Florida HEALTH

# Mobile Opportunity by Interstate License Endorsement (MOBILE)

**Department of Health**
**P.O. Box 6330**
**Tallahassee, FL 32314-6330**
**Website: FLHealthSource.gov**
**Phone: 850-488-0595**

DH-MQA-5103, Revised 8/2025, Rule 64B7-25.001, F.A.C.

## *Qualifications for Licensure*

Expedite your application by applying online at www.flhealthsource.gov.

1. Must hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, determined by the board or the department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

2. Must have obtained a passing score on a national licensure examination or hold a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state;

   **OR**

   An applicant for a profession that does not require a national examination or national certification is eligible for licensure if the applicable board, or the department if there is no board, determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in this state.

3. **Must have actively practiced** the profession for which the applicant is applying **for least two years during the four-year period immediately** preceding the date of submission of this application. **Medical Doctors** who do not meet this requirement may submit evidence to the board's satisfaction of the successful completion of either a board-approved postgraduate training program within two years preceding the filing of an application or a board-approved clinical competency examination within the year preceding the filing of the application. Medical Doctors who do not meet the practice requirement must complete page 22 of this application.

4. **Must not be**, at the time of submission of the application, **the subject of a disciplinary proceeding** in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reason related to the practice of the profession for which the applicant is applying.

5. **Must not have had disciplinary action** taken against you **in the five years immediately preceding** the date of submission of the application.

6. Must meet the financial responsibility requirements of s. 456.048, Florida Statutes, or the applicable practice act, if required for the profession for which you are applying. The following professions must demonstrate compliance with financial responsibility as part of licensure.

| | | |
|---|---|---|
| Acupuncturist (ch. 457) | Chiropractic Physician (ch. 460) | Dentist (ch. 466) |
| Medical Doctor (ch. 458) | Podiatric Physician (ch. 461) | Licensed Midwife (ch. 467) |
| Osteopathic Physician (ch. 459) | Advanced Practice Registered Nurse (ch. 464) | Anesthesiologist Assistant (ch. 458, 459) |

7. Refer to s. 456.0145(2)(c), Florida Statutes, for licensure **ineligibility criteria**.

8. All professions require Livescan screening with the exception of Emergency Medical Technicians (EMT), Paramedics, Pharmacy Interns, Pharmacy Technicians, and Radiologic Technologists. Visit https://flhealthsource.gov/background-screening/bgs-requirements/ for more information.

9. Apply online at www.flhealthsource.gov or submit your application, any applicable fees, and any supplemental documentation to the Department of Health at the address listed on the application below.

10. **Practitioner Profiling:** Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

| | | |
|---|---|---|
| Medical Doctor (ch. 458) | Chiropractic Physician (ch. 460) | Advanced Practice Registered Nurse (ch. 464) |
| Osteopathic Physician (ch. 459) | Podiatric Physician (ch. 461) | |

# Mobile Opportunity by Interstate Licensure Endorsement (MOBILE)

**Department of Health**
**P.O. Box 6330**
**Tallahassee, FL 32314-6330**

**Do Not Write in this Space**
**For Revenue Receipting Only**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Certain fees are refundable for up to three years from the date of receipt. Requests for a refund must be made in writing. Refer to pages 12 and 13 to determine the appropriate fee to submit with your application.

**List the profession you are applying for:**

_____
(Examples: Dentist, Medical Doctor, Osteopathic Physician, Registered Nurse, Licensed Practical Nurse, etc.)

## 1. PERSONAL INFORMATION

**Name:** _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

**Mailing Address:** (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

**Physical Address:** (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

**EQUAL OPPORTUNITY DATA:**

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 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 | Race: | Native Hawaiian or Pacific Islander | Hispanic or Latino | White |
| | Female | | American Indian or Alaska Native | Black or African American | Asian |
| | | | Two or More Races | | |

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email 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 the office by phone or in writing.

## 2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** _____

**First Name:** _____

**Middle Name:** _____

**U.S. 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 § 653 and 654; and s. 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.

## 3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice as defined in s. 456.0145(2)(a)2., Florida Statutes, in the profession for which you are applying? Yes No

C. List all health-related licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

| License Type | License # | State/Country | Original Date Issued (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY) | Status of License |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

D. Have you actively practiced the profession for which you are applying for at least two years during the four-year period immediately preceding the date of submission of the application? Yes No

Note: If you responded "No" to question D, you may be ineligible for licensure under this method per section 456.0145(2)(a)4., Florida Statutes.

Medical Doctors Only: If you responded "No" to question D, have you completed a board-approved postgraduate training within two years or completed a board-approved clinical competency examination within the year immediately preceding the submission of this application? Yes No

E. Have you obtained a passing score on a national licensure examination or do you hold a national certification recognized by the board for the profession for which you are applying? Yes No

If "Yes," complete one of the following:

| Licensure Examination | Date of Examination (MM/DD/YYYY) |
|---|---|
| | |

OR

| National Certification | Date of Certification (MM/DD/YYYY) |
|---|---|
| | |

Board staff will obtain national scores from the examination vendor, if available. Applicants must submit proof of national certification.

F. Does your profession require a national licensure examination or national certification? Yes No

If "No," submit evidence that you meet the established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements that are substantially similar to the requirements for licensure in your profession in Florida.

## 4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

**This information is exempt from public records disclosure.**

## 5. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, Florida Statutes, and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? Yes No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? Yes No

**If a "Yes" response was provided** to any of the questions in this section, provide the following documents directly to the board office:

**A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

## 6. DISCIPLINE HISTORY

A. Are you currently the subject of a disciplinary proceeding in a jurisdiction in which you hold a license or by the United States Department of Defense for reasons related to the practice of the profession for which you are applying? Yes No

B. Have you ever had any disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country? Yes No

C. **If you responded "Yes" to question B,** have you had disciplinary action taken against any license by the licensing authority in any state, jurisdiction, or country within the last five years? Yes No N/A

D. Do you have a complaint, an allegation, or investigation pending before a licensing entity in any U.S. jurisdiction or territory? Yes No

E. Have you ever had a license to practice a health care profession revoked or suspended by any U.S. jurisdiction or territory or voluntarily surrendered any such license in lieu of having disciplinary action taken against the license? Yes No

**Note: If you responded "Yes" to any question in this section,** you may be ineligible for licensure under this method per section 456.0145(2), Florida Statutes.

**If you responded "Yes" to any of the questions in this section, complete the following:**

| Name of Agency | State | Action Date (MM/DD/YYYY) | Final Action | Under Appeal? |
|---|---|---|---|---|
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint, Final Order, and proof of compliance of any obligations, if applicable**.

F. Have you been reported to the National Practitioner Data Bank (NPDB)? Yes No

G. **If you responded "Yes" to question F,** have you successfully appealed to have your name removed from the data bank? Yes No N/A

Staff will complete a NPDB query. For more information, visit the National Practitioner Data Bank at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp.

**Note: A person is ineligible for licensure under this method** if they have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have their name removed from the data bank per section 456.0145(2)(c), Florida Statutes.

Licensure **may be permissible** if the reported adverse action was a result of conduct that would not constitute a violation of any Florida law or rule. Licensure in this case may be subject to conditions such as restrictions or probation per section 456.0145(2)(c), Florida Statutes.

## 7. CRIMINAL HISTORY

*For the question below, you* must include *all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are* not *minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health* must disclose *expunged and sealed criminal history records.*

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? Yes No

If you responded "Yes" in this section, complete the following:

| Offense | Jurisdiction | Date (MM/DD/YYYY) | Final Disposition | Under Appeal? |
|---|---|---|---|---|
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges, and final results.

Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

## 8. 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 time frames as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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.

a. If "Yes" to 1, 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. If "Yes" to 1, 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 s. 893.13(6)(a), Florida Statutes)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

d. If "Yes" to 1, 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, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) 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.**

   a. If "Yes" to 2, 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 s. 409.913, Florida Statutes? Yes No

**If you responded "No" to the question above, skip to question 4.**

   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 5.**

   a. If "Yes" to 4, 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 (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

**Supporting documentation** that includes court dispositions, agency orders, and completion of sentence documents, if applicable.

Name: _____

## 9. LIVESCAN PRIVACY STATEMENT (for professions requiring background screening only)

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 (found in the forms following this application).

**The board will not receive your Livescan results if you do not confirm the above statement by checking the box.**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically, background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

| Profession | ORI Number | Profession | ORI Number | Profession | ORI Number |
|---|---|---|---|---|---|
| Acupuncture (ch. 457) | EDOH4500Z | Anesthesiologist Assistant (ch. 458, 459) | EDOH4510Z | Athletic Trainer (ch. 468 Part XIII) | EDOH4520Z |
| Certified Nursing Assistant (ch. 464 Part II) | EDOH0380Z | Chiropractic Professions (ch. 460) | EDOH2016Z | Clinical Laboratory Personnel (ch. 483 Part I) | EDOH4530Z |
| Dental Professions (ch. 466) | EDOH4560Z | Dietetics/Nutrition (ch. 468 Part X) | EDOH4570Z | Electrolysis (ch. 478) | EDOH4580Z |
| Genetic Counselor (ch. 483 Part III) | EDOH4750Z | Hearing Aid Specialist (ch. 484 Part II) | EDOH4590Z | Massage Therapist (ch. 480) | EDOH4600Z |
| Medical Doctor (ch. 458) | EDOH2014Z | Medical Physicist (ch. 483 Part II) | EDOH4610Z | Mental Health Professions (CSW/MFT/MHC) (ch. 491) | EDOH4550Z |
| Midwifery (ch. 467) | EDOH4620Z | Nurse (LPN/RN/APRN) (ch. 464) | EDOH4420Z | Nursing Home Administrator (ch. 468 Part II) | EDOH4640Z |
| Occupational Therapy (ch. 468 Part III) | EDOH4650Z | Opticianry (ch. 484) | EDOH4660Z | Optometry (ch. 463) | EDOH4670Z |
| Orthotist, Prosthetist, and Pedorthist (ch. 468) | EDOH3451Z | Osteopathic Physician (ch. 459) | EDOH2015Z | Pharmacist (ch. 465) | EDOH4680Z |
| Physical Therapy (ch. 486) | EDOH4690Z | Physician Assistant (ch. 458, 459) | EDOH4700Z | Podiatric Professions (ch. 461) | EDOH2017Z |
| Psychology (ch. 490) | EDOH4710Z | Respiratory Care (ch. 468 Part V) | EDOH4720Z | School Psychology (ch. 490) | EDOH4730Z |
| Speech-Language Pathology and Audiology (ch. 468 Part I) | EDOH4740Z | | | | |

Name: _____

## 10. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in denial of certification/licensure, disciplinary action against my certification/license, or criminal penalties pursuant to s. 456.067, Florida Statutes. I have read ch. 456, Florida Statutes, the practice act governing the profession for which I am applying, and the Florida Administrative Code chapter governing the profession for which I am applying.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Department of Health information which is material to my application for licensure.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my certification/license to practice the profession for which I am applying in the state of Florida. Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____

You may print out this application and sign it or sign digitally. MM/DD/YYYY

**Total Fees by Profession -** The following chart shows the total fee breakdown for each profession. Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Licensure Fees, Unlicensed Activity Fees, and Additional Fees are refundable for up to three years from the date of receipt. The Application Fees are non-refundable. Requests for a refund must be made in writing.

| Profession | Application Fee | Licensure Fee | Unlicensed Activity Fee | Additional Fees | Total Fee |
|---|---|---|---|---|---|
| **Acupuncture -** Acupuncturist | $200.00 | $200.00 | $5.00 | - | $405.00 |
| **Athletic Training -** Athletic Trainer | $100.00 | $100.00 | $5.00 | - | $205.00 |
| **Chiropractic Medicine** | | | | | |
| Chiropractic Physician | - | - | $5.00 | - | $5.00 |
| Chiropractic Physician's Assistant | $100.00 | $100.00 | $5.00 | SPF* - $100.00 | $305.00 |
| **Clinical Laboratory Personnel** | | | | | |
| Director | $90.00 | $65.00 | $5.00 | - | $160.00 |
| Supervisor | $70.00 | $55.00 | $5.00 | - | $130.00 |
| Technologist | $50.00 | $45.00 | $5.00 | - | $100.00 |
| Technician | $25.00 | $25.00 | $5.00 | - | $55.00 |
| **Dentistry** | | | | | |
| Dentist | - | $300.00 | $5.00 | - | $305.00 |
| Dental Hygienist** | - | $37.50 **or** $75.00 | $5.00 | - | $42.50 **or** $80.00 |
| Dental Radiographer | - | $35.00 | - | - | $35.00 |
| **Dietetics and Nutrition -** Dietitian/Nutritionist | $85.00 | $80.00 | $5.00 | - | $170.00 |
| **Electrolysis -** Electrologist | $100.00 | $100.00 | $5.00 | - | $205.00 |
| **Emergency Medical Services** | | | | | |
| Emergency Medical Technician | - | $35.00 | - | - | $35.00 |
| Paramedic | - | $45.00 | - | - | $45.00 |
| **Genetic Counseling -** Genetic Counselor | - | - | $5.00 | - | $5.00 |
| **Hearing Aid Specialists -** Hearing Aid Specialist | - | $320.00 | $5.00 | - | $325.00 |
| **Massage Therapy -** Massage Therapist | $50.00 | $100.00 | $5.00 | - | $155.00 |
| **Medical Physicists -** Medical Physicist | $500.00 | $100.00 | $5.00 | - | $605.00 |
| **Medicine** | | | | | |
| Medical Doctor | $350.00 | $350.00 | $5.00 | NICA*** | $705.00 |
| Resident, Intern, and Fellow | $200.00 | - | - | - | $200.00 |
| House Physician | $300.00 | - | - | - | $300.00 |
| Physician Assistant | $100.00 | $200.00 | $5.00 | - | $305.00 |
| Anesthesiologist Assistant | $150.00 | $100.00 | $5.00 | - | $255.00 |
| **Mental Health Professions** | | | | | |
| Clinical Social Worker | $100.00 | $75.00 | $5.00 | - | $180.00 |
| Marriage and Family Therapist | $100.00 | $75.00 | $5.00 | - | $180.00 |
| Mental Health Counselor | $100.00 | $75.00 | $5.00 | - | $180.00 |
| **Midwifery -** Licensed Midwife | $200.00 | $500.00 | $5.00 | $250.00 | $955.00 |
| **Nursing** | | | | **Student Loan Forgiveness** | |
| Certified Nursing Assistant | - | - | - | - | $0.00 |
| Licensed Practical Nurse | $50.00 | $50.00 | $5.00 | $5.00 | $110.00 |
| Registered Nurse | $50.00 | $50.00 | $5.00 | $5.00 | $110.00 |
| Advanced Practice Registered Nurse | $50.00 | $50.00 | $5.00 | $5.00 | $110.00 |
| **Nursing Home Administrators -** Nursing Home Administrator | - | $500.00 | $5.00 | - | $505.00 |
| **Occupational Therapy** | | | | | |
| Occupational Therapist | $100.00 | $75.00 | $5.00 | - | $180.00 |
| Occupational Therapist Assistant | $100.00 | $75.00 | $5.00 | - | $180.00 |

| Profession | Application Fee | Licensure Fee | Unlicensed Activity Fee | Additional Fees | Total Fee |
|---|---|---|---|---|---|
| **Opticianry -** Optician** | - | $62.50 **or** $125.00 | $5.00 | - | $67.50 **or** $130.00 |
| **Optometry -** Optometrist | - | $300.00 | $5.00 | - | $305.00 |
| **Orthotists and Prosthetists** | | | | | |
| Prosthetist-Orthotist | $400.00 | $400.00 | $5.00 | - | $805.00 |
| Orthotist | $400.00 | $400.00 | $5.00 | - | $805.00 |
| Prosthetist | $400.00 | $400.00 | $5.00 | - | $805.00 |
| Orthotic Fitter | $400.00 | $400.00 | $5.00 | - | $805.00 |
| Orthotic Fitter Assistant | $400.00 | $400.00 | $5.00 | - | $805.00 |
| Pedorthist | $400.00 | $400.00 | $5.00 | - | $805.00 |
| **Osteopathic Medicine** | | | | | |
| Osteopathic Physician | - | $300.00 | $5.00 | NICA*** | $305.00 |
| Intern, Resident, and Fellow | - | $100.00 | - | - | $100.00 |
| **Pharmacy** | | | | | |
| Pharmacist | $100.00 | $190.00 | $5.00 | - | $295.00 |
| Registered Pharmacy Technician | $50.00 | $50.00 | $5.00 | - | $105.00 |
| **Physical Therapy** | | | | | |
| Physical Therapist | $100.00 | $75.00 | $5.00 | - | $180.00 |
| Physical Therapist Assistant | $100.00 | $75.00 | $5.00 | - | $180.00 |
| **Podiatric Medicine** | | | | | |
| Podiatric Physician | - | $350.00 | $5.00 | - | $355.00 |
| Certified Podiatric X-Ray Assistant | - | - | $5.00 | $75.00 Certification Fee | $80.00 |
| **Psychology -** Psychologist | $200.00 | $100.00 | $5.00 | - | $305.00 |
| **School Psychologists -** School Psychologist | $175.00 | $175.00 | $5.00 | - | $355.00 |
| **Speech-Language Pathology and Audiology** | | | | | |
| Audiologist** | $75.00 | $100.00 **or** $200.00 | $5.00 | - | $180.00 **or** $280.00 |
| Audiologist Assistant | $75.00 | $50.00 | $5.00 | - | $130.00 |
| Speech-Language Pathologist** | $75.00 | $100.00 **or** $200.00 | $5.00 | - | $180.00 **or** $280.00 |
| Speech-Language Pathologist Assistant | $75.00 | $50.00 | $5.00 | - | $130.00 |

***SPF -** Supervising Physician Fee

****This profession's Licensure Fee is based on the length of time the initial license will be valid. Depending on what point during the licensure biennium you apply, your Licensure Fee may be different.

*****Florida Birth-Related Neurological Injury Compensation Association (NICA) Fund -** All allopathic and osteopathic physicians licensed in Florida are required to pay into the NICA fund unless qualified for exemption. Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

**"Participating,"** is for Florida licensed physicians who practice obstetrics or perform obstetrical services on a full or part-time basis and do not meet any of the exemption criteria. **NICA Participating: $5,000.00** in addition to the total fee listed above.

**"Non-participating,"** is for Florida licensed physicians who do not practice obstetrics or perform obstetrical services and do not meet any of the exemption criteria. **NICA Non-Participating: $250.00** in addition to the total fee listed above.

To determine if you qualify for exemption review the exemptions at the NICA website listed above. Applicants who qualify for NICA exemption are not required to submit a NICA fee in addition to the total fee listed above. Exempt applicants must submit proof of exemption. Refer to and complete the appropriate "Florida Birth-Related Neurological Injury Compensation Association (NICA) Form" on page 17 or 18 for your profession.

**FLORIDA DEPARTMENT OF LAW ENFORCEMENT**

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 to be employed, licensed, work under contract, or 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 Person 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 Clearinghouse 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 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 your 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, Florida Statutes, and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. 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 of 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 many 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, disclosure 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 additional information 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.

# Department of Health
# Electronic Fingerprinting

**This form is only for the professions that require Livescan.**

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening.
- Livescan screenings done by Florida Police or Sheriff's Departments require that you login into the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the Department of Health.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider applicable board offices will not receive your background screening results; ORI #s are listed by profession on page 10.
- You must provide demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically, background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____

Aliases: _____ Date of Birth: _____
MM/DD/YYYY

Citizenship: _____ Place of Birth: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

**Keep this form for your records.**

**This form is required for all Medical Doctors.**

# Board *of* Medicine
# Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

**All applicants must choose one of the three options described below. Check only one.**

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

| Exempt- $0.00 | Non-participating- $250.00 | Participating- $5,000.00 |
|---|---|---|

**Amount Enclosed:** $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

**Participating and Non-participating applicants** must complete and attach this form and appropriate fees to the application or submit to the Board of Medicine at:

Board *of* Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330

**Applicants claiming exemption** must complete this form, and return it with proof of qualification for the exemption to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

**AND**

NICA
P.O. Box 14567
Tallahassee, FL 32317-4567

**Exemptions Include:**

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, Florida Statutes, who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

**I have read the information provided by NICA at www.nica.com and I have selected the option above.**

Applicant Signature _____ Date _____
MM/DD/YYYY

**This form is required for all Osteopathic Physicians.**

# Board *of* Osteopathic Medicine
## Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

**All applicants must choose one of the three options described below. Check only one.**

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

| Exempt- $0.00 | Non-participating- $250.00 | Participating- $5,000.00 |
|---|---|---|

**Amount Enclosed:** $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

**Participating and Non-participating applicants** must complete and attach this form and appropriate fees to the application or submit to the Board of Osteopathic Medicine at:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

**Applicants claiming exemption** must complete this form, and return it with proof of qualification for the exemption to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

**AND**

NICA
P.O. Box 14567
Tallahassee, FL 32317-4567

**Exemptions Include:**

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Osteopathic Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, Florida Statutes, who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

**I have read the information provided by NICA at www.nica.com and I have selected the option above.**

Applicant Signature _____ Date _____
MM/DD/YYYY

Medical Doctors ONLY

# Board *of* Medicine
## Financial Responsibility


Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
**Choose only ONE** option that best describes your situation, unless you choose **option 6** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

### FINANCIAL RESPONSIBILITY COVERAGE

1. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

2. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

3. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

4. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

5. I have elected not to carry medical malpractice insurance; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, Florida Statutes. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), Florida Statutes.

6. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category on the following page).***

Name: _____

**EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE**

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I hold a limited license issued pursuant to s. 458.317, Florida Statutes, and practice only under the scope of such limited license.
3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents **do not** qualify for this exemption.)
4. I have no malpractice exposure because I do not practice in the state of Florida. I will notify the Department of Health immediately before commencing practice in the state.
5. I am exempt from demonstrating financial responsibility due to meeting **all** the following criteria (if you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):
   a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
   b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
   c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
   d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, Florida Statutes, or the medical practice act in any other state.
   e. I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of ch. 458, Florida Statutes, or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See s. 458.320(5)(f), Florida Statutes, for specific notice requirements.

Section 456.067, Florida Statutes: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Medical Doctors ONLY

# Board *of* Medicine
## Financial Responsibility Affidavit of Exemption


**This affidavit is <u>only</u> required if you are claiming exemption based on #5 on the preceding page.**

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, Florida Statutes, or the medical practice act in any other state.
e. I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of ch. 458, Florida Statutes, or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See section 458.320(5)(f), Florida Statutes, for specific notice requirements.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the form and sign it before a notary public.

(SEAL)

**Medical Doctors who do not have two years of active practice ONLY**

***If you are using FCVS do not submit this form.***

**Complete verifications must be sent directly from the chairman/director of the postgraduate training program to the board office by email at BOM_InitialApps@flhealth.gov, by fax to (850) 412-1268 or by mail to:**


Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257


# Board *of* Medicine
# Postgraduate Training Verification

Name: _____

## Part I: To be completed by applicant

Institution Name: _____

Department: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

## Part II: To be completed by Training Institution

The above-named doctor has applied for licensure in the state of Florida. Please complete this section and submit to the above address.

1. Dates of internship/residency/fellowship: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)
2. Matriculation date: _____ (MM/DD/YYYY)
3. Completion date: _____ (MM/DD/YYYY)
4. Specialty: _____
5. The levels completed under your purview:

| PGY I | PGY II | PGY III | PGY IV | PGY V |
|---|---|---|---|---|

6. Accredited by:

| ACGME | RCPSC | CFPC | ACGME-I |
|---|---|---|---|
| Other: | | | |

Program Director/Chair Name _____

Signature _____ Date _____ (MM/DD/YYYY)

**Osteopathic Physicians ONLY**

# Board *of* Osteopathic Medicine
## Financial Responsibility



Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 6** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

### FINANCIAL RESPONSIBILITY COVERAGE

1. I do not have hospital privileges and I have obtained and will maintain professional liability coverage in an amount of not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

2. I have hospital staff privileges and I have obtained and maintain liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110, Florida Statutes.

3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, Florida Statutes, in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, Florida Statutes, in the per-claim amounts specified above.

4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, Florida Statutes, in an amount no less than $250,000 per claim, with a minimum aggregate availability of credit not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, Florida Statutes, in the per-claim amounts specified above.

5. I have decided to not carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgements pursuant to the terms and conditions contained in s. 459.0085(5)(g), Florida Statutes. I understand that I shall be required to either post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided to pursuant to Florida law.

Name: _____

**6.** I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

**EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE**

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I hold a limited license issued pursuant to s. 459.0075, Florida Statutes, and practice only under the scope of such limited license.
3. I practice only in conjunction with my teaching duties at a college of osteopathic medicine (residents **do not qualify** for this exemption).
4. I have no malpractice exposure because I do not practice in the state of Florida. I will notify the Department of Health immediately before commencing practice in the state.
5. I am exempt from demonstrating financial responsibility due to meeting all the following criteria (if you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):
    a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
    b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
    c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
    d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, Florida Statutes, or the practice act of any state.
    e. I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, Florida Statutes, or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Section 456.067, Florida Statutes: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

**If you selected an option out of options one through four in the "Financial Responsibility Coverage" section, proof of liability coverage must be sent directly by the insuring company to the board at:**

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

**Osteopathic Physicians ONLY**

# Board *of* Osteopathic Medicine
## Financial Responsibility Affidavit of Exemption


**This affidavit is <u>only</u> required if you are claiming exemption based on #5 on the preceding page.**

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, Florida Statutes, or the practice act of any state.
e. I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, Florida Statutes, or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the application and sign it before a notary public.

(SEAL)

**Anesthesiologist Assistants ONLY**

# Board *of* Medicine
# Anesthesiologist Assistant
# Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

## FINANCIAL RESPONSIBILITY COVERAGE

1. I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.
2. I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.
3. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

## EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I do not practice medicine in the state of Florida.
3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals.

Section 456.067, Florida Statutes: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

# Department of Health
# Practitioner Profile



Name: _____

***This form is only for the professions that require a practitioner profile, listed below. This form must be submitted with your application.*** Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

| | | |
|---|---|---|
| Medical Doctor (ch. 458) | Chiropractic Physician (ch. 460) | Advanced Practice Registered Nurse (ch. 464) |
| Osteopathic Physician (ch. 459) | Podiatric Physician (ch. 461) | |

## 1. BACKGROUND / EDUCATION AND TRAINING

A. List the year you legally began to practice your profession. Year: _____
YYYY

B. List in chronological order all schools or training programs attended, including graduate education, whether completed or not. Attach a separate sheet if necessary.

| School / Training Program Name | School Address | Dates of Attendance: From-To (MM/DD/YYYY) | Date Degree Received (MM/DD/YYYY) |
|---|---|---|---|
| | | to | |
| | | to | |
| | | to | |
| | | to | |

C. List in chronological order all professional and postgraduate training attended. List all programs you began, whether or not you completed or received credit for the training.

| Program Name / Address | Specialty Area | Dates of Attendance: From-To (MM/DD/YYYY) | Credit Received? |
|---|---|---|---|
| | | to | Y N |
| | | to | Y N |
| | | to | Y N |

D. Are you certified by any specialty board recognized by the Florida board that regulates the profession you are applying for? Yes No

**If you responded "Yes," complete the following:**

| Board Name | Certification/Specialty/Subspecialty | Date of Certification (MM/YYYY) |
|---|---|---|
| | | |
| | | |
| | | |

## 2. ACADEMIC FACULTY APPOINTMENTS

A. Do you currently hold a faculty appointment at an accredited medical school? Yes No

B. Have you had the responsibility for graduate education within the last 10 years? Yes No

**If you responded "Yes," complete the following:**

| Name of Institution | City/State | Title of Appointment |
|---|---|---|
| | | |
| | | |

Name: _____

## 3. STAFF PRIVILEGES *(Not required for APRNs)*

A. Do you currently hold staff privileges in any hospital, health institution, clinic, or medical facility? Yes No

**If you responded "Yes," complete the following:**

| Name of Facility | City/State | Type of Privileges | From-To (MM/DD/YYYY) |
|---|---|---|---|
| | | | to |
| | | | to |

B. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? Yes No

**If you responded "Yes," complete the following:**

| Name of Facility | Address | From-To (MM/DD/YYYY) | Under Appeal? |
|---|---|---|---|
| | | to | Y N |
| | | to | Y N |

**If you responded "Yes" to B, you must provide the following:**

**A written self-explanation** on a separate sheet describing in detail the circumstances.

**Supporting documents** from the applicable entity.

## 4. DISCIPLINE HISTORY

A. Within the previous 10 years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, national nursing specialty board recognized by the Board of Nursing, or other similar national organization? Yes No

B. Within the previous 10 years, have you ever had any final disciplinary action taken against you by the licensing agency in this state or any jurisdiction? Yes No

C. Within the previous 10 years, have you ever had any final disciplinary action taken against you by an institution such as a licensed hospital, health maintenance organization, pre-paid health clinic, nursing home, or ambulatory surgical center in this state or any jurisdiction? Yes No

D. Within the previous 10 years, have you ever been asked to or allowed to resign from or had any staff privileges restricted or not renewed by any medical health-related institution in lieu of facing disciplinary action or during any pending investigation into your practice? Yes No

**If you responded "Yes" to any of the questions in this section, complete the following:**

| Name of Agency | State | Action Date (MM/DD/YYYY) | Final Action | Under Appeal? |
|---|---|---|---|---|
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |
| | | | | Y N |

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

Name: _____

## 5. LIABILITY CLAIM HISTORY *(Allopathic and Osteopathic Physicians Only)*

Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? Yes No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation** listing your involvement in each case

**Completed Exhibit 1 form** for each case (found at the appropriate link below)
Allopathic Physicians: https://flboardofmedicine.gov/forms/exhibit-i-form.pdf
Osteopathic Physicians: https://floridasosteopathicmedicine.gov/forms/exhibit-I-form.pdf

**A copy of the complaint and disposition for each case**

**For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

## 6. LIABILITY CLAIM HISTORY *(Podiatric Physicians Only)*

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? Yes No

**If you responded "Yes," complete the Exhibit 1 form** for each case (found at https://floridaspodiatricmedicine.gov/forms/Form_-_Exhibit_I.pdf)

## 7. PRACTITIONER SIGNATURE

I, the undersigned, state that I am the person referred to in this Florida Practitioner Profile. I have carefully read the profiling questions and have answered them completely. These statements are true and correct.

Applicant Signature _____ Date _____
MM/DD/YYYY