



Florida Department of Agriculture and Consumer Services
Division of Consumer Services

HEALTH STUDIO
REGISTRATION APPLICATION

Make Check or Money Order payable to FDACS and remit with application to:

FDACS
Health Studio Program
P.O. Box 6700
Tallahassee, FL 32314-6700

NICOLE "NIKKI" FRIED
COMMISSIONER

Sections 501.012 - 501.019, Florida Statutes
Rule 5J-4.004, Florida Administrative Code

1-800-HELP-FLA (435-7352) • (850) 410-3800
www.FDACS.gov • (850) 410-3804 Fax

All documents and attachments submitted with this application may be subject to public review pursuant to chapter 119, Florida Statutes (F.S.). PLEASE TYPE OR PRINT. Additional pages may be attached if extra space is needed. Annual Registration Fee: \$300 for each health studio location. Active duty military, honorably discharged veterans, military spouses or surviving spouses may be eligible for a waiver of the registration fee. See section 501.015(2), F.S., and rule 5J-4.004, Florida Administrative Code, for eligibility requirements. If an item is not applicable to your business please mark N/A.

Business Information

Please Select one: [] New Filing [] Renewal HS#: [] Change of Owner [] Previous HS#

1. Business Name (If applicant is not an individual, state legal name as registered with the Florida Department of State, Division of Corporations):

* Fictitious (DBA) Name (if applicable):

*As registered with the Division of Corporations.

2. Business Street Address (include APT or SUITE #):

City: State: Zip Code:

Mailing Address (if different from above):

City: State: Zip Code:

3. Telephone Number: Fax Number:
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Email Address: Website:

4. Name of Contact Person: Title of Contact Person:

Mailing Address (if different from above):

City: State: Zip Code:

F&A Use Only

Org Code: 42 10 06 25 000
EO: A2
Object Code: 001106 \$300.00

Telephone Number:
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Email Address:

5. Federal Employer ID #:
- _____

6. Provide the name and address of each owner and all partners of the business. If a corporation, list the name and address for each corporate officer and director. (Attach additional pages as necessary using the same format.)

Name: _____	Name: _____
Title: _____	Title: _____
Address: _____	Address: _____
City, State, Zip Code: _____	City, State, Zip Code: _____
Telephone Number: () -	Telephone Number: () -
Ownership _____ %	Ownership _____ %

Name: _____	Name: _____
Title: _____	Title: _____
Address: _____	Address: _____
City, State, Zip Code: _____	City, State, Zip Code: _____
Telephone Number: () -	Telephone Number: () -
Ownership _____ %	Ownership _____ %

Type of Security Provided

7. Type of Security Provided (if applicable, please check one and select location of security):

- | | | |
|---|--|--|
| <input type="checkbox"/> Surety Bond (\$25,000): | <input type="checkbox"/> original enclosed | <input type="checkbox"/> on file with the department |
| <input type="checkbox"/> Irrevocable Letter of Credit (\$25,000): | <input type="checkbox"/> original enclosed | <input type="checkbox"/> on file with the department |
| <input type="checkbox"/> Certificate of Deposit (\$25,000): | <input type="checkbox"/> original enclosed | <input type="checkbox"/> on file with the department |

OR

- Request for security reduction.** Pursuant to s. 501.016(6), F.S., the security amount shall be \$25,000. A reduction to a security amount of \$10,000 may be granted upon submission of the following: Evidence satisfactorily representing that the aggregate dollar amount of all current outstanding contracts of the health studio is less than \$5,000.

Health studios whose bonds have been reduced shall provide the department with an annually updated list of members. The department shall increase the security requirement to \$25,000 for a health studio that fails to file an annual report.

Request for security waiver. This health studio is not subject to the security requirement of s. 501.016, F.S., for the reason(s) checked below (please attach documents which support your claim):

- This health studio:
 - has operated in compliance with ss. 501.012 - 501.019, F.S., and the rules adopted thereunder, under the same ownership and control, continuously for the most recent 5-year period;
 - has not had any civil, criminal, or administrative adjudication against it by any state or federal agency; AND
 - has a satisfactory consumer complaint history as defined in s. 501.016(8), F.S.
- This health studio is not engaged in the sale of future services and operates and will continue to operate on a daily cash basis or will collect money only after services are rendered. [s. 501.016, F.S.]
- This health studio offers or sells only a single contract for 30 days or less, without any option or other condition which establishes any right or obligation of a member beyond the 30-day period. (Please attach a copy of each membership contract). [s. 501.016, F.S.]
- This health studio offers or sells contracts with payments collected directly by the studio on a monthly basis, and any service fee charged is reasonable and fair, as defined in s. 501.0125, F.S. The number of monthly payments in the contract must be equal to the number of months in the contract, and the contract must specify in the terms of the contract the charges to be assessed for health studio services. (Please attach a copy of each membership contract). [s. 501.016, F.S.]

Health Studio Escrow Agreement. This business is not yet in operation and is conducting pre-opening sales. Pursuant to s. 501.016(7), F.S., you must provide the department with a copy of the escrow account, if established, which would contain all funds received for future consumer services sold prior to full operation of the health studio location and specify a date certain for openings.

A sample escrow agreement is available at <https://www.FDACS.gov/Business-Services/Health-Studios>.

CONTRACTS

NOTE: Please provide a copy of your contract(s). See the contract checklist located at <https://www.FDACS.gov/Business-Services/Health-Studios> for statutorily required provisions. To **expedite** processing of this application, highlight each of the provisions in the contract(s) submitted to the department.

THE DEPARTMENT DOES NOT APPROVE THE CONTENT OF CONTRACTS WHEN PROCESSING APPLICATIONS FOR LICENSURE. IT IS RECOMMENDED YOU SEEK LEGAL COUNSEL TO ENSURE THESE DOCUMENTS ARE IN COMPLIANCE WITH FLORIDA STATUTES.

Preparer Information

Prepared By (please print name):

Title of Preparer:

Telephone Number of Preparer:

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Application Certification

I am empowered to execute this application on behalf of the above-named entity or individual.

Print Name of Applicant

Title

Signature of Applicant

_____ / _____ / _____

Month Day Year

Phone Number (required)

NOTE: The department must be notified by certified mail at least 30 days in advance of a change in the majority ownership, location move, or business closure. [s. 501.018(2), F.S.]

**HEALTH STUDIO
SURETY BOND**

Sections 501.012 – 501.019, Florida Statutes
Rule 5J-4.004, Florida Administrative Code

1-800-HELP-FLA (435-7352) • (850) 410-3800
www.FDACS.gov • (850) 410-3804 Fax

Return completed application to:

FDACS
Health Studio Program
2005 Apalachee Parkway
Tallahassee, FL 32399-6500

Surety Bond Number:

Date of Surety Bond:

____ / ____ / ____

KNOWN ALL BY THIS PRESENT INSTRUMENT that we,

Principal (Applicant/Registrant)

Legal Name of Applicant:

Physical Street Address of Health Studio:

City: _____ **State:** _____ **Zip Code:** _____ - _____

Mailing Address *(if different from above):*

City: _____ **State:** _____ **Zip Code:** _____ - _____

Telephone Number:

Fax Number:

(_____) _____ - _____

(_____) _____ - _____

Email Address:

AND

Surety

Name *(Full legal name of Surety):*

Street Address:

City: _____ **State:** _____ **Zip Code:** _____ - _____

Mailing Address *(if different from above):*

City: _____ **State:** _____ **Zip Code:** _____ - _____

Telephone Number:

Fax Number:

(_____) _____ - _____

(_____) _____ - _____

which Surety is authorized to do business and issue surety bonds in the state of Florida, are held firmly bound unto the State of Florida, Department of Agriculture and Consumer Services, ("Obligee"), the sum of \$25,000 for the use and benefit of any consumer who is injured as a result of any violation of ss. 501.012 – 501.019, Florida Statutes. NOW, THEREFORE, the condition of this obligation is such that if the Principal shall perform or cause to be performed the contracted services for which the Principal may be held liable by reason of the Principal's failure to perform, fulfill, or carry out any contract, agreement, or arrangement governed by provisions of ss. 501.012 – 501.019, F.S., then this obligation shall be void. Otherwise this obligation shall remain in force and effect in law subject, however, to the following limitations:

1. That the Obligee (state of Florida) shall notify the Surety of any default of the Principal hereunder, at the earliest possible time following the discovery of such default.
2. That the Surety shall promptly notify the Obligee in writing of any changes in either the Principal or amount of bond set forth above. However, failure of the Surety to provide such notice shall not affect the validity of this bond.
3. That if the Surety shall so elect, this bond may be canceled by giving 30 days written notice to the Obligee. Said notice shall contain the full name, city, and state where the Principal is located, and the health studio registration number assigned to the Principal by the Obligee. The Surety, however, will remain liable for any default occurring during the period up to the expiration of said 30 days notice and such 30 day period shall begin only upon receipt of said notice by the Obligee.
4. That in no event shall the Surety be liable for a greater amount than that shown above.

This bond is effective this _____ day of _____, 20_____, 12:01 A.M., standard time and shall continue in force until canceled.

In witness hereof, the Principal and Surety have executed this instrument through their respective undersigned representatives, who are fully authorized to execute this instrument, on the _____ day of _____, 20_____.

Principal

Witness

Signature

Witness

Title

Full Legal Name of Principal (Applicant)

Surety

Witness

Signature (Seal)

Witness

Title

Local Agent

Name of Local Agent

Address

Contact Person

Contact Telephone Number

NOTE: The Department shall not accept for filing a Health Studio Irrevocable Letter of Credit which is not printed on the official letterhead of the Issuer.

Health Studio Irrevocable Letter of Credit

Legal Name of Applicant:

Physical Street Address of Health Studio:

City: _____ **State:** _____ **Zip Code:** _____ - _____

Mailing Address *(if different from above):*

City: _____ **State:** _____ **Zip Code:** _____ - _____

Telephone Number: _____ **Fax Number:** _____
(_____) _____ - _____ (_____) _____ - _____

Email Address:

Letter of Credit Number: _____ **Date of Letter of Credit:** _____ / _____ / **20** _____ **Date of Expiration:** _____ / _____ / **20** _____

(Name and Address of Issuer) ("Issuer") does hereby establish this

Irrevocable Letter of Credit in the name of _____
(Name and complete address of registrant/licensee as registered with the Department)

("Principal"), in the aggregate amount of \$ _____ available by draft at sight, for the benefit of the Florida Department of Agriculture and Consumer Services ("Department"), pursuant to s. 501.016, F.S. Drafts made under this Irrevocable Letter of Credit shall be marked "Drawn under Irrevocable Letter of Credit Number _____," and must be accompanied by any one of the following:

- Written notice by the Department that the Principal failed to perform its obligation to provide services to a paid consumer;
- Written notice by the Department that the Principal failed to pay its liabilities after such liabilities were adjudicated between Principal and a customer, or the state of Florida, and a judgment of a court of competent jurisdiction was entered against the Principal, with copy of the final judgment being attached to the Department's written notice;
- Written notice by the Department that the Principal, after reasonable notice, failed to perform its obligations to any consumer under the terms of its contracts or as required by Florida law; or
- Notice by the Department that the Principal is insolvent, or is no longer in active operation, or is otherwise unable to meet its obligations to any customer, and that the Principal is not satisfying said obligations.

Partial draft by the Department is permitted and surrender of this Irrevocable Letter of Credit will not be required for endorsements in such event.

The Issuer guarantees all drafts made under and in compliance with this Irrevocable Letter of Credit will be honored when presented on or before _____ (Date of Expiration), or during any period of extension of this Irrevocable Letter of Credit.

This Irrevocable Letter of Credit shall be in effect, without amendment, until the date set forth in the previous paragraph. This Irrevocable Letter of Credit automatically shall be extended for additional one (1) year periods, each commencing upon expiration of the prior period, unless at least ninety (90) days prior to the expiration date the Issuer notifies the Department in writing that the Issuer elects not to extend this Irrevocable Letter of Credit.

This Irrevocable Letter of Credit is established for the Principal at the following registered/licensed business physical location:

Drafts under this Irrevocable Letter of Credit are limited only to claims or other obligations arising from the operations of the Principal at the specified registered/licensed business location.

This Irrevocable Letter of Credit is governed by the following:

- A. The laws of the state of Florida, as amended subsequent to the effective date of this Irrevocable Letter of Credit, including without limitation Chapter 675, F.S., all other statutes, all other acts of the Florida Legislature, and all administrative regulations applicable to this Irrevocable Letter of Credit, the Issuer, or the Principal;
- B. To the extent the following are not in conflict with Chapter 675, F.S., any other law of the state of Florida, or any administrative regulations applicable to this Irrevocable Letter of Credit, the Issuer, or the Principal, the provisions of *(the Issuer may designate only one of the following conventions to the exclusion of the terms of the alternate; failure to so designate excludes all terms of the following)*:

_____ International Standby Practices ISP 98 Publication 590

_____ Uniform Customs and Practice for Documentary Credits (2007 Rev.), ICC Publication 600.

Venue for any administrative proceeding or judicial action arising from this Irrevocable Letter of Credit, including any action to enforce its terms against the Issuer, shall be in Leon County, Florida.

Authorized Signature and Title of Financial Institution Officer

Printed Name and Title of Authorized Officer

Authorization: Attached and incorporated into this Irrevocable Letter of Credit is a true copy of the written designation, delegation, or other official authorization from the Issuer to the above-named Officer to execute this Irrevocable Letter of Credit as a binding obligation of the Issuer. **The Department shall not accept any Irrevocable Letter of Credit which does not include the foregoing authorization as an attachment.**

NOTE: The Department shall not accept for filing a Health Studio Certificate of Deposit Assignment which is not printed on the official letterhead of the acknowledging depository.

Health Studio Certificate of Deposit Assignment Form

_____ (Legal Name of Applicant for Health Studio License), Assignor, does hereby assign, transfer, and set over unto the Florida Department of Agriculture and Consumer Services, Assignee, all right, title, and interest to and in Certificate of Deposit Number _____ and issued by _____, (Name and address of Depository) Depository, in the amount of \$25,000.00, excluding interest payable thereon. This assignment is made as security pursuant to Sections 501.012-501.019, Florida Statutes, the Florida Health Studio Law, for _____ (Legal Name and address of Health Studio - separate certificate of deposit or other security for each location). This assignment includes any substitution or renewals to the Certificate of Deposit described, and shall remain in effect until Assignee notifies Depository in writing of the cancellation of this assignment.

Assignee is authorized to draw against the above Certificate of Deposit pursuant to the Florida Health Studio Law, and Depository is directed to pay up to the Principal Sum to Assignee upon demand. Partial draft is permitted. Any payments made pursuant to this assignment shall constitute acquittance of Depository. Depository shall not pay any portion of the Principal Sum to Assignor without prior written cancellation of this assignment from the Assignee. This Certificate of Deposit may not be encumbered in any way, and any attempted encumbrance is void.

Signature of Assignor

Date

Depository Acknowledgement of Assignment

The Assignor's signature above compares correctly with our files. Principal Sum is \$_____, and the above assignment will be considered valid and honored until written cancellation is received from Assignee.

Depository Name:

Address:

City:

State:

Zip Code:

Telephone Number:

(_____) _____ - _____

Name of Authorized Depository Officer:

Title of Authorized Depository Officer:

Signature of Authorized Depository Officer

Date