

**PAIN MANAGEMENT CLINIC AFFIDAVIT**

Business Name: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**In accordance with Orange County Ordinance # 2010-17, there is currently a moratorium on the issuance of Business Tax Receipts for new Pain Management Clinics in the unincorporated area of Orange County.**

*Pain Management Clinic* means any privately owned pain management clinic, facility or office which advertises in any medium for any type of pain management services, or employs a physician who is primarily engaged in the treatment of pain by prescribing or dispensing controlled substance medication and is required to register with the Florida Department of Health pursuant to sections 458.3265 or 459.0137, Florida Statutes, as may be amended from time to time.

**Is this practice/physician required under Florida law to register as a Pain Management Clinic with the Florida Department of Health?**

- Yes (If yes, see exemptions below)  No

**The moratorium on the issuance of a new Business Tax Receipt shall apply unless any of the following conditions are met:**

- The majority of the physicians who provide services in the clinic, facility, or office primarily provide surgical services.
- The clinic, facility or office is
  - licensed as a facility pursuant to chapter 395, Florida Statutes;
  - owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded \$50 million dollars;
  - affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;
  - does not prescribe or dispense controlled substances for the treatment of pain; or
  - owned by a corporate entity exempt from federal taxation under 26 U.S.C. 501(c) (3) or (4) as may be amended.

I hereby certify that information provided in this application is true and correct based on my knowledge and belief. In accordance with s. 837.06, Florida Statutes, I understand and acknowledge that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor in the second degree, punishable as provided in s. 775.082 or s. 775.083, Florida Statutes.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

STATE OF FLORIDA :  
COUNTY OF \_\_\_\_\_ :

I certify that the foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ by \_\_\_\_\_. He/she is personally known to me or has produced \_\_\_\_\_ as identification and did/did not take an oath.

Witness my hand and official seal in the county and state stated above on the \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_.

(Notary Seal)

\_\_\_\_\_  
Signature of Notary Public  
Notary Public for the State of Florida  
My Commission Expires:  
\_\_\_\_\_