HEALTH CARE CLINIC ESTABLISHMENT
Signature Page

Please complete the information below. Scan and attach this with your online application.
If it becomes necessary to mail in this form please include the cover sheet included in the application summary you received via email.

Company Name: ____

Company Physical Address: ____

____

____

This application requires signatures of both the qualifying practitioner and the owner or company officer:

DESIGNATED QUALIFYING PRACTITIONER (an individual employed at the establishment who will be responsible for all legal and regulatory requirements and will be contacted in case of an emergency)

______________________________	______________	______________
Signature of Designated Qualifying Practitioner	License Number	Date

On behalf of the applicant business, I understand and affirm that a Health Care Clinic Establishment and the designated qualifying practitioner are required to comply with the provisions of Chapter 499, F.S. and Rule 61N-1, Florida Administrative Code (F.A.C.). Further, on behalf of the Applicant Business, I swear or affirm that the information submitted online to the Department on this application is true and correct.

______________________________	______________	______________
Signature of Owner or Company Officer	Title	Date

If signed by someone other than an owner or officer, you must submit a letter for the signer to bind the applicant.

Department of Business and Professional Regulation
Drugs, Devices, and Cosmetics
2601 Blair Stone Road
Tallahassee, FL 32399-1047