CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Electrolysis Council

Name:________________________________________________________

Last     First    Middle

Social Security Number: _______________________________________

* This page is exempt from public records disclosure pursuant to subparagraph 119.071(5)(a)2., Florida Statutes, which provides in relevant part: “An agency that collects social security numbers shall also segregate that number on a separate page from the rest of the record, or as otherwise appropriate, in order that the social security number be more easily redacted, if required, pursuant to a public records request.”

Mission Statement: To protect and promote the health of all persons in Florida by diligently regulating health care practitioners and facilities.

4052 Bald Cypress Way, Bin # C05
Tallahassee, Florida 32399-3255
Phone: (850) 245-4373 Fax: (850) 414-6860
Website: www.doh.state.fl.us/mqa/
Florida Department of Health
Electrolysis Council

Mailing Address for Application and Fees
P.O. Box 6330
Tallahassee, FL 32314-6330

Mailing Address for Supporting Documents
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255
(850) 245-4373 • Fax: (850) 414-6860

RE-EXAM APPLICATION
Fee: $135.00

<table>
<thead>
<tr>
<th>NAME:</th>
<th>(Last) _______________________________ (First) ___________________________ (Middle) ________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAILING ADDRESS:</td>
<td>(Mailing address will display on the Internet if you have not provided a practice location address.) (Apt. #) __________</td>
</tr>
<tr>
<td>City:</td>
<td>___________________________</td>
</tr>
<tr>
<td>State:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Zip:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Country:</td>
<td>___________________________</td>
</tr>
<tr>
<td>WORK NUMBER:</td>
<td>( _____ ) _______ - ____________</td>
</tr>
<tr>
<td>HOME NUMBER:</td>
<td>( _____ ) _______ - ____________</td>
</tr>
<tr>
<td>FAX NUMBER:</td>
<td>( _____ ) _______ - ____________</td>
</tr>
<tr>
<td>MOBILE NUMBER:</td>
<td>( _____ ) _______ - ____________</td>
</tr>
<tr>
<td>DATE OF BIRTH:</td>
<td><strong><strong><strong>/</strong></strong><em>/</em></strong>___</td>
</tr>
<tr>
<td>PLACE OF BIRTH:</td>
<td>___________________________</td>
</tr>
<tr>
<td>CORRESPONDENCE VIA E-MAIL:</td>
<td>(Please print legibly. By checking “yes” you are agreeing to allow the council office to contact you with information regarding your application via email. If you choose this option please check your email account frequently and notify the council office of any change to your email address.) □ YES □ NO Email Address: ___________________________ @ ___________________________</td>
</tr>
</tbody>
</table>

NAME CHANGE
Have you ever changed your name through marriage or action of a court, of have you ever been known by any other name? □ YES □ NO
If “YES”, please list the name(s) and date(s) of change.
______________________________________________________________________________ ______/_____/______
______________________________________________________________________________ ______/_____/______

EXAM HISTORY AND SCHEDULING DATA
Please indicate the month and year of previous examination(s).
Original Exam: ______/_____/______
Retake 1: ______/_____/______
Retake 2: ______/_____/______
EQUAL OPPORTUNITY DATA

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect you candidacy for licensure.

Are you a US citizen? □ YES □ NO If “no,” give your alien number: __________________________

Sex: □ Male □ Female

Race: □ White □ Black □ Asian/Pacific Islander □ Hispanic □ Other: __________________________

SPECIAL TESTING ACCOMMODATION

Special Testing Accommodation Requested: Please indicate if you require special testing accommodations due to disability, or if you have a religious conflict with the scheduled examination date. If yes, contact testing services immediately at (850) 245-4252 for detailed information and application. All requests must be in writing and include supporting documents. □ YES □ NO

SIGNATURE

__________________________________________  __________________________
Signature of Applicant (required)  Date Signed (required)

FOR OFFICE USE ONLY, PLEASE DO NOT WRITE IN THIS AREA

Category: ______________  # of Retakes: _____ Original Receipt # __________ School Code: __________

Exam Site: ______________________________________ Exam Date: ____ / ____ / ____

Exam Code: __________________  Candidate # ______________________