# Application for Medical Physicist Temporary License

Florida HEALTH
Medical Quality Assurance

Medical Physicists
4052 Bald Cypress Way
Bin #C07
Tallahassee, FL 32399-3257
Email: mqa.medicalphysicist@flhealth.gov
Phone: (850) 245-4355
FAX: (850) 922-8876


**Are you an active duty member of the United States Armed Services?**

**Are you a veteran of the United States Armed Services?**

**Are you the spouse of a veteran of the United States Armed Services?**

**Are you the spouse of an active member of the United States Armed Services?**

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

Florida HEALTH
Medical Quality Assurance

# Application for Medical Physicist Temporary License

**Medical Physicists**
**P.O. Box 6330**
**Tallahassee, FL 32314-6330**
**Fax: (850) 922-8876**
**Email: mqa.medicalphysicist@flhealth.gov**

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

**Medical Physicist Temporary- $255.00**

*If you are applying for a temporary license in more than one specialty, you must submit a separate application and fees for each specialty.*

**Total fee of $255.00 includes the following:**

| | |
|---|---|
| Application Fee | $250.00 |
| Unlicensed Activity Fee | $5.00 |

**A temporary license is valid for one year from the date of issuance and may be renewed for one additional year.** Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.

***Select the specialty type*:**

- ☐ **Diagnostic Radiological Physicist (6001)**
- ☐ **Therapeutic Radiological Physicist (6002)**
- ☐ **Medical Nuclear Radiological Physicist (6003)**
- ☐ **Medical Health Physicist (6004)**

## 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 (Input without dashes)

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

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

**EQUAL OPPORTUNITY DATA:**

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

**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 Department of Health.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

## 2. SOCIAL SECURITY DISCLOSURE

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

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

**Last Name:** _____

**First Name:** _____

**Middle Name:** _____

**Social Security Number:** _____
(Input without dashes)

**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, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

## 3. APPLICANT BACKGROUND

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

_____

B. Do you hold, or have you ever held a license to practice as a medical physicist or any other health-related license(s)? ☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed).

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

## 4. AREA OF SPECIALIZATION

A. List academic qualifications and specialty of the completed residency program. The residency program must be completed at the time of application.

| School Name | City/State or Country | Dates of Attendance: From-To (MM/DD/YYYY) | Graduation Date (MM/DD/YYYY) | Degree Awarded |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

B. List your specialty: _____

☐ **Applicants must supply documentation of completion of a residency program.**

Name: _____

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

## 5. 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 Department of Health:

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

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

Name: _____

## 6. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? ☐ Yes ☐ No

B. Have you ever been refused a license to practice, or the renewal thereof in any state? ☐ Yes ☐ No

C. Have you ever had an application for a professional license, or any application to practice, denied by any state board or governmental agency (state or country)? ☐ 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**.

## 7. CRIMINAL HISTORY

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? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

**If you responded "Yes," complete the following:** (Attach additional sheets if necessary.)

| 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 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 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.

Name: _____

## 8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (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 ten 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), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., 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 (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 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, F.S.? ☐ 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. 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** includes court dispositions or agency orders where applicable.

**Documents in sections 5, 6, 7, and 8 must be mailed to:**

**Medical Physicists**
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3257

## 9. APPLICANT SIGNATURE

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

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

Florida law requires me to immediately inform the Department of Health of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

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

Applicant Signature _____ Date _____
*You may print this application and sign it or sign digitally.* MM/DD/YYYY

# Medical Physicists Temporary Licensure - Supervision Form

This form must be completed by the applicant's supervisor and must be submitted with the completed application.

**Important Information:** The supervisor must hold a Florida medical physicist license in the appropriate specialty to supervise the applicant for temporary licensure. The decision by the supervising medical physicist to permit a temporary medical physicist to perform a task or procedure, whether under direct, indirect or general supervision, is based on the patient and the temporary physicist's knowledge and skills in performing said tasks and procedures.

**Applicant for Temporary Licensure:** _____
Last/Surname First Middle

**Supervisor:** _____
Last/Surname First Middle

**Mailing Address:**

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

_____ _____ _____
State ZIP License Number

**Primary Practice Location:**

_____ _____ _____
Street Suite No. City

_____ _____ _____
State ZIP Business Telephone (Input without dashes)

*I hold a Florida medical physicist license in the appropriate specialty, agree to provide supervision for a period of one year to this applicant, to be a responsible medical physicist for all medical physicist activities performed by this applicant under my supervision and to sign all reports by the temporary medical physicist.*

Supervisor's Signature _____ Date _____
MM/DD/YYYY