



APPLICATION CHECKLIST

Health Care Licensing Application

DRUG FREE WORKPLACE LABORATORY

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 112, Part I, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-24, Florida Administrative Code (F.A.C.). Applications must be received **at least 60 days prior** to the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. **The application will be withdrawn from review if all the required documents are not included with this application or received within 21 days of an omission notice.**

All forms listed below may be obtained from the website: <http://ahca.myflorida.com/Publications/Forms/HQA.shtml>. Send completed applications to: Agency for Health Care Administration, Clinical Laboratory Unit, 2727 Mahan Drive, MS 32, Tallahassee, FL 32308.

A. Initials, Renewals and Change of Ownership Applications must include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- The biennial licensure fee (**\$16,435.00 per license**) - Please make check or money order payable to the **Agency for Health Care Administration (AHCA)**. All fees are nonrefundable. *NOTE: Starter checks and temporary checks are not accepted.*
- Health Care Licensing Application, Drug Free Workplace Laboratory, AHCA Form 3170-5001
- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).
- Proof that the Laboratory Director is qualified in accordance with Subsection 59A-24.006(1)(a), F.A.C.
- For providers enrolled in CAP's forensic toxicology accreditation program, submit proof of non-provisional accreditation for the current year and a copy of the most recently completed accreditation inspection report.
- For SAMSHA(HHS) certified providers, submit a copy of the most recently completed SAMHSA(HHS) inspection report.
- A Level 2 background screening for the Administrator (Laboratory Director) and Financial Officer is required every 5 years. Please check all boxes below that apply to this application:

For Drug Free Workplace Laboratories physically located within Florida:

- The Administrator (Laboratory Director) Financial Officer submitted a Level 2 screening through a **LiveScan vendor** approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan vendors please see the Agency's background screening website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

All screening results **must be sent** to the **Agency for Health Care Administration** (Agency) for review and eligibility determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you **must provide** the following **ORI FL922020Z** and identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the result, additional screening and fees may be required.

The Agency has created a form that you may use to take to the vendor. You may access this form, Background Screening Validation, on the Agency's website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

- Proof of Level 2 screening within the previous 5 years for the Administrator (Laboratory Director) Financial Officer from the Agency's Medicaid Division. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

- Level 2 screening has been conducted within the previous 5 years for the Administrator (Laboratory Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

For Drug Free Workplace Laboratories NOT physically located within Florida:

- The Administrator (Laboratory Director) Financial Officer are out of state and do not have access to a Florida LiveScan vendor and will submit a fingerprint card (**you must obtain a fingerprint card from the Agency**). To request a fingerprint card please contact the Agency's Background Screening Section at (850)412-4503 or email bgscreen@ahca.myflorida.com). The completed fingerprint card must then be submitted to:
- The Agency's contracted vendor, Cogent Systems (www.cogentid.com), along **with a fee of \$55.50** (\$40.50 for the screening + \$15.00 processing fee). (Need to change to whatever the new price is.) The fingerprint card must be filled out completely and the fingerprints taken by law enforcement personnel or individual trained in processing fingerprints. Return the completed card to:
- 3M Cogent
ATTN: FL Cardscan
5025 Bradenton Avenue, Suite A
Dublin, OH 43017
- Another LiveScan vendor authorized to provide services in Florida that is equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all LiveScan vendors have this ability. You may find LiveScan vendor contact information on the FDLE website:
<http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx>.
- Proof of Level 2 screening within the previous 5 years for the Administrator (Laboratory Director) Financial Officer from the Agency's Medicaid Division. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.
- Level 2 screening has been conducted within the previous 5 years for the Administrator (Laboratory Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional Information needed for INTIAL Applications:

- For corporate applicants for licensee and management company, a current certificate of status or authorization pursuant to Section 607.0128, F.S.
- Proof of fictitious name registration, if applicable.
- Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.

C. Additional information needed for CHANGE OF OWNERSHIP Applications [see 59A-35.070, Florida Administrative Code]:

- Documented evidence of change of ownership such as an asset purchase agreement, stock transfer/sale agreement and/or proof of corporate reorganization
- Proof of fictitious name registration, if applicable.
- For corporate applicants for licensee and management company, a current certificate of status or authorization pursuant to Section 607.0128, F.S.

D. Change During Licensure Period:

Request to change the name or address of provider:

- Complete and submit sections 1, 2 and 12 of the Health Care Licensing Application, Drug Free Workplace Laboratory, AHCA Form 3170-5001

- Effective date of the change. NOTE: Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date.
- For a change in the address of record: Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
- For corporate licensee name changes (other than change of ownership): A current certificate of status or authorization pursuant to Section 607.0128, F.S..
- For provider name changes: Proof of fictitious name registration, if applicable.
- \$25.00 fee for replacement license / reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable.

Definitions of terms used in this application and the addendum, AHCA Form 3110-1024:

"Administrator" means individual who is responsible for the day-to-day operation of the provider. For clinical laboratories, this individual is the Laboratory Director. [see s. 408.809 (1), F.S]

"Clinical Consultant" as described in section 493.1411 -1419 of the Code of Federal Regulation and required for clinical laboratory operations under Florida Rule 59A-7.035, Florida Administrative Code.

"Exclusive Use Laboratory" means a clinical laboratory operated by one or more of the following exclusively in connection with the diagnosis and treatment of their own patients: physician licensed under Chapter 458 or 459, F.S.; chiropractor licensed under Chapter 460, F.S.; podiatrist licensed under Chapter 461, F.S.; naturopathist licensed under Chapter 462, F.S.; or dentist licensed under Chapter 466, F.S. [see 59A-7.020(11), F.A.C.]

"Financial Officer" means individual who is responsible for the financial operation of the licensee or provider. [see s. 408.809 (1), F.S]

"Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency. **The licensee is legally responsible for all aspects of the provider operation.** [see s. 408.803 (9), F.S]

"Provider" means any activity, service, agency, or facility regulated by the agency such as a clinical laboratory. *Providers* are often the fictitious name used by the *licensee*. [see s. 408.803 (11), F.S]

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you **please place checks, money orders and fingerprint cards on top of the application and paperclip** everything together. Please **do not staple or bind documents** submitted to the Agency.



APPLICATION CHECKLIST

Health Care Licensing Application

MULTIPHASIC HEALTH TESTING CENTER

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 483, Florida Statutes (F.S.) and Chapters 59A-35 and 59A-6, Florida Administrative Code (F.A.C.). Applications must be received **at least 60 days prior** to the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. **The application will be withdrawn from review if all the required documents are not included with this application or received within 21 days of an omission notice.**

All forms listed below may be obtained from the Agency's website at: <http://ahca.myflorida.com/Publications/Forms/HQA.shtml>. Send completed applications to: Agency for Health Care Administration, Lab Unit, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308.

A. Initials, Renewals and Change of Ownership Applications must include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- The biennial licensure fee **(\$625.00)**. Please make check or money order payable to the Agency for Health Care Administration (AHCA). All fees are nonrefundable. *NOTE: Starter checks and temporary checks are not accepted.*
- Health Care Licensing Application, Multiphasic Health Testing Center, AHCA Form 3170-4001. **NOTE:** All Agency correspondence will be sent to the mailing address provided in Section 1A (Provider Information) of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 1B (Licensee Information) of this application must be the same as the information registered with the Division of Corporations as provided in section 59A-35.060(4), Florida Administrative Code.
- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).
- A copy of CLIA Certificate of Waiver if performing clinical laboratory waived testing on site.
- Curriculum Vitae for the Medical Director
- A Level 2 background screening for the Administrator (Medical Director) and Financial Officer is required every 5 years. Please check all boxes below that apply to this application:

- The Administrator (Medical Director) Financial Officer submitted a Level 2 screening through a **LiveScan vendor** approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan vendors please see the Agency's background screening website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

All screening results **must be sent** to the **Agency for Health Care Administration** (Agency) for review and eligibility determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you **must provide** the following **ORI FL922020Z** and identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the result, additional screening and fees may be required.

The Agency has created a form that you may use to take to the vendor. You may access this form, Background Screening Validation, on the Agency's website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

- The Administrator (Medical Director) Financial Officer are out of state and do not have access to a Florida LiveScan vendor and will need to submit a fingerprint card (**you must obtain a fingerprint card from the Agency.**) To request a fingerprint card please contact the Agency's Background Screening Section at (850)412-4503 or email bgscreen@ahca.myflorida.com. The fingerprint card will be submitted to:

- The Agency's contracted vendor, Cogent Systems (www.cogentid.com), along **with a fee of \$55.50** (\$40.50 for the screening + \$15.00 processing fee). The fingerprint card must be filled out completely and the fingerprints taken by law enforcement personnel or individual trained in processing fingerprints. Return the completed card to:

3M Cogent
ATTN: FL Cardscan
5025 Bradenton Avenue, Suite A
Dublin, OH 43017

- Another LiveScan vendor authorized to provide services in Florida that is equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all LiveScan vendors have this ability. For more information you may find LiveScan vendor contact information on the FDLE website: <http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx>.

- Proof of Level 2 screening within the previous 5 years for the Administrator (Medical Director) Financial Officer from the Agency's Medicaid Division. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

- Level 2 screening has been conducted within the previous 5 years for the Administrator (Medical Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. **Additional Information needed for INTIAL Applications:**

- For corporate applicants for licensee and management company, a current certificate of status or authorization pursuant to Section 607.0128, F.S.
- Proof of fictitious name registration, if applicable.
- Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.

C. **Additional Information needed for CHANGE OF OWNERSHIP Applications:**

- For corporate applicants for licensee and management company, a current certificate of status or authorization pursuant to Section 607.0128, F.S.
- Proof of fictitious name registration, if applicable.
- Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
- Documented evidence of change of ownership such as an asset purchase agreement, stock transfer/sale agreement and/or proof of corporate reorganization

D. **Change During Licensure Period:**

Request to change the name or address of provider:

- Complete and submit sections 1, 2 and 10 of the Health Care Licensing Application, Multiphasic Health Testing Center, AHCA Form 3170-4001
- Effective date of the change. NOTE: Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date.
- For a change in the address of record: Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
- For corporate licensee name changes (other than change of ownership): A current certificate of status or authorization pursuant to Section 607.0128, F.S..
- For provider name changes: Proof of fictitious name registration, if applicable.

- \$25.00 fee for replacement license/reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.

Definitions of terms used in this application and the addendum, AHCA Form 3110-1024:

“Administrator” means individual who is responsible for the day-to-day operation of the provider. For clinical laboratories, this individual is the Laboratory Director. [see s. 408.809 (1), F.S]

“Clinical Consultant” as described in section 493.1411 -1419 of the Code of Federal Regulation and required for clinical laboratory operations under Florida Rule 59A-7.035, Florida Administrative Code.

“Exclusive Use Laboratory” means a clinical laboratory operated by one or more of the following exclusively in connection with the diagnosis and treatment of their own patients: physician licensed under Chapter 458 or 459, F.S.; chiropractor licensed under Chapter 460, F.S.; podiatrist licensed under Chapter 461, F.S.; naturopathist licensed under Chapter 462, F.S.; or dentist licensed under Chapter 466, F.S. [see 59A-7.020(11), F.A.C.]

“Financial Officer” means individual who is responsible for the financial operation of the licensee or provider. [see s. 408.809 (1), F.S]

“Licensee” means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency. **The licensee is legally responsible for all aspects of the provider operation.** [see s. 408.803 (9), F.S]

“Provider” means any activity, service, agency, or facility regulated by the agency such as a clinical laboratory. *Providers* are often the fictitious name used by the *licensee*. [see s. 408.803 (11), F.S]

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you **please place checks, money orders and fingerprint cards on top of the application and paperclip** everything together. Please **do not staple or bind documents** submitted to the Agency.



AHCA USE ONLY:	
File #:	_____
Application #:	_____
Check #:	_____
Check Amt:	_____
Batch #:	_____

Health Care Licensing Application MULTIPHASIC HEALTH TESTING CENTER

Under the authority of Chapters 408 Part II and 483, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-6, Florida Administrative Code (F.A.C.), an application is hereby made to operate a multiphasic health testing center as indicated below.

1. Provider / Licensee Information

A. Provider Information – please complete the following for the multiphasic health testing center name and location. <i>Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/.</i>			
License # (for renewal & change of ownership applications)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #
Name of Multiphasic Health Testing Center (if operated under a fictitious name, list that here)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number	E-mail Address	Provider Website
Mailing Address or <input type="checkbox"/> Same as above (All mail will be sent to this address)			
City	State	Zip	
Contact Person for this application		Contact Telephone Number	
Contact e-mail address or <input type="checkbox"/> Do not have e-mail		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	

B. Licensee Information – please complete the following for the entity seeking to operate the multiphasic health testing center.			
Licensee Name (This is the owner of the laboratory - see definition of "licensee" on the instruction checklist)		Federal Employer Identification Number (EIN)	
Mailing Address or <input type="checkbox"/> Same as above			
City	State	Zip	
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one):			
For Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other	Not for Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other	Public <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District	

2. Application Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. All fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

Initial Licensure

Was this entity previously licensed as a Multiphasic Health Testing Center in Florida?

YES

NO

If yes, please provide the name of the agency (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:
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Licensure Renewal

Change of Ownership

Name/address change of the facility

Proposed Effective Date: _____

Proposed Effective Date: _____

**With the exception of name/address change, if more than one action is needed, then a separate application and fee must be submitted. Providers may not "X" both "change of ownership" and "renewal" boxes, for example. Two separate applications and two fees are required and the information contained with these applications will, by definition [see 408.803(5), F.S.], be different. Applications with an "X" in more than one box will not be accepted and will be returned.*

Action	Fee	TOTAL FEES
LICENSE FEE (Initial, Renewal and Change of Ownership):	\$625.00	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		
<i>NOTE: Starter checks and temporary checks are not accepted.</i>		

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of Social Security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include Social Security numbers on this form. All Social Security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the

management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization.

Management Company, as defined in s. 59A-35.030 (4), F.A.C., means an entity retained by a licensee to administer or direct the operation of a provider. This does not include an entity that serves solely as a lender or lien holder.

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee (5% or more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest.

B. Board Members and Officers of Licensee

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Licensee

If the licensee is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

D. Administration

MEDICAL DIRECTOR (full name)	Florida Professional License #	Hours Spent in Center (Per Week)
FINANCIAL OFFICER (Full Name)	Florida Professional License # (optional)	

4. Management Company Controlling Interests

Does a company other than the licensee manage the licensed provider?

If NO, skip to section 5 – *Required Disclosure*.

If YES, provide the following information:

Name of Management Company		EIN (No SSN)	Telephone Number / Fax	
Street Address		E-mail Address		
City	County	State	Zip	
Mailing Address or <input type="checkbox"/> Same as above				
City		State	Zip	
Contact Person	Contact E-mail		Contact Telephone Number	

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company (5% or more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest.

B. Board Members and Officers of Management Company

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Management Company

If the management company is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

5. Required Disclosure

The following disclosures are required:

- A. Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809(5), F.S., for each controlling interest.

Has the applicant or any individual listed in sections 3 and 4 of this application been convicted of any level 2 offense pursuant to subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held
- A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

-
- B. Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held
- A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

-
- C. Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

YES NO Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, within the previous 15 years prior to the date of this application;

YES NO Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, and not been in good standing with the Florida Medicaid program for the most recent 5 years;

YES NO Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from the federal Medicare program or from any other state Medicaid program, have not been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination was less than 20 years prior to the date of this application.

6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES NO

If yes, please complete the following for each incidence (attach additional sheets if necessary):

Amount: \$ _____ assessed by: Agency for Health Care Administration Case # _____ CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES NO

Please attach a copy of the approved repayment plan if applicable.

7. Category of Center

Indicate one: Fixed OR Mobile

Indicate all that apply: Consumer Contract

NOTE: See Section 483.288, F.S. for definitions of Consumer and Contract Multiphasic Health Testing Centers.

8. Services

Specimens taken from the human body are delivered to the following clinical laboratories for analysis:

Name	Address	License # 8000
Name	Address	License # 8000

Other services (check all that apply):

CLIA waived clinical laboratory testing performed on-site. CLIA Certificate of Waiver #: _ _D_ _ _

Height/Weight Determinations Blood Pressure Determinations

Limited Audio Testing Limited Visual Testing

Electrocardiograms (EKG)

EKG Interpretation Provided by:

Name	Address	License #
Name	Address	License #

X-rays

X-ray Interpretation Provided by:

Name	Address	License #
Name	Address	License #

Other (List below. Attach additional sheets as needed.):

9. Personnel

Provide the following information on ALL personnel employed by the center. If any individual has not been formally licensed or certified, indicate their respective job titles assigned by the center and provide a resume for each person indicating medical training.

Full Name	Licensure/Certification or Registration Title	Florida Professional License #	Job Title

10. Affidavit

I, _____, hereby swear or affirm that the statements in this application are true and correct. As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Signature of Licensee or Authorized Representative

Title

Date

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
CLINICAL LAB UNIT
2727 MAHAN DR MS 32
TALLAHASSEE FL 32308-5407

Questions? Review the information available at:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/clinical.shtml.

If the director or administrator has questions after review, contact the Clinical Laboratory unit at 850.412-4500



APPLICATION CHECKLIST

Health Care Licensing Application

DRUG FREE WORKPLACE LABORATORY

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 112, Part I, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-24, Florida Administrative Code (F.A.C.). Applications must be received **at least 60 days prior** to the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. **The application will be withdrawn from review if all the required documents are not included with this application or received within 21 days of an omission notice.**

All forms listed below may be obtained from the website: <http://ahca.myflorida.com/Publications/Forms/HQA.shtml>. Send completed applications to: Agency for Health Care Administration, Clinical Laboratory Unit, 2727 Mahan Drive, MS 32, Tallahassee, FL 32308.

A. Initials, Renewals and Change of Ownership Applications must include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- The biennial licensure fee (**\$16,435.00 per license**) - Please make check or money order payable to the **Agency for Health Care Administration (AHCA)**. All fees are nonrefundable. *NOTE: Starter checks and temporary checks are not accepted.*
- Health Care Licensing Application, Drug Free Workplace Laboratory, AHCA Form 3170-5001
- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).
- A Level 2 background screening for the Administrator (Laboratory Director) and Financial Officer is required every 5 years. Please check all boxes below that apply to this application:

For Drug Free Workplace Laboratories physically located within Florida:

- The Administrator (Laboratory Director) Financial Officer submitted a Level 2 screening through a **LiveScan vendor** approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan vendors please see the Agency's background screening website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

All screening results **must be sent** to the **Agency for Health Care Administration** (Agency) for review and eligibility determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you **must provide** the following **ORI FL922020Z** and identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the result, additional screening and fees may be required.

The Agency has created a form that you may use to take to the vendor. You may access this form, Background Screening Validation, on the Agency's website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

- Proof of Level 2 screening within the previous 5 years for the Administrator (Laboratory Director) Financial Officer from the Agency's Medicaid Division, the Department of Children and Families, Department of Health, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority to operate a continuing care retirement community) is included with this application. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.
- Level 2 screening has been conducted within the previous 5 years for the Administrator (Laboratory Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor.

For Drug Free Workplace Laboratories NOT physically located within Florida:

- The Administrator (Laboratory Director) Financial Officer are out of state and do not have access to a Florida LiveScan vendor and will submit a fingerprint card (**you must obtain a fingerprint card from the Agency**. To request a fingerprint card please contact the Agency's Background Screening Section at (850)412-4503 or email bgscreen@ahca.myflorida.com). The completed fingerprint card must then be submitted to:
 - The Agency's contracted vendor, Cogent Systems, along **with a fee of \$58.25** (\$43.25 for the screening + \$15.00 processing fee). The fingerprint card must be filled out completely and the fingerprints taken by law enforcement personnel or individual trained in processing fingerprints. Return the completed card to:
Cogent Systems
5450 Frantz Rd.
Dublin, OH 43016
 - Another LiveScan vendor authorized to provide services in Florida that is equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all LiveScan vendors have this ability. You may find LiveScan vendor contact information on the FDLE website:
<http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx>.
- Proof of Level 2 screening within the previous 5 years for the Administrator (Laboratory Director) Financial Officer from the Agency's Medicaid Division, the Department of Children and Families, Department of Health, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority to operate a continuing care retirement community) is included with this application. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.
- Level 2 screening has been conducted within the previous 5 years for the Administrator (Laboratory Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional information needed for CHANGE OF OWNERSHIP Applications [see 59A-35.070, Florida Administrative Code]::

- Documented evidence of change of ownership such as an asset purchase agreement, stock transfer/sale agreement and/or proof of corporate reorganization
- Proof of fictitious name registration, if applicable.
- Copy of current Certificate of Status filed with the FL Department of State for licensee and Management Company, if applicable.

C. Change During Licensure Period:

Request to change the name or address of provider:

- Complete and submit sections 1, 2 and 12 of the Health Care Licensing Application, Drug Free Workplace Laboratory, AHCA Form 3170-5001
- \$25.00 fee for replacement license / reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable.
- Copy of current Certificate of Status filed with the FL Department of State for licensee and Management Company, if applicable.
- Proof of fictitious name registration, if applicable.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you **please place checks, money orders and fingerprint cards on top of the application and paperclip** everything together. Please **do not staple or bind documents** submitted to the Agency.



AHCA USE ONLY:	
File #:	_____
Application #:	_____
Check #:	_____
Check Amt:	_____
Batch #:	_____

Health Care Licensing Application DRUG FREE WORKPLACE LABORATORY

Under the authority of Chapters 408, Part II and 112, Part I Florida Statutes (F.S.), and Chapters 59A-35 and 59A-24, Florida Administrative Code (F.A.C.), an application is hereby made to operate a drug free workplace laboratory as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the drug free workplace laboratory name and location. Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/			
Florida Clinic License # 80000 Permanent License # T (Renewal Applications)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #
Name of Drug Free Workplace Laboratory (if operated under a fictitious name, list that here)			
Street Address			
City		County	State Zip
Telephone Number	Fax Number	E-mail Address	Provider Website
Mailing Address or <input type="checkbox"/> Same as above (All mail will be sent to this address)			
City		State	Zip
Contact Person for this application		Contact Telephone Number	
Contact e-mail address or <input type="checkbox"/> Do not have e-mail		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	

B. Licensee Information – please complete the following for the entity seeking to operate the drug free workplace laboratory.			
Licensee Name (may be same as provider name above)		Federal Employer Identification Number (EIN)	
Mailing Address or <input type="checkbox"/> Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one):			
<u>For Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other	<u>Not for Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other	<u>Public</u> <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District	

2. Application Type and Fees

Indicate the type of fees submitted with an "X." **Applications will not be processed if all applicable fees are not included.** Please make check or money order payable to the Agency for Health Care Administration (AHCA). **Pursuant to s. 408.805(4), F.S., fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

***DO NOT "X" MORE THAN ONE BOX BELOW.**

Initial Licensure

Was this entity previously licensed as a Drug Free Workplace Laboratory in Florida? YES NO

If yes, please provide the name of the agency (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:

Renewal Licensure

Change of Ownership

Proposed Effective Date: _____

Name/address change

Proposed Effective Date: _____

**If more than one action is needed, then a separate application and fee must be submitted. Providers may not "X" both "change of ownership" and "renewal" boxes, for example. Two separate applications and two fees are required and the information contained with these applications will, by definition [see 408.803(5), F.S.], be different. Applications with an "X" in more than one box will not be accepted and will be returned.*

LICENSE FEE: **DO NOT "X" MORE THAN ONE BOX BELOW.

Action	Fee	TOTAL FEES
LICENSE FEE (Initial, Renewal and Change of Ownership):	\$16,435.00	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		
<i>NOTE: Starter checks and temporary checks are not accepted</i>		

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of Social Security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include Social Security numbers on this form. All Social Security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization.

Management Company, as defined in s. 59A-35.030 (4), F.A.C., means an entity retained by a licensee to administer or direct the operation of a provider. This does not include an entity that serves solely as a lender or lien holder. In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee (5% of more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest. Information provided above should not be the same information contained in 1B of this application.

B. Board Members and Officers of Licensee

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Licensee

If the licensee is a not-for-profit corporation/organization, provide the requested information for each individual that serves as a voluntary board member. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

D. Administration

TITLE	NAME	TELEPHONE NUMBER	E-MAIL	FLORIDA LICENSE NUMBER
Lab Director				
Chief Financial Officer				N/A

4. Management Company Controlling Interests

Does a company other than the licensee manage the licensed provider?

If NO, skip to section 5 – *Required Disclosure*.

If YES, provide the following information:

Name of Management Company		EIN (No SSN)	Telephone Number / Fax	
Street Address		E-mail Address		
City	County	State	Zip	
Mailing Address or <input type="checkbox"/> Same as above				
City		State	Zip	
Contact Person	Contact E-mail	Contact Telephone Number		

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company (5% of more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest.

B. Board Members and Officers of Management Company

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Management Company

If the management company is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

5. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809(5), F.S., for each controlling interest.

Has the applicant or any individual listed in sections 3 and 4 of this application been convicted of any level 2 offense pursuant to subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held
- A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

B. Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held

A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

YES NO Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, within the previous 15 years prior to the date of this application;

YES NO Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, and not been in good standing with the Florida Medicaid program for the most recent 5 years;

YES NO Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from the federal Medicare program or from any other state Medicaid program, have not been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination was less than 20 years prior to the date of this application.

6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the Agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the Agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES NO

If yes, please complete the following for each incidence (attach additional sheets if necessary):

Amount: \$ _____ assessed by: Agency for Health Care Administration Case # _____ CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES NO

Please attach a copy of the approved repayment plan if applicable.

7. Days and Hours of Operation

List the regular operating hours. Section 59A-8.003(10)(a), F.A.C., requires that an agency be open for 8 consecutive hours per day, Monday through Friday between the hours of 7 a.m. and 6 p.m., excluding legal and religious holidays:

Day of the Week	Opening Time	Closing Time
<input type="checkbox"/> 24 hours/7 days a week or indicate daily hours below:		
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

8. Proficiency Testing Provider Information

SAMHSA (HHS)

CAP (UDC)

Other: _____

9. Specimen Type

Urine

Blood

Hair

10. Inspection

Is this laboratory SAMHSA (HHS) certified? YES NO

Date of last SAMHSA (HHS) inspection: _____

In lieu of annual inspection submit a copy of the most recently completed SAMHSA (HHS) inspection report.

Is this laboratory enrolled in an approved forensic toxicology accreditation program? YES NO

(NOTE: Participation in a Proficiency Testing Program is not equivalent to accreditation.)

Accreditation organization name: _____

Date of last accreditation inspection: _____

In lieu of annual inspection submit a copy of the most recently completed accreditation organization inspection report and proof of non-provisional accreditation for the current year.

11. Equipment

List the major equipment/test systems used by the laboratory. Ancillary equipment such as centrifuges, shakers, rotators, computer equipment, etc., does not need to be included. Abbreviations are acceptable. Attach additional sheets as needed.

12. Staffing

Please provide the information requested below. Attach additional sheets as needed.

A. Certifying Scientists

Name	Florida Clinical Laboratory License Number (Required only if laboratory is located in the State of Florida)	Florida License Level (If required)	Florida Licensure Specialty(s) (If required)	Toxicology Experience (Years)

B. Certifying Scientists for Negative Tests

Name	Florida Clinical Laboratory License Number (Required only if laboratory is located in the State of Florida)	Florida License Level (If required)	Florida Licensure Specialty(s) (If required)	Toxicology Experience (Years)

C. Person(s) Responsible for the day-to-day Supervision of Analysts

Name	Florida Clinical Laboratory License Number (Required only if laboratory is located in the State of Florida)	Florida License Level (If required)	Florida Licensure Specialty(s) (If required)	Toxicology Experience (Years)

D. Technical Personnel Performing Toxicology Testing

Name	Florida Clinical Laboratory License Number (Required only if laboratory is located in the State of Florida)	Florida License Level (If required)	Florida Licensure Specialty(s) (If required)	Toxicology Experience (Years)

13. Collection Stations

List all locations in Florida for which the laboratory accepts drug free workplace specimens. Attach additional sheets as needed.

Collection Site Name	Address	City	Zip

14. Affidavit

NOTE: Only the Laboratory Director listed in section 3D of this application is authorized to execute this affidavit.

I, _____, hereby swear or affirm, under penalty of perjury, that the statements in this application are true and correct. As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Signature of Laboratory Director

Title

Date

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
CLINICAL LABORATORY UNIT
2727 MAHAN DR., MS 32
TALLAHASSEE FL 32308

Questions? Review the information available at: <http://ahca.myflorida.com/> or contact the Clinical Laboratory Unit at (850) 412-4500.



Health Care Licensing Application Addendum

AUTHORITY: Pursuant to section 408.806, Florida Statutes (F.S.), the Agency for Health Care Administration is required to obtain the name, address and Social Security number of the applicant and each controlling interest if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest if the applicant or controlling interest is not an individual. Disclosure of your Social Security number is mandatory. Your Social Security number will be used to secure the proper identification of persons listed on this application for licensure, criminal background checks and the indexing of controlling interests.

1. Provider / Licensee Information

A. Please complete the following and indicate whether background screening was conducted as part of this application. (if you are seeking licensure as a Risk Manager please skip to 1B; Applicants for Health Care Clinics **must also** complete 1C):

Provider/Facility Type:		National Provider ID#: (if applicable)
Provider/Facility Name:		
Administrator/CEO/Managing Employee:	Social Security #:	Background Screening Conducted <input type="checkbox"/> YES <input type="checkbox"/> NO
Chief Financial Officer:	Social Security #:	Background Screening Conducted <input type="checkbox"/> YES <input type="checkbox"/> NO

Laboratory Directors are considered administrators for clinical laboratories.

B. RISK MANAGERS ONLY:

Name	Social Security #:
HCRM License # (for renewal applications) 550-	Background Screening Conducted <input type="checkbox"/> YES <input type="checkbox"/> NO

C. Additional information needed for HEALTH CARE CLINIC applicants:

In accordance with sections 408.806(1)(a) and 400.991 F.S., the medical or clinic director and each licensed health care practitioners as provided in section 3D of the Health Care Licensing Application, Health Care Clinics, AHCA Form 3110-0013, must provide their Social Security number. The Social Security number will be used to secure the proper identification of persons listed on this application for licensure and criminal background checks. *Please attach additional sheets if necessary.*

FULL NAME	SOCIAL SECURITY NUMBER	BACKGROUND SCREENING CONDUCTED
Medical or Clinical Director:		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO

2. Controlling Interests of Licensee

A. Individual and/or Entity Ownership of Licensee

Provide the following information for **each person with 5% or greater ownership interest** in the licensee/provider. This information must match the information contained in Section 3A of the *Health Care Licensing Application*. Attach additional sheets if necessary.

FULL NAME	SOCIAL SECURITY NUMBER

B. Board Members and Officers of Licensee

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the licensee/provider. This information must match the information contained in Section 3B of the *Health Care Licensing Application*. Attach additional sheets if necessary.

TITLE	FULLNAME	SOCIAL SECURITY NUMBER
Director/CEO		
President		
Vice President		
Secretary		
Treasurer		
Other:		

3. Management Company Controlling Interests

If a company other than the licensee manages the licensee/provider, complete the following information:

A. Individual and/or Entity Ownership of Management Company

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the management company. This information must match the information contained in Section 4A of the *Health Care Licensing Application*. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL	SOCIAL SECURITY NUMBER

B. Board Members and Officers of Management Company

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members). This information must match the information contained in Section 4B of the *Health Care Licensing Application*. Attach additional sheets if necessary.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Director/CEO		
President		
Vice President		
Secretary		
Treasurer		
Other:		

4. Affidavit

I, _____, hereby swear or affirm, under penalty of perjury that the statements in this addendum to the application for licensure as a health care provider are true and correct.

Signature of Licensee or Authorized Representative

Title

Date



AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(i) Section 784.011, relating to assault, if the victim of the offense was a minor.

(j) Section 784.03, relating to battery, if the victim of the offense was a minor.

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

(m) Section 787.025, relating to luring or enticing a child.

(n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(r) Section 794.011, relating to sexual battery.

(s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(t) Section 794.05, relating to unlawful sexual activity with certain minors.

(u) Chapter 796, relating to prostitution.

(v) Section 798.02, relating to lewd and lascivious behavior.

(w) Chapter 800, relating to lewdness and indecent exposure.

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

(z) Section 810.14, relating to voyeurism, if the offense is a felony.

(aa) Section 810.145, relating to video voyeurism, if the offense is a felony.

(bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S

(a) Any authorizing statutes, if the offense was a felony.

- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (g) Section 817.234, relating to false and fraudulent insurance claims.
- (h) Section 817.505, relating to patient brokering.
- (i) Section 817.568, relating to criminal use of personal identification information.
- (j) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (l) Section 831.01, relating to forgery.
- (m) Section 831.02, relating to uttering forged instruments.
- (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (p) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screened conducted by: _____ Date of Prior Screening: _____

- Agency for Health Care Administration
- Department of Health
- Agency for Persons with Disabilities
- Department of Children and Family Services
- Department of Financial Services

Affidavit

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date