



OFFICE SURGERY REGISTRATION APPLICATION

Please read the laws and rules that pertain to this registration application prior to completing the form. The laws and rules state the minimum requirements for the general standards, policy and procedure manuals, surgical logs, equipment, supplies, accreditation or inspection, definitions of the surgery levels, background and training for physicians, assistants and recovery room personnel. A copy of the laws and rules are available on line at www.doh.state.fl.us/mqa/medical/osr_application.html. If you have any questions about the information contained in the laws and rules, please contact the Office Surgery Registration and Inspection Program at (850) 245-4131.

The registered physician(s) must notify the Board of Medicine, in writing, of any changes to the registration documentation immediately. This includes changes in accreditation status, accrediting certificates, inspection, staff privileges and/or transfer agreements, ACLS/BLS certification, staff who assist in surgery and/or recovery, staff protocols, facility name and address changes (requires a new application) and any other information required by 64B8-9 F.A.C.

I. Facility Identification			
Name of Facility _____			OSR # if available _____
Street Address _____	City _____	State _____	Zip Code _____
Telephone _____	Fax Number _____	Email address _____	
Office Manager _____		Email address _____	

II. Application Type and Fee (if any)	
<input type="checkbox"/> Initial registration of office (\$150.00) <input type="checkbox"/> Change to DOH State inspection (\$1500.00) <input type="checkbox"/> Additional physician registration (No fee) <input type="checkbox"/> Remove physician from registration (No fee) <input type="checkbox"/> Change of surgery level (No fee)	<input type="checkbox"/> Change in anesthesia provider (No fee) <input type="checkbox"/> Change of facility name (No fee) <input type="checkbox"/> Request to withdraw or close registration (No fee) <input type="checkbox"/> Change to approved nationally accrediting agency (No fee) <input type="checkbox"/> Other

III. Facility: All questions in this section must be answered or the application will be rejected.

Pursuant to Section 4565.0635 (2) Florida Statutes, the following questions are being asked. If you answer yes to any of the questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C ss.801-907 or 42 U.S.C. ss1395-1396? (If no, do not answer 1b.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	1b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, Florida Statutes? (If no, do not answer 2b.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	2b. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and is in good standing with the Florida Medicaid Program for the most recent five years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal Medicare program? (If no, do not answer 3b or 3c.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	3b. Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3c. Did the termination occur at least 20 years prior to the date of this application?

IV. Accreditation or Inspection

All office-based surgery facilities are required by Section 458.309(3) F.S. to be inspected by the Department of Health or be accredited by a nationally recognized accrediting agency. Please check the appropriate inspection or accrediting agency.

- Inspection by the Department of Health (fee: \$1500.00)
(A Department of Health inspector will contact you to make an appointment for the inspection.)
- AAAASF (American Association for Accreditation of Ambulatory Surgery)
- AAAHC (Accreditation Association for Ambulatory Health Care)
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- Other _____

(If you are accredited with a nationally recognized accrediting agency, submit a copy of your accreditation certificate and a copy of the accreditation survey with the application.)

V. Physician(Surgeon) Information

Physician Name

License Number

Mailing Address

City

State

Zip Code

Telephone Number

Email Address

Indicate the level(s) of surgery that you intend to perform at this facility.

_____ Level II _____ Level III _____ Level II & Level III

To determine level of surgery, refer to Rule 64B8-9.009 F.A.C. for description of surgery levels.

List the types of procedures that will be performed, by the physician, at this facility.

VI. Physicians: All questions in this section must be answered or the application will be rejected.

Pursuant to Section 4565.0635 (2) Florida Statutes, the following questions are being asked. If you answer yes to any of the questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>1. Have you been terminated for cause from the Florida Medicaid program or any state Medicaid program? If the answer is yes, please explain on a separate sheet of paper.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 2b.)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 3b.)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3b. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4a. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 4b or 4c.)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4c. Did the termination occur at least 20 years prior to the date of this application?</p>

VII. (1) Physician(Surgeon) Background and Training

Do you hold current certification or are you eligible for certification with a Specialty Board approved by the Florida Board of Medicine?

Yes If yes, submit a copy of your certificate or the board eligibility letter with the registration application.

No If no, the physician must provide documentation to establish comparable background, training and experience.

VII. (2) List residency, fellowship, background, experience and any additional training.	Specialty	Dates of Attendance

VII. Physician(Surgeon) Staff Privileges

Do you have staff privileges to perform the procedures that you intend to perform in the office setting?

Yes If so, please submit a letter of good standing and a copy of the delineation of privileges with this registration application. Staff privileges must be within reasonable proximity.

No Submit a copy of a transfer agreement, between the physician and a hospital within 30 minutes of transport time.

Do you hold a current ACLS certification?

Yes If yes, submit a copy of the ACLS card with this application

No The surgeon is required by Rule 64B8-9.009 F.A.C. to be ACLS certified. Please obtain ACLS (PALS if appropriate) certification and submit a copy of the ACLS Card to the Board of Medicine. The registration will not be approved until the Board receives this information.

IX. Anesthesia Provider

Name of Anesthesia provider.

License Number

(If this facility utilizes more than one anesthesia provider, please list name, license number and practitioner code for each individual on a separate page.)

MD/DO Anesthesiologist PA CRNA ARNP RN (Level II only)

Do you hold a current ACLS or PALS certification? Yes No

The physician performing a surgical procedure is required by Rule 64B8-9.009 F.A.C. to be ACLS certified. Please obtain ACLS (PALS if appropriate) certification and submit a copy of the ACLS Card to the Board of Medicine. The registration will not be approved until the Board receives this information.

X. Recovery Personnel

Name of Recovery personnel

License Number

Name of Recovery personnel

License Number

____ MD/DO Anesthesiologist ____ PA ____ CRNA ____ ARNP ____ RN ____ ACLS
(Check all that apply)

Recovery personnel are required to be ACLS certified. Rule 64B8-9.009(4)(b)(4) F.A.C.

XI. Other Personnel on Surgical Team List any additional personnel who will be assisting in surgery.
One assistant to the surgeon must be BLS certified. Submit a copy of the BLS certification card with the application.

Name	License Number	Practitioner Code (PA, CRNA, ARNP, RN, Surgical Tech, Medical Assistant)	Type of Involvement

XII. Affirmation Statement of Physician Submitting Registration

I affirm that all information provided herein is true and correct and I confirm compliance with Florida Statutes and Rule 64B8-9 Florida Administrative Code.

Additionally, I agree to immediately notify the Board of Medicine in writing of any changes to the information provided in this registration application.

Signature of Physician (Surgeon)

Date

Mailing Instructions: Mail the application with the physician's original signature and \$150.00 registration fee to:

Department of Health
P.O. Box 6330
Tallahassee, FL 32314

Submit any additional documentation not included in the original application to:

Florida Board of Medicine
Office Surgery Registration and Inspection Program
4052 Bald Cypress Way, Bin C-03
Tallahassee, FL 32399-3253