(13) NA-KSE

AHCA USE ONLY:

File #: 139600083
Application #: 1669
Check #: _____
Check Amt: _____
Batch #: _____

Health Care Licensing Application
Abortion Clinic

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: http://ahca.myflorida.com/onlinelicensure

Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. **Applications will not be considered for review until payment has been received. Renewal and Change During Licensure applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.**

Under the authority of Chapters 408, Part II and 390, Florida Statutes (F.S.) and Chapters 59A-35 and 59A-9, Florida Administrative Code (F.A.C.), an application is hereby made to operate an abortion clinic as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the abortion clinic name and location. Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/

License # (if applicable) 873		National Provider Identifier (NPI) (if applicable) N/A	
Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) Caprihealthcare, Inc. dba Aastra Women's Center			
Street Address 10 SW 44th Avenue			
City Plantation	County Broward	State FL	Zip 33317
Telephone Number 954-792-9198	Fax Number 954-792-4437		
Mailing Address or ☐ Same as above X			
City	County	State	Zip
Telephone Number	E-mail Address cindy@caprihealthcare.com		
Provider Website aastrawomen'scenter.com	NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.		

Received

OCT 28 2019

Central Services

B. **LICENSEE INFORMATION** – Please complete the following for the entity seeking to operate the abortion clinic.			
Licensee Name (This is the owner of the abortion clinic) Caprihealthcare, Inc		Federal Employer Identification Number (EIN) 020601301	
Mailing Address or X Same as above			
City		State	Zip
Telephone Number 954-792-9198	Fax Number 954-792-4437	E-mail Address cindy@caprihealthcare.com	

Description of Licensee (check one):

For Profit	Not for Profit	Public
X Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

C. **CONTACT PERSON** – Please complete the following for the contact person for this application.	
Contact Person for this application Cynthia D Stockman	Contact Telephone Number 954-383-3853
Contact e-mail address tcstockman@deccacable.com	NOTE: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. Pursuant to subsection 408.805(4), F.S., fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

A. TYPE OF APPLICATION

☐ Initial licensure — Proposed Effective Date:

Was this entity previously licensed as an abortion clinic? YES ☐ NO ☐

If YES, please provide the name of the provider (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:

☐ Renewal licensure

☐ Change of Ownership — Proposed Effective Date:

☐ Change During Licensure Period - select all that apply: — Proposed Effective Date:

Fee Required	No Fee Required
☐ Provider Name	X Personnel
☐ Provider Address	☐ Management Company
Services/Qualifications:	☐ Change of Controlling Interest less than 51%
☐ Change in type of procedure performed	

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership): ☐ License Fee Exemption (County or Municipal Government pursuant to section 390.014(4), F.S.) = $ 0.00	$550.50	$
Biennial Assessment	$300.00	$
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Controlling Interests of Licensee

AUTHORITY:
Pursuant to section 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number (SSN) 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 social security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include social security numbers on this form. All social security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITION:
Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Special note: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. Individual and/or Entity Ownership of Licensee as listed in section 1B above – Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary. Note: This excludes Not-for-Profit and publicly held licensees.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. Board Members and Officers of Licensee – Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company

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

If ☐ NO, skip to section 5 Personnel

If ☐ YES, provide the following information:

Name of Management Company		EIN (No SSNs)	Telephone Number / Fax	
Street Address		E-mail Address		
City		County	State	Zip
Mailing Address or ☐ Same as above				
City			State	Zip
Contact Person	Contact E-mail		Contact Telephone Number	

DEFINITION:

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Special note: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. **Individual and/or Entity Ownership of Management Company:** Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. **Board Members and Officers of Management Company:** *Provide the information for each individual or entity (corporation,* partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

5. Personnel

A. **Please provide information for the individual(s) who perform the following roles. Special note:** Pursuant to section 408.809, F.S., the administrator and financial officer are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Date of Birth		
Effective Date		
End Date		
Telephone Number		
E-mail Address		
Personal/Primary Address		

B. **Medical Director –** Pursuant to section 390.012(3), F.S., if second trimester abortions N/A are performed, provide the following information. WE ARE A FIRST TRIMESTER CLINIC ONLY

INFORMATION	MEDICAL DIRECTOR
Full Name	Uzy Bodman MD
Florida License Number (Dept. of Health)	**ME25342**
Effective Date	**11/21/2017**
End Date	**11/31/2020**
Telephone Number	954-540-4689
E-mail Address	cindy@caprihealthcare.com
Personal/Primary Address	3305 NE 40th Street, Ft. Lauderdale, FL 33308

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, F.S.? YES ☐ NO ☐

If YES, provide the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of any convictions

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.

C. Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

Convicted of, or entered a plea of guilty or nolo contendere 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, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application? YES ☐ NO ☐

Terminated for cause from the Medicare program or a state Medicaid program? YES ☐ NO ☐

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

7. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If YES, please complete the following for each incidence (attach additional sheets, if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

Please attach a copy of the approved repayment plan, if applicable.

8. Procedure/Transfer/Admitting Information

PROCEDURES PERFORMED (check all that apply):

☐ First Trimester Only - which is the period of time from fertilization through the end of the 11th week of gestation.

☐ First and Second Trimester - which is the period of time from the beginning of the 12th week of gestation through the end of the 23rd week of gestation.

TRANSFER AGREEMENTS/ADMITTING PRIVILEGES (check all that apply):

☐ 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.
If checked, provide the hospital information below. Attach additional sheets, if necessary.

Hospital Name			
Street Address		Telephone Number	
City	County	State	Zip

9. Hours of Operation

List the regular operating hours (**NOTE:** Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine).

DAY OF THE WEEK	OPENING TIME	CLOSING TIME	BY APPOINTMENT
☐ Sunday			☐
☐ Monday			☐
☐ Tuesday			☐
☐ Wednesday			☐
☐ Thursday			☐
☐ Friday			☐
☐ Saturday			☐

10. Supporting Documentation

Applicants must include the following attachments as stated in Chapters 408, Part II and 390 F.S. and Chapters 59A-35 and 59A-9, F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change during licensure period)**

DOCUMENTS TO BE PROVIDED	REQUIRED FOR
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change in Personnel, and Change of Ownership application types
Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement	Initial, Change of Ownership, and Change of ,Provider Name or Address application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial, Change of Address, and Change of Ownership application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application type
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types

11. Attestation

I, Cynthia Stockman, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes, 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, 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, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to sections 408.809 and 435.05, Florida Statutes, 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, 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, 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, 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.

Signature of Licensee or Authorized Representative	Owner Title	October 4, 2019 Date

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308-5407

Questions?

Review the information available at http://ahca.myflorida.com/ or contact the Hospital & Outpatient Services Unit at (850) 412-4549.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency

CAPRI HEALTHCARE, INC
dba
AASTRA WOMEN'S CENTER
10 SW 44th Avenue
Plantation, Florida 33317
954-792-9198

October 22, 2019

Agency for Healthcare Administration
Hospital and Outpatient Services Unit
2727 Mahan Drive MS31
Tallahassee, FL 32308-5407

To Whom It May Concern,

Enclosed please find an application for change of Medical Director for Aastra Women's Center.

In the Health Care Clinic Licensing Application, Section 5B, it calls for information "if the Clinic performs second trimester abortions". We are a FIRST TRIMESTER ONLY Clinic, but provided the information nonetheless.

Also, the same application calls for a signature in Section 12. There is no section 12, so we signed the last section which is Section 11.

On the Background Screening Profile, please be advised that our facility does not participate in anything to do with Medicare or Medicaid.

After speaking to the Background Clearing Center, I was advised that the Medicaid Provider Enrollment was not something that our Clinic needed to be concerned with.

Sincerely,

Cynthia D. Stockman
Owner

AGENCY FOR HEALTH CARE ADMINISTRATION

Medical / Clinic Director Information

A licensed health care clinic may not operate or be maintained without the day-to-day supervision of a single medical or clinic director. Failure by a clinic to employ a qualified medical director or clinic director constitutes a ground for emergency suspension of the license by the agency.

You must report a change of medical or clinic director to the agency within 21 calendar days from the effective date of the change, as required by s. 408.810 (3)(a), Florida Statutes.

References:
Section 400.9905(5), Florida Statutes
Section 400.9935, Florida Statutes
Section 400.9915, Florida Statutes
Rule 59A-33.008, Florida Administrative Code
Rule 59A-33.013, Florida Administrative Code

How to Report a Change of a Medical/Clinic Director:

1. Complete and submit sections 1, 2, 5B, and 12 of the **Health Care Clinic Licensing Application**
2. Complete and submit sections 1, 3, and 4 of the **Health Care Licensing Application Addendum**
3. Original **Health Care Clinic Medical/Clinic Director Attestation Form** [30KB, DOC]
4. A copy of the practitioner's current, active license issued by the Florida Department of Health.
5. A copy of the practitioner's Level 2 background screening results through the Agency for Health Care Administration.
6. A copy of the new director's contract or agreement with the health care clinic.
7. A copy of the previous director's letter of resignation to the clinic or a copy of the clinic's letter of termination to the previous director.
8. A copy of the facility's current health care clinic license.

HEALTH CARE CLINIC
MEDICAL / CLINIC DIRECTOR
ATTESTATION

INSURANCE FRAUD NOTICE.—A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law, commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for personal injury protection benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in s. 817.234, Florida Statutes.

As the Medical or Clinic Director I hereby agree to accept legal responsibility for the activities on behalf of the clinic, Aastra Women's Center, as specified in Section 400.9935, Florida Statutes - Clinic Responsibilities.

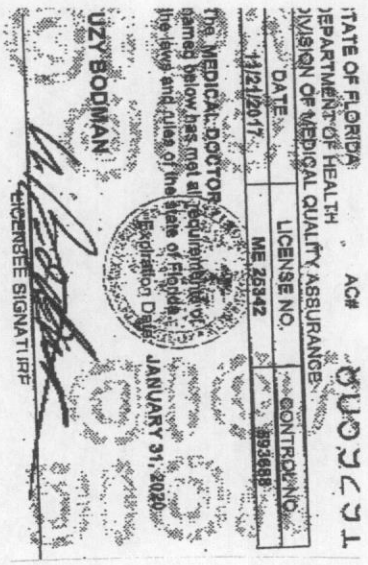
Signature of Medical or Clinic Director — October 4, 2019 **Date**

Uzy Bodman, MD
Printed Name of Medical or Clinic Director — October 4, 2019 **Date**

Received
OCT 28 2019
Central Services

Dr Bodman

ME25342


STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/21/2017	ME 25342	893688

THE MEDICAL DOCTOR named below has met all requirements of law and is hereby licensed to practice medicine in the State of Florida.

Expiration Date: JANUARY 31, 2020

UZY BODMAN

LICENSEE SIGNATURE

AC# 8000271

UZY BODMAN, MD

October 4, 2019

AASTRA WOMEN'S CENTER
10 SW 44th Avenue
Plantation, Florida 33317
954-792-9198

Dear Cynthia Stockman,

Please accept this letter as my notification accepting the responsibilities as Medical Director on behalf of Aastra Women's Center, as specified in Florida Statues 400-9935, effective October 31, 2019 (or before – as approved).

As a board certified OB/GYN MD specialist it is my pleasure to accept this position.

Our signatures below constitute our full agreement of duties and responsibilities.

Thank you for the opportunity to work with you in this capacity.

Sincerely

Uzy Bodman, MD, October 4th, 2019

Cynthia Stockman, Owner October 4th, 2019

RAYMOND HUDANICH, MD

October 4, 2019

AASTRA WOMEN'S CENTER
10 SW 44th Avenue
Plantation, Florida 33317
954-792-9198

Dear Cynthia Stockman,

Please accept this letter as my notification of resignation, effective on October 31, 2019.

Thank you for the opportunity to work with you over the past 39 years.

I hope four weeks notice is long enough for you to find a suitable replacement for me. If I can be of service in any way during this time, please don't hesitate to call.

Sincerely

Raymond Hudanich, MD

View current license information at: Floridahealthfinder.gov

LICENSE #: 873
CERTIFICATE#: 1347

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

Abortion Clinic

Licensed

This is to confirm that Capri Healthcare, Inc has complied with the rules and regulations adopted by the State of Florida, Agency for Health Care Administration, and authorized in Chapter 390, Florida Statutes, and is authorized to operate the following:

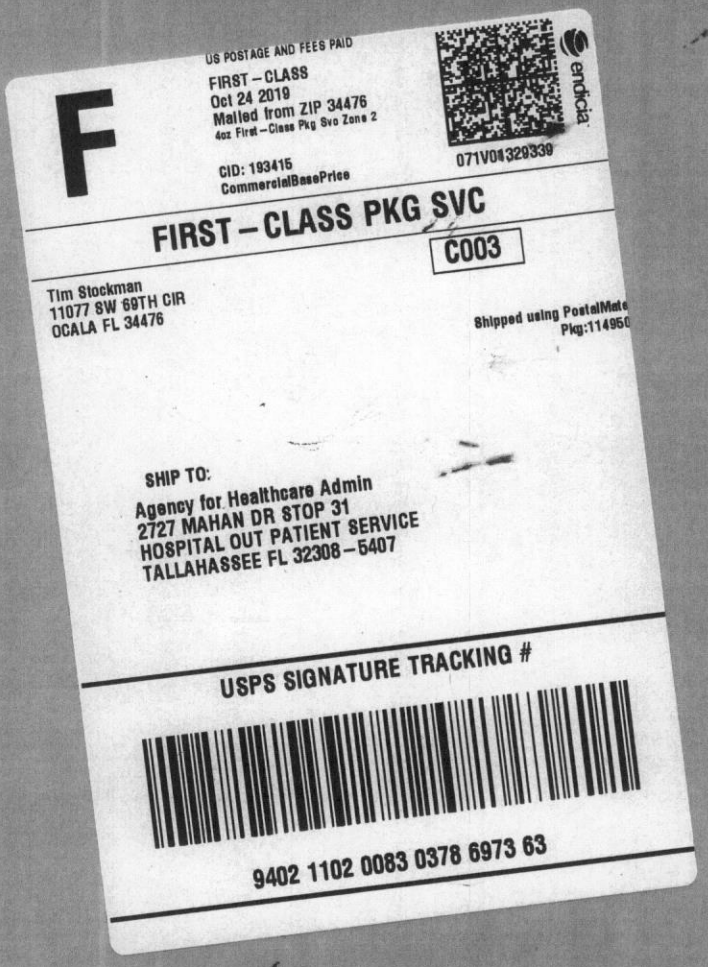
AASTRA WOMEN'S CENTER
10 SW 44th Ave
Plantation, FL 33317
BROWARD COUNTY

Authorized Procedures:
First Trimester Only

EFFECTIVE DATE: 02/18/2018

EXPIRATION DATE: 02/17/2020

Deputy Secretary, Division of Health Quality Assurance



F

US POSTAGE AND FEES PAID
FIRST – CLASS
Oct 24 2019
Mailed from ZIP 34476
4oz First – Class Pkg Svc Zone 2

CID: 193415
CommercialBasePrice

endicia
071V01329339

FIRST – CLASS PKG SVC

C003

Tim Stockman
11077 SW 69TH CIR
OCALA FL 34476

Shipped using PostalMate
Pkg:114950

SHIP TO:
Agency for Healthcare Admin
2727 MAHAN DR STOP 31
HOSPITAL OUT PATIENT SERVICE
TALLAHASSEE FL 32308 – 5407

USPS SIGNATURE TRACKING #

9402 1102 0083 0378 6973 63