5. Personnel

A. **Please provide information for the individual(s) who perform the following roles. NOTE:** For the administrator, and financial officer an AHCA Screening through the Care Provider Background Screening Clearinghouse (Clearinghouse) is needed, or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name	Roneika Pettermon	**Roneika Pettermon**
Date of Birth	**07-20-1990**	**07-20-1990**
Effective Date	**5-14-2018**	**6-7-2018**
Telephone Number	850-478-9660	**850-478-9660**
Email Address	**opmgr@4aps.org**	**opmgr@4aps.org**
Personal/Primary Address	**6115 Village Oaks Drive, Pensacola, FL 32504**	**6115 Village Oaks Drive, Pensacola, FL 32504**

B. **Medical Director –** Pursuant to section 390.012(3), F.S., if second trimester abortions are performed, provide the following information.

INFORMATION	MEDICAL DIRECTOR
Full Name	Christopher Denapoles, MD
Florida License Number (Dept. of Health)	**ME132255**
Effective Date	**08-01-2019**
Telephone Number	**850-478-9660**
Email Address	**opmgr@4aps.org**
Personal/Primary Address	**6115 Village Oaks Drive, Pensacola, FL 32504**

6. Required Disclosure

The following disclosures are required:

A. Pursuant to section 408.809, F.S., the applicant shall submit to the Agency a description and explanation of any convictions of offenses prohibited by Sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to section 408.809, Florida Statutes? YES ☐ NO ☐

If YES, provide the following information the full legal name of the individual/entity and the position held

B. 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.

Has the applicant or any individual/entity listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES ☐ NO ☐

If YES, enclose the following information:

☐ The full legal name of the individual (and the position held) or the entity

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