Office Surgery
Registration Application

Department of Health
Office Surgery Registration and Inspection Program
P.O. Box 6330
Tallahassee, FL 32314-6330

Website: http://www.floridahealth.gov/licensing-and-regulation/office-surgery-registration/index.html

Email: PMC_OSR@flhealth.gov

Phone: (850) 245-4131

Fax: (850) 488-0596

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Do Not Write in this Space
For Revenue Receipting Only

Pursuant to section 395.002(3), Florida Statutes, an **ambulatory surgical center** is a facility, the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within 24 hours, and which is not part of a hospital. An office maintained by a physician for the practice of medicine may not be construed to be an ambulatory surgical center.

Pursuant to sections 458.328(1)(a) and 459.0138(1)(a), Florida Statutes, an **office surgery** is a facility in which a physician may perform a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a Level II office surgery, or a Level III office surgery, and which must register with the Department of Health. A facility licensed under chapter 390 or chapter 395, Florida Statutes, **may not** be registered as an office surgery.

Is the primary purpose of the facility to be registered to provide elective surgical care? Yes No

If "Yes," the facility to be registered may not qualify for an office surgery registration. Ambulatory surgical centers are regulated by the Agency for Health Care Administration. Visit https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/ambulatory-surgical-center for more information.

If "No," indicate the physician's office to be registered below:

Physician's Name (if applicable):		**License #:**
Applicant's Corporate or Legal Name:		
Physical Address of Physician's Office:		**Suite #:**
City:	**State:**	**ZIP:**

Accurately complete and submit the application, all required supplemental documents, and the appropriate fee to the P.O. Box provided above. Fees must be paid in the form of a cashier's check or money order made payable to the Department of Health. Application fees are non-refundable. Pursuant to sections 458.328(1)(a)2. and 459.0138(1)(a)2., Florida Statutes, all applicants seeking a new office surgery registration will be subject to a preregistration inspection as part of the application process.

Select One Office Surgery Registration Type:	**Sections to Complete**	**Fee**	**Effective Date (MM/DD/YYYY)**
Initial Registration	Full application	$150.00	
Change of Ownership	Full application	$145.00	
Change of Location	Full application	$145.00	
Change in Office Surgery Name	Pages 2 and 3	$25.00	
Request to Withdraw or Close Registration	Section 2	No Fee	
Request to Change Office Surgery's Financial Responsibility	Section 2 and Page 11	No Fee	
New Designated Physician	Sections 2 and 4	No Fee	
Change from Accreditation by National and Board-approved Organizations to Inspection	Sections 2 and 9	No Fee	
Change from Inspection to Accreditation by National and Board-approved Organizations	Sections 2 and 9	No Fee	

Registration # *(only required for office surgeries with an existing registration):* _____

1. OFFICE INFORMATION

Hours of Operation

Weekday	Opening Time		Closing Time	
Monday	AM	PM	AM	PM
Tuesday	AM	PM	AM	PM
Wednesday	AM	PM	AM	PM
Thursday	AM	PM	AM	PM
Friday	AM	PM	AM	PM
Saturday	AM	PM	AM	PM
Sunday	AM	PM	AM	PM

Room/Bed Capacity

Number of patient examination or consultation rooms:	
Number of surgical procedure rooms:	
Number of recovery beds:	

Floor Plan

Legibly draw a floor plan of the physician's office in ink on a separate page. The drawing should include annotations noting the purpose of each room and any other areas that are part of the office sought to be registered. A multi-story building where the entire building is to be registered must show the details of each floor. Attach the diagram to the application for registration. Pursuant to section 456.013(1)(a), Florida Statutes, **any material change to the floor plan or room designations that could affect the decision to issue a registration will require the submission of a supplement to this application.**

2. BUSINESS INFORMATION

Corporate or Legal Name of Office Surgery (if applicable):		
Doing Business As (if applicable):		
Federal Employer Identification # (FEIN):		
Mailing Street Address:		**Suite #:**
City:	**State:**	**ZIP:**
Telephone #:	**Fax #:**	
Office Surgery Physical Street Address (if different from mailing address):		**Suite #:**
City:	**State:**	**ZIP:**
Email Address*:		

Office Manager:
Office Manager Email Address*:

* Under Florida law, email addresses are public records. 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. Instead contact the office by phone or in writing.

Corporate Name: _____

3. OFFICE SURGERY PERSONNEL

List the following information for all office surgery owner(s)/principal(s), officer(s), agent, and managing employee. Throughout the application, **"License #"** refers to a health care license issued by the Department of Health. If the individual does not have a **"License #"** leave the field blank. Attach additional sheets if necessary.

Owner(s)/Principal(s)

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Officer(s)

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Agent

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Managing Employee

Name:		
License #:	**Telephone #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Corporate Name: _____

4. DESIGNATED PHYSICIAN

- The Designated Physician is responsible for **ensuring compliance with the laws and rules** governing office surgeries.
- Information regarding any change to the Designated Physician must be provided to the Department of Health **within 10 days of the change**.

Physician's Name:		
Physician's Florida License #:	**Physician's Telephone #:**	
Mailing Street Address:		**Suite #:**
City:	**State:**	**ZIP:**
Physician's Email Address*:		

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A. Does the designated physician have a full, clear, and active license issued in Florida? Yes No

B. Does the designated physician practice at the office for which they have assumed responsibility?
Yes No

C. Does the designated physician perform surgery at the office? Yes No

If "Yes," complete section 5 for the Designated Physician.

5. PHYSICIAN (SURGEON) INFORMATION

Complete this section for **each** surgeon practicing at the office surgery. **All surgeons must be disclosed.** Attach additional sheets if necessary.

Physician's Name:		
Physician's Florida License #:	**Physician's Telephone #:**	
Mailing Street Address:		**Suite #:**
City:	**State:**	**ZIP:**
Physician's Email Address*:		

* Under Florida law, email addresses are public records. 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. Instead contact the office by phone or in writing.

Indicate all levels of surgery to be performed by the above-named physician at this office surgery.

	Level I	See Rules 64B8-9.009(3)(a) and 64B15-14.007(3)(a), Florida Administrative Code (F.A.C.), for the scope of Level I office surgery procedures.
	Level II	See Rules 64B8-9.009(4)(a) and (5)(a) and 64B15-14.007(4)(a) and (5)(a), F.A.C., for the scope of Level II office surgery procedures.
	Level III	See Rules 64B8-9.009(6)(a) and 64B15-14.007(6)(a), F.A.C., for the scope of Level III office surgery procedures.

List all procedures that will be performed **by the above-named physician** at this office surgery.

_____

_____

_____

Section continues on following page.

Corporate Name: _____

PHYSICIAN (SURGEON) INFORMATION – Continued

Physician Name: _____

The following questions are specific to the above-named physician (surgeon):

A. Does the physician maintain current certification or is the physician eligible for certification with a specialty board approved by the Florida Board of Medicine? Yes No

If "Yes," submit a copy of the **physician's certificate or board eligibility letter** with this application.

If "No," submit documentation with this application demonstrating the **physician's comparable background, training, and experience** pursuant to Rules 64B8-9.009(4)(b)2.a. and (6)(b)1.a. and 64B15-14.007(4)(b)2.a. and (6)(b)1.a., Florida Administrative Code.

B. Does the physician have staff privileges at a licensed hospital to perform the same procedures in that hospital as those to be performed in the office surgery setting? Yes No

If "Yes," submit **a letter of good standing and a copy of the delineation of privileges**. Staff privileges must be at a hospital within reasonable proximity to the office surgery (i.e., 30 minutes or less transport time).

If "No," submit a **copy of a transfer agreement** between the physician and a hospital within reasonable proximity to the office surgery (i.e., 30 minutes or less transport time).

C. Does the physician hold a current Advanced Cardiovascular Life Support (ACLS) certification from an approved provider listed in Rules 64B8-9.009(4) or 64B15-14.007(4), Florida Administrative Code? Yes No

If "Yes," submit a **copy of a current ACLS card** with this application for the listed physician. **A registration cannot be issued** until the board receives a copy of ACLS certification for **each physician** practicing at the office surgery.

Note: A physician performing any surgical procedure in an office surgery is required to have ACLS certification (or Pediatric Advanced Life Support certification, if appropriate) from an approved provider listed in the rules.

D. List any Residency/Fellowship training, background experience, and any additional training. Attach additional sheets if necessary.

Training Program Name	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)
		to
		to
		to

6. ANESTHESIA PROVIDER

A. List all anesthesia providers administering anesthesia at the office surgery. Attach additional sheets if necessary.

Anesthesia Provider:			**ACLS Certified?** Yes No		
License #:			**PALS Certified?** Yes No		
Practitioner Code:	Anesthesiologist (M.D. or D.O.)	PA	CRNA	APRN	RN (Level II only)

Anesthesia Provider:			**ACLS Certified?** Yes No		
License #:			**PALS Certified?** Yes No		
Practitioner Code:	Anesthesiologist (M.D. or D.O.)	PA	CRNA	APRN	RN (Level II only)

Anesthesia Provider:			**ACLS Certified?** Yes No		
License #:			**PALS Certified?** Yes No		
Practitioner Code:	Anesthesiologist (M.D. or D.O.)	PA	CRNA	APRN	RN (Level II only)

B. Does the office contract anesthesia services with a **mobile anesthesia** provider? Yes No

If "Yes," provide the following additional information:

Anesthesia Provider:		**Telephone #:**
Address:		**Suite #:**
City:	**State:**	**ZIP:**

As indicated above, submit a copy of a current ACLS or PALS card with this application for each physician listed. A registration cannot be issued until the board receives a copy of each required ACLS or PALS certification.

7. RECOVERY PERSONNEL

A. List all recovery personnel at the office surgery. Attach additional sheets if necessary.

Recovery Personnel:			**ACLS Certified?** Yes No		
License #:			**PALS Certified?** Yes No		
Practitioner Code:	Anesthesiologist (M.D. or D.O.)	PA	CRNA	APRN	RN

Recovery Personnel:			**ACLS Certified?** Yes No		
License #:			**PALS Certified?** Yes No		
Practitioner Code:	Anesthesiologist (M.D. or D.O.)	PA	CRNA	APRN	RN

As indicated above, submit the following with this application:

A copy of a current ACLS card for **each** certified individual listed, or in the case of pediatric patients, a current PALS card.

A curriculum vitae or **written statement** outlining Post Anesthesia Care Unit (PACU) or equivalent experience for **each** listed individual.

Note: Pursuant to Rules 64B8-9.009, F.A.C., and 64B15-14.007, F.A.C., recovery personnel in a **Level II or Level III office surgery** are required to have ACLS certification, or in the case of pediatric patients, a current PALS certification, from an approved provider listed in the rules.

B. List all other locations where patients are transferred for recovery following surgery. Attach additional sheets if necessary.

Location Name:		
Telephone #:	**License #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Location Name:		
Telephone #:	**License #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

Location Name:		
Telephone #:	**License #:**	
Address:		**Suite #:**
City:	**State:**	**ZIP:**

8. OTHER PERSONNEL ON SURGICAL TEAM

List all additional personnel who will assist in surgery. Attach additional sheets if necessary.

Name of Additional Personnel:						
License #:					**BLS Certified?** Yes No	
Type of Involvement:						
Practitioner Code:	PA	CRNA	APRN	RN	Surgical Tech	Medical Assistant

Name of Additional Personnel:						
License #:					**BLS Certified?** Yes No	
Type of Involvement:						
Practitioner Code:	PA	CRNA	APRN	RN	Surgical Tech	Medical Assistant

Note: One assistant to the surgeon **must** hold a current Basic Life Support certification.

Submit a copy of a current BLS card from an approved provider with this application for **each** certified individual listed.

9. ACCREDITATION OR INSPECTION

In addition to a preregistration inspection, all office surgeries are required by sections 458.328(1)(e) and 459.0138(1)(e), Florida Statutes, to be inspected by the Department of Health or accredited by a nationally recognized accrediting agency. Select the appropriate inspection or accrediting agency choice below.

	Inspection by the Department of Health
	QUAD A
	Accreditation Association for Ambulatory Health Care (AAAHC)
	Joint Commission on Accreditation of Healthcare Organization (JCAHO)
	American Accreditation Commission International (AACI)
	Accreditation Commission for Health Care (ACHC)

If the office surgery is accredited by a nationally recognized accrediting agency, **submit a copy of each of the following** with this application:

Active accreditation certificate

Associated accreditation survey

Most recent inspection

10. REVOCATION HISTORY

Has any person named in this registration application, including the persons who own or operate the office surgery, individually or as part of a group, had an office surgery registration with which they were associated revoked?
Yes No

If "Yes," provide the following information:

Person's Name	Name of Office Surgery Registration	Date of Revocation (MM/DD/YYYY)

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if they have felony convictions that fall within certain timeframes as established by section 456.0635(2), Florida Statutes.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter 409, Florida Statutes (relating to social and economic assistance), chapter 817, Florida Statutes (relating to fraudulent practices), chapter 893, Florida Statutes (relating to drug abuse prevention and control), or any similar felony offense in another state or jurisdiction? Yes No

If "No," skip to question 2.

a. If "Yes" to 1, for felonies of the first or second degree (or the equivalent level of felony in another state or jurisdiction), has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

b. If "Yes" to 1, for felonies of the third degree (or the equivalent level of felony in another state or jurisdiction), 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, or any similar felony offense committed in another state or jurisdiction. Yes No

c. If "Yes" to 1, for felonies of the third degree (or the equivalent level of felony in another state or jurisdiction) under section 893.13(6)(a), Florida Statutes, or a similar felony offense committed in another state or jurisdiction, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

d. 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? Yes No

2. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. sections 801-970 (relating to controlled substances) or 42 U.S.C. sections 1395-1396 (relating to public health, welfare, Medicare, and Medicaid issues)? Yes No

If "No," skip to question 3.

a. If "Yes" to 2, is the date of application more than 15 years after the sentence and any subsequent period of probation? Yes No

3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, Florida Statutes?
   Yes No

If "No," skip to question 4.

   a. If "Yes" to 3, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been reinstated and 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 been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If "No," skip to question 5.

   a. If "Yes" to 4, 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

   b. If "Yes" to 4, did the termination occur at least 20 years prior to 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 the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If "Yes" to 5, is the applicant, principal, officer, agent, managing employee, or affiliated person of the applicant listed because the individual defaulted or is delinquent on a student loan?
      Yes No

   b. If "Yes" to 5.a., is the student loan default or delinquency the only reason the individual is listed on the LEIE? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following:

A written explanation for each "Yes" response including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation related to each "Yes" response including court dispositions or agency orders where applicable.

Documents must be sent to the board office at PMC_OSR@flhealth.gov, or mailed to the following address:

Department of Health
Office Surgery Registration and Inspection Program
4052 Bald Cypress Way, Bin C-03
Tallahassee, FL 32399-3253

Corporate Name: _____

12. PROFESSIONAL LIABILITY COVERAGE DISCLOSURE

All applicants must choose ONE of the following options from the Professional Liability Coverage section. Failing to make a choice or choosing more than one option will make this section invalid. Staff is unable to advise which option to choose. If the applicant has questions regarding an option, the applicant should consult legal counsel, an insurance company, or a financial institution.

PROFESSIONAL LIABILITY COVERAGE

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 section 624.09, Florida Statutes, from a surplus lines insurer as defined under section 626.914(2), Florida Statutes, from a risk retention group as defined under section 627.942, Florida Statutes, from the Joint Underwriting Association established under section 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in section 627.357, Florida Statutes.

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 section 624.09, Florida Statutes, from a surplus lines insurer as defined under section 626.914(2), Florida Statutes, from a retention group as defined through a plan of self-insurance as provided in section 627.357, Florida Statutes.

3. The office has established an irrevocable letter of credit or escrow account in an amount of $100,000/$300,000, in accordance with chapter 675, Florida Statutes, for a letter of credit and section 625.52, Florida Statutes, 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, Florida Statutes, for a letter of credit and section 625.52, Florida Statutes, for an escrow account.

5. The office has elected not to carry medical malpractice insurance, however, agrees to satisfy any adverse judgments up to the minimum amounts pursuant to sections 458.320(5)(g) or 459.0085(5)(g), Florida Statutes. The applicant understands that either a posted notice must be prominently displayed in the reception area, or a written statement must be provided to any person to whom medical services are being provided that the office does not carry medical malpractice insurance. The applicant understands that such a sign or notice must contain the wording specified in sections 458.320(5)(g) or 459.0085(5)(g), Florida Statutes.

OFFICES PERFORMING GLUTEAL FAT GRAFTING PROCEDURES

An office in which a physician performs a gluteal fat grafting procedure must **also** establish financial responsibility by demonstrating that it has met and continues to maintain, at a minimum, the same requirements applicable to physicians in s. 458.320(2)(b) or (c), Florida Statutes, and 459.0085(2)(b) or (c), Florida Statutes, as applicable.

If the office will be performing gluteal fat grafting procedures, check the appropriate box below.

The office performs gluteal fat grafting procedures and **HAS** established financial responsibility by meeting and continuing to maintain, at a minimum, the same requirements applicable to physicians in s. 458.320(2)(b) or (c), Florida Statutes, and 459.0085(2)(b) or (c), Florida Statutes, as applicable.

The office performs gluteal fat grafting procedures and **HAS NOT** established financial responsibility by meeting and continuing to maintain, at a minimum, the same requirements applicable to physicians in s. 458.320(2)(b) or (c), Florida Statutes, and 459.0085(2)(b) or (c), Florida Statutes, as applicable.

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.