City of Hialeah
Business Tax Receipt Division
Doctor/Health Provider/Pharmacist Verification Affidavit

This is to inform the City of Hialeah that I, _____ will be

working at the following facility: _____

located at _____Hialeah, FL _____.

My State License is _____ Expires on _____.

and my Driver's License number is _____Expires on _____.

I understand that when I cease work at the above location I will notify the Business Tax Receipt Division by form of a letter to cancel my license.

_____ _____

Signature of Applicant Date

State of Florida. County of Dade.

Sworn and subscribed before me this _____ day of _____, 20_____.

_____ _____

My commission Expires **Notary Public, State of Florida**
Print, type or stamp Notary's name.

Personally Known ☐

Produced I.D. ☐ _____

Type of Identification