

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13910025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TAMPA WOMAN'S HEALTH CENTER, INC.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2010 E. FLETCHER AVENUE TAMPA, FL 33612</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced Licensure survey was conducted at Tampa Woman's Health Center, Inc., an abortion clinic located in Tampa, Fl. on 8/7/17. License #8150.</p> <p>The provider had no deficiencies at the time of the visit.</p>	A 000		

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE