

Checklist for Pain Management Clinic Business License

1. The application must be completed in its entirety before being accepted by the Business License Office. Provide one original and one duplicate of the completed application and all attachments.
2. The application and all attachments must be typed or legibly printed in black ink. The Business License Office reserves the right to refuse to accept any application and/or attachment(s) that are considered illegible by the Business License Office.
3. A driver's license or government-issued identification showing that the applicant is more than 18 years of age.
4. A copy of the articles of incorporation and bylaws, or articles of organization and operating agreement, or partnership agreement of the Business Entity that will be operating under the Pain Management Business License.
5. Signed, notarized authorizations from the following persons authorizing the City to conduct a GCIC/NCIC criminal records background check:
 - a. The applicant
 - b. All of the partners, shareholders, or members of the Business Entity that will operate under the Pain Management Business License
 - c. All of the directors of the Business Entity that will operate under the Pain Management Business License
 - d. All of the officers of the Business Entity that will operate under the Pain Management Business License
 - e. All of the physicians that will be writing prescriptions at the Pain Management Clinic
6. The name and DEA number of every physician who:
 - a. Is to practice at the Pain Management Clinic
 - b. Is employed in any capacity at the Pain Management Clinic
 - c. Is an independent contractor or consultant retained by the Pain Management Clinic
 - d. Who has a financial or ownership interest in the Pain Management Clinic
7. A statement concerning whether the Pain Management Clinic will dispense Schedule II, II, or IV Drugs.
8. A blue line copy of a surveyor's plat, 8 ½ inches by 11 inches in size, with a scale of one inch per 200 feet. The surveyor's plat shall show the proposed location and the location of all customer or patient entries in relation to distance, measured as provided in Article XVI, to all real property and buildings on such real property which fall within the distance requirements as provided in Article XVI, together with zoning district and present uses of all such real property and the proposed location.
9. A legal description of the property where the Pain Management Clinic is either currently located or at which it will be located upon issuance of a Pain Management Business License.
10. A \$250 nonrefundable application fee must be submitted with the application payable to the City of Lilburn by certified check, cashier's check or money order or cash.
11. Zoning – The zoning of the proposed location must be noted on the application and must be verified by a City of Lilburn Zoning staff member. The Planning & Zoning Department is located at 340 Main Street, Lilburn, GA 30047.

NOTICE – Any and all false information provided to the Business License Department verbally or written will subject that person that provides this false information to prosecution to the full extent of the law and will subject the application to administrative denial or revocation. It shall be the responsibility of the applicant to assure that the application for the Pain Management Business License is complete. No employee of the City of Lilburn shall have any responsibility to notify the applicant of any deficiency in the application. The fact that the City accepts the application from the applicant is not an indication that the application is either correct or complete. If there are any questions regarding the application, please contact the Business License Department at (770) 279-3708.



APPLICATION FOR PAIN MANAGEMENT BUSINESS LICENSE

Date _____

Name of Applicant (Full Legal Name) _____

(List any other names used by the Applicant in the preceding five years)

Applicant Address _____

_____ Phone # _____

Social Security # _____ Date of Birth _____

Business Name _____

Business Address _____

_____ Phone # _____

Names of persons who have any ownership interest (legal or equitable), including but not limited to shareholders, partners (general and limited), members, managers, directors, and officers:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Please attach additional sheets as necessary

1. Have any of the following persons been convicted of a felony, plead guilty to a felony, or plead nolo contendere to a felony in any State within Five (5) years preceding the date of this application:

- a. Applicant Yes ____ No ____
- b. Any person who has an ownership interest in the Business Entity that will operate under the Pain Management Business License whether such ownership is legal or equitable Yes ____ No ____
- c. Any of the partners (general or limited), shareholders, or members of the Business Entity that will operate under the Pain Management Business License Yes ____ No ____
- d. Any of the directors of the Business Entity that will operate under the Pain Management Clinic Business License Yes ____ No ____
- e. Any of the officers or managers of the Business Entity that will operate under the Pain Management Business License Yes ____ No ____

2. If you answered yes, please provide the following:

- a. The name of the person who was convicted, plead guilty, or plead nolo contendere
- b. A complete description of the crime including the date of the plea or conviction, the name of the court where it occurred, the name under which the plea or conviction occurred, and the penalty assessed

3. Please provide the name of all other Business Entities in which any of the following persons own any interest:

- a. Applicant
- b. Any of the partners (general or limited), shareholders, or members of the Business Entity that will operate under the Pain Management Business License
- c. Any of the directors of the Business Entity that will operate under the Pain Management Business License
- d. Any of the officers or managers of the Business Entity that will operate under the Pain Management Business License

4. Please provide the names of all physicians who will be writing any prescriptions for any pain medicine at the Pain Management Clinic



This section is to be completed and signed by the City of Lilburn Zoning staff

How is the proposed location zoned? _____

Zoning verified by City of Lilburn Zoning Division staff member

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The undersigned certifies that it has received a copy of this chapter or the ordinance from which this chapter is derived and that all information provided within the application is true and accurate.

Signature: _____ Date: _____

Printed Name and Title: _____

Sworn to and subscribed to before me,

On this ____ day of _____, 20____.

Notary Public

Commission Expires: _____