Physician Group Certificate of Ownership

Medicaid Identification Number: Pending
(Write "pending" if this form is submitted with an application)

Physician Group Name: Integrative Cancer Clinics of Florida Inc.

Doing Business As (DBA) Name: *(if applicable)*

Service Address: 339 Cypress pkwy suite 110

City, State, Zip Code: Kissimmee, FL, 34758

This entity is:

- [x] 50% or more owned by **physicians** and located in a free-standing clinic or office.
- [ ] 50% or more owned by **physicians** and located in a hospital.
- [ ] 50% or more owned by **non-physicians** and located in a free-standing clinic or office.
  NOTE: A $50,000 Surety Bond and a site visit is required if this box is checked.
- [ ] 50% or more owned by **non-physicians** and located in a hospital.
  NOTE: A $50,000 Surety Bond and a letter from the hospital director confirming the group is located in or attached to the hospital and holds all hospital privileges is required if this box is checked.
- [ ] Owned by a **not-for-profit** hospital.
  NOTE: A letter from the hospital director confirming the group is located in or attached to the hospital and holds all hospital privileges is required if this box is checked.
- [ ] Owned by a **for-profit** hospital.
  NOTE: A $50,000 Surety Bond and a letter from the hospital director confirming the group is located in or attached to the hospital and holds all hospital privileges is required if this box is checked.

List the full name, social security number, and percentage of ownership for each owner of 5% or more. If the owner is a licensed practitioner, list the license number. Attach additional sheet if necessary.

Owner's Full Name	Owner's Social Security Number*	% of Ownership	Professional License (if applicable)
Samvel Gonzalez	581-61-7221	100%	ME 121889

"I do hereby certify that the entity identified above meets one or more of the criteria specified above, under penalty of perjury, in accordance with section 409.920, Florida Statutes."

Signature of Authorized Signer

MD/CEO
Signer's Title

Samvel Gonzales
Print Name of Authorized Signer

8/7/2023
Date

*Florida Medicaid is authorized to collect this information in accordance with Section 1902(a)(78) of the Social Security Act.