

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



Department of Health  
P.O. Box 6330  
Tallahassee, FL 32314-6330  
Website: <http://www.flhealthsource.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 (ch.) 456, Florida Statutes.
3. Must meet the requirements for full licensure in the profession for which the applicant is seeking licensure. Applicants must submit the full licensure application for the profession they are seeking licensure in along with any supporting documents required by that application.
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 <http://www.flhealthsource.gov/background-screening/> for a list of authorized Livescan providers. See the “**Electronic Fingerprinting**” form in the application.
5. Staff will complete a National Practitioner Data Bank (NPDB) query. For more information, visit the National Practitioner Data Bank at <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>.
6. Apply online at [www.flhealthsource.gov](http://www.flhealthsource.gov) or submit your application and any supplemental documentation to the Department of Health at the address listed on the application below.

### **Additional Information:**

- Notify the board office immediately of any address change.
- Documentation that is required for both applications, such as license verifications, are only required to be submitted once.



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

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P.O. Box 6330  
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Applicants must submit the full licensure application for the profession they are applying for along with this application.

**License for Spouse of Active-Duty Member**

**No Fee**

List the profession you are applying for: \_\_\_\_\_  
(Examples: 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

**Spouse's Name:** \_\_\_\_\_  
Last/Surname First Middle

**Spouse's Branch of Service:** \_\_\_\_\_ **Spouse's Duty Station:** \_\_\_\_\_

**Date Duty Began or Will Begin in Florida:** \_\_\_\_\_ (Contact the board office if this date changes.)  
MM/DD/YYYY

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**.

**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.

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

## 2. 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:

<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.

## 3. 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, disciplinary action against my certification, 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 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

**Applicants must submit the full licensure application for the profession they are applying for along with this application.**

## FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL REOCRDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREEING 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: <http://www.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 <http://www.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.**