CITY OF MARGATE
Together We Make It Great

# Medical Office Certification

Corporate Name : _____

Fictitious Name (DBA): _____

Address: _____

Select one of the following:

☐ I hereby certify that the above referenced clinic/facility/office is a pain management clinic; therefore, it is required to register with the Florida Department of Health pursuant to section 458.3265 or 459.0137, Florida Statutes, as amended.

☐ I hereby certify that the above referenced clinic/facility/office is ***not*** a pain management clinic; therefore, it is ***not*** required to register with the Florida Department of Health pursuant to section 458.3265 or 459.0137, Florida Statutes, as amended.

**FORM MUST BE PRINTED AND SIGNED IN THE PRESENCE OF A NOTARY**

_____ _____

Printed Applicant Name Applicant Title

_____ _____

Applicant Signature Date

Sworn to (or affirmed) and subscribed before me by means of ☐ physical presence or ☐ online notarization, this ____ day of _____, __(year), by _____ (name of person making statement).

_____ _____

Signature of Notary Printed name or stamp of Notary

Personally known to me_____

Produced identification: _____

Type of Identification: _____