Corporate Name: _____

13. REQUIRED SIGNATURES

The undersigned have carefully read the questions in the foregoing application, have answered them completely, and state that the answers and all statements made are true and correct. The undersigned have included all required documentation necessary to process the application and state that all documentation is true and correct. Should the undersigned furnish any false information as part of the application process, they agree that such act constitutes cause for denial, suspension, or revocation of the registration of the office surgery registration. 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 office within 10 days.

The undersigned recognize that providing false information to the Department of Health may result in denial of licensure, disciplinary action against licenses held, and/or criminal penalties as provided in section 456.067, Florida Statutes.

The undersigned have reviewed chapters 456, 458, 459, and sections 766.301-316, Florida Statutes, and chapters 64B8 and 64B15, F.A.C. The undersigned acknowledge that section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant's Name: _____

Authorized Signature*: _____ Date: _____
MM/DD/YYYY

Designated Physician's Name: _____

Designated Physician's Signature*:_____ Date: _____
MM/DD/YYYY

*This page must be printed, signed and dated by hand, scanned, and returned as an attachment with your completed application.