

# PLEASE READ!!!

ATTACHMENT B

## FLORIDA PUBLIC SERVICE COMMISSION

### Application Form

DEPOSIT TREAS. REC. DATE

FOR

D404 24-4-112 NOV 19 '96

### Certificate to Provide Pay Telephone Service

#### Within the State of Florida

- 96 NOV 18 81 AM '96
- A. This form is used for an original application for a certificate to provide pay telephone service within the State of Florida.
  - B. A \$100 non-refundable application fee along with the enclosed Applicant Acknowledgement Card must be completed and accompany the application before processing will begin.
  - C. If the answer to question #2 is a Fictitious Name or Corporate Name, documentation from the Secretary of States office must accompany your application.
  - D. Once a certificate has been granted, regulatory assessment fees will be due for that calendar year regardless of whether or not pay telephones have been installed.
  - E. When completing the application, respond to each item. If an item is not applicable, explain why. Failure to respond to any item will result in the application being returned and a delay in the application process.
  - F. Use a separate sheet for each answer which will not fit the allotted space.
  - G. If you have any questions about completing the form, contact the Certificate Section at (904) 413-6556.
  - H. Once completed, the original plus two (2) copies of this form, along with \$100 application fee, are to be submitted to:

Florida Public Service Commission  
Gunter Building, 2540 Shumard Oak Boulevard  
Capital Circle Office Center  
Tallahassee, FL 32399-0850

DOCUMENT NUMBER-DATE

12233 NOV 18 96

FPSC-RECORDS/REPORTING

FLORIDA PAY TELEPHONE CERTIFICATE APPLICATION

1. LEGAL NAME OF THE APPLICANT

ST. LUKE'S HOSPITAL ASSOCIATION

2. NAME UNDER WHICH THE APPLICANT WILL DO BUSINESS

ST. LUKE'S HOSPITAL

3. ADDRESS OF THE APPLICANT(S)

STREET 4201 Belfort Road

CITY Jacksonville, Florida

STATE & ZIP Florida 32216

4. TYPE OF ORGANIZATION (CHECK ONE)

A. INDIVIDUAL DOING BUSINESS UNDER HIS/HER: [ ]  
OWN NAME.

DOCUMENTATION: No other documentation needed.

B. PARTNERSHIP: [ ]

DOCUMENTATION: Attach a copy of the partnership agreement, and a list with the name and address of all partners.

C. CORPORATION: [x]

DOCUMENTATION: Attach proof that articles of incorporation have been filed with the Florida Secretary of State's Office. If incorporated outside of Florida, attach proof from the Florida Secretary of State that applicant has authority to operate in Florida and provide name and address of Florida Registered Agent.

NAME See Attached

ADDRESS \_\_\_\_\_

D. DOING BUSINESS UNDER A FICTITIOUS NAME: [ ]

DOCUMENTATION: Attach proof that fictitious name has been registered with the Florida Secretary of States Office.

# State of Florida



Department of State

I certify that the attached is a true and correct copy of the Articles of Incorporation of ST. LUKE'S HOSPITAL ASSOCIATION, filed in the Office of the Clerk of the Circuit Court of Duval County County, on September 14, 1903, coming into this office by Certificate of Amendment under the name of ST. LUKE'S HOSPITAL ASSOCIATION, a corporation not for profit organized under the Laws of the State of Florida, filed on March 16, 1982, as shown by the records of this office.

The charter number for this corporation is 762438.

Given under my hand and the  
Great Seal of the State of Florida,  
at Tallahassee, the Capital, this the  
16th day of March, 1982.



Superseded by Amended &  
Restated Articles Adopted  
on February 21, 1986.

5. PROVIDE NAME, TITLE, AND TELEPHONE NUMBER OF THE INDIVIDUAL WHO IS RESPONSIBLE FOR COMMISSION CONTACTS:

NAME: Bob Taylor

TITLE: Director, Plant Operations

PHONE: (904) 296-3736

6. HAS APPLICANT OR ANY SUBSIDIARY, PARTNER, OFFICER, DIRECTOR, ETC., OR IN THE CASE OF A CLOSELY HELD CORPORATION ANY SHAREHOLDER OF THE APPLICANT EVER BEEN GRANTED OR DENIED A PAY TELEPHONE CERTIFICATE IN THE STATE OF FLORIDA? THIS INCLUDES ACTIVE AND CANCELLED PAY TELEPHONE CERTIFICATES.

No

7. IF THE ANSWER TO QUESTION 6 IS YES, PLEASE EXPLAIN AND LIST THE CERTIFICATE HOLDER AND CERTIFICATE NUMBER.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. LIST THE STATES IN WHICH THE APPLICANT:

A. IS CURRENTLY PROVIDING PAY TELEPHONE SERVICE

No

B. HAS APPLICATIONS PENDING TO BE CERTIFICATED AS A PAY TELEPHONE PROVIDER.

No

C. HAS BEEN DENIED AUTHORITY TO OPERATE AS A PAY TELEPHONE PROVIDER. EXPLAIN CIRCUMSTANCES.

No  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. HAS HAD REGULATORY PENALTIES IMPOSED FOR VIOLATIONS OF TELECOMMUNICATIONS STATUTES. EXPLAIN CIRCUMSTANCES.

No

---

---

---

9. PLEASE INDICATE IF ANY OFFICERS OF THE CORPORATION, PARTNERSHIP OR INDIVIDUAL APPLICANT HAVE BEEN ADJUDGED BANKRUPT, MENTALLY INCOMPETANT, OR FOUND GUILTY OF ANY FELONY OR OF ANY CRIME, OR WHETHER SUCH ACTIONS MAY RESULT FROM PENDING PROCEEDINGS.

None

---

---

---

---

10. PLEASE CHECK THE SERVICES THAT WILL BE PROVIDED:

LOCAL	<input checked="" type="checkbox"/>	]
LONG DISTANCE	<input checked="" type="checkbox"/>	]
COIN	<input checked="" type="checkbox"/>	]
CALLING CARD	<input checked="" type="checkbox"/>	]
CREDIT CARD	<input checked="" type="checkbox"/>	]
OTHER, DESCRIBE	<input checked="" type="checkbox"/>	] 411/911

11. PROPOSED NUMBER OF PAY TELEPHONE INSTRUMENTS THE APPLICANT PLANS TO PLACE IN THE FIRST YEAR: 16.

12. HOW DOES THE APPLICANT INTEND TO SERVICE AND MAINTAIN EACH PAYPHONE?

PERSONALLY	<input type="checkbox"/>	]
FULL-TIME TECHNICIAN	<input checked="" type="checkbox"/>	]
PART-TIME TECHNICIAN	<input type="checkbox"/>	]
SERVICE/REPAIR/MAINTENANCE CONTRACT	<input type="checkbox"/>	]
OTHER, DESCRIBE	<input type="checkbox"/>	]

---

---

13. WILL EACH OF THE PAY TELEPHONES WHICH YOU PLAN TO INSTALL PROVIDE ACCESS TO ALL LOCALLY AVAILABLE LONG DISTANCE CARRIERS VIA IOXXX+0, 950-XXXX, AND 1-800? (See Rule 25-24.515(6), F.A.C.)

Yes

---

---

---

14. WILL EACH OF THE PAY TELEPHONES WHICH YOU PLAN TO INSTALL CONFORM TO SUBSECTIONS 4.29.2 - 4.29.4 and 4.29.7 - 4.29.8 OF THE AMERICAN NATIONAL STANDARDS SPECIFICATIONS FOR MAKING BUILDINGS AND FACILITIES ACCESSIBLE AND USABLE BY PHYSICALLY HANDICAPPED PEOPLE (ATTACHMENT F)? (See Rule 25-24.515(14), F.A.C.)

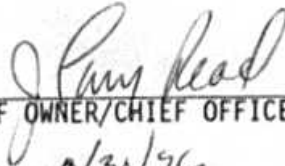
Yes

---

---

---

I, THE UNDERSIGNED OWNER OR OFFICER OF THE ABOVE NAMED ENTITY, HAVE READ THE FOREGOING AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION IS A TRUE AND CORRECT STATEMENT. I AM AWARE THAT PURSUANT TO s. 837.06, FLORIDA STATUTE, WHOEVER KNOWINGLY MAKES A FALSE STATEMENT IN WRITING WITH THE INTENT TO MISLEAD A PUBLIC SERVANT IN THE PERFORMANCE OF HIS OFFICIAL DUTY SHALL BE GUILTY OF A MISDEMEANOR OF THE SECOND DEGREE. I WILL COMPLY WITH ALL CURRENT AND FUTURE COMMISSION REQUIREMENTS REGARDING THE PAY TELEPHONE SERVICE. I UNDERSTAND THAT A NON-REFUNDABLE APPLICATION FEE OF \$100 MUST ACCOMPANY THE APPLICATION. ALSO, I UNDERSTAND THAT I AM REQUIRED TO PAY A REGULATORY ASSESSMENT FEE (MINIMUM \$50.00 PER CALENDAR YEAR), FILE AN ANNUAL PAY TELEPHONE SERVICE REPORT, AND PAY GROSS RECEIPTS TAX. FURTHERMORE, I AGREE TO KEEP THE COMMISSION ADVISED OF ANY CHANGES IN THE NAMES OR ADDRESSES LISTED ABOVE WITHIN TEN (10) DAYS OF THE CHANGE.

  
\_\_\_\_\_  
(SIGNATURE OF OWNER/CHIEF OFFICER OF APPLICANT)  
DATE: 10/30/96

APPLICANT ACKNOWLEDGEMENT CARD

Applicant St. Luke's Hospital

I acknowledge receipt and understanding of the Florida Public Service Commission's Rules and Requirements relating to my provision of Pay Telephone Service.

Signature 

Title Director, Plant Operations

Date \_\_\_\_\_

THIS MUST BE COMPLETED AND RETURNED WITH THE APPLICATION BEFORE THE CERTIFICATION PROCESS BEGINS. FAILURE TO DO SO WILL RESULT IN A DELAY OF THE CERTIFICATE BEING ISSUED.



**PLEASE READ!!!**

ATTACHMENT B

FLORIDA PUBLIC SERVICE COMMISSION

Application Form

DEPOSIT TO ACCOUNT DATE

FOR

DATE OF SERVICE BY 1996

Certificate to Provide Pay Telephone Service

Within the State of Florida

- A. This form is used for an original application for a certificate to provide pay telephone service within the State of Florida.
- B. A \$100 non-refundable application fee along with the enclosed Applicant Acknowledgement Card must be completed and accompany the application before processing will begin.
- C. If the answer to question #2 is a Fictitious Name or Corporate Name, documentation from the Secretary of States office must accompany your application.
- D. Once a certificate has been granted, regulatory assessment fees will be due for that calendar year regardless of whether or not pay telephones have been installed.
- E. When completing the application, respond to each item. If an item is not applicable, explain why. Failure to respond to any item will result in the application being returned and a delay in the application process.
- F. Use a separate sheet for each answer which will not fit the allotted space.
- G. If you have any questions about completing the form, contact the Certificate Section at (904) 413-6556.

THIS MULTI-TONE AREA OF THE DOCUMENT CHANGES COLOR GRADUALLY AND EVENLY FROM DARK TO LIGHT WITH DARKER AREAS BOTH TOP AND BOTTOM

Date 11/08/96

**St. Luke's Hospital Association**  
4201 BELFORT ROAD, JACKSONVILLE, FLORIDA 32216

No. 319092

FIRST BANK OF ROCHESTER  
ROCHESTER, MINNESOTA

OPERATING ACCOUNT

VOID AFTER 90 DAYS

VOID VOID VOID VOID VOID

PAY  ONE HUNDRED DOLLARS AND 00 CENTS

\*\*\*\*\*\$100.00

*Maia Sorous*  
Authorized Signature

FLORIDA PUBLIC SVC COMMISSION  
GUNTER BUILDING  
2540 SHUMARD OAK BLVD  
TALLAHASSEE, FL 32399-0850

DOCUMENT NUMBER-DATE  
12233 NOV 18 96

AUTHORIZED SIGNATURE

FPSC-RECORDS/REPORTING

TO THE ORDER OF

