Hillsborough County Pain Management Clinic Licensing
Application and Important Information

The Pain Management Clinic Ordinance applies to clinics that operate in unincorporated Hillsborough County and the cities of Temple Terrace and Plant City. The City of Tampa maintains its own ordinance related to Pain Management Clinics.

- **Pain Management Clinic Ordinance –** It is highly recommended that all persons associated with the management or operation of the clinic read and become familiar with the Pain Management Clinic Ordinance, Hillsborough County Code of Ordinances, Part A, Chapter 10, Article IX, as amended. Article IX can be found on our website.

https://library.municode.com/fl/hillsborough_county/codes/code_of_ordinances,_part_a?nodeId=HICOCOORLA_CH10BU_ARTIXPAMACL

- **Fees –** Each application for a pain management clinic license shall be accompanied by a nonrefundable application fee and the additional license fee will be required after the annual site visit inspection and all requirements have been met. Once payment is received the license will be issued.

Annually Required License	Fee	Comment
Pain Management Clinic Application	$500.00	Fee is non-refundable and includes associated background check, inspection and placard
Pain Management Clinic License	$1,500.00	License

Payments can be made by CREDIT or DEBIT CARD online at the following page:

https://hcfl.gov/residents/property-owners-and-renters/code-violations/pay-my-code-enforcement-fines-and-registration-fees

Other methods of payment are Cashier's Check, Money Order, Escrow or Trust Account Checks, made payable to BOCC or "Board of County Commissioners."

Payments should be mailed to:

Hillsborough County Code Enforcment
Attn: R/C Payment Remittance
3629 Queen Palm Drive
Tampa, FL 33619

***** NOTE: No Personal Checks Accepted *****

- **Designation of Physician** – The clinic will be responsible for the designation of a properly licensed physician who will be responsible for complying with all requirements related to the registration and operation of the clinic. Within ten (10) days after termination or absence of a designated physician, the clinic must notify the Regulatory Compliance Code Enforcement Department of the identity of another designated physician for the clinic or forfeit the clinic's license.

- **Hours of Operation -** The hours of operation of the clinic shall be limited to 7:00 a.m. to 9:00 p.m., Monday through Saturday.

- **List of Employees/FDLE Backgrounds – "Section G"** of the application be fully completed and list all persons associated with the management or operation clinic.

  Please contact Isaac Ruffin at (813) 274-6779 or RuffinI@HCFLGov.net *to schedule an appointment for your clinic employees to be fingerprinted.*

- **Inspections** – Any time the clinic is open or occupied, the clinic must allow for inspections by a Code Enforcement Officer or any other person authorized to enforce ordinance violations in Hillsborough County. Failure to do so will result in license denial or revocation.

- **Sworn and Notarized Statement** – The applicant must provide a sworn and notarized statement from **both the designated physician and the clinic owner** attesting to the veracity and accuracy of the information provided in the application.

The printable application for Pain Management Clinic License" may be downloaded at:

https://www.hillsboroughcounty.org/library/hillsborough/media-center/documents/code-enforcement/pain-management-clinic/renewal-of-pain-management-clinic-license-application-printable.pdf

The fillable application for Pain Management Clinic License" may be downloaded at:

https://www.hillsboroughcounty.org/library/hillsborough/media-center/documents/code-enforcement/pain-management-clinic/renewal-of-pain-management-clinic-license-application-fillable.pdf

Any incomplete sections will delay processing and will cause the application to be returned or denied. After completing the application, save it to your computer and submit as an email attachment. The notarized statements can be scanned and submitted by email to Isaac Ruffin at RuffinI@HCFLGov.net The application fee should be mailed or paid the same day as the application.

APPLICATION FOR PAIN MANAGEMENT CLINIC LICENSE

☐ Renewal – HCPMC License # _____ ☐ Change of Property Owner or Property Owner Address

☐ Clinic Relocation ☐ Change in Clinic Name or Clinic Ownership

☐ Registering New Designated Physician ☐ Other: _____

SECTION A: CLINIC OFFICE INFORMATION:

1. Corporate or Legal Name of Pain Management Clinic: _____
2. Fictitious Name or Doing Business As: _____
3. Clinic Physical Address: _____
4. Clinic Mailing Address: _____
5. Clinic Days & Hours of Operation: _____
6. Clinic Telephone Number: _____ 7. Federal Tax I.D. Number (FEID#): _____
8. Name of Clinic's Designated Contact: _____

   Designated Contact's Email Address: _____

***NOTE – All correspondence from Hillsborough County regarding the clinic's application and license will be sent to this email address**

9. Florida Department of Health Pain Management Clinic License number: _____
10. Agency for Health Care Administration Health Care Clinic License Number: HCC_____ or Exempt ☐
11. Hillsborough County Business Tax Receipt Account Number: _____
12. Does any person listed on Section G, Clinic Employee List, have a financial interest or employment relationship with any pharmacy? Yes ☐ No ☐

    If yes, indicate the name of the employee and the name and address of the pharmacy below.

_____

SECTION B: CLINIC OWNER(S) INFORMATION:

(If the clinic is owned by more than one individual, attach a separate sheet to this application with the same information)

1. Full Legal Name: _____
2. Clinic Owner Address: _____
3. Clinic Owner Email Address: _____
4. Telephone Numbers: (Home) _____ (Cellular) _____
5. Does the clinic owner own a pain management clinic in another jurisdiction?

   If yes, indicate the name and address of the clinic(s) below.

_____

SECTION C: PROPERTY OWNER(S) INFORMATION:

1. Full Legal Name: _____

2. Address: _____

3. Telephone Numbers: (Business) _____ (Cellular) _____

SECTION D: DESIGNATED PHYSICIAN (DP) INFORMATION:

1. Designated Physician Full Legal Name: _____

2. Designated Physician Email Address: _____

3. Florida Medical License Number: _____ 4. Designated Physician DEA Number: _____

5. List of ALL pain management clinics currently supervised by DP or where DP practices:
Include the clinic name and address as well as the clinic owner's name and the hours the DP works at the clinic.

_____

_____

_____

6. a. Has the designated physician ever had disciplinary action taken against his/her license? Yes ☐ No ☐

b. Has the designated physician ever had any administrative complaints filed against him/her? Yes ☐ No ☐

c. Are you aware that you must update the Consumer and Veterans Services within thirty (30) days if either 6a or 6b occurs? Yes ☐ No ☐

SECTION E: ADDITIONAL PHYSICIAN INFORMATION:

1. Do any other physicians' practice or work at the clinic? Yes ☐ No ☐

If Yes, complete Section E for each additional physician.

If No, skip to Section F.

2. Physician Full Legal Name: _____

3. Physician Email Address: _____

4. Florida Medical License Number: _____ 5. Physician DEA Number: _____

6. List of ALL pain management clinics currently supervised by physician or where physician practices:
Include the clinic name and address as well as the clinic owner's name and the hours the DP works at the clinic.

_____

_____

_____

7. a. Has the physician ever had disciplinary action taken against his/her license? Yes ☐ No ☐

b. Has the physician ever had any administrative complaints filed against him/her? Yes ☐ No ☐

c. Are you aware that you must update the Regulatory Compliance Code Enforcement Department within thirty (30) days if either 7a or 7b occurs? Yes ☐ No ☐

SECTION F: REQUIRED ATTACHMENTS:

1. A floor plan or the pain management clinic showing the location and size of the waiting area, location and size of the patient rooms and location of any type of diagnostic equipment. In addition, if any controlled substances are dispensed at the site or are stored at the site, the location and method of security for any controlled substances must be shown. If the floor plan is the same as was what was provided in previous Hillsborough County Pain Management Clinic Applications, the clinic is not required to submit this attachment.

2. A copy of property ownership records or the lease agreement if the property is being leased. If the lease agreement and property owner information are the same as was what was provided in previous Hillsborough County Pain Management Clinic Applications, the clinic is not required to submit this attachment.

3. **Check or money order in the amount of $500.00 payable to: Hillsborough County BOCC**

Send the completed application to:

Code Enforcement Department
Attn: Regulatory Compliance
2709 East Hanna Avenue
Tampa, FL 33610

Pay Online by CREDIT or DEBIT CARD at the following page:

https://www.hillsboroughcounty.org/en/government/departments/code

Send your payment to:

Hillsborough County Center
Citizen Boards Support
601 E. Kennedy Blvd.,
18th Floor
County Center, Tampa, FL, 33602

For your convenience, a payment drop box is also available in the lobby of the 18th Floor

Section G:
Clinic Employee List

Clinic Name: _____ **Date:**_____

Employee Name	Employee Title	Date of Birth	Home Address	Telephone Number	Check Yes or No for Each			Driver's License Number
					Arrest	Drug Arrest	Criminal Conviction	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	
					Y N	Y N	Y N	

SECTION H: DESIGNATED PHYSICIAN AUTHORIZATION AND CERTIFICATION:

Pursuant to Hillsborough County Ordinance Article IX, as amended, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. I also understand and agree that I may be asked to provide additional information once my application has been reviewed as a requirement to the issuance of a clinic license. Once a license has been issued, I agree to provide any supplemental information that may be requested by Regulatory Compliance, Code Enforcement Department and, with the exception of changes of information under Sections 10-270 (3) (10) & 10-272 (B), to update the Regulatory Compliance, Code Enforcement Department within ten (10) days of any changes to the information in this application. With respect to Sections 10-270 (F) & (G), I agree to update Regulatory Compliance, Code Enforcement Department within thirty (30) days of any change in information. I also understand that I have been appointed as the designated physician for the clinic on this application. I understand that, as designated physician, I am responsible for complying with all requirements related to registration and operation of the clinic as well as providing my DEA number to Regulatory Compliance, Code Enforcement Department. I understand that I must have a full, active and unencumbered license under Florida Statutes Chapters 456 or 459 and shall practice at the clinic location for which I have assumed responsibility.

Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.

_____ _____

Designated Physician Signature (before a notary) | Print Name

Notary Certification:

Sworn to (or affirmed) and subscribed before me this ____ day of _____, 20____, by _____

_____, who is personally known to me or who has produced _____

as identification and did take an oath.

_____ Seal:

Notary Signature

SECTION I: CLINIC OWNER AUTHORIZATION AND CERTIFICATION:

Pursuant to Hillsborough County Ordinance Article IX, as amended, I authorize any law enforcement officer, code enforcement officer, or any other person authorized to enforce ordinance violations in Hillsborough County, access to this clinic at any time someone is present to determine compliance with local, state or federal law. I also understand and agree that I may be asked to provide additional information once my application has been reviewed as a requirement to the issuance of a clinic license. Once a license has been issued, I agree to provide any supplemental information that may be requested by the Regulatory Compliance, Code Enforcement Department with the exception of changes of information under Sections 10-270 (3) (10) & 10-272 (B), to update Regulatory Compliance, Code Enforcement Department within ten (10) days of any changes to the information in this application. With respect to Sections 1 0 - 2 7 0 (F) & (G), I agree to update the Regulatory Compliance, Code Enforcement Department within thirty (30) days of any change in information.

Having been duly sworn, I certify that the foregoing statements and attachments are all true, complete and accurate. I understand and agree that any false, misleading, inaccurate or incomplete statements and attachments may result in the denial or revocation of a Pain Management Clinic License.

_____ _____

Clinic Owner Signature (before a notary) Print Name

Notary Certification:

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20_____, by _____

_____, who is personally known to me or who has produced _____

as identification and did take an oath.

_____ Seal:

Notary Signature