Department of Health
Office Surgery Registration and Inspection Program
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399
(850) 245-4131
PMC_OSR@FLHealth.gov

OFFICE SURGERY REGISTRATION APPLICATION

☐ Registration of Office Surgery Facility: Initial **($150 Fee)**
☐ Registration of Office Surgery Facility: Change of ownership **($150 Fee)** – effective date: _____
☐ Registration of Office Surgery Facility: Change of location **($150 Fee)** – effective date: _____
☐ Change in Office Surgery Facility Name only **($25 Fee)** – effective date: _____
☐ New designated physician **(No fee)** – effective date: _____
☐ Change from accreditation by national and board approved organizations to inspection **(No fee)**
☐ Change from inspection to accreditation by national and board approved organizations **(No fee)**
☐ Request to withdraw or close registration **(No fee)** – effective date: _____
☐ Request to change facility financial responsibility **(No fee)** – effective date: _____

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

1. Office Identification

Corporate or Legal Name of Office Surgery Facility

Doing Business As Name: _____

Federal Tax Identification Number (FEIN#): _____

Office Surgery Physical Address (if different from physical location):

_____
Street

_____
City State ZIP

_____
Mailing Address _____ State ZIP

_____ _____ _____
Telephone Fax Number Email address

_____ _____
Office Manager Email address

Under Florida law, email addresses are public records. If you choose to provide an email address, the department will provide information by email. 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. Contact the office by phone or in writing.

2. Office Surgery Facility Personnel

The names and address of any and all Office Surgery Facility owner(s), principal(s), officer(s), agent(s), managing employee(s), and affiliated person(s) - Use additional sheets of paper if necessary. "License" refers to a health care license issued by the Department of Health.

Owner(s):
- Name _____
- License Number _____
- Address _____
- Address _____
- Telephone Number _____

Principal(s):
- Name _____
- License Number _____
- Address _____
- Address _____
- Telephone Number _____

Officer(s):
- Name _____
- License Number _____
- Address _____
- Address _____
- Telephone Number _____

Agent(s):
- Name _____
- License Number _____
- Address _____
- Address _____
- Telephone Number _____

Managing Employee(s)
- Name _____
- License Number _____
- Address _____
- Address _____
- Telephone Number _____

3. Designated Physician

Physician Name: _____

Physician's Florida License Number: _____

Physician's Email address, if available: _____

Physician's Telephone Number: _____

Mailing Address: _____

(Street) (Suite #)

4. Accreditation or Inspection

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

____ Inspection by the Department of Health

____ AAAASF (American Association for Accreditation of Ambulatory Surgery)

____ AAAHC (Accreditation Association for Ambulatory Health Care)

____ JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

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.

5. Facility: All questions in this section must be answered or the application will be rejected.

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide 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 to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

☐ Yes ☐ No	**1.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.)
☐ Yes ☐ No	**1a.** If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
☐ Yes ☐ No	**1b.** If "yes" to 1, for the felonies of the third degree, has it been more than 10 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 Section 893.13(6)(a), Florida Statutes).
☐ Yes ☐ No	**1c.** If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?
☐ Yes ☐ No	**1d.** 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? (If "yes", please provide supporting documentation).
☐ Yes ☐ No	**2.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?
☐ Yes ☐ No	**2a.** If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?
☐ Yes ☐ No	**3.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)
☐ Yes ☐ No	**3a.** If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with the Florida Medicaid Program for the most recent five years?
☐ Yes ☐ No	**4.** Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)
☐ Yes ☐ No	**4a.** 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	**4b.** Did the termination occur at least 20 years before 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 Inspector General's List of Excluded Individuals and Entities?

6. Physician (Surgeon) Information

Physician Name _____ License Number _____

Mailing Address _____ City _____ State _____ ZIP _____

Telephone Number _____ E-mail Address _____

Indicate the level(s) of surgery that you intend to perform at this facility.

_____ Level I _____ Level II _____Level III _____Level II & III

Refer to rule 64B8-9.009, 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 physician, at this facility.

_____

_____

Physician (Surgeon) Background and Training

Do you hold current certification or are you eligible for certification with a Specialty Board approved by the Florida Board of Medicine?

____ Yes Submit a copy of your certificate or the board eligibility letter with the registration application.

____ No The physician must provide documentation to establish comparable background, training and experience.

Physician (Surgeon) Staff Privileges

Do you have staff privileges to perform the procedures that you intend to perform in the office setting?

____ 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).

____ No Submit a copy of a transfer agreement, between the physician and a hospital within 30 minutes of transport time.

Do you hold a current ACLS certification?

____ Yes Submit a copy of the ACLS card with this application

____ No

Under Rule 64B8-9.009, F.A.C, and Rule 64B15-14.007, F.A.C., the surgeon is required to be ACLS certified.

Obtain ACLS certification and submit a copy of the ACLS Card to the Board of Medicine.

The registration will not be approved until the Board receives this information.

Physician (Surgeon) Residency, Fellowship, Background Experience and Any Additional Training.		
Name	**Specialty**	**Dates of Attendance**

7. Anesthesia Provider

_____

Name of anesthesia provider. License Number

(If this facility uses more than one anesthesia provider, list name, license number and practitioner code for each individual on a separate page.)

____ Anesthesiologist _____PA _____CRNA _____APRN _____RN (Level II only)

Do you hold a current ACLS or PALS certification? _____Yes _____ No

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 be ACLS certified. Please obtain ACLS (PALS if appropriate) certification and submit a copy of the ACLS Card to the Board of Medicine. The registration will not be approved until the Board receives this information.

8. Recovery Personnel

_____

Name of recovery personnel License Number

_____

Name of recovery personnel License Number

_____ Anesthesiologist _____PA _____CRNA _____APRN _____RN _____ACLS
(Check all that apply)

Under Rule 64B8-9.009, F.A.C., or Rule 64B15-14.007, F.A.C., recovery personnel are required to be ACLS certified.

9. Other Personnel on Surgical Team List any additional personnel who will be assisting in surgery.
One assistant to the surgeon must be BLS certified. Submit a copy of the BLS certification card with the application.

Name	**License Number**	**Practitioner Code (PA, CRNA, APRN, RN, Surgical Tech, Medical Assistant)**	**Type of Involvement**

10. Professional Liability Coverage

Choose one of these options:

☐ **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 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.

☐ **3.** The office has established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 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 Chapter 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 the form of a "sign" prominently displayed in the 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 contact the wording specified in s. 458.320(5)(g)1, F.S.

11. Statement of Applicant

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 pursuant to Sections 456.067, 775.083, and 775.084, F.S. The applicant states it has read Chapters 456, 458 and 766.301-.316, F.S. and Chapter 64B8, 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 applicant must notify the board within 30 days.

Printed name of applicant:_____

Signature of applicant: _____ **Date**_____

Mailing Instructions:

The original application, with the applicant's original signature and processing fees must be mailed to the Department of Health. Faxed copies are not acceptable.

*Mail registration application(s) and fee of $150.00, if applicable, to:

Department of Health
P.O. Box 6320
Tallahassee, FL 32314