CONFIDENTIAL DOCUMENT

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)	
Provider/Facility Name: American Family Planning		
Administrator/CEO/Managing Employee: Roneika Pettermon	**Social Security #:**	**Background Screening Conducted** ☒ YES ☐ NO
Chief Financial Officer: Nancy Luke	**Social Security #:**	**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
Warren Taylor, DO		☒ 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
Chesapeake Free State Holdings, LLC	
Alpha Real Estate Holdings, LLC	

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	Nancy Luke	
President		
Vice President		
Secretary		
Treasurer		
Other:	Warren Taylor, DO	

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

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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		
President		
Vice President		
Secretary		
Treasurer		
Other:		

4. Affidavit

I, Nancy Luke, 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.

Nancy Luke/RS
Signature of Licensee or Authorized Representative

CEO/CFO
Title

5/14/18
Date

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