

**Private Provider
Duly Authorized Representative Employment Affidavit**

Private Provider Name: _____
(First and Last Name)

Duly Authorized Representatives: (use additional form if necessary)

First and Last Name of Representative

Florida license, Registration or Certification Number

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Florida license, Registration or Certification Number

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Florida license, Registration or Certification Number

First and Last Name of Representative

Florida license, Registration or Certification Number

First and Last Name of Representative

Florida license, Registration or Certification Number

I hereby affirm that the Duly Authorized Representatives listed above are my employees as required by Florida Statute 553.791 and are entitled to receive unemployment compensation benefits under Chapter 443 Florida Statutes. Said Duly Authorized Representatives may only perform inspection services that are within the disciplines covered by that person's license or certification under chapter 468, chapter 471, or chapter 481 Florida Statutes.

Signature of Private Provider

Date

State of Florida,
County of _____

Subscribed and sworn to before me this _____ day of _____ 20____, personally appeared _____, who is personally known to me or produced _____ as identification, and who did/did not take an oath.

Notary Public Signature

Seal:

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