

AHCA USE ONLY:	
File #:	
Application #:	
Check #:	
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Batch #:	

Health Care Licensing Application ABORTION CLINIC

Under the authority of Chapters 408 Code (F.A.C.), an application is here	Part II, and 39 bby made to op	0 Florida Statute erate an abortior	s (F.S.), and (n clinic as indi	Chapters sicated belo	59A-35 and 59A-9, FI ow:	orida Administrative
1. Provider / Licensee	Informa	tion				
						
A. Provider Information – ple address and telephone number wi	ease comple	te the followin	g for the ab	ortion c	linic name and loc	ation. Provider name,
License # (for renewal & change of ownership applications) 819		ovider Identifier				
Name of Abortion Clinic (include fict						
A WOMAN'S CHOICE, LLC.	,	,				
Street Address 18400 NW 75 TH PLACE, STE 118				***************************************		
City HIALEAH	County MIAMI-	DADE	State FL			Zip 33015
Telephone Number	Fax Nur		E-mail /	Address		Provider Website
305-558-4440	305-828		ŀ	ANSCHO	CE186@GMAIL.CO	M N/A
Mailing Address or ⊠ Same as abo	ve (All mail will	be sent to this add	ress)			
City		-	State		1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974 - 1974	Zip
Contact Person for this application MILTA TURBIDES			Contact Telep		nber	
Contact e-mail address or Do no	ot have e-	NOTE: Punto	viding vour o	mail addes		-A
mail		correspondence	riding your e-i e from the Ag	mali addre ency,	ess you agree to acce	pt e-maii
MJT95@AOL.COM						
B. Licensee Information – pl	ease comple	te the followin	a for the er	tity soo	king to operate the	shortion olinia
Licensee Name (may be same name a	s listed in above)	g for the en		Employer Identification	
A WOMAN'S CHOICE, LLC.	,			65-0585	• •	(2.11)
Mailing Address or ⊠ Same as abo	ve					
City				State	[2	Zip
Telephone Number	Fax Number		E-mail	Address		· · · · · · · · · · · · · · · · · · ·
Description of Licensee (check one):						RECEIVED
<u>For Profit</u> ☐ Corporation		Not for Profit Corporation	n		<u>Public</u> ☐ State	
	y	Religious A			☐ City/County	AUG 2 8 2014
☐ Partnership ☐ Individual ☐ Sole Proprietor		☐ Other			☐ Hospital District	Central Systems
☐ Sole Liobilefor						Management Unit

Other 2. Application Type and Fees	· · · · · · · · · · · · · · · · · · ·		
Indicate the type of application with an "X." Applications will Pursuant to subsection 408.805(4), Florida Statutes, fees are not must be received 60 days prior to the expiration of the license or the renewal application is received by the Agency less than 60 days prior to the amount of the late feetatute. The applicant will receive notice of the amount of the late feetature.	onrefundable. Renewal and e proposed effective date of to or to the expiration date, it is	I Change of Ownership ap he change to avoid a late subject to a late fee as se	pplications fine. If the
Initial licensure Is this application to reactivate an expired license?	YES □ NO [
If yes, please provide the name of the agency (if different	;), the EIN # and the year	– the prior license expired	d or closed:
NAME:	EIN#	Year Expired/Clo	· · · · · · · · · · · · · · · · · · ·
 ☐ Change during licensure period proposed effective da ☐ Name/address change of the provider ☐ Change in Administrator or Financial Officer (No feed) 			
Action		Fee	TOTAL FEES
LICENSE FEE (Initial, Renewal and Change of Ownership): License Fee Exemption (County or Municipal Government pursuant to	390.014(4), F.S.) = \$ 0.00	\$545.05	\$ 545.05
Change During Licensure Period/Replacement License		\$ 25.00	\$
Biennial Assessment (Renewal applications only)		\$300.00	\$ 300.00
Late fee, if applicable		Contact licensure unit for details.	\$
Other:		ior detaile.	\$
	OTAL FEES INCLUDED I	_	\$ 845.05
Please make check or money order payable to the Note: Starter checks and temp			
	The second secon		
O4 II' 1-4444			
. Controlling Interests of Licensee			
UTHORITY:			
ursuant to section 408.806(1)(a) and (b), Florida Statutes, an application of the applicant and each controlling interest, if the ddress, and federal employer identification number (EIN) of the applicatest is not an individual. Disclosure of Social Security number(s) see such information for purposes of securing the proper identification.	applicant or controlling intere plicant and each controlling in is mandatory. The Agency t	est is an individual; and the nterest, if the applicant or of for Health Care Administra	e name, controlling ation shall

DEFINITIONS:

AUG 2 8 2014

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; bystems person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the

effort to protect all personal information, do not include Social Security numbers on this form. All Social Security numbers must

be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.

management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. term does not include a voluntary board member.	The

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In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee

PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST
18794 NW 80 AVE, Hialeah,FL33015	305-785-4934	65-0585033	100%
	18794 NW 80 AVE,	18794 NW 80 AVE, 305-785-4934	18794 NW 80 AVE, 305-785-4934 65-0585033

B. Board Members and Officers of Licensee (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO	Milta Turbides	18794 NW 80 AVE, HIALEAH,FL33015	305-785-4934
President	Milta Turbides	18794 NW 80 AVE, HIALEAH,FL33015	305-785-4934
Vice President	SAME AS PRES.	SAME AS ABOVE	305-785-4934
Secretary	Milta Turbides	18794 NW 80 AVE, HIALEAH,FL33015	305-785-4934
Treasurer	SAME AS SECTY.	SAME AS ABOVE	305-785-4934
Other:	N/A		

4. Management Compa	ny Control				
Does a company other than the lice If ⊠ NO, skip to section 5 – If □ YES, provide the follow	Required Disclosure	ensed pro	ovider?		
Name of Management Company		EIN (No S	SNs)	Telephone N	umber / Fax
Street Address			E-mail Address	<u> </u>	
City		County	***************************************	State	Zip
Mailing Address or ☐ Same as above					
City				State	Zip
Contact Person	Contact E-mail			Contact Tele	phone Number

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In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	0WNERSH INTEREST
B. Board Membe	rs and Officers of Manager	ment Company (Exclud	les Voluntary Bo	ard Member
TITLE	FULL NAME	PERSONAL OR BUSINESS AD	DRESS	TELEPHONE NUMBER
Director/CEO		T ENCONAL ON BOOMESS AL	DRESS	NUMBER
President				
/ice President		· • • • • • • • • • • • • • • • • • • •		· · · · · · · · · · · · · · · · · · ·
Secretary				
reasurer				
Other:				1,000
convictions of offens las the applicant or any inc		408.809(5), F.S., for each consider of sapplication been convicted of	trolling interest. any level 2 offense pi	irsuant to
\- \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	#3100-0008.) YES 🗌	NO ⊠	THE WILL BACKGROUNG	ociecinig
<u>requirements,</u> AHCA Form				
If yes, enclose the fo	ollowing information:			
If yes, enclose the fo	ollowing information: ne of the individual and the position he	ld.		
If yes, enclose the fo	ne of the individual and the position he planation of the conviction(s) - If the inc		ion from disqualification	on for the
☐ The full legal nan ☐ A description/exp offense, include a	ne of the individual and the position he planation of the conviction(s) - If the inc	lividual has received an exempt	on of any exclusions	suspensions o

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Central Systems

Section 59A-9 020(1) Florida Administrative Code

If yes, enclose the following information:

☐ The full legal name of the individual and the position held

A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to Se	ection 408.815(4), F.S., does the applicant or	any controlling interest in an ap	plicant have an	y of the following:
YES □ NO 🏻	Convicted of, or entered a plea of guilty or refelony under chapter 409, chapter 817, chapter 409, Medicare fraud, or insurance fraud, w	oter 893, 21 U.S.C. ss. 801-970), or 42 U.S.C. s	s. 1395-1396. Medicaid
YES □ NO ☒	Terminated for cause from the Medicare prowith the Medicare program or a state Medic least 20 years before the date of this application.	aid program for the most recent	ram, have not be t 5 years and the	een in good standing e termination occurred at
6. Provide	r Fines and Financial Infor	mation	·-···	
by final order of the	tion 408.831(1)(a), Florida Statutes, the Ager controlling interest with the applicant if they ha agency or final order of the Centers for Medi t plan is approved by the agency.	ave failed to pay all outstanding	fines, liens, or o	overpayments assessed
Are there any incide	ences of outstanding fines, liens or overpaym	ents as described above? YE	ES □ NO)
Amount: S Date of rel Due date of	ated inspection, application or overpayment pof payment:	y for Health Care Administratio		CMS
	Please attach a copy of the ap		nlicable	
	. rease attack a copy of are up	ргочестераутет ріап п арр	nicable.	
7. Proce	dure / Director / Hospital In	formation		
PROCEDURES F	PERFORMED (check all that apply):			
	ester Abortions (the first 12 weeks of pre	gnancy)		
Second T	rimester Abortions (the portion of the pre	gnancy following the 12 th we	ek through the	e 24 th week)
If second trimes	ter abortions are performed, provide t	ne following information:		
DESIGNATED MEDIC	CAL DIRECTOR:	FLORIDA MEDICAL LICENS	E NUMBER:	
MARK SPENCE, MD		ME74724	7471	
MEDICAL DIRECTO ☐ Admitting priv ☐ A transfer agr With the following	ileges and/or	CENTED		
Hospital Street Addres		V=111 E11		
160 NW 170 TH ST	is		Telephone Numb 305-651-1100	er
City NORTH MIAMI BEA	АСН	County MIAMI-DADE	State FL	Zip 33169

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8. Personnel

Administrative Personnel:

TITLE	NAME	TELEHPONE NUMBER	E-MAIL
Administrator/Facility Manager	Milta Turbides	305-785-4934	MJT95@AOL.COM
Financial Officer	Milta Turbides	305-558-4440	AWOMANSCHOICE186@gmail.com

9.	٨	ffi	4		:4
J .	А	П	O i	av	П

I, MILL TWO LOS, hereby swear or affirm, under penalty of perjury, that the statements in this application are true and correct. As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if arrested for or convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Signature of Licensee or Authorized Representative

<u>Yresident</u>

Da

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION HOSPITAL AND OUTPATIENT SERVICES UNIT 2727 MAHAN DR., MS 31 TALLAHASSEE FL 32308-5407

Questions?

Review the information available at http://ahca.myflorida.com/ or contact the Hospital & Outpatient Services Unit at (850) 412-4549

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Central Systems



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File #: 13950334 Application #: 1383 Check #: 101 Check Amt: 545.05 Batch #: 100001	13) 14 12
7731/14	

Health Care Licensing Application ABORTION CLINIC

Under the authority of Chapters 408 Part II, and 390 Florida Statutes (F.S.), and Chapters 59A-35 and 59A-9, Florida Administrative Code (F.A.C.), an application is hereby made to operate an abortion clinic as indicated below:

1. Provider / License	e Info	rma	tion					
A. Provider Information – p	lease co	omple	te the follow	ing fo	or the ab	oortion c	linic name and loca	ation. Provider name,
address and telephone number was License # (for renewal & change of ownership applications) 819	Natio		ovider Identifi		der.gov/			
Name of Abortion Clinic (include fic	titious nar	me, if ap	pplicable)					
A WOMAN'S CHOICE, LLC.								
Street Address 18400 NW 75 TH PLACE, STE 118								
City HIALEAH		County MIAMI-	DADE	St	ate -			Zip 33015
Telephone Number 305-558-4440	F	ax Nun 05-828	nber		E-mail /		ICE186@GMAIL.COM	Provider Website
Mailing Address or Same as about	ove (All n	nail will	be sent to this a	dress	1			
City				Sta	ate			Zip
Contact Person for this application MILTA TURBIDES	***				act Telep -785-4934	hone Nun	nber	
Contact e-mail address or Do n	ot have e	-	140777					
mail			NOTE: By pr corresponder	ovidin ce fro	g your e-i	mail addre encv	ess you agree to accep	t e-mail
MJT95@AOL.COM	····							
B. Licensee Information – p. Licensee Name (may be same name a	lease co	omple	te the follow	ing fo	or the er			
	as listed in	above)	ı				Employer Identification	Number (EIN)
A WOMAN'S CHOICE, LLC. Mailing Address or ⊠ Same as about	WA					65-0585	033	
	VC							
City						State	Z	ip
Telephone Number	Fax Nur	mber			E-mail	Address		
Description of Licensee (check one)	:		<u>-</u>		<u> </u>			
For Profit			Not for Drofi				D. It's	RECEIVED
Corporation			Not for Profi				<u>Public</u> ☐ State	4110.0
Limited Liability Compar	ny		Religious		ation		☐ City/County	AUG 0 4 2014
☐ Partnership ☐ Individual			☐ Other				☐ Hospital District	Control
Sole Proprietor		· · ·						Central Systems Management Unit

☐ Other			
2. Application Type and Fees			
Indicate the type of application with an "X." Applications w Pursuant to subsection 408.805(4), Florida Statutes, fees are n must be received 60 days prior to the expiration of the license or th renewal application is received by the Agency less than 60 days pri statute. The applicant will receive notice of the amount of the late f	conrefundable. Renewal and e proposed effective date of ior to the expiration date it is	d Change of Ownership ar the change to avoid a late	oplications fine. If the
☐ Initial licensure			
Is this application to reactivate an expired license?	YES NO [
If yes, please provide the name of the agency (if differen	t), the EIN # and the year	the prior license expire	d or closed:
NAME:	EIN#	Year Expired/Clo	
M. D		- Jour Expired of	
☒ Renewal licensure☐ Change of ownership, proposed effective date:			
Change during licensure period proposed effective d			
☐ Name/address change of the provider	ale		
☐ Change in Administrator or Financial Officer (No	fee required)		
Action		Fee	TOTAL FEES
LICENSE FEE (Initial, Renewal and Change of Ownership): License Fee Exemption (County or Municipal Government pursuant to	390.014(4), F.S.) = \$ 0.00	\$545.05	\$ 545.05
Change During Licensure Period/Replacement License		\$ 25.00	\$
Biennial Assessment (Renewal applications only)		\$300.00	\$ 300.00
Late fee, if applicable		Contact licensure unit for details.	\$
Other:			\$
T	OTAL FEES INCLUDED	WITH APPLICATION:	\$ 845.05
Please make check or money order payable to ti	he Agency for Health Care	Administration (AHCA)	
Note: Starter checks and tem			
		RE	CEIVED
3. Controlling Interests of Licensee			G 0 4 2014
AUTHORITY:		Cent Mans	tral Sys <mark>tems</mark> agement Uni
Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an appli Security number of the applicant and each controlling interest, if the address, and federal employer identification number (EIN) of the applinterest is not an individual. Disclosure of Social Security number(s) use such information for purposes of securing the proper identification effort to protect all personal information, do not include Social Security on the Health Care Licensing Application Addendum	applicant or controlling intere plicant and each controlling in his mandatory. The Agency to on of persons listed on this ap urity numbers on this form	ude: the name, address a est is an individual; and the nterest, if the applicant or of for Health Care Administra polication for licensure.	and Social e name, controlling ation shall
DEFINITIONS:			
	-		
Controlling interests, as defined in subsection 408.803(7), Florida serves as an officer of, is on the board of directors of, or has a 5-per person or entity that serves as an officer of, is on the board of directors.	cent or greater ownership into	erest in the applicant or lic	encee: or a

management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

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In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST
_				

B. Board Members and Officers of Licensee (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			-
President			
Vice President			
Secretary			
Treasurer			
Other:			

4. Management Compan	y Control			
Does a company other than the licen	see manage the licensed p	provider?		
If \boxtimes NO, skip to section 5 – Re	equired Disclosure			
If YES, provide the following	g information:			
Name of Management Company	EIN (No	SSNs)	Telephone Number	er / Fax
Street Address	1	E-mail Address		
City	County		State	Zip
Mailing Address or ☐ Same as above				
City			State	Zip
Contact Person	Contact E-mail		Contact Telephon	e Number

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In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company

FULL NAME of INDIVIDUAL or ENTI	PERSONAL OR BUSINESS	DDRESS TELEPHONE NUMBE	ER EIN (No SSNs)	% OWNERSHIF INTEREST
	nbers and Officers of M	nagement Company (E	xcludes Voluntary Bo	oard Members
TITLE	FULL NAME	PERSONAL OR BUSIN	ESS ADDRESS	TELEPHONE NUMBER
				HOMBER
Director/CEO			1	
Director/CEO President				

Trea	asurer					
Oth	er:				· · · · · · · · · · · · · · · · · · ·	
	D					
<u>5.</u>	Requii	red Disclosure				
The	following	disclosures are required:				
Α.	Pursuant t conviction	to subsection 408.809(1)(d), F.S., is of offenses prohibited by Section	, the applicant shall sons 435.04 and 408.	submit to the age 809(5), F.S., fo	ency a description and exp r each controlling interest.	lanation of any
อนมะ	66011011 400.0	t or any individual listed in sectior 809(1)(d), Florida Statutes? (Thes HCA Form #3100-0008.)	ns 3 and 4 of this app e offenses are listed YES []	plication been co l on the <u>Affidavit</u> NO ⊠	onvicted of any level 2 offe of Compliance with Backg	nse pursuant to round Screening
	If yes, enc	close the following information:		_		
	☐ The ful	ll legal name of the individual and	the position held.			
	☐ A desc	ription/explanation of the convicti e, include a copy.		al has received	an exemption from disqua	lification for the
В.	Pursuant to sterminations	Section 408.810(2), F.S., the app from the Medicare, Medicaid, or	licant must provide a federal Clinical Labo	description and	d explanation of any exclusion the temperature of the explanation of any exclusion of the explanation of the	ions, suspensions, or ograms.
Has witho	the applicant Irawn from p	t or any individual listed in Sectior articipation in Medicare or Medica	ns 3 and 4 of this app aid in any state?	plication been ex	kcluded, suspended, termin	nated or involuntarily
	If yes, encl	lose the following information:				
	☐ The ful	ll legal name of the individual and	the position held			
	☐ A desc	cription/explanation of the exclusion	on, suspension, term	ination or involu	ntary withdrawal.	PECFIVE

AHCA Recommended Form 3130-1000 January 2014

Secretary

Section 59A-9 020(1) Florida Administrative Code

AUG 0 4 2014

C. Purs	uant to Se	ection 408.815(4), F.S., does the applicant or	any controlling interest in an a	pplicant have a	ny of the following:
YES 🗌	NO ⊠	Convicted of, or entered a plea of guilty or national felony under chapter 409, chapter 817, chapter and, Medicare fraud, or insurance fraud, with	oter 893, 21 U.S.C. ss. 801-97	0, or 42 U.S.C.	ss. 1395-1396, Medicaid
YES 🗌	NO ⊠	Terminated for cause from the Medicare pro with the Medicare program or a state Medica least 20 years before the date of this applica	aid program for the most recei		
6. P	rovide	r Fines and Financial Infor	nation		
shares a by final or	common or rder of the	tion 408.831(1)(a), Florida Statutes, the Ager controlling interest with the applicant if they ha agency or final order of the Centers for Medi t plan is approved by the agency.	ive failed to pay all outstandin	g fines, liens, o	r overpayments assessed
Are there	any incid	ences of outstanding fines, liens or overpaym	ents as described above?	YES 🗌 1	NO 🖾
) 	Amount: \$ Date of re Due date	ated inspection, application or overpayment por payment:	y for Health Care Administrati		□ смѕ
•	io tricre ar			nnlicable	
		Please attach a copy of the ap	ргочео гераутет ріап ії ар	opiicable.	
7.	Proce	dure / Director / Hospital In	formation		
	- 1000	duic / Director / Hospital III	TOTTILLOTT		
PROCEI	DURES F	PERFORMED (check all that apply):			
		ester Abortions (the first 12 weeks of pre	egnancy)		
		rimester Abortions (the portion of the pre	•	week through	the 24 th week)
	,	ter abortions are performed, provide t			
	43 40 20 20 6	CAL DIRECTOR:	FLORIDA MEDICAL LICEN		
MARK SP	ENCE, MD		ME74724		
Adm A tra	nsfer agı	ileges and/or	CENTER		
Hospital St	treet Addre	ss		Telephone Nu	
160 NW 1	170''' ST		County	305-651-1100 State	Zip
•	ИІАМІ ВЕ	ACH	MIAMI-DADE	FL	33169



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Q	Personne	ì
O.	Personne	ł

Administrative Personnel:

TITLE	NAME	TELEHPONE NUMBER	E-MAIL
Administrator/Facility Manager	Milta Turbides	(3)7854934	MJT950aul.com
Financial Officer			MJT95@aucon

9.	Affida	vit
----	---------------	-----

Quilto Aulo

I, MIHA TUNDIDES , hereby swear or affirm, under penalty of perjury, that the statements in this
application are true and correct. As administrator or authorized representative of the above named provider/facility,
hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum
standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if arrested for or convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

_	1 mas	<u>へ </u>	MYZ			
5	Signature of	f Licens	ee or Au	uthorized	Representative	-

PY	eside	nt	计		
Title				_	

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION HOSPITAL AND OUTPATIENT SERVICES UNIT 2727 MAHAN DR., MS 31 TALLAHASSEE FL 32308-5407

Questions?

Review the information available at http://ahca.myflorida.com/ or contact the Hospital & Outpatient Services Unit at (850) 412-4549

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