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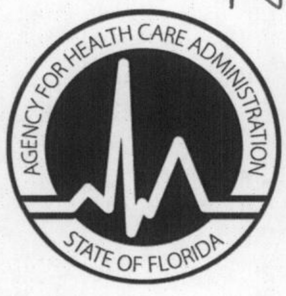
8/13

AHCA USE ONLY:	
File #:	13960131
Application #:	1748
Check #:	59939
Check Amt:	25.00
Batch #:	10100122



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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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) 921	National Provider Identifier (NPI) (if applicable) 157881734		
Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) Planned Parenthood of South, East and North Florida			
Street Address 2300 N FL. Mango Rd.			
City West Palm Beach	County Palm Beach County	State FL.	Zip 33409
Telephone Number 561-296-4819	Fax Number 561-721-3474		
Mailing Address or X Same as above SAME AS ABOVE			
City	County	State	Zip
Telephone Number 561-296-4819	E-mail Address NA		
Provider Website PPSENFL.ORG	NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.		

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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) Planned Parenthood of South Florida and the Treasure Coast Inc.		Federal Employer Identification Number (EIN) 59-139-1115	
Mailing Address or X Same as above SAME AS ABOVE			
City		State	Zip
Telephone Number 561-848-6402	Fax Number 561-472-9979	E-mail Address N/A	

Description of Licensee (check one):

For Profit	Not for Profit	Public
☐ Corporation	x 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 Penny Alterizio	Contact Telephone Number 561-472-9952
Contact e-mail address or ☐ Do not have e-mail Penny.alterizio@ppsenfl.org	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:

X Change During Licensure Period - Proposed Effective Date: close 11/2/2021, reopen 11/10/2021

Fee Required

☐ Provider Name

X Provider Address

Services/Qualifications:

☐ Change in type of procedure performed

No Fee Required

☐ Personnel

☐ Management Company

☐ Change of Controlling Interest less than 51%

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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: change of location		$ 25.00
TOTAL FEES INCLUDED WITH APPLICATION		$ 25.00
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
Planned Parenthood of South Florida & The Treasure Coast Inc.	2300 N FL. Mango Rd. West Palm Beach, FL. 33409	561-848-6402	59-139-1115	100%	1971	N/A

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	N/A				
Board Member/Officer					
Board Member/Officer					

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Board Member/Officer					
Board Member/Officer					

4. Management Company

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

If X 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					

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Board Member/Officer					
Board Member/Officer					

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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	Lillian Tamayo	David Gartner
Date of Birth	10/2/1956	3/3/1958
Effective Date	8/9/1999	2/25/2013
End Date	N/A	N/A
Telephone Number	561-848-6402	561-848-6402
E-mail Address	Lillian.tamayo@ppsenfl.org	David.gartner@ppsenfl.org
Personal/Primary Address	2300 N FL. Mango Rd. WPB, FL. 33409	2300 N FL. Mango Rd WPB, FL. 33409

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	Robert Pearl
Florida License Number (Dept. of Health)	**OS 10079**
Effective Date	**10/2/2010**
End Date	**N/A**
Telephone Number	561-296-4919
E-mail Address	Robert.pearl@ppsenfl.org
Personal/Primary Address	2300 N FL. Mango Rd WPB, FL. 33409

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 **X**

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 **X**

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.

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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 X

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

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.

X 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.

X 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 Palms West			
Street Address 13001 Southern Blvd.		Telephone Number 561-798-6030	
City Loxahatchee	County Palm Beach	State FL.	Zip 33470

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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	closed		☐
☐ Monday	closed		☐
X Tuesday	12:noon	8:pm	☐
X Wednesday	10:30am	4:30pm	☐
X Thursday	9:am	5:pm	☐
☐ Friday	closed		☐
X Saturday	8:am	4:pm	☐

10. Supporting Documentation

Applicants <u>must</u> 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

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11. Attestation

I, Lillian Tamayo, 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	Pres/CEO Title	8/10/2021 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

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Owner Information

Change of Address

Owner(s)
PLANNED PARENTHOOD OF THE PALM BEACH
AND TREASURE COAST AREA, INC

Mailing Address
2300 N FLORIDA MANGO RD
WEST PALM BEACH FL 33409 6416

Sales Information

Sales Date	Price	OR Book/Page	Sale Type	Owner
JUL-2002	$1,187,500	13889 / 01120	WARRANTY DEED	PLANNED PARENTHOOD OF THE PALM BEACH
FEB-1990	$100	06358 / 00321	QUIT CLAIM	BILLS JOHN C & VIRGINIA K
FEB-1988	$820,000	05566 / 01963	WARRANTY DEED	
SEP-1986	$300,000	05008 / 01744	WARRANTY DEED	
JAN-1981	$750,000	03442 / 01808	WARRANTY DEED	

NOTE: Sales do not generally appear in the PAPA database until approximately 1 to 3 weeks after the closing date. If a recent sale does not show up in this list, please allow more time for the sale record to be processed.

Exemption Information

Portability Calculator

Exemption Year: 2021

Applicant/Owner	Year	Detail
	2021	

Property Information

Tangible Account(s)

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ADJUST FONT SIZE: + − RESET

Website Search

DOROTHY JACKS CFA, AAS
Palm Beach County Property Appraiser
We Value What You Value

Real Property

Search by Owner Name(Last Name first) or Address or PCN | Search

Classic PAPA | MyPAPA | Print This Page | Save as PDF | Print Property Summary

2020 Proposed Notice

Property Detail • Owner Information • Sales Information • Exemption Information • Property Information • Appraisals • Assessed and Taxable Values • Taxes

Filtered Property Detail

Property Detail

Show Full Map

Location Address	2300 N FLORIDA MANGO RD
Municipality	WEST PALM BEACH
Parcel Control Number	74-43-43-29-07-003-0061
Subdivision	AIRPORT INDUSTRIAL PARK IN
Official Records Book/Page	13889 / 1120
Sale Date	JUL-2002
Legal Description	AIRPORT INDUSTRIAL PARK S 70 FT OF LT 6 (LESS E 180 FT) LTS 7 & 8 (LESS E 180 FT) BLK C

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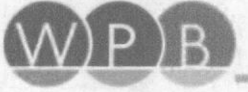
Nearby Sales Search



WEST PALM BEACH

Development Services

April 22, 2020

Thomas Morea
Planned Parenthood of Palm Beach
And The Treasure Coast, Inc.
2300 N. Florida Mango Rd.
West Palm Beach, FL 33409

Re: 2300 N Florida Mango Rd, West Palm Beach, FL
PCN: 74-43-43-29-07-003-0061

Dear Mr. Morea:

This letter is written in regard to the property located at 2300 N. Florida Mango Rd (**PCN: 74-43-43-29-07-003-0061**). Our records indicate that the referenced property is currently zoned Industrial Light (IL) and has an Industrial (I) Future Land Use designation. Per your request, the existing professional office building was legally established before July 10, 1989, therefore, "Offices, Professional (Medical)" is a permitted use.

This letter does not grant approval of any specific use. Additionally, this letter does not verify the existing use(s) on the property and does not certify conformance or non-conformance of existing uses or structures. This letter constitutes a preliminary review; the official zoning review will be done during the Business Tax/Certificate of Use application process. The information in this letter is provided without any representation or warranty as to the completeness or accuracy of the data or information contained herein, or to the suitability or fitness of the property or structures thereon for a particular purpose.

For additional information, the Zoning and Land Development Regulations may be viewed online at www.municode.com or visit the City of West Palm Beach Development Services Department – Planning Division website at www.wpb.org/planning/. All code enforcement inquiries should be directed to the Code Enforcement Division (561) 822-1465. All permitting, occupational licensing, Certificates of Occupancy, as well as copies of site plans and landscape plans approved for a Certificate of Occupancy, may be obtained from the Construction Services Division (561) 805-6700.

If you require any additional information, please contact me at (561) 822-1442.

Sincerely,

Rachel Falcone

Rachel Falcone
Associate Planner

20-042 - 2300 N. Florida Mango Rd

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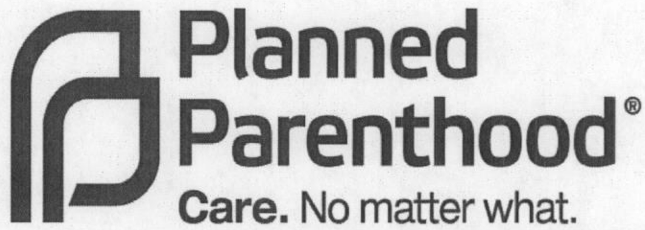
PLANNING DIVISION
401 CLEMATIS STREET
P.O. BOX 3147
WEST PALM BEACH, FL 33402
561.822.1435



Planned Parenthood of South, East and North Florida

AHCA Lab Unit
2727 Mahan Dr.
Tallahassee, FL. 32308
August 11, 2021

To Whom it May Concern,

Re: CLIA 10D0722304

Planned Parenthood of South, East and North Florida, will be moving to a new site.
We will be moving from our current site at 10111 Forest Hill Blvd, Wellington, FL 33414, on November 2, 2021.
Our new location will be located at 2300 N FL. Mango Rd, West Palm Beach, FL. 33409. Opening is planned for November 10, 2021
Please feel free to contact me with any questions.

Sincerely,

Jeffery Good MD
Laboratory Director

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Pull to open.

FedEx
TRK# 0215 8139 4719 8739
SH TLHA

FRI - 13 AUG AA
MORNING 2DAY
ISR
32308
FL-US
TLH

670359 11Aug2021 FPRA 56DG1/BAF3/1B23

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FZ

00100

FedEx Express Package US Airbill

FedEx Tracking Number 8139 4719 8739

Form ID No. 0215

Recipient's Copy

1 From
Date 8/11/2021
Sender's Name Penny Alterizio Phone
Company PLANNED PARENTHOOD
Address 2300 N FLORIDA MANGO RD Dept./Floor/Suite/Room
City WEST PALM BEACH State FL ZIP 33409-6416

2 Your Internal Billing Reference

3 To
Recipient's Name AHCA Phone
Company
Address 2727 Mahan Dr
We cannot deliver to P.O. boxes or P.O. ZIP codes. Dept./Floor/Suite/Room
Address Mail Stop # 31
Use this line for the HOLD location address or for continuation of your shipping address.
City Tallahassee State FL ZIP 32308

Hold Weekday — FedEx location address REQUIRED. NOT available for FedEx First Overnight.
Hold Saturday — FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

0132510192

8139 4719 8739

4 Express Package Service *To most locations.
Packages up to 150 lbs.

Next Business Day
- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.

2 or 3 Business Days
- [x] FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging *Declared value limit $500.
- [x] FedEx Envelope*
- [ ] FedEx Pak*
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.
- [ ] Saturday Delivery — NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.
- [ ] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery.
- [x] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods? One box must be checked.
- [ ] No
- [ ] Yes — As per attached Shipper's Declaration.
- [ ] Yes — Shipper's Declaration not required.
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ___ x ___ kg
- [ ] Cargo Aircraft Only

Restrictions apply for dangerous goods — see the current FedEx Service Guide.

7 Payment Bill to:
Enter FedEx Acct. No. or Credit Card No. below.
- [x] Sender — Acct. No. in Section 1 will be billed.
- [ ] Recipient
- [ ] Third Party
- [ ] Credit Card
- [ ] Cash/Check

Obtain recip. Acct. No.

Total Packages | Total Weight ___ lbs. | Credit Card Auth.

†Our liability is limited to US$100 unless you declare a higher value. See the current FedEx Service Guide for details.

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