Application for Massage Establishment License

Florida Board of Massage Therapy
PO Box 6330
Tallahassee, FL 32314-6330

Web: www.floridasmassagetherapy.gov
E-mail: info@floridasmassagetherapy.gov

Do not write in this space.
For Revenue receipting only.

APPLICATION FEES: New Massage Establishment (X-1020)

Initial Licensure Fee:	$100.00
Application Fee:	$50.00
Inspection Fee:	$100.00
Unlicensed Activity Fee:	$5.00
Total Fees:	**$255.00**

Applications received without fee payment will not be processed.

Fees must be paid in the form of a cashier's check or money order made payable to "Department of Health."

An applicant who is denied licensure or who withdraws their application prior to licensure is entitled to a refund of $105.00 (initial licensure fee and unlicensed activity fee). An applicant who is denied licensure or who withdraws their application prior to inspection is entitled to a refund of $205.00 (initial licensure fee, inspection fee, and unlicensed activity fee). A request to withdraw and/or receive a refund must be made in writing. Fees are refundable for three years from the date of receipt.

Part A: Establishment Information – *Complete all sections in this part.*

BUSINESS INFORMATION

Ownership Entity Name: _____
The name of your establishment. If you are applying as an individual (sole proprietor), this will be your name. For partnerships, limited liability companies and corporations, this will be the name of your entity as filed with the Division of Corporations.

Doing Business As (D/B/A) Name: _____
The name you would like to appear on the license, if it differs from your establishment name.

Fictitious Name Registration Number (if D/B/A Name was provided): _____
Your fictitious name registration will be verified with the Division of Corporations prior to the issuance of your license.

Mailing Address

All correspondence relating to your application and license will be mailed to this address.

Street / PO Box: _____ **Suite/Apt:** _____

City: _____ **State:** _____ **ZIP:** _____ **Phone: (___)-___-_____**

Physical Location

The location of the massage establishment. This address appears as a part of online license verification.

Street Address: _____ **Suite/Apt:** _____

City: _____ **State:** _____ **ZIP:** _____ **Phone: (___)-___-_____**

☐ **This establishment carries property damage and bodily injury liability insurance.**
Property damage and bodily injury liability insurance is required pursuant to 64B7-26.002(2), Florida Administrative Code.

Submit a copy of your insurance policy.

EMAIL NOTIFICATION

If you want to be notified of the status of your application by email, please check "Yes" and provide your email address. Information about your application will be sent via email. You will be responsible for checking your email regularly and updating your email address with the Board office.

I want to be notified by email: ☐ **Yes** ☐ **No**

E-Mail Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead, contact us by phone or in writing.

DESIGNATED MASSAGE ESTABLISHMENT MANAGER

The Designated Massage Establishment Manager is a massage therapist who holds a clear and active license without restrictions, who will be responsible for the operation of your establishment in accordance with 480, F.S.

Name of Designated Massage Establishment Manager: _____

License Number: MA _____

The named designated establishment manager will be notified prior to the issuance of your license.

Part B: Ownership Entity – *Complete ONLY the section in this part which applies to your ownership.*

OWNERSHIP INFORMATION FOR INDIVIDUALS (SOLE PROPRIETOR)

If you are applying as an individual (sole proprietor), complete this section.

I am an individual (sole proprietor). My name appears in response to the "Ownership Entity" question on this application. ☐ **Yes** ☐ **No**

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice in the state of Florida. I acknowledge that operation of a massage establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to comply with 456 and 480, F.S., and Rule Title 64B7, F.A.C.

I understand that it is my duty and responsibility to supplement my application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure, as required by Section 456.013(1), F.S.

Signature: _____ **Date:** _____

Complete PART C of this application as the individual (sole proprietor) who owns this establishment.

Continue with PART C of this application.

OWNERSHIP INFORMATION FOR PARTNERSHIPS (GP, LP, LLP, RLLP)

If you are applying as a general or limited liability partnership, complete this section.

I am a general partner of the GP, LP, LLP, or RLLP, *or* have been authorized by the partnership applying for this license to complete the application. The name of the partnership appears in response to the "Ownership Entity" question on this application. ☐ **Yes** ☐ **No**

FEI/EIN Number (if applicable): _____

Name of Filing Partner/Authorized Person: _____

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice in the state of Florida. I acknowledge that operation of a massage establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to comply with 456 and 480, F.S., and Rule Title 64B7, F.A.C.

I understand that it is my duty and responsibility to supplement this application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure, as required by Section 456.013(1), F.S.

Signature: _____ **Date:** _____

Submit a copy of your Partnership Registration as filed with the Division of Corporations.

The members of your partnership will be confirmed with the Division of Corporations.

Complete PART C of this application for each partner.

Continue with PART C of this application.

OWNERSHIP INFORMATION FOR LIMITED LIABILITY COMPANIES (LLC)

If you are applying as a limited liability company, complete this section.

I am a member of the limited liability company applying for this license *or* have been authorized by the limited liability company applying for this license to complete this application. The name of the partnership appears in response to the "Ownership Entity" question on this application. ☐ **Yes** ☐ **No**

FEI/EIN Number (if applicable): _____

Name of Filing Member/Authorized Person: _____

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice in the state of Florida. I acknowledge that operation of a massage establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to comply with 456 and 480, F.S., and Rule Title 64B7, F.A.C.

I understand that it is my duty and responsibility to supplement this application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure, as required by Section 456.013(1), F.S.

Signature: _____ **Date:** _____

Submit a copy of your Articles of Organization *or* most recent Annual Report as filed with the Division of Corporations.

The members of your limited liability company will be confirmed with the Division of Corporations.

Complete PART C of this application for each member of your limited liability company.

Continue with PART C of this application.

OWNERSHIP INFORMATION FOR CORPORATIONS (INC)

If you are applying as a corporation, complete this section.

I am an owner/officer or authorized corporate representative of the corporation *or* have been authorized by the corporation to complete this application. The name of the corporation appears in response to the "Ownership Entity" question on this application. ☐ **Yes** ☐ **No**

FEI/EIN Number: _____

This corporation has more than $250,000 in taxable business assets in the state of Florida.
☐ **Yes** ☐ **No**

If you answered "Yes" above, list the names of each interested party which is directly involved in the management of the establishment:

_____ _____

_____ _____

_____ _____

_____ _____

If you answered "Yes" to the taxable assets question above, submit documentation demonstrating $250,000 in taxable business assets in the state of Florida. This documentation may either be a letter from a Certified Public Accountant, or Form F-1120 (Florida Corporate Income/Franchise Tax Return) as filed with the Department of Revenue for the most recent tax year.

OWNERSHIP INFORMATION FOR CORPORATIONS (INC) - Continued

Name of Filing Owner/Officer/ACR: _____

Role of Filing Person:

- ☐ Corporate Owner/Officer
- ☐ Authorized Corporate Representative (ACR)
- ☐ Other Interested Party (specify): _____

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice in the state of Florida. I acknowledge that operation of a massage establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to comply with 456 and 480, F.S., and Rule Title 64B7, F.A.C.

I understand that it is my duty and responsibility to supplement this application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure, as required by Section 456.013(1), F.S.

Signature: _____ **Date:** _____

Submit a copy of your Articles of Incorporation *or* most recent Annual Report as filed with the Division of Corporations.

The owners/officers will be confirmed with the Division of Corporations.

Complete PART C of this application for each owner/officer of your corporation.

If you indicated "Yes" to the taxable assets question, complete PART C of this application the named interested parties as well as each owner/officer of your corporation.

Continue with PART C of this application.

OWNERSHIP INFORMATION FOR OTHER ENTITIES

If your ownership does not match any of the types identified in the other sections in this part, complete this section.

I am an interested party to the establishment identified on this application who has been authorized to complete this application. The name of the entity appears in response to the "Ownership Entity" question on this application. ☐ **Yes** ☐ **No**

Type of ownership: _____

Specify the type of entity submitting this application (i.e. municipal charter, association type).

list the names of each interested party which is directly involved in the management of the establishment:

_____ _____

_____ _____

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice in the state of Florida. I acknowledge that operation of a massage establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to comply with 456 and 480, F.S., and Rule Title 64B7, F.A.C.

I understand that it is my duty and responsibility to supplement this application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure, as required by Section 456.013(1), F.S.

Signature: _____ **Date:** _____

Complete PART C of this application for each named interested party listed above.

Continue with PART C of this application.

Establishment Name: _____

Part C: Individual Information – *Complete this section for each person identified in Part B.*

INDIVIDUAL NAME

Name: _____
First *Middle* *Last*

Other Names (a/k/a): _____
List any other names by which you have been known in the past.

INDIVIDUAL MAILING ADDRESS

All correspondence relating to your individual information will be mailed to this address.

Street / PO Box: _____ **Suite/Apt:** _____

City: _____ **State:** _____ **ZIP:** _____ **Phone: (___) -___-_____**

*If you are a licensed massage therapist, information will be sent to the mailing address for your **therapist** license. Listing a different address above will **not** update the mailing address for your therapist license.*

LICENSURE HISTORY

Are you currently licensed as a massage therapist in Florida? ☐ **Yes** ☐ **No**

If "Yes", please provide your license number. **MA** _____

Are you currently a massage establishment owner in Florida? ☐ **Yes** ☐ **No**

If "Yes", please list the establishment license (MM) numbers for which you are an owner:

_____

List all health care related licenses you have held in any state, territory, or jurisdiction, excluding the licenses already listed above:

State/Country	Profession	License Number	Date Issued

For each license listed, submit a license verification from the issuing state, territory or jurisdiction.
You do not need to submit license verifications for licenses held in Florida.

Failure to disclose additional licenses may result in a delay in processing your application.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth: _____

SOCIAL SECURITY DISCLOSURE

Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Social Security Number: _____

Social Security Information: *Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Section 653 and 654; and Section 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.*

EQUAL OPPORTUNITY DATA

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:
- ☐ **Male**
- ☐ **Female**

Race:
- ☐ **Native Hawaiian or Pacific Islander**
- ☐ **American Indian or Alaska Native**
- ☐ **White**
- ☐ **Two or More Races**
- ☐ **Hispanic or Latino**
- ☐ **Black or African American**
- ☐ **Asian**

Establishment Name: _____ Individual Name: _____

BACKGROUND SCREENING REQUIREMENTS

As an establishment owner, you are required to submit to the background screening requirements of 456.0135, Florida Statutes.

The Florida Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement (FDLE). Pursuant to 456.0135, Florida Statutes, other forms of background screening will not meet requirements for the purposes of licensing.

The Originating Agency Identification (ORI) number for the Board of Massage Therapy is:

EDOH4600Z

Background screening results submitted by a Livescan service provider are typically made available to the Department via the Care Provider Clearinghouse within 72 hours.

Visit www.flhealthsource.gov/background-screening for a list of approved Livescan vendors and answers to frequently asked questions.

LIVESCAN PRIVACY STATEMENT

The following items are included with this application, as required by the Florida Department of Law Enforcement and the Federal Bureau of Investigation:

- Statement from the FDLE regarding the sharing, retention, privacy and right to challenge incorrect criminal history records (page 10)
- Federal Bureau of Investigation "Privacy Statement" (page 11)

Complete the following attestation by checking the box below:

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation.

Failure to complete this attestation may delay the processing of your background screening.

CRIMINAL HISTORY

Have you **ever** been convicted of, or entered a plea of guilty, nolo contendere or no contest to a crime in any jurisdiction other than a minor traffic offense? **You must include all misdemeanors and felonies, even if adjudication was withheld.** ☐ **Yes** ☐ **No**

*Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence, or driving while impaired (DWI) are **not** minor traffic offenses for the purposes of this question.*

If you answered "Yes" to this question, submit the following for each offense:

- **Self-Explanation** describing in detail the circumstances surrounding each offense.
- **Arrest Records** and **Final Disposition**
  These documents are available from the Clerk of Courts in the arresting jurisdiction. If these records are no longer available, the Clerk of Courts will need to provide a written statement that the records are not available.
- **Completion of Sentencing** documents for any sentence imposed after conviction.
  This documentation must include the start date of the sentence, the end date of the sentence, and that the conditions of the sentence were satisfied.

If you are required to submit the documentation above, you may include your documents with this application. If you opt to submit these documents separately, please submit them directly to the Background Screening Unit in one of the following ways:

Email: *MQA.BackgroundScreen@flhealth.gov*

Mail: *Department of Health, Division of Medical Quality Assurance*
Bureau of Operations – Background Screening Unit
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, Florida 32399

Failure to disclose criminal history may result in the denial of your application.

Establishment Name: _____ Individual Name: _____

CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Important Notice: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in Section 456.0635(2), Florida Statutes.

1. Have you ever been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ **Yes** ☐ **No**

   If you responded "No" to the question above, skip to question 2.
   If you responded "Yes", complete a., b., c., and d., below:

   a. For the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ **Yes** ☐ **No**

   b. For the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes.) ☐ **Yes** ☐ **No**

   c. For the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ **Yes** ☐ **No**

   d. Have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? ☐ **Yes** ☐ **No**

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ **Yes** ☐ **No**

   If you responded "No" to the question above, skip to question 3.
   If you responded "Yes", complete a., below:

   a. Has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ **Yes** ☐ **No**

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? ☐ **Yes** ☐ **No**
   If you responded "No" to the question above, skip to question 4.
   If you responded "Yes", complete a., below:

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ **Yes** ☐ **No**

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ **Yes** ☐ **No**
   If you responded "No" to the question above, skip to question 4.
   If you responded "Yes", complete a. and b., below:

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ **Yes** ☐ **No**

   b. Did termination occur at least 20 years before the date of this application? ☐ **Yes** ☐ **No**

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities? ☐ **Yes** ☐ **No**

If you answered "Yes" to any of the questions in this section, submit the following:

- **Self-explanation,** which includes the county, state, and date of each termination or conviction.
- **Supporting documentation,** including court dispositions or agency orders where applicable.

Failure to disclose criminal history may result in the denial of your application.

Establishment Name: _____ Individual Name: _____

UNLICENSED ACTIVITY / PRIOR ACTION

Have you ever been issued a cease and desist or citation for the unlicensed practice of massage therapy or for operating an establishment without a license in Florida, or had similar action taken against you in another state, territory, or jurisdiction, for unlicensed practice of massage therapy or unlicensed operation of a massage establishment? ☐ **Yes** ☐ **No**

If you answered "Yes," submit documentation of the occurrence, including any relevant criminal or administrative filings. This documentation should demonstrate resolution of the incident.

Have you ever had a license or certificate of registration to practice massage therapy or any other licensed health care profession, or a massage establishment, denied for any reason in any state, territory or jurisdiction? ☐ **Yes** ☐ **No**

If you answered "Yes," submit documentation of the denial, including the final order or other administrative filing which resulted in the denial.

Failure to disclose unlicensed activity or license, certification, or registration denial may result in the denial of your application.

DISCIPLINARY HISTORY

Have you ever had disciplinary action taken against your license or certificate of registration in a disciplinary proceeding in any state, jurisdiction or territory? ☐ **Yes** ☐ **No**

Have you ever surrendered a license to practice any health care related profession in any state, jurisdiction or territory while disciplinary action was pending against you? ☐ **Yes** ☐ **No**

Is there any pending investigation in any state, jurisdiction or territory for professional conduct or competence? ☐ **Yes** ☐ **No**

Have you ever been the defendant in a civil litigation in which the basis of the complaint against you was an alleged negligence, malpractice, sexual misconduct or fraud? ☐ **Yes** ☐ **No**

If you answered "Yes" to any question in this section, submit the following:

- **Self-explanation** of each disciplinary action, license surrender, pending investigation, or civil litigation.
- **Supporting documentation,** including an administrative complaint and final order for disciplinary action or license surrender, and court records for civil litigation.

INDIVIDUAL STATEMENT

I understand that it is my duty and responsibility to supplement my application after it has been submitted if and when any material changes in circumstances or conditions occur which might affect the Department's decision concerning eligibility for licensure as required by Section 456.013(1), Florida Statutes. I understand that failure to provide such supplement may result in disciplinary action or denial of licensure.

I have carefully read the questions in Part C of this application and have answered them completely, without reservation of any kind, and I declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida.

I understand that it is my responsibility to operate the establishment in accordance with Chapters 456 and 480, F.S. and Rule Title 64B7, F.A.C., and that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C.

Applicant Signature: _____

Date: _____

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. “Specified agency” means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearing house will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies’ duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person’s fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 305-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI’s Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice, FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.