



Health Care Licensing Application Abortion Clinic - Renewal Licensure

Provider/Facility Information

Provider Information

Provider name, address, telephone number will be listed on Florida Health Finder at: <http://www.floridahealthfinder.gov/>

License Number:	873	National Provider Identifier:	None
File Number:	13960083		
Provider/Facility:	AASTRA WOMEN'S CENTER		
Street Address			
Street Address:	10 SW 44TH AVE	(Bld, Suite, Floor, Villa, Apt)	
City:	PLANTATION	State:	FLORIDA
		Zip:	33317
County:	BROWARD		
Telephone:	(954) 792-9198	Telephone Ext:	
		Fax:	(954) 792-4437
Provider Website:	aastrawomenscenter.com		Email Address:
		cindy@caprihealthcare.com	

Transparency Page:

Mailing Address (All mail will be sent to this address)

Street Address:	10 SW 44th AVENUE	(Bld, Suite, Floor, Villa, Apt)	
City:	PLANTATION	State:	FLORIDA
		Zip:	33317
County:	BROWARD		
Telephone:	(954) 792-9198	Telephone Ext:	
Email Address	CINDY@CAPRIHEALTHCARE.COM		

Contact Details

Contact Person

Contact Person:	CYNTHIA STOCKMAN	Suffix:	
Telephone:	(954) 792-9198	Telephone Ext:	
		Fax:	(954) 792-4437
Email:	Cindy@caprihealthcare.com		Note: By providing your email address you agree to accept email correspondence from the Agency

Licensee Information

Description of Licensee:	For Profit	Ownership Type:	Corporation
Licensee Name:	CAPRI HEALTHCARE, INC		FEIN: 020601301
Mailing Address:	10 SW 44TH AVE		(Bld, Suite, Floor, Villa, Apt.)
City:	PLANTATION	State:	FLORIDA
		Zip:	33317-3758
County:	BROWARD		
Telephone:	(954) 792-9198	Telephone Ext:	
		Fax:	(954) 792-4437
Email:	cindy@caprihealthcare.com		

Ownership Information

Y Does any person or entity serve as an officer of, is on the board of directors of, or have a 5% or greater ownership interest in the applicant or licensee?

Person and/or Entity Ownership of Licensee

Full Name of Individual/Entity:	CYNTHIA D STOCKMAN	SSN/EIN:	xxx-xxx-xxxx
Board Member/ Officer:	YES	Suffix:	
% Ownership:	50.00		
Effective Date:	02/10/2003	End Date:	
Mailing Address Type:	Business		
Street Address:	1740 NORTHEAST 9TH STREET	(Bld, Suite, Floor, Villa, Apt)	
City:	FORT LAUDERDALE	State:	FL
Zip:	33304	County:	BROWARD
Telephone:	(954) 792-9198	Telephone Ext.:	
Email:	cindy@caprihealthcare.com		
Full Name of Individual/Entity:	RICHARD T STOCKMAN	SSN/EIN:	xxx-xxx-xxxx
Board Member/ Officer:	YES	Suffix:	
% Ownership:	50.00		
Effective Date:	02/10/2003	End Date:	
Mailing Address Type:	Business		
Street Address:	1740 NORTHEAST 9TH STREET	(Bld, Suite, Floor, Villa, Apt)	
City:	FORT LAUDERDALE	State:	FL
Zip:	33304	County:	BROWARD
Telephone:	(954) 792-9198	Telephone Ext.:	
Email:	cindy@caprihealthcare.com		

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

Management Company

N Does a company other than the licensee manage the licensed provider?

Procedures Performed

- First Trimester Abortions
 Second Trimester Abortions

Medical Director

Full Name:		FL Medical License #:	
Effective Date:		End Date:	
Address Type:			
Mailing Address:		(Bld, Suite, Floor, Villa, Apt.):	
City:		County:	
State:		Zip:	

Transfer Agreement / Admitting Privileges

Transfer Agreement / Admitting Privileges

- All the physicians performing abortions have admitting privileges at a hospital within reasonable proximity.
- The abortion clinic has a transfer agreement with a hospital within reasonable proximity.

Transfer Agreement Hospitals

<u>Provider Name</u>	<u>License Number</u>	<u>Telephone</u>	<u>Street Address</u>

Personnel Information

Personnel

First Name:	CYNTHIA	Middle:	D	Last Name:	STOCKMAN
Suffix:		SSN:	xxx-xxx-xxxx	DOB:	
Address Type:	Business				
Street Name or P.O. Box:	1740 NORTHEAST 9TH STREET	(Bld, Suite, Floor, Villa, Apt.):			
City:	FORT LAUDERDALE	State:	FLORIDA		
Zip:	33304	County:	BROWARD		
Telephone:	(954) 792-9198	Telephone Ext:			
Email:	cindy@caprihealthcare.com				

<u>Title</u>	<u>Effective Date</u>	<u>End Date</u>	<u>FL License Number</u>
Administrator / Facility Manager	3/5/1999		
Financial Officer	3/5/1999		

Required Disclosures

Convictions

Pursuant to subsection [408.809\(1\)\(d\)](#), F.S., the applicant shall submit to the agency a description and explanation of any convictions or offences prohibited by sections [435.04](#) and [408.809\(4\)](#), F.S., for each controlling interest.

- N Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offence pursuant to subsection [408.809\(1\)\(d\)](#), Florida Statutes? (These offences are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form (#3100-0008))

<u>Full Name</u>	<u>SSN</u>	<u>Description</u>	<u>Exemption</u>
------------------	------------	--------------------	------------------

Exclusions

Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or Federal Clinical Laboratory Improvement Amendment (CLIA) programs.

- N Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

<u>Full Name</u>	<u>SSN</u>	<u>Description</u>
------------------	------------	--------------------

Felonies / Terminations

Pursuant to section [408.815\(4\)](#), F.S., does the applicant or any controlling interest in an applicant have any of the following:

N Convicted of, or entered a plea of guilty or no contest to, regardless of adjudication, a felony under chapter [409](#), chapter [817](#), chapter [893](#), [21 U.S.C. ss. 801-970](#), or [42 U.S.C. ss. 1395-1396](#), within the previous 15 years prior to the date of this application?

N Terminated for cause from the Medicare program or a state Medicaid program.

Days and Hours of Operation

<u>Day</u>	<u>Opening Time</u>	<u>Closing Time</u>	<u>By Appointment</u>
MONDAY			X
TUESDAY			X
WEDNESDAY	8:30 AM	5:00 PM	
THURSDAY			X
FRIDAY			X
SATURDAY			X
SUNDAY			X

Affidavit

I **CYNTHIA STOCKMAN**, under penalty of perjury, attest as follows:

- (1) Pursuant to section 837.06, Florida Statutes (F.S.), I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.
- (2) Pursuant to section 408.815, Florida Statutes (F.S.), I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.
- (3) Pursuant to section 408.806, Florida Statutes (F.S.), the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes (F.S.).
- (4) Pursuant to section 408.809 and 435.05, Florida Statutes (F.S.), every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II and Chapter 435, Florida Statutes (F.S.), and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.
- (5) Pursuant to section 435.05, Florida Statutes (F.S.), the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II or Chapter 435, Florida Statutes (F.S.), as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

CYNTHIA STOCKMAN

Signature of Licensee or Authorized Representative

OWNER

Title

11/29/2017

Date