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

PAIN CLINIC APPLICATION
DELETE OWNER

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: _____

___delete owner

EFFECTIVE DATE: _____

Owner Name:	**License Number/Profession:**
Address:	
Telephone Number:	
DEA Number:	Email Address:

_____

Signature **Date**