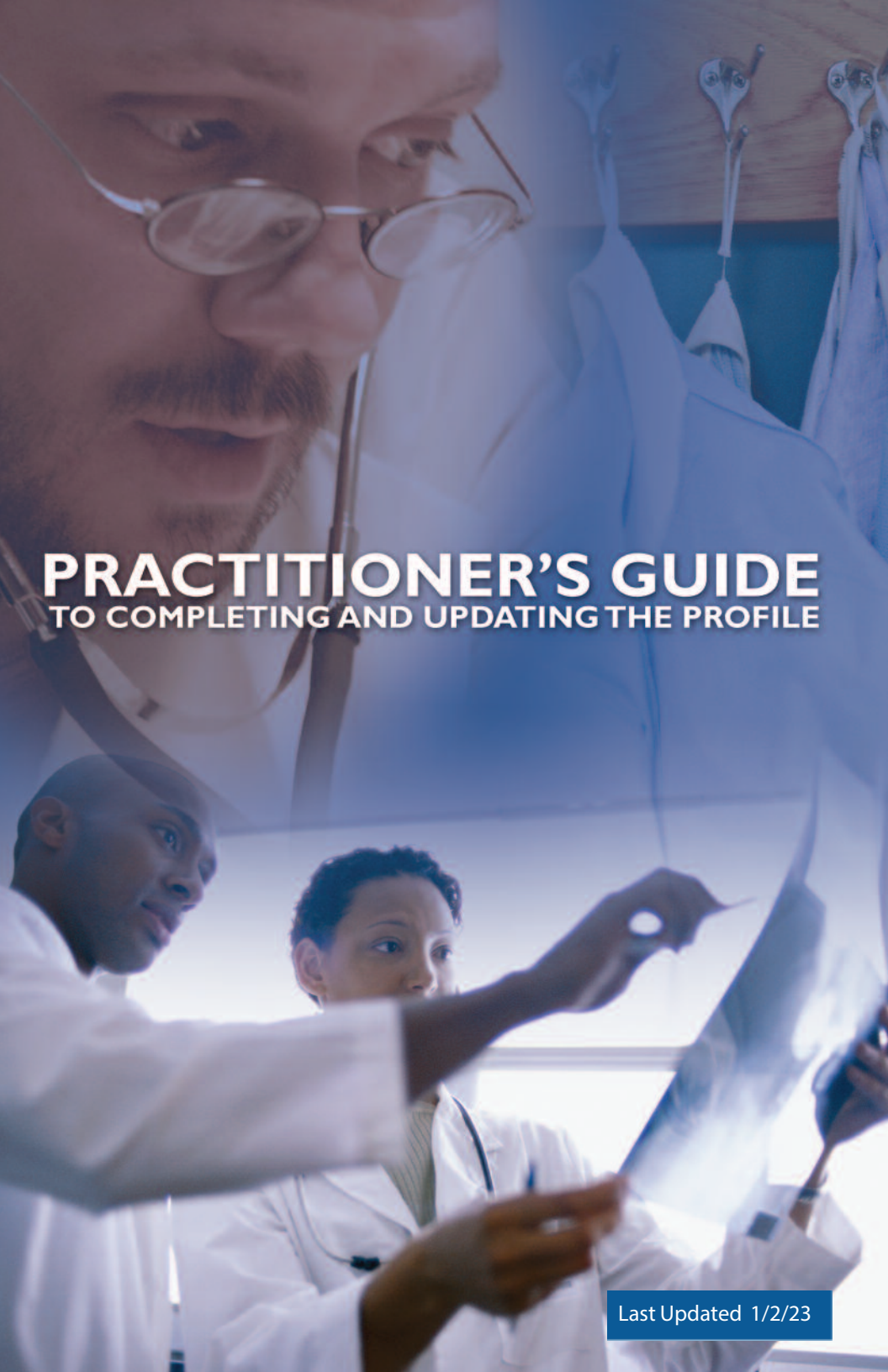

# PRACTITIONER'S GUIDE
## TO COMPLETING AND UPDATING THE PROFILE

Last Updated 1/2/23

## UNDERSTANDING PROFILING

In 1997, the Florida Legislature passed a law requiring the Department of Health to maintain profiles on certain health professionals licensed in Florida. The law also specified the information to be maintained, how it was to be reported, and other requirements dealing with compiling and updating the information in the profiles, according to section 456.041, Florida Statutes.

## Which professions are required to have profiles?

Practitioner profiles are required for all Medical Doctors (M.D.s), Osteopathic, Chiropractic and Podiatric Physicians, and Advanced Practice Registered Nurses licensed in Florida, according to section 456.041, Florida Statutes.

## What information is included in the profile?

The profile contains required and optional information from the practitioner.
Required information includes:

- **Practitioner's education and training**
- **Practitioner's current practice and mailing addresses**
- **Practitioner's staff privileges and faculty appointments**
- **Practitioner's reported financial responsibility**
- **Legal actions taken against the practitioner**
- **Board final disciplinary action taken against the practitioner**
- **Any liability claims filed against Podiatric Physicians which exceed $5,000**
- **Any liability claims filed against M.D.s and Osteopathic Physicians which exceed $100,000**
- **Practitioner's response in regard to the Florida Birth-Related Neurological Inquiry Compensation Association assessment**

Optional information may include committees/memberships, professional or community service awards, and publications the practitioner has authored.

## How often do I need to review my profile?

If you are a licensed profiled practitioner, you should review your profile information frequently and report any corrections to the department immediately. By law, you are responsible for updating your profile information within 15 days after a change of an occurrence in each section of the profile.

# PRACTITIONER PROFILE FACT SHEET

| General Information | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Primary Practice Address | The primary practice address for the practitioner | Self-Reported | Mandatory | Not verified by DOH |
| Example: John Q. Public, 1234 Profile Drive, Health, FL 55555 | | | | |
| Secondary Address(es) | The address of a secondary practice location | Self-Reported | Mandatory | Not verified by DOH |
| Example: John Q. Public, 1234 Profile Drive, Health, FL 55555 | | | | |
| Medicaid | Indicates whether or not the practitioner participates in the Medicaid program | Self-Reported | Optional | Not verified by DOH |
| Indicate by responding Yes or No - Example: Yes | | | | |
| Staff Privileges | A list of licensed hospitals, Health Maintenance Organizations, Prepaid Health Clinics, and Ambulatory Surgical Centers that the practitioner holds staff privileges. | Self-Reported | Mandatory except for Advanced Registered Nurse Practitioners | Information is verified by the department at the time of initial licensure. Any changes post-licensure are considered self-reported and the licensing board accepts and reports the information as submitted by the practitioner. |
| Example: Institution Name: Health Memorial Hospital, City: Health, State: Florida | | | | |

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Email Address | The practitioner's email address | Self-Reported | Optional | Not verified by DOH |
| Example: health@practitioner.com | | | | |
| Other State Licensure | A list of states in which the practitioner received a professional license and the license type. | Self-Reported | Optional | Information is verified by the department at the time of initial licensure. Any changes post-licensure are considered self-reported and the licensing board accepts and reports the information as submitted by the practitioner. |
| Example: Jurisdiction: Georgia; Profession: M.D.; Jurisdiction: Alabama; Profession: D.O. | | | | |
| Florida Birth-Related Neurological Injury Compensation (NICA) | Indicates whether the practitioner has submitted payment of the assessment. | Self-Reported | Mandatory | Information is verified by DOH at the time of initial licensure and renewal. |
| Example: Please indicate Yes, No, or if you are Exempt. If no, please contact NICA regarding payment. | | | | |
| Year Began Practicing | The year the practitioner received a license in this or any other jurisdiction. | Self-Reported | Mandatory | Not verified by DOH |
| Example: 1/1/9999 | | | | |

# PRACTITIONER PROFILE FACT SHEET

| Education and Training | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| | Provides the name of the school or training program attended by the practitioner; dates of attendance; date of graduation; and a description of all graduate medical or professional education completed. | Supporting documentation received from a primary source | Mandatory | Information is verified by the department at the time of initial licensure. |

Example: Institution Name: University of Health or Health University
Dates of Attendance: 1/1/9999-1/1/0003
Graduation Date: 1/1/0003
Degree Title: Medical Doctor(MD)

| | | | | |
|---|---|---|---|---|
| Other Health Related Degrees | Provides information about other health related degrees received by the practitioner. | Self-Reported | Mandatory | Information is not verified by DOH. |

Example:
School/University: University of Florida
City: Gainesville
State/Country: FL
Dates attended From: 1/1/2000
Dates attended To:1/1/2003
Degree title: Master in Clinical Social Work(MSW) or Doctorate in Pharmacy (Pharm.D)

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Professional and Postgraduate Training | Provides information about profes-sional and post-graduate training attended by the practitioner.. | Self-Reported | Mandatory | Not verified by DOH |

Example:
Program Name: Health Memorial Medical Center
Program Type: Residency
Specialty Area: Family Practice(FP)
Other area: Gynecology(OBGYN)
City: Health
State or Country: FL
Dates Attended From: 1/1/0003
Dates Attended To: 1/1/0006

| **Academic Appointment** | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| | Provides information about faculty appointments the practition-er received within the past ten years. | Self-Reported | Mandatory | Not verified by DOH |

Example:
Faculty Title: Asst. Dean of the School of Business
Faculty Institution: Anywhere University
City : Health, State: FL
Begin Date :1/07/0007
End Date: Present
Status: Active

# PRACTITIONER PROFILE FACT SHEET

| Specialty Certification | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| | Provides information on specialty certifications received by the practitioner. | Self-Reported | Mandatory | Information is verified by the department at the time of initial licensure. Any changes post-licensure are considered self-reported and the licensing board accepts and reports the information as submitted by the practitioner. |

Example:
Specialty board: American Board of Family Practice
Certification: Family Practice (FP
Date Certified: 1/1/1000

| Financial Responsibility | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| | Information on how the practitioner has elected to comply with financial responsibility requirements. | Self-Reported | Mandatory | Not verified by DOH |

Indicate your coverage for financial responsibility here. To make updates to your financial responsibility online, please log onto your MQA Online Services account at www.flhealthsource.gov.

# PRACTITIONER PROFILE FACT SHEET

| Proceedings and Actions | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Criminal Offenses | Description of any criminal offenses of which the practitioner has been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere. | Self-reported by the practitioner. | Mandatory | Information is verified by DOH at the time of initial licensure and renewal. |

Example:
Please indicate Yes or No. If yes, complete as follows:
Description of offense: Illegal possession of a firearm
Date:1/9/1996
Jurisdiction: Health County
Under appeal: Yes
Status: Corroborated
Date of Corroboration: 1/19/1997

| | | | | |
|---|---|---|---|---|
| Medicaid Sanctions and Terminations | Indicates whether the practitioner has been sanctioned or terminated for cause from participation in the Medicaid program. | Self reported by the practitioner, reported by DOH, or reported directly from the source. | Mandatory | Information is verified by DOH through the Agency for Health Care Administration. |

Example:
Please indicate Yes or No to each of the questions.

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Final Disciplinary Actions (within last 10 years) | Indicates final actions taken by the department within the last ten years. | Self-reported by the practitioner and reported by the department. | Mandatory | Information is verified by DOH through the National Practitioner Data Bank. |
| Final disciplinary action taken by a specialty board within the previous 10 years | Indicates final action taken by a specialty board recognized by the department. | Self-Reported | Mandatory | Information is verified by DOH through the National Practitioner Data Bank. |

Example:
Please indicate Yes or No. If yes, complete as follows:
Action taken by: American Board of Surgery
Date: 1/1/2002
Description of disciplinary action: Revoked
Under Appeal: Yes

| | | | | |
|---|---|---|---|---|
| Final disciplinary action taken by a licensing agency within the previous 10 years | Indicates final actions taken by a licensing agency regulating the practitioner's license in Florida or any other jurisdiction. | Self-reported by the practitioner as well as directly from the source. | Mandatory | Information is verified by DOH through the National Practitioner Data Bank. |

Example:
Please indicate Yes or No. If yes, complete as follows:
Action taken by: Department of Health
Date: 1/1/2001
Description of disciplinary action: Suspension Under Appeal: Yes

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Final disciplinary action taken by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center within the previous 10 years | Indicates final action taken by an institution, such as a health maintenance organization, clinic or nursing home. | Self-reported by the practitioner as well as directly from the source. | Mandatory | Information is verified by DOH through the National Practitioner Data Bank. |

Example:
Please indicate Yes or No. If yes, complete as follows:
Date: 1/1/1999
Related to professional competence: No
Related to delivery of service: Yes

| | | | | |
|---|---|---|---|---|
| Resigned from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center | Indicates information related to restriction, resignation or revocation of staff privileges to settle a pending disciplinary action. | Self-Reported | Mandatory | Information is verified by DOH through the National Practitioner Data Bank. |

Example:
Please indicate Yes or No. If yes, complete as follows:
Taken by: Health Memorial
Date: 1/1/1999
Description of disciplinary Action: 30 day suspension of staff privileges
Under Appeal: No

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Liability Claims Exceeding $100,000.00 (within last 10 years). | Indicates any action or claim providing the date, county, case number, settlement date, amount and policy amount for personal injury alleged to have been caused. | Self-reported by the practitioner, and reported directly to DOH from the Department of Financial Services. | Mandatory for M.D.s and Osteopathic physicians to report to the Department of Financial Services (DFS). DOH is required to publish all claims received from DFS. | Information is verified by the National Practitioner Data Bank. |

Example:
Please indicate by Yes or No. If yes, complete as follows:
Incident date: 1/1/1999
County: Health
Judicial case: cl-99-9999
Settlement date: 1/12001
Amount: $150,000.00
Policy amount: $750.000.00

| | | | | |
|---|---|---|---|---|
| Liability Claims Exceeding $5000.00 (within the last 10 years) | Indicates any action or claim providing the date, county, case number, settlement date, amount and policy amount for personal injury alleged to have been caused. | Self-reported by the practitioner and reported directly to DOH from the Department of Financial Services. | Mandatory for Podiatric physicians to report to the Department of Financial Services (DFS). DOH is required to publish all claims received from DFS. | Information is verified by the National Practitioner Data Bank. |

Example:
Please indicate by Yes or No. If yes, complete as follows:
Incident date: 1/1/1999
County: Health
Judicial case: cl-99-9999
Settlement date:1/12001
Amount: $150,000.00
Policy amount: $750.000.00

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Bankruptcies | Indicates any bankruptcy information received by the department against the practitioner. If no bankruptcy information has been received, this field will not show in the profile. | Self-reported by the practitioner as well as directly from the source | Not required by the practitioner, but any information in possession of the department is reported for M.D.s, and Osteopathic and Podiatric physicians | Not verified by DOH |
| **Optional Information** | **Description** | **Reported By** | **Reporting Requirement** | **Verification** |
| Committees/ Memberships | A list of any committees on which the practitioner served for any health entity with which they are affiliated. | Self-reported | Optional | Not verified by DOH |
| Example: Committee/Membership: MQA Profile Team | | | | |
| Professional or Community Service Awards | A list of any professional or community service activities, honors, or awards received by the practitioner. | Self-Reported | Optional | Not verified by DOH |
| Example:<br>Community Service/Award/Honor: Big Health Bend<br>Organization: Health Memorial Hospital | | | | |

# PRACTITIONER PROFILE FACT SHEET

| | Description | Reported By | Reporting Requirement | Verification |
|---|---|---|---|---|
| Publications | A list of publications authored by the practitioner and published in peer-reviewed medical or nursing literature. Profile includes publication title and the year it was published. | Self-Reported | Optional | Not verified by DOH |
| Example: Title: Health Related Publication: New MQA Health Journal Date: 1/1/0007 | | | | |
| Professional Web Page | A link to the practitioner's professional website. | Self-Reported | Optional | Not verified by DOH |
| Example: Professional web page: www.doh-mqaservices.com | | | | |
| Languages Other Than English | Languages, other than Self-Reported English, that the practitioner uses to communicate with patients or any-translation services available to patients at the practitioner's primary place of practice. | Self-Reported | Optional | Not verified by DOH |
| Example: Language: Spanish | | | | |
| Other Affiliations | A list of any national, state, local, county, or professional affiliations. | Self-Reported | Optional | Not verified by DOH |
| Example: Affiliation: Physician Association | | | | |

## UPDATING YOUR PROFILE

Changes (excluding year began practicing, education, training and medical malpractice) can be made to your profile electronically, using your Account/User ID and Password at www.flhealthsource.gov. Any Medical Malpractice changes should be faxed to (850) 245-4791. If you have any questions regarding your Account/User ID and Password or about updating your profile, you can contact a Profiling Specialist at (850) 488-0595, extension 3 for assistance, Monday through Friday, from 8:00 a.m. until 5:00 p.m., excluding state holidays.

Go to www.FLHealthSource.gov

**CONTACT INFORMATION**

**Web site: www.FLHealthSource.gov**

**Email: MQAOnlineService@flhealth.gov**

**Telephone: (850) 488-0595**

**Fax: (850) 245-4791**

**Mailing Address:**

**Department of Health**

**Division of Medical Quality Assurance**

**Bureau of Operations – Licensure Support Services Unit**

**4052 Bald Cypress Way, Bin #C-10**

**Tallahassee, Florida 32399-3260**

www.FLHealthSource.gov