| BOARD USE ONLY – DO NOT WRITE IN THIS SECTION | |
|---|---|
| *DATE STAMP* | **Receipt Number:** |
| | **Amount:** |
| | **Applicant Number:** |
| | **Initials/Date:** |

# PAIN CLINIC APPLICATION
# ADD, DELETE, OR REVISE
# PRACTICING PHYSICIAN

**If you are adding more than one practicing physician, a $75 fee is required for EACH addition.**

## SECTION I: PAIN MANAGEMENT CLINIC - OFFICE INFORMATION

Corporate or Legal Name of Pain-Management Clinic:

_____

Doing Business As Name:

_____

Federal Tax Identification Number (FEI#) OR Employer Identification Number:

_____

**Pain-Management Clinic Physical Address**: ***(P.O. Boxes are not acceptable)***

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

**Mailing Address**:

_____
(Street) (Suite #)

_____
(City) State (Zip Code) (County)

Pain Management Clinic Telephone Number: _____

Pain Management Clinic Fax Number: _____

Pain Management Clinic Email Address: _____

1. List the business operating hours.

**Business Operating Hours:**

| | |
|---|---|
| Monday | ___: ___am/pm **to** _: ___am/pm |
| Tuesday | ___: ___am/pm **to** _: ___am/pm |
| Wednesday | ___: ___am/pm **to** _: ___am/pm |
| Thursday | ___: ___am/pm **to** _: ___am/pm |
| Friday | ___: ___am/pm **to** _: ___am/pm |
| Saturday | ___: ___am/pm **to** _: ___am/pm |
| Sunday | ___: ___am/pm **to** _: ___am/pm |

2. Person to be contacted for communication, or notice and citation matters:

Name: _____Title: _____

Address: _____

Phone #: (____) _____-_____

EMAIL ADDRESS: _____

| | |
|---|---|
| **Managing Employee Name:** | **License Number/Profession:** |
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

**AFFILIATED PERSONNEL INFORMATION: Complete the section below for each practicing physician who will be employed at the clinic. If you have <u>more than one practicing physician who you wish to add to your clinic,</u> copy this sheet.**

| **Practicing Physician Name:** | |
|---|---|
| License Number/Profession: | |
| Address: | |
| Telephone Number: | |
| DEA Number: | Email Address: |

___add practicing physician

___delete practicing physician

___revise hours of practicing physician

**EFFECTIVE DATE:**

_____

**Hours Practicing Physician Present in Clinic:**

| | |
|---|---|
| Monday | ___: ___am/pm **to** _: ___am/pm |
| Tuesday | ___: ___am/pm **to** _: ___am/pm |
| Wednesday | ___: ___am/pm **to** _: ___am/pm |
| Thursday | ___: ___am/pm **to** _: ___am/pm |
| Friday | ___: ___am/pm **to** _: ___am/pm |
| Saturday | ___: ___am/pm **to** _: ___am/pm |
| Sunday | ___: ___am/pm **to** _: ___am/pm |

**IF YOU ARE <u>REVISING</u> THE HOURS, <u>LIST THE CURRENT APPROVED HOURS FOR THIS PHYSICIAN HERE</u>:**

_____

_____

_____

_____

_____

_____

_____

**Does the practicing physician listed above currently work at any other pain clinic? ____YES___NO**
(This includes any pain clinic location, **other than the one identified on page 1**, even if it is one of your other locations)

1. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

2. If Yes, list pain clinic name: _____

Pain Clinic Location: _____

List hours present in clinic: _____

## SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

This form should be completed if you are requesting to be **added as a practicing physician.**

All information requested on this form is mandatory. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications to work in a pain clinic. This information may be shared with other government agencies upon receipt of an official request.

**NAME:** _____

**SEX:** ____**MALE** _____**FEMALE**

**STREET ADDRESS:** _____

_____

**City** **State** **Zip Code**

**Date of Birth:** _____

**Social Security Number:** _____

**Telephone:** _____

**Fax:** _____

**Pain Clinic Name:** _____

**Position with the Pain Clinic: (check below all those that apply)**

____Owner ____Principal ____Officer ____Agent
____Managing Employee ____Practicing Physician ____Physician Assistant ____APRN

____**Other:**_____

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed.

Print Name: _____

Applicant Signature: _____

Date: _____