



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/

REQUIRED

Tape a 2"x2" photo here.
 This photo must have been taken within the last six months. It must be professional quality depicting the head and shoulders.

Please print your name on the back of the photo.

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

PROFILE INFORMATION... LIST YOUR FULL, LEGAL NAME AS IT SHOULD APPEAR ON YOUR LICENSE (NO NICKNAMES)

NAME: (Last) _____ (First) _____ (Middle) _____

MAILING ADDRESS: _____ (Apt. #) _____

(Mailing address will display on the Internet if you have not provided a practice location address.)

City: _____ State: _____ Zip: _____ Country: _____

WORK NUMBER: (_____) _____ - _____ **HOME NUMBER:** (_____) _____ - _____

FAX NUMBER: (_____) _____ - _____ **MOBILE NUMBER:** (_____) _____ - _____

DATE OF BIRTH: _____ / _____ / _____ **PLACE OF BIRTH:** _____

CORRESPONDENCE VIA E-MAIL:

(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:** _____ @ _____

NAME CHANGE

Have you ever changed your name through marriage or action of a court, or 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 your 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 ACCOMODATION

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 #** _____