

AC# 2375090

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/09/2007	CH 9331	22763

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01/09/2007	CH 9331	22763

The **CHIROPRACTIC PHYSICIAN** named below has met all requirements of the laws and rules of the state of Florida.
 Expiration Date: **MARCH 31, 2008**
JAVIER ALEJANDRO HUNG
 400 GALLERJA PKWY
 SUITE 1500
 ATLANTA, GA 30339

The **CHIROPRACTIC PHYSICIAN** named below has met all requirements of the laws and rules of the state of Florida.
 Expiration Date: **MARCH 31, 2008**
JAVIER ALEJANDRO HUNG



Charlie Crist
 Charlie Crist
 GOVERNOR

Joseph J. Chiaro
 Joseph J. Chiaro, M.D., FAAP
 INTERIM SECRETARY

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **MARCH 31, 2008**

Your license number is **CH 9331**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to www.flhealthsource.com
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here (**Account ID and Password are case sensitive**) Account ID: **hungjavi** Password: **mkPDih52**
6. Click on Login

Your opinion is important to us. To help us continue to improve our customer service, please take a moment to complete our online survey about the kind of service we provided you in obtaining your license. <http://www.doh.state.fl.us/mqa/Surveys/new-lic.htm> Thank you for helping us better serve you and our other customers.

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **\$25.00**. Now that you have your license, make sure you keep it. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

MAIL TO: DEPARTMENT OF HEALTH
 DIVISION OF MEDICAL QUALITY ASSURANCE
 LICENSURE SERVICES
 P.O. BOX 6320
 TALLAHASSEE, FLORIDA 32314-6320

PRACTICE LOCATION ADDRESS CHANGE
 (This address will be printed on your license and posted on the Internet.)

NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

MAILING ADDRESS CHANGE
 (This address will be used when mailing your license and for all other correspondence from the Department.)

FROM: _____

TO: _____

LAST	FIRST	MIDDLE
_____	_____	_____

CITY _____ STATE _____ ZIP _____