State Zip
Mailing Address:	No. and Street No.	City State Zip

2. MEDICAL/CLINICAL DIRECTOR INFORMATION

(PLEASE TYPE OR PRINT IN BLACK INK)

Name:	Last	First	Middle	Profession of Director:	License Number of Director:
Residence Address:	No. and Street .		Apt. No.	Business Telephone: ()	Fax ()
	City	State	Zip		
E-mail Address:					

3. CERTIFICATION

I affirm that I have read Section 456.0375(3)(b), Florida Statutes, and agree, as the director of the clinic named in this application, to accept legal responsibility as set out in Section 456.0375(3)(b), Florida Statutes.

Further, I affirm that this information is true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 775.082, 775.083 and 775.084, Florida Statutes.

Signature of Medical/Clinical Director

Date