

Mission:

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

How to Make a Payment

Online:

www.myfloridaEHpermit.com

For "Billing Code" or "Audit Control Number", refer to the 06-BID-XXXXX number

Credit card docusign authorization form:

To access, [Click-here](#)

Mail:

Make check payable to: **Florida Department of Health in Broward County** and send to:

Florida Department of Health - Broward County

Cashier's Office

780 SW 24th Street

Fort Lauderdale, FL 33315

Mail credit card authorization form or fax to (954)467-4434

In Person:

Florida Department of Health - Broward County

Cashier's Office - Operations Building (2nd Floor)

2421-A SW 6th Avenue

Fort Lauderdale, FL 33315

Hours of Operation: Monday-Friday 8:00AM-4:30PM

Florida Department of Health Broward County

780 SW 24th Street, Fort Lauderdale, FL 33315

PHONE: 954-467-4700 • FAX: 954-760-7798

www.FloridaHealth.gov



Accredited Health Department
Public Health Accreditation Board

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CREDIT CARD AUTHORIZATION FORM

Facility: (Name) _____

Address: _____

City, State, Zip: _____ Phone: _____

TO: FLORIDA DEPARTMENT OF HEALTH IN BROWARD COUNTY

We have taken an extra step to protect our clients from credit card fraud. An authorization form filled out and faxed to us along with a copy of your current ID will ensure us that the person using your card is you. This is to confirm that you are using our services with your credit card. It is very important for us to have you complete this form and fax it back to us as soon as possible, so we can process your payment. Thank you for your cooperation.

Cardholder: _____ Card #: _____

Circle Type: **VISA** **MASTERCARD** **AMERICAN EXPRESS** **DISCOVER**

Expiration Date: _____ Security Code: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone Number: _____

I AUTHORIZE THE FLORIDA DEPARTMENT OF HEALTH (FDOH) IN BROWARD COUNTY TO CHARGE MY ACCOUNT FOR THE FOLLOWING:

Amount: \$ _____ and Service _____

If this is a renewal of FDOH - Broward County License or Permit, please print your Permit # **06-** _____

Signature: _____ **Date:** _____

FAX THIS FORM TO: (954) 467-4434 OR E-MAIL IT TO: BrowardEHCashier@flhealth.gov

Please make any updates to the renewal of your FDOH - Broward County License or Permit.

Facility Name: _____ **License/Permit#** _____

Location Address: _____ **Location City, State, Zip** _____

Location Phone: _____ **Location Fax:** _____

Business Name: _____ **Address:** _____

City, State, Zip: _____ **Owner/Manager/Contact** _____

Phone: _____ **Email:** _____ **Fax #:** _____

PLEASE PRINT CLEARLY OR TYPE ALL INFORMATION

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