Certificate of Use Application

Date: _____ **Folio: _____** **CU#:_____**

Business Information

Location Address: _____ Unit/Suite: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Name of Business/DBA: _____Corporate Name: _____

Corporate Officer/Owner: _____ Title: _____

Previous Business Name and/or use_____

Phone Number: _____ Size of Space (Sq. Feet) _____ Number of Employees_____

Cell Number: _____ Fax Number: _____

Email: _____

Are you sharing spaces with another business? Yes_____ No _____
Will used merchandise be sold on the property? Yes_____ No _____

Describe the type of business _____
□ Office □ Home Office □ Apt □ Retail □Warehouse □ Other_____

Applicant's Signature: _____ Date: _____

*****Fill out this portion only when directed by Department ***** Detailed statement describing use (please include: hours of operation and number of employees) _____
_____
_____
_____

Signature of application verifies the above information is true and correct. I understand the conditions under which my Certificate of Use is being approved and accepted that no charges or refunds can be made once issued. I am authorized to sign for the business and understand that any misrepresentation of information on this application may result in the revocation of the Certificate of Use. And or possible enforcement action being initiated against the business and or its authorized representatives. I further understand that a separate Certificate of Occupancy is also required and is obtainable from the Planning, Zoning and Code Compliance Department.

Departmental Use Only

Inspection Required: □Yes □No Inspected By: _____

Approved By: _____ Zoning District: _____

Conditions under which approved: _____

Inspection Date: _____ Approval Date: _____

Denied By: _____ Denial Date: _____

Denial Comments: _____

TOWN OF MIAMI LAKES
6601 Main Street ● Miami Lakes, FL 33014
Office: (305) 364-6100 ● Fax: (305) 558-8511
Website: www.miamilakes-fl.gov

Permit #:_____Date: _____
Address: _____

CERTIFICATE OF USE CHECKLIST

Medical Office or Clinics, Medical or Dental Laboratories, and Pain Management Clinics

Pursuant to Ordinance 11-133 of the Town of Miami Lakes: Medical offices or clinics, medical or dental laboratories, and pain management clinics shall, in addition to all other information required by the Town's Code, shall provide as part of the certificate of use application:

□ A detailed statement of the nature of the proposed practice, inclusive but limited to information such as:

- Type of medicine practiced
- Hours of operation
- Number of doctors
- Licenses of doctors
- Locations of other branches, if any.

Any applicant for a certificate of use for a medical office or clinic, medical or dental laboratory or pain management clinic, shall also address the following in writing (Please circle yes or no, when required provide additional information):

Yes No 1) Whether the proposed use is licensed as a facility pursuant to Chapter 395, Florida Statutes. If yes, provide license No._____

Yes No 2) Whether the majority of the physicians who provide services in the propose use primarily provide surgical services

Yes No 3) Whether the proposed use is owned by publicity 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 exceeded $50 million. If yes, provide Name _____

Yes No 4) Whether the proposed use is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows. If yes, identify_____

Yes No 5) Whether the proposed use does not prescribe or dispense controlled substances for the treatment of pain

Yes No 6) Whether the proposed use is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3). If yes, provide Name_____

Yes No 7) Provide proof that he/she has obtained or complied with all required State, County and or local certifications, registrations, licenses or other requirements and all such items are in good standing and are currently valid. If yes, provide copies certifications, registrations and licenses.

Yes No 8) Provide the Drug Enforcement Administration number of each physician practicing at the business or under contract with the business and verify that the Drug Enforcement Administration number has been revoked. If yes, provide Name of Doctor_____ DEA #_____

Yes No 9) Whether the applicant's license to prescribe, dispense or administer controlled substances has ever been denied by any jurisdiction or governmental agency.

The Director shall determine whether or not the proposed medical office or clinic, medical or dental laboratory or pain management clinical shall be classified as a pain management clinic based on the information provided at the time of the application for the certificate of use. A pain management clinic shall be subjected to the requirements of Division 6.10(b)

Applicant's Signature_____