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 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:

Provider/Facility Type: ABORTION CLINIC	**National Provider ID#:** (if applicable) 1770702284
Provider/Facility Name: PRESIDENTIAL WOMEN'S CENTER, INC.	

B. Risk Managers Only:

Name: N/A	**Social Security #:**
HCRM License # (for renewal applications) 550-	

2. Controlling Interests of Licensee

***A.* Individual Ownership of Licensee:** *Provide the following information for **each person with 5% or greater ownership interest** in the licensee/provider. The individuals listed below must match those listed in Section 3A of the Health Care Licensing Application. Attach additional sheets if necessary. Entities (corporations, partnerships, associations, etc.) need not be listed.*

FULL NAME	SOCIAL SECURITY NUMBER
PRESIDENTIAL WOMEN'S CENTER, INC.	59-2011653

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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. The individuals listed below must match those listed in Section 3B of the Health Care Licensing Application. Attach additional sheets if necessary.

TITLE	FULLNAME	SOCIAL SECURITY NUMBER
Director/CEO	**MONA S. REIS**	
President	**MONA S. REIS**	
Vice President	**MONA S. REIS**	
Secretary	**MONA S. REIS**	
Treasurer	**MONA S. REIS**	
Other		

3. Management Company Controlling Interests

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

A. **Individual Ownership of Management Company:** Provide the following information for each person with 5% or greater ownership interest in the management company. The individuals listed below must match those listed in Section 4A of the Health Care Licensing Application. Attach additional sheets if necessary. Entities (corporations, partnerships, associations, etc.) need not be listed.

FULL NAME of INDIVIDUAL	SOCIAL SECURITY NUMBER
N/A	

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). The individuals listed below must match those listed in Section 4B of the Health Care Licensing Application. Attach additional sheets if necessary.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Director/CEO	**N/A**	
President		
Vice President		
Secretary		
Treasurer		
Other:		

4. Personnel

A. **Administration:** This information must match the information in the Personnel section of the Health Care Licensing Application.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Administrator/ CEO/Managing Employee/Lab Director	**MONA S. REIS, PRESIDENT** **DANIEL N. SACKS, MD, LAB DIRECTOR**	
Financial Officer	**MONA S. REIS, TREASURER**	
Safety Liaison		

B. **Additional information required 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 5b and 5c 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.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Medical or Clinical Director	**DANIEL N. SACKS, MEDICAL DIRECTOR**	
Licensed Health Care Practitioners		

5. Attestation

I, **MONA S. REIS**, under penalty of perjury, attest that the statements in this addendum to the application for licensure as a health care provider are true and correct.

Signature of Licensee or Authorized Representative

PRESIDENT
Title

3/29/19
Date

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