CONFIDENTIAL DOCUMENT

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Health Care Licensing Application Addendum

AUTHORITY: Pursuant to section 408.806, Florida Statutes (F.S.), the Agency for Health Care Administration is required to obtain the name, address and Social Security number of the applicant and each controlling interest if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest if the applicant or controlling interest is not an individual. Disclosure of your Social Security number is mandatory. Your Social Security number will be used to secure the proper identification of persons listed on this application for licensure, criminal background checks and the indexing of controlling interests.

1. Provider / Licensee Information

A. *Please complete the following and indicate whether background screening was conducted as part of this application.* *(if you are seeking licensure as a Risk Manager please skip to 1B; Applicants for Health Care Clinics **must also** complete 1C)*:

Provider/Facility Type: Abortion Clinic		**National Provider ID#:** (if applicable) 1831347293
Provider/Facility Name: All Women's Health Center of Gainesville, Inc		
Administrator/CEO/Managing Employee: Kathleen Olson	**Social Security #:**	**Background Screening Conducted** ☒ YES ☐ NO
Chief Financial Officer: Melinda Miller	**ity #:**	**Background Screening Conducted** ☒ YES ☐ NO

B. *RISK MANAGERS ONLY:*

Name	**Social Security #:**
HCRM License # (for renewal applications) **550-**	**Background Screening Conducted** ☐ YES ☐ NO

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C. *Additional information needed for HEALTH CARE CLINIC applicants:*

In accordance with sections 408.806(1)(a) and 400.991 F.S., the medical or clinic director and each licensed health care practitioners as provided in sections 8 and 9 of the Health Care Licensing Application, Health Care Clinics, AHCA Form 3110-0013, must provide their Social Security number. The Social Security number will be used to secure the proper identification of persons listed on this application for licensure and criminal background checks. *Please attach additional sheets if necessary.*

FULL NAME	SOCIAL SECURITY NUMBER	BACKGROUND SCREENING CONDUCTED
Medical or Clinical Director:		☐ YES ☐ NO
Fernando Betancourt, MD		☒ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

2. Controlling Interests of Licensee

A. *Individual and/or Entity Ownership of Licensee*

Provide the following information for **each person with 5% or greater ownership interest** in the licensee/provider. This information must match the information contained in Section 3A of the *Health Care Licensing Application*. Attach additional sheets if necessary.

FULL NAME	SOCIAL SECURITY NUMBER
American Medical Management, Inc.	N/A

B. *Board Members and Officers of Licensee*

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the licensee/provider. This information must match the information contained in Section 3B of the *Health Care Licensing Application*. Attach additional sheets if necessary.

TITLE	FULLNAME	SOCIAL SECURITY NUMBER
Director/CEO	Gary Dresden	
President	Robin Rygiel	
Vice President	Melinda Miller	
Secretary	Dezra Owens	
Treasurer	Melinda Miller	
Other:	Dara Dresden	

3. Management Company Controlling Interests

If a company other than the licensee manages the licensee/provider, complete the following information:

A. *Individual and/or Entity Ownership of Management Company*

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the management company. This information must match the information contained in Section 4A of the *Health Care Licensing Application*. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL	SOCIAL SECURITY NUMBER
Bryan Dresden	
Scott Dresden	
Dara Dresden	

B. Board Members and Officers of Management Company

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members). This information must match the information contained in Section 4B of the *Health Care Licensing Application*. Attach additional sheets if necessary.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Director/CEO	Gary Dresden	
President	Gary Dresden	
Vice President	Robin Rygiel	
Secretary	Dezra Owens	
Treasurer	Melinda Miller	
Other:	Bryan Dresden	

4. Affidavit

I, Robin Rygiel, hereby swear or affirm, under penalty of perjury that the statements in this addendum to the application for licensure as a health care provider are true and correct.

Robin L Rygiel — Signature of Licensee or Authorized Representative

President — Title

1/30/18 — Date

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