Office Surgery Registration Application

Florida HEALTH
Medical Quality Assurance

Department of Health
Office Surgery Registration and Inspection Program
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://www.floridahealth.gov/licensing-and-regulation/office-surgery-registration/index.html
Email: PMC_OSR@flhealth.gov
Phone: (850) 245-4131
Fax: 850-488-0596

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Do Not Write in this Space
For Revenue Receipting Only

Select One Office Surgery Facility Registration Type:	Sections to Complete	Fee	Effective Date (MM/DD/YYYY)
☐ Initial Registration	Full application	$150.00	
☐ Change of Ownership	Full application	$145.00	
☐ Change of Location	Full application	$145.00	
☐ Change in Office Surgery Facility Name	Full application	$25.00	
☐ Request to Withdraw or Close Registration	Section 1	No Fee	
☐ Request to Change Facility Financial Responsibility	Section 1 & Page 8	No Fee	
☐ New Designated Physician	Sections 1 & 3	No Fee	
☐ Change from Accreditation by National and Board-approved Organizations to Inspection	Sections 1 & 4	No Fee	
☐ Change from Inspection to Accreditation by National and Board-approved Organizations	Sections 1 & 4	No Fee	

Registration # *(only required for facilities with an existing registration):* _____

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees are non-refundable.

1. BUSINESS INFORMATION

Corporate or Legal Name of Office Surgery Facility: _____

Doing Business As (D/B/A): _____

Federal Employer Identification # (FEIN): _____

_____ _____ _____
Mailing Address Suite No. City

_____ _____ _____ _____
State ZIP Telephone (Input without dashes) Fax Number (Input without dashes)

_____ _____ _____
Office Surgery Physical Address (if different from physical location) Suite No. City

_____ _____ _____
State ZIP **Email Address ***

_____ _____
Office Manager **Email Address ***

***** Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Corporate Name: _____

2. OFFICE SURGERY FACILITY PERSONNEL

List the following information for any and all Office Surgery Facility owner(s)/principal(s), officer(s), agent(s), managing employee(s), and affiliated person(s). **"License #"** refers to a health care license issued by the Department of Health. If the individual does not have a **"License #"** leave the field blank. Attach additional copies of this page if necessary.

Owner(s)/Principal(s)

Name	License #	Address	Telephone #

Officer(s)

Name	License #	Address	Telephone #

Agent(s)

Name	License #	Address	Telephone #

Managing Employee(s)

Name	License #	Address	Telephone #

3. DESIGNATED PHYSICIAN (responsible for ensuring compliance with the laws and rules governing office surgeries)

Physician Name: _____
Last/Surname First Middle

Physician Florida License #: _____ **Physician Telephone #:** _____

Mailing Address:

_____ _____ _____ _____ _____
Street Suite No. City State ZIP

Physician Email Address: _____

Corporate Name: _____

4. PHYSICIAN (SURGEON) INFORMATION

Physician Name: _____
Last/Surname First Middle

Physician Florida License #: _____ **Physician Telephone #:** _____

Mailing Address:

_____ _____ _____ _____ _____
Street Suite No. City State ZIP

Physician Email Address: _____

Indicate the Level(s) of Surgery to be performed by the above-named physician at this facility.

☐ **Level I** ☐ **Level II** ☐ **Level III** ☐ **Level II & III**

Refer to Rule 64B8-9.009, Florida Administrative Code (F.A.C.), or Rule 64B15-14.007, F.A.C., to determine the level of surgery.

List the types of procedures that will be performed **by the above-named physician** at this facility.

_____

_____

The following questions are to be answered by the above-named physician:

A. Do you hold current certification or are you eligible for certification with a specialty board approved by the Florida Board of Medicine? ☐ Yes ☐ No

If "Yes," submit a copy of your certificate or the board eligibility letter with the registration application.

If "No," you must provide documentation to establish comparable background, training, and experience.

B. Do you have staff privileges to perform the procedures that you intend to perform in the office setting?
☐ Yes ☐ No

If "Yes," submit a letter of good standing and a copy of the delineation of privileges with this registration application. Staff privileges must be within reasonable proximity (30 minutes of transport time).

If "No," submit a copy of a transfer agreement, between the physician and a hospital within 30 minutes of transport time.

C. The surgeon is required to be Advanced Cardiovascular Life Support (ACLS) certified by an approved provider listed in Rules 64B8-9.009 or 64B15-14.007, F.A.C. Do you hold a current ACLS certification by an approved provider? ☐ Yes ☐ No

If "Yes," submit a **copy of the ACLS card** with this application.

The registration will not be approved until the board receives a copy of your ACLS certification.

D. List any Residency/Fellowship training, background experience, and any addition training. Attach additional sheets if necessary.

Training Program Name	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)
		to
		to
		to

Corporate Name: ____

5. ANESTHESIA PROVIDER

List the anesthesia provider for the facility. If this facility uses more than one anesthesia provider, list name and license number for each individual on a separate page.

Anesthesia Provider		**License #**		**ACLS / PALS Certified?**	☐ Y ☐ N
Practitioner Code	☐ Anesthesiologist	☐ PA	☐ CRNA	☐ APRN	☐ RN (Level II only)

Note: The physician performing a surgical procedure is **required** by Rule 64B8-9.009 F.A.C., or Rule 64B15-14.007, F.A.C., to have ACLS (or Pediatric Advanced Life Support (PALS) if appropriate) certification from an approved provider, listed in Rules 64B8-9.009 or 64B15-14.007, F.A.C.

☐ **Submit a copy of the ACLS Card** to the Board of Medicine **for each anesthesia provider**. *The registration will not be approved until the board receives this information.*

6. RECOVERY PERSONNEL

List recovery personnel for the facility. Attach additional sheets if necessary.

Recovery Personnel		**License #**		**ACLS Certified?**	☐ Y ☐ N
Practitioner Code	☐ Anesthesiologist	☐ PA	☐ CRNA	☐ APRN	☐ RN

Recovery Personnel		**License #**		**ACLS Certified?**	☐ Y ☐ N
Practitioner Code	☐ Anesthesiologist	☐ PA	☐ CRNA	☐ APRN	☐ RN

Recovery Personnel		**License #**		**ACLS Certified?**	☐ Y ☐ N
Practitioner Code	☐ Anesthesiologist	☐ PA	☐ CRNA	☐ APRN	☐ RN

Note: Under Rule 64B8-9.009 or 64B-15-14.007, F.A.C., recovery personnel are **required** to be ACLS certified by an approved provider, listed in rules.

7. OTHER PERSONNEL ON SURGICAL TEAM

List any additional personnel who will be assisting in surgery. Attach additional sheets if necessary.

Name of Additional Personnel	License #	BLS Certified?	Type of Involvement
1.		☐ Y ☐ N	
Practitioner Code: ☐ PA ☐ CRNA ☐ APRN	☐ RN	☐ Surgical Tech	☐ Medical Assistant
2.		☐ Y ☐ N	
Practitioner Code: ☐ PA ☐ CRNA ☐ APRN	☐ RN	☐ Surgical Tech	☐ Medical Assistant
3.		☐ Y ☐ N	
Practitioner Code: ☐ PA ☐ CRNA ☐ APRN	☐ RN	☐ Surgical Tech	☐ Medical Assistant

Note: One assistant to the surgeon **must** be Basic Life Support (BLS) certified.

☐ Submit a copy of the BLS Certification Card with the application.

8. ACCREDITATION OR INSPECTION

All office-based surgery facilities are required by section (s.) 458.328(1)(e), Florida Statutes (F.S.), or s. 459.0138(1)(e), F.S., to be inspected by the Department of Health unless accredited by a nationally recognized accrediting agency. Select the appropriate inspection or accrediting agency.

☐ Inspection by the Department of Health
☐ American Association for Accreditation of Ambulatory Surgery (AAAASF)
☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ Joint Commission on Accreditation of Healthcare Organization

☐ If you are accredited with a nationally recognized accrediting agency, submit a **copy of your accreditation certificate** and a **copy of the accreditation survey** with the application.

9. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree (or the equivalent level of felony in another state or jurisdiction), has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree (or the equivalent level of felony in another state or jurisdiction), has it been more than ten years from the date of the plea, sentence, and completion of any subsequent probation? This question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S. or similar felony offense committed in another state or jurisdiction. ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree (or the equivalent level of felony in another state or jurisdiction) under s. 893.13(6)(a), F.S. or a similar felony offense committed in another state or jurisdiction has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? ☐ Yes ☐ No

2. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, is the date of application more than 15 years after the sentence and any subsequent period of probation? ☐ Yes ☐ No

3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If "Yes" to 3, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

Corporate Name: _____

4. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

a. If "Yes" to 4, has the applicant or any principal, officer, agent, managing, employee, or affiliated person of the applicant been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. If "Yes" to 4, did the termination occur at least 20 years prior to the date of this application? ☐ Yes ☐ No

5. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

a. If "Yes" to 5, is the applicant, principal, officer, agent, managing employee, or affiliated person of the applicant listed because the individual defaulted or is delinquent on a student loan? ☐ Yes ☐ No

b. If "Yes" to 5.a., is the student loan default or delinquency the only reason the individual is listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents must be sent to the board office at PMC_OSR@flhealth.gov, or mailed to:

Department of Health
Office Surgery Registration and Inspection Program
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

10. APPLICANT SIGNATURE

To the best of my knowledge, the applicant states that these statements are true and correct. The applicant recognizes that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties to s. 456.067, F.S. The applicant states it has read ch. 456, 458, 459, and 766.301-316, F.S., and ch. 64B8 and 64B15, F.A.C.

The applicant has carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and states that the answers and all statements made are true and correct. Should the applicant furnish any false information in this application, the applicant agrees that such act constitutes cause for denial, suspension, or revocation of the registration of the office surgery registration practice. If there are any changes to the applicant's status or any change that would affect any of the answers to this application the Designated Physician must notify the board within 10 days.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Name _____

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Department of Health
Office Surgery Registration and Inspection Program
Professional Liability Coverage

Name: _____

Choose only ONE option that best describes your situation. Failing to make a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

PROFESSIONAL LIABILITY COVERAGE

☐ 1. The office has obtained and will maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ 2. The office has professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a retention group as defined through a plan of self-insurance as provided in s. 627.357, F.S.

☐ 3. The office has established an irrevocable letter of credit or escrow account in an amount of $100,000/$300,000, in accordance with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

☐ 4. The office has established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

☐ 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F.S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F.S.

Applicant Signature _____ Date _____
MM/DD/YYYY

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Tallahassee, FL 32399-3253