

LOCAL BUSINESS TAX RECEIPT APPLICATION

CITY OF LAKE MARY

100 N. COUNTRY CLUB ROAD, P.O. BOX 958445, LAKE MARY, FL 32795-8445

407-585-1415 407-585-1498 - FAX

FILING THIS APPLICATION FOR A CITY RECEIPT DOES NOT ALLOW APPLICANT TO OPERATE OR ENGAGE IN ANY TYPE OF BUSINESS UNTIL THE CITY CLERK ISSUES A BUSINESS TAX RECEIPT TO THE APPLICANT. ANY PERSON, FIRM OR CORPORATION WHO SHALL ENGAGE IN ANY OCCUPATION, BUSINESS OR PROFESSION WITHOUT A BUSINESS TAX RECEIPT SHALL BE PUNISHED IN ACCORDANCE WITH CITY CODE.

PLEASE TYPE OR PRINT CLEARLY:

TODAY'S DATE: _____

1. Check the following which applies: New Business in Lake Mary Transfer: Name Address Ownership
Transferred from _____

2. Name of Business (DBA): _____

3. Street Address of Business: _____ DATE OPENED IN LAKE MARY _____

4. Mail Renewal Notice to: _____

5. Federal ID No.: _____ Type of Ownership: Private _____ Corp. _____

6. Business Phone No.: (_____) _____ Emergency Phone No.: (_____) _____

7. Business Owner/Corporation's Registered Agent:

Name: _____ Phone No.: (_____) _____

Address: _____ City _____ State _____ Zip _____

*Social Sec. #: _____ Owner's D/O/B _____ DL #: _____

***Social Security # required if the federal employer identification number is not supplied. (Per Florida Statute 205.0535 (5))**

8. Applicant's Information (if different from #7):

Name: _____ Title _____ Phone No.: (_____) _____

Home Address: _____ City _____ State _____ Zip _____

*Social Sec. #: _____ Appl's D/O/B _____ DL #: _____

***Social Security # required if the federal employer identification number is not supplied. (Per Florida Statute 205.0535 (5))**

9. Type of Business Office Commercial Retail Commercial Wholesale Manufacturing/Warehouse/Storage
Describe business activity (required) _____

(Physicians, clinics, & medical offices are required to complete attached "Pain Management Clinic" questionnaire)

10. Additional Information: # of Employees at location (including applicant): _____ Seating Capacity (Restaurants) _____

of Vending/Amusement Machines: _____ Total Square Footage(Merchants) _____ # of students (schools) _____

Hazardous Materials (Specify type and amt. on hand): _____

Temporary Receipt Duration (Specify Dates): _____

Reason for Fictitious Name Exemption: Licensed Professional First & Last Name Used Incorporated Attorney

I ACKNOWLEDGE THAT THE ISSUANCE OF THE LOCAL BUSINESS TAX RECEIPT IMPLIES ONLY THAT THE ZONING OF THE LOCATION IN WHICH I INTEND TO OPERATE MY BUSINESS, AS REFERENCED ON THE BUSINESS TAX RECEIPT, IS APPROPRIATE FOR THAT TYPE OF BUSINESS AND IS CONTINGENT UPON BUILDING AND FIRE PREVENTION REQUIREMENTS OF THE CITY OF LAKE MARY. I CERTIFY THAT THE FOREGOING INFORMATION IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND ACCURATE. I ACKNOWLEDGE THAT A BUSINESS TAX RECEIPT ISSUED PURSUANT TO THIS APPLICATION DOES NOT WAIVE REQUIREMENTS OF ANY CITY, COUNTY, STATE OR FEDERAL ORDINANCE, STATUTE OR REGULATION THAT I MUST MEET PRIOR TO ENTERING INTO THE BUSINESS, PROFESSION OR OCCUPATION FOR WHICH THE BUSINESS TAX RECEIPT IS SOUGHT. I HAVE OR WILL COMPLY WITH ALL SUCH REQUIREMENTS.

DATE

APPLICANT'S SIGNATURE

*****FOR CITY USE ONLY*****

DATE ROUTING BEGAN: _____

FEE \$ _____

AMOUNT/DATE PAID _____

COMMUNITY DEVELOPMENT: APPROVED DENIED DATE: _____

BUILDING/LIFE SAFETY: APPROVED DENIED DATE: _____

CONDITIONS OF APPROVAL _____

RECEIPT # _____

**CITY OF LAKE MARY
BUSINESS TAX RECEIPT
PAIN MANAGEMENT CLINIC
STATUTORY AND CODE CRITERIA**

NAME OF APPLICANT/BUSINESS.....
.....

BUSINESS ADDRESS.....
Lake Mary, FL 32746

WARNING: Providing false and/or misleading information or documentation may result in the City taking one or more of the following actions: 1) refusal to issue a new business tax receipt; 2) refusal to issue a renewal of an existing business tax receipt; 3) revocation of an existing business tax receipt; 4) reporting to state and/or local enforcement and regulatory agencies; and 5) other actions as may be warranted.

CRITERIA – Under City Code, issuance of a Business Tax Receipt is contingent upon proof of a state registration, or documents evidencing the clinic is not required to register with the state as a pain management clinic.

Check the applicable boxes below.

The applicant/clinic advertises in any medium (print, electronic, etc.) for any type of pain management services. Yes..... No.....

In any month, the majority of the patients are prescribed benzodiazepines, opioids, barbiturates, or carisoprodoals for the treatment of chronic non-malignant pain. Yes..... No.....

If you answered yes to one or both of the above criteria, the clinic is a pain management clinic, per section 458.3265, F.S., and 459.0137, F.S. If so, are you **required to register** with the Florida Department of Health?

Yes..... No.....

If no, please indicate the criteria upon which the exemption is based:

- 1) The clinic complies with and is licensed as a hospital, per Chapter 395, F.S. **Yes.....**
- 2) The majority of the physicians who provide services in the clinic primarily provide surgical services. **Yes.....**
- 3) The clinic is 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 exceed \$50 million. **Yes.....**
- 4) The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents or fellows. **Yes.....**

Name of medical school.....
.....

- 5) The clinic does not prescribe controlled substances for the treatment of pain. **Yes.....**
- 6) The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s.501(c)(3). **Yes.....**
- 7) The clinic is wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, psychiatrists, rheumatologists, or neurologists. **Yes.....**

If yes, provide a copy of the documentation from the certifying association for each physician who is board eligible or certified.

- 8) The clinic is wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists who have also completed fellowships in pain medicine by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association, or who are also board certified in pain medicine by the American Board of Pain Medicine or board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association and perform interventional pain procedures of the type routinely billed using surgical codes. **Yes.....**

If yes, provide a copy of the documentation from the certifying association for each physician who is board eligible or certified.

I attest that the above information that I have provided is accurate and correct.

Signed.....

Company name.....

Title/Position.....

Date.....