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

PAIN CLINIC APPLICATION
ADD, DELETE, OR REVISE INFORMATION
APRN

If you are adding more than one APRN, 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:

Complete the section below for the APRN who will be employed at the clinic. If you have more than one APRN who you wish to add to your clinic, copy this sheet.

APRN Name:
License Number/Profession:
Address:
Telephone Number:
DEA Number: Email Address:
Delegating Physician Name:
Delegating Physician License Number:

___add APRN

___delete APRN

___revise hours of APRN

EFFECTIVE DATE:

_____

Hours APRN 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 REVISING THE HOURS, LIST THE CURRENT APPROVED HOURS FOR THIS APRN HERE:

_____

_____

_____

_____

_____

_____

_____

If you wish to delete a APRN, please have the APRN, owner, or managing employee to sign here:

_____

Signature **Date**

Does the APRN 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)

If Yes, list pain clinic name: _____
Pain Clinic Location: _____
List hours present in clinic: _____

A. Will the APRN be prescribing controlled substances for this location? _____YES ____NO
B. If yes, does the APRN have an approved protocol agreement for this location? _____YES ___NO

SECTION IV: PERSONNEL CERTIFICATION FORM

INSTRUCTIONS:

This form should be completed if you are requesting to be **added as an APRN**.

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

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: _____