

# License for the Spouse of an Active-Duty Member of the Armed Forces Application



**Department of Health  
Office of Veteran Licensure Services  
P.O. Box 6330  
Tallahassee, FL 32314-6330  
Website: [FLHealthSource.gov](http://FLHealthSource.gov)  
Email: [OVLS@FLHealth.gov](mailto:OVLS@FLHealth.gov)  
Phone: 850-488-0595**



## Qualifications for Licensure

Expedite your application by applying online at [www.FLHealthSource.gov](http://www.FLHealthSource.gov).

1. Must be married to a member of the United States Armed Forces who is assigned to an active-duty station in Florida.
2. Must hold an active, unencumbered license as a health care practitioner in a U.S. jurisdiction. Applicants will not qualify for this license if they have been or currently are the subject of disciplinary proceedings in any U.S. jurisdiction in which they hold a license to practice a profession regulated in Florida under Chapter 456, Florida Statutes.
3. Must meet the requirements for full licensure in the profession for which the applicant is seeking licensure.
4. Must complete a background check and have it submitted to the board office from an approved Livescan service provider. Fees are required for the background screening (paid directly to the Livescan vendor). Visit [FLHealthSource.gov/Background-Screening/](http://FLHealthSource.gov/Background-Screening/) for a list of authorized Livescan providers. See the **“Electronic Fingerprinting” form** in the application.
5. All initial licensure, application, unlicensed activity, and NPDB fees are waived. Fees are required for the background screening (paid directly to the Livescan vendor). Medical Doctors and Osteopathic Physicians may be required to pay fees for the Florida Birth-Related Neurological Injury Compensation Association (NICA) participation. Visit [FLBoardofMedicine.gov/Frequently-Asked-Questions/?FAQs=NICA](http://FLBoardofMedicine.gov/Frequently-Asked-Questions/?FAQs=NICA) to determine if you are required to pay this fee. Proof of qualification for a claimed exemption must be submitted to NICA, P.O. Box 14567, Tallahassee, FL 32317-4567. Make the cashier’s check or money order payable to the Department of Health, if applicable.
6. Staff will complete a National Practitioner Data Bank (NPDB) query. For more information, visit the National Practitioner Data Bank at [NPDB.HRSA.gov/TopNavigation/AboutUs.jsp](http://NPDB.HRSA.gov/TopNavigation/AboutUs.jsp).

**Financial Responsibility:** The following professions must demonstrate compliance with financial responsibility as part of licensure.

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

**Practitioner Profiling:** Sections 456.039 and 456.0391, Florida Statutes, require practitioners to furnish specific information for publication on the Department of Health’s website. Required information must be submitted within 12 months from the date of initial licensure. The following professions are required to comply with the profiling requirements:

Medical Doctor (Chapter 458)	Chiropractic Physician (Chapter 460)	Advanced Practice Registered Nurse (Chapter 464)
Osteopathic Physician (Chapter 459)	Podiatric Physician (Chapter 461)	



## 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](http://www.ssa.gov) or by calling 1-800-772-1213.

Name: \_\_\_\_\_

**3. MILITARY INFORMATION**

<b>Spouse's Name:</b>		
Last/Surname	First	Middle
<b>Spouse's Branch of Service:</b>		
<b>Spouse's Duty Station:</b>		
<b>Date Duty Began or Will Begin in Florida:</b>	(MM/DD/YYYY)	Contact the board office if this date changes.

Applicants must provide **proof of marriage** to verify marriage to a **member of the United States Armed Forces**.

Applicants must provide **a copy of their spouse's military orders** showing their spouse is assigned to an **active-duty station in Florida**.

**4. APPLICANT BACKGROUND**

- A. Do you hold a valid license issued by another state, the District of Columbia, or a possession or territory of the United States for the profession for which you are applying?      Yes      No
- B. 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.

- C. Are you the subject of any disciplinary proceeding in any jurisdiction in which you hold a license to practice?      Yes      No

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

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

**If you responded "Yes," 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**.

**Note: A person is ineligible for licensure under this method** if they have had a health care provider license revoked or suspended from another U.S. state, the District of Columbia, or a U.S. territory per section 456.024(5)(g), Florida Statutes.

Name: \_\_\_\_\_

- D. Have you been reported to the National Practitioner Data Bank (NPDB)?      Yes      No
- E. **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 [NPDB.HRSA.gov/topNavigation/aboutUs.jsp](http://NPDB.HRSA.gov/topNavigation/aboutUs.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 456.024(5)(g), Florida Statutes.

## 5. VETERANS FLORIDA

Veterans Florida is a non-profit organization created by the State of Florida to help military veterans transition to civilian life. They provide tools for veterans to take advantage of the benefits of living and working in the Sunshine State.

- A. Are you interested in receiving assistance with resume writing and proofreading?      Yes      No
- B. Are you interested in receiving assistance with job application completion?      Yes      No
- C. Are you interested in receiving assistance with interviewing skills and techniques?      Yes      No

## 6. 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.

## 7. EDUCATION HISTORY

Section 456.0242(3)(e)2., Florida Statutes, requires the Department of Health to report the educational and training background of each individual seeking licensure.

List any education and training related to the license or certification you are registering in chronological order, whether completed or not (if incomplete, list N/A for completion date):

School Name	Degree / Certificate	Completion Date MM/DD/YYYY

## 8. LICENSURE QUALIFICATION

As required by section 456.024(5)(a)5., Florida Statutes, I confirm that I am otherwise entitled to full licensure under the appropriate practice act and would be eligible to take the respective licensure examination as required by Florida.      Yes      No

**Note: A person is ineligible for licensure under this method** if they have previously failed the Florida examination required to receive a license to practice the profession for which the applicant is seeking licensure per section 456.024(5)(g), Florida Statutes.

Name: \_\_\_\_\_

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

## 9. HEALTH HISTORY

### Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice?      Yes      No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?  
Yes      No

### Substance-Related Disorders Impacting Ability to Practice

- C. 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 would impair your ability to practice?      Yes      No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse?      Yes      No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?      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: \_\_\_\_\_

**10. 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.

**Note:** A person is ineligible for licensure under this method if they have been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession per section 456.024(5)(g), Florida Statutes.

**11. 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 409, Florida Statutes (relating to social and economic assistance), Chapter 817, Florida Statutes (relating to fraudulent practices), Chapter 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

Name: \_\_\_\_\_

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 or agency orders where applicable

Name: \_\_\_\_\_

## 12. LIVESCAN PRIVACY STATEMENT

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:

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

Name: \_\_\_\_\_

### 13. APPLICANT SIGNATURE

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.

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 revocations of my certification/license to practice the profession for which I am applying in the state of Florida. If there are any changes to my status or any change that would affect any of my answers to this application, I must notify the Florida Department of Health within 30 days.

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 \_\_\_\_\_  
MM/DD/YYYY

## 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.**

## **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



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: [FLHealth.gov/Background-Screening/](https://FLHealth.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 receive will not your background screening results. **Locate your profession's ORI number online at [FLHealthSource.gov/BGS-Requirements](https://FLHealthSource.gov/BGS-Requirements).**
- 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/](http://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	<b>Amount Enclosed:</b> \$ _____
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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:

<p><b>Board of Medicine</b> 4052 Bald Cypress Way Bin C-03 Tallahassee, FL 32399-3253</p>	<b>AND</b>	<p><b>NICA</b> P.O. Box 14567 Tallahassee, FL 32317-4567</p>
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**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 Chapter 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](http://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](http://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/](http://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	<b>Amount Enclosed:</b> \$ _____
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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	<b>AND</b>	NICA P.O. Box 14567 Tallahassee, FL 32317-4567
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### 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 Chapter 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](http://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](http://www.NICA.com) and I have selected the option above.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY

Acupuncture ONLY

# Board of Acupuncture 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 4** in the ‘**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 hereby certify that I have professional liability coverage in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.
2. I hereby certify that I have an irrevocable letter of credit, established pursuant to Chapter 675, Florida Statutes, in an amount not less than \$10,000 per claim, with a minimum aggregate availability of credit no less than \$30,000.
3. I hereby certify that I have obtained a surety bond in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.
4. 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 exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I practice only in conjunction with my teaching duties at an accredited acupuncture school.
3. I do not practice in the state of Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in s. 456.067, 456.072, 775.082, 775.083, and 775.084, Florida Statutes.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY

Board of Acupuncture  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257

Board of Medicine  
Financial Responsibility

Page 1 of 3



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 Chapter 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 Chapter 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.*)

Board of Medicine
Financial Responsibility
Page 2 of 3



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 Chapter 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 Chapter 458, Florida Statutes, or the medical practice act of another jurisdiction.

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

Board of Medicine
Financial Responsibility Affidavit of Exemption
Page 3 of 3



This affidavit is only 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 Chapter 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 Chapter 458, Florida Statutes, or the medical practice act of another jurisdiction.

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)



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 Chapter 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 Chapter 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 to 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  
Page 3 of 3



This affidavit is only 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 to 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)



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. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

**FINANCIAL RESPONSIBILITY COVERAGE**

1. I have obtained and will maintain professional liability coverage in an amount not less than \$100,000, and in compliance with Rule 64B2-17.009(1), F.A.C. (Proof of coverage must come directly from the company.)
2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in Chapter 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, and in compliance with Rule 64B2-17.009(2), F.A.C.
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 exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.
3. I have no malpractice exposure because I do not practice in the state of Florida.

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

# Florida Board of Podiatric 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 4** in the “**Financial Responsibility Coverage**” section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

### FINANCIAL RESPONSIBILITY COVERAGE

1. I have obtained and will maintain professional liability coverage in an amount of not less than \$100,000. (Proof of coverage must come directly from the company.)
2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in Chapter 675, Florida Statutes, in an amount no less than \$100,000 per claim.
3. I have established and will maintain an escrow account consisting of cash or securities eligible for deposit in accordance with s. 625.52, Florida Statutes, in an amount of not less than \$100,000.
4. 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 exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I practice only in conjunction with my teaching duties at an accredited podiatric medicine school/college or in its main teaching hospitals.
3. I have no malpractice exposure because I do not practice in the state of Florida.

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 options one or two in the “Financial Responsibility Coverage” section, provide proof of liability coverage sent directly by the insuring company to the board by email at [MQA.PodiatricMedicine@FLHealth.gov](mailto:MQA.PodiatricMedicine@FLHealth.gov) or by mail to:**

**Board of Podiatric Medicine**  
4052 Bald Cypress Way Bin C-08  
Tallahassee, FL 32399-3258

Dentistry ONLY

# Board of Dentistry 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. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

### FINANCIAL RESPONSIBILITY COVERAGE

1. I have obtained and will maintain professional liability coverage in an amount of not less than \$100,000, 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 obtained and will maintain an unexpired irrevocable letter of credit as defined in Chapter 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.
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 exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.
3. I have no malpractice exposure because I do not practice in the state of Florida.

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

Board of Dentistry  
4052 Bald Cypress Way Bin C-08  
Tallahassee, FL 32399-3258

Licensed Midwife ONLY

# Council of Licensed Midwifery 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 2** 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 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.
- 2. 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 exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- 2. I have an inactive license, and do not practice in the state of Florida.
- 3. I practice only in conjunction with my teaching duties at an approved midwifery school.
- 4. I do not practice in the state of Florida. I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state.
- 5. I have no malpractice exposure in the state of Florida.

I confirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties as provided in s. 456.067, 456.072, 467.201(5), 4567.203(1)(a), 775.082, 775.083, and 775.084, Florida Statutes.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY

## Board of Nursing 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 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, or a risk retention group under s. 627.942, Florida Statutes.
2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, Florida Statutes., which is in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000, and which is payable to the APRN as beneficiary.
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 hold a limited license issued pursuant to s. 456.015, Florida Statutes, and practice only under the scope of the limited license.
3. My Florida license is inactive, and I do not practice in the state of Florida.
4. I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.
5. My Florida license is active, but I do not practice in the state of Florida.
6. I have just completed my Advanced Practice Registered Nurse Program and/or I am not yet practicing in Florida.

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

Board of Nursing  
4052 Bald Cypress Way Bin C-02  
Tallahassee, FL 32399-3252

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 Chapter 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 \_\_\_\_\_



**Department of Health  
Practitioner Profile**

Page 2 of 3



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**.

Department of Health  
Practitioner Profile

Page 3 of 3



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: [FLBoardofMedicine.gov/Forms/Exhibit-I-Form.pdf](http://FLBoardofMedicine.gov/Forms/Exhibit-I-Form.pdf)

Osteopathic Physicians: [FloridasOsteopathicMedicine.gov/Forms/Exhibit-I-Form.pdf](http://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 [FloridasPodiatricMedicine.gov/Forms/Form - Exhibit I.pdf](http://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