Florida HEALTH

Mobile Opportunity by Interstate License Endorsement (MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FLHealthSource.gov
Phone: 850-488-0595

DH-MQA-5101, Revised 8/2025, Rule 64B21-500.002, F.A.C.

Qualifications for Licensure

Expedite your application by applying online at www.flhealthsource.gov.

1. Must hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, determined by the board or the department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

2. Must have obtained a passing score on a national licensure examination or hold a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state;

   OR

   An applicant for a profession that does not require a national examination or national certification is eligible for licensure if the applicable board, or the department if there is no board, determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in this state.

3. **Must have actively practiced** the profession for which the applicant is applying **for at least two years during the four-year period immediately** preceding the date of submission of this application.

4. **Must not be,** at the time of submission of the application, **the subject of a disciplinary proceeding** in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reason related to the practice of the profession for which the applicant is applying.

5. **Must not have had disciplinary action** taken against you **in the five years immediately preceding** the date of submission of the application.

6. Must meet the financial responsibility requirements of s. 456.048, Florida Statutes, or the applicable practice act, if required for the profession for which you are applying. The following professions must demonstrate compliance with financial responsibility as part of licensure.

Acupuncturist (ch. 457)	Chiropractic Physician (ch. 460)	Dentist (ch. 466)
Medical Doctor (ch. 458)	Podiatric Physician (ch. 461)	Licensed Midwife (ch. 467)
Osteopathic Physician (ch. 459)	Advanced Practice Registered Nurse (ch. 464)	Anesthesiologist Assistant (ch. 458, 459)

7. Refer to s. 456.0145(2)(c), Florida Statutes, for licensure ineligibility criteria.

8. All professions require Livescan screening with the exception of Emergency Medical Technicians (EMT), Paramedics, Pharmacy Interns, Pharmacy Technicians, and Radiologic Technologists. Visit https://flhealthsource.gov/background-screening/bgs-requirements/ for more information.

9. Apply online at www.flhealthsource.gov or submit your application, any applicable fees, and any supplemental documentation to the Department of Health at the address listed on the application below.

10. **Practitioner Profiling:** Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

Medical Doctor (ch. 458)	Chiropractic Physician (ch. 460)	Advanced Practice Registered Nurse (ch. 464)
Osteopathic Physician (ch. 459)	Podiatric Physician (ch. 461)	

Mobile Opportunity by Interstate Licensure Endorsement (MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

Do Not Write in this Space
For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Certain fees are refundable for up to three years from the date of receipt. Requests for a refund must be made in writing. Refer to pages 12 and 13 to determine the appropriate fee to submit with your application.

List the profession you are applying for:

_____
(Examples: Dentist, 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

Physical Address: (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

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 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.

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, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

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, Florida Statutes. 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 an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice as defined in s. 456.0145(2)(a)2., Florida Statutes, in the profession for which you are applying? ☐ Yes ☐ No

C. List all health-related licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

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

☐ Staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

D. Have you actively practiced the profession for which you are applying for at least two years during the four-year period immediately preceding the date of submission of the application? ☐ Yes ☐ No

Note: If you responded "No" to question D, you may be ineligible for licensure under this method per section 456.0145(2)(a)4., Florida Statutes.

E. Have you obtained a passing score on a national licensure examination or do you hold a national certification recognized by the board for the profession for which you are applying? ☐ Yes ☐ No

If "Yes," complete one of the following:

Licensure Examination	Date of Examination (MM/DD/YYYY)

OR

National Certification	Date of Certification (MM/DD/YYYY)

☐ Board staff will obtain national scores from the examination vendor, if available. Applicants must submit proof of national certification.

F. Does your profession require a national licensure examination or national certification? ☐ Yes ☐ No

☐ **If "No,"** submit evidence that you meet the established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements that are substantially similar to the requirements for licensure in your profession in Florida.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

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 board office:

☐ **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.

6. DISCIPLINE HISTORY

A. Are you currently the subject of a disciplinary proceeding in a jurisdiction in which you hold a license or by the United States Department of Defense for reasons related to the practice of the profession for which you are applying? ☐ Yes ☐ No

B. Have you ever had any disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country? ☐ Yes ☐ No

C. **If you responded "Yes" to question B,** have you had disciplinary action taken against any license by the licensing authority in any state, jurisdiction, or country within the last five years? ☐ Yes ☐ No ☐ N/A

D. Do you have a complaint, an allegation, or investigation pending before a licensing entity in any U.S. jurisdiction or territory? ☐ Yes ☐ No

E. Have you ever had a license to practice a health care profession revoked or suspended by any U.S. jurisdiction or territory or voluntarily surrendered any such license in lieu of having disciplinary action taken against the license? ☐ Yes ☐ No

Note: If you responded "Yes" to any question in this section, you may be ineligible for licensure under this method per section 456.0145(2), Florida Statutes.

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, Final Order, and proof of compliance of any obligations, if applicable**.

F. Have you been reported to the National Practitioner Data Bank (NPDB)? ☐ Yes ☐ No

G. **If you responded "Yes" to question F,** have you successfully appealed to have your name removed from the data bank? ☐ Yes ☐ No ☐ N/A

Staff will complete a NPDB query. For more information, visit the National Practitioner Data Bank at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp.

Note: A person is ineligible for licensure under this method if they have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have their name removed from the data bank per section 456.0145(2)(c), Florida Statutes.

Licensure **may be permissible** if the reported adverse action was a result of conduct that would not constitute a violation of any Florida law or rule. Licensure in this case may be subject to conditions such as restrictions or probation per section 456.0145(2)(c), Florida Statutes.

Name: _____

7. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

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? ☐ Yes ☐ No

If you responded "Yes" in this section, complete the following:

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 the 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 the 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.

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 time frames as established in s. 456.0635(2), Florida Statutes.

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, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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 10 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), Florida Statutes)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, 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? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) 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, Florida Statutes? ☐ 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. If "Yes" to 4, 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** that includes court dispositions, agency orders, and completion of sentence documents, if applicable.

Name: _____

9. LIVESCAN PRIVACY STATEMENT (for professions requiring background screening only)

☐ 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. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Profession	ORI Number	Profession	ORI Number	Profession	ORI Number
Acupuncture (ch. 457)	EDOH4500Z	Anesthesiologist Assistant (ch. 458, 459)	EDOH4510Z	Athletic Trainer (ch. 468 Part XIII)	EDOH4520Z
Certified Nursing Assistant (ch. 464 Part II)	EDOH0380Z	Chiropractic Professions (ch. 460)	EDOH2016Z	Clinical Laboratory Personnel (ch. 483 Part I)	EDOH4530Z
Dental Professions (ch. 466)	EDOH4560Z	Dietetics/Nutrition (ch. 468 Part X)	EDOH4570Z	Electrolysis (ch. 478)	EDOH4580Z
Genetic Counselor (ch. 483 Part III)	EDOH4750Z	Hearing Aid Specialist (ch. 484 Part II)	EDOH4590Z	Massage Therapist (ch. 480)	EDOH4600Z
Medical Doctor (ch. 458)	EDOH2014Z	Medical Physicist (ch. 483 Part II)	EDOH4610Z	Mental Health Professions (CSW/MFT/MHC) (ch. 491)	EDOH4550Z
Midwifery (ch. 467)	EDOH4620Z	Nurse (LPN/RN/APRN) (ch. 464)	EDOH4420Z	Nursing Home Administrator (ch. 468 Part II)	EDOH4640Z
Occupational Therapy (ch. 468 Part III)	EDOH4650Z	Opticianry (ch. 484)	EDOH4660Z	Optometry (ch. 463)	EDOH4670Z
Orthotist, Prosthetist, and Pedorthist (ch. 468)	EDOH3451Z	Osteopathic Physician (ch. 459)	EDOH2015Z	Pharmacist (ch. 465)	EDOH4680Z
Physical Therapy (ch. 486)	EDOH4690Z	Physician Assistant (ch. 458, 459)	EDOH4700Z	Podiatric Professions (ch. 461)	EDOH2017Z
Psychology (ch. 490)	EDOH4710Z	Respiratory Care (ch. 468 Part V)	EDOH4720Z	School Psychology (ch. 490)	EDOH4730Z
Speech-Language Pathology and Audiology (ch. 468 Part I)	EDOH4740Z				

Name: _____

10. APPLICANT SIGNATURE

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

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/licensure, disciplinary action against my certification/license, or criminal penalties pursuant to s. 456.067, Florida Statutes. I have read ch. 456, Florida Statutes, the practice act governing the profession for which I am applying, and the Florida Administrative Code chapter governing the profession for which I am applying.

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 revocation of my certification/license to practice the profession for which I am applying in the state of Florida. Florida law requires me to immediately inform the board 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), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____

You may print out this application and sign it or sign digitally. MM/DD/YYYY

Total Fees by Profession - The following chart shows the total fee breakdown for each profession. Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Licensure Fees, Unlicensed Activity Fees, and Additional Fees are refundable for up to three years from the date of receipt. The Application Fees are non-refundable. Requests for a refund must be made in writing.

Profession	Application Fee	Licensure Fee	Unlicensed Activity Fee	Additional Fees	Total Fee
Acupuncture - Acupuncturist	$200.00	$200.00	$5.00	-	$405.00
Athletic Training - Athletic Trainer	$100.00	$100.00	$5.00	-	$205.00
Chiropractic Medicine					
Chiropractic Physician	-	-	$5.00	-	$5.00
Chiropractic Physician's Assistant	$100.00	$100.00	$5.00	SPF* - $100.00	$305.00
Clinical Laboratory Personnel					
Director	$90.00	$65.00	$5.00	-	$160.00
Supervisor	$70.00	$55.00	$5.00	-	$130.00
Technologist	$50.00	$45.00	$5.00	-	$100.00
Technician	$25.00	$25.00	$5.00	-	$55.00
Dentistry					
Dentist	-	$300.00	$5.00	-	$305.00
Dental Hygienist**	-	$37.50 **or** $75.00	$5.00	-	$42.50 **or** $80.00
Dental Radiographer	-	$35.00	-	-	$35.00
Dietetics and Nutrition - Dietitian/Nutritionist	$85.00	$80.00	$5.00	-	$170.00
Electrolysis - Electrologist	$100.00	$100.00	$5.00	-	$205.00
Emergency Medical Services					
Emergency Medical Technician	-	$35.00	-	-	$35.00
Paramedic	-	$45.00	-	-	$45.00
Genetic Counseling - Genetic Counselor	-	-	$5.00	-	$5.00
Hearing Aid Specialists - Hearing Aid Specialist	-	$320.00	$5.00	-	$325.00
Massage Therapy - Massage Therapist	$50.00	$100.00	$5.00	-	$155.00
Medical Physicists - Medical Physicist	$500.00	$100.00	$5.00	-	$605.00
Medicine					
Medical Doctor	$350.00	$350.00	$5.00	NICA***	$705.00
Resident, Intern, and Fellow	$200.00	-	-	-	$200.00
House Physician	$300.00	-	-	-	$300.00
Physician Assistant	$100.00	$200.00	$5.00	-	$305.00
Anesthesiologist Assistant	$150.00	$100.00	$5.00	-	$255.00
Mental Health Professions					
Clinical Social Worker	$100.00	$75.00	$5.00	-	$180.00
Marriage and Family Therapist	$100.00	$75.00	$5.00	-	$180.00
Mental Health Counselor	$100.00	$75.00	$5.00	-	$180.00
Midwifery - Licensed Midwife	$200.00	$500.00	$5.00	$250.00	$955.00
Nursing				**Student Loan Forgiveness**	
Certified Nursing Assistant	-	-	-	-	$0.00
Licensed Practical Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Registered Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Advanced Practice Registered Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Nursing Home Administrators - Nursing Home Administrator	-	$500.00	$5.00	-	$505.00
Occupational Therapy					
Occupational Therapist	$100.00	$75.00	$5.00	-	$180.00
Occupational Therapist Assistant	$100.00	$75.00	$5.00	-	$180.00

Profession	Application Fee	Licensure Fee	Unlicensed Activity Fee	Additional Fees	Total Fee
Opticianry - Optician**	-	$62.50 **or** $125.00	$5.00	-	$67.50 **or** $130.00
Optometry - Optometrist	-	$300.00	$5.00	-	$305.00
Orthotists and Prosthetists					
Prosthetist-Orthotist	$400.00	$400.00	$5.00	-	$805.00
Orthotist	$400.00	$400.00	$5.00	-	$805.00
Prosthetist	$400.00	$400.00	$5.00	-	$805.00
Orthotic Fitter	$400.00	$400.00	$5.00	-	$805.00
Orthotic Fitter Assistant	$400.00	$400.00	$5.00	-	$805.00
Pedorthist	$400.00	$400.00	$5.00	-	$805.00
Osteopathic Medicine					
Osteopathic Physician	-	$300.00	$5.00	NICA***	$305.00
Intern, Resident, and Fellow	-	$100.00	-	-	$100.00
Pharmacy					
Pharmacist	$100.00	$190.00	$5.00	-	$295.00
Registered Pharmacy Technician	$50.00	$50.00	$5.00	-	$105.00
Physical Therapy					
Physical Therapist	$100.00	$75.00	$5.00	-	$180.00
Physical Therapist Assistant	$100.00	$75.00	$5.00	-	$180.00
Podiatric Medicine					
Podiatric Physician	-	$350.00	$5.00		$355.00
Certified Podiatric X-Ray Assistant	-	-	$5.00	$75.00 Certification Fee	$80.00
Psychology - Psychologist	$200.00	$100.00	$5.00	-	$305.00
School Psychologists - School Psychologist	$175.00	$175.00	$5.00	-	$355.00
Speech-Language Pathology and Audiology					
Audiologist**	$75.00	$100.00 **or** $200.00	$5.00	-	$180.00 **or** $280.00
Audiologist Assistant	$75.00	$50.00	$5.00	-	$130.00
Speech-Language Pathologist**	$75.00	$100.00 **or** $200.00	$5.00	-	$180.00 **or** $280.00
Speech-Language Pathologist Assistant	$75.00	$50.00	$5.00	-	$130.00

***SPF -** Supervising Physician Fee

****This profession's Licensure Fee is based on the length of time the initial license will be valid. Depending on what point during the licensure biennium you apply, your Licensure Fee may be different.

*****Florida Birth-Related Neurological Injury Compensation Association (NICA) Fund -** All allopathic and osteopathic physicians licensed in Florida are required to pay into the NICA fund unless qualified for exemption. Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

"Participating," is for Florida licensed physicians who practice obstetrics or perform obstetrical services on a full or part-time basis and do not meet any of the exemption criteria. **NICA Participating: $5,000.00** in addition to the total fee listed above.

"Non-participating," is for Florida licensed physicians who do not practice obstetrics or perform obstetrical services and do not meet any of the exemption criteria. **NICA Non-Participating: $250.00** in addition to the total fee listed above.

To determine if you qualify for exemption review the exemptions at the NICA website listed above. Applicants who qualify for NICA exemption are not required to submit a NICA fee in addition to the total fee listed above. Exempt applicants must submit proof of exemption.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING 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.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

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

This form is only for the professions that require Livescan.

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.flhealthsource.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 will not receive your background screening results; ORI #s are listed by profession on page 10.
- 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: - _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown)

Sex: - _____
(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.

Acupuncture ONLY

Board *of* Acupuncture
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 4** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I hereby certify that I have professional liability coverage in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

☐ 2. I hereby certify that I have an irrevocable letter of credit, established pursuant to ch. 675, Florida Statutes, in an amount not less than $10,000 per claim, with a minimum aggregate availability of credit no less than $30,000.

☐ 3. I hereby certify that I have obtained a surety bond in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

☐ 4. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I practice only in conjunction with my teaching duties at an accredited acupuncture school.

☐ 3. I do not practice in the state of Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in s. 456.067, 456.072, 775.082, 775.083, and 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Board *of* Acupuncture
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Chiropractic Medicine ONLY

Florida Board *of* Chiropractic Medicine
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount not less than $100,000, and in compliance with Rule 64B2-17.009(1), F.A.C. (Proof of coverage must come directly from the company.)

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, Florida Statutes, in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000, and in compliance with Rule 64B2-17.009(2), F.A.C.

☐ 3. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ 3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, Florida Statutes: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Podiatric Medicine ONLY

Florida Board *of* Podiatric Medicine
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 4** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000. (Proof of coverage must come directly from the company.)

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, Florida Statutes, in an amount no less than $100,000 per claim.

☐ 3. I have established and will maintain an escrow account consisting of cash or securities eligible for deposit in accordance with s. 625.52, Florida Statutes, in an amount of not less than $100,000.

☐ 4. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I practice only in conjunction with my teaching duties at an accredited podiatric medicine school/college or in its main teaching hospitals.

☐ 3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, Florida Statutes: Penalty for giving false information- In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

If you selected options one or two in the "Financial Responsibility Coverage" section, provide proof of liability coverage sent directly by the insuring company to the board by email at MQA.PodiatricMedicine@flhealth.gov or by mail to:

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Dentistry ONLY

Board *of* Dentistry
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, Florida Statutes, in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000.

☐ 3. I am exempt from financial responsibility coverage (***if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ 3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, Florida Statutes: Penalty for giving false information - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the Department of Health, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the Department of Health, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Board *of* Dentistry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Licensed Midwife ONLY

Council of Licensed Midwifery
Financial Responsibility

Florida HEALTH

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 2** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer.

☐ 2. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I have an inactive license, and do not practice in the state of Florida.

☐ 3. I practice only in conjunction with my teaching duties at an approved midwifery school.

☐ 4. I do not practice in the state of Florida. I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state.

☐ 5. I have no malpractice exposure in the state of Florida.

I confirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties as provided in s. 456.067, 456.072, 467.201(5), 467.203(1)(a), 775.082, 775.083, and 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Department of Health
Practitioner Profile

Name: _____

This form is only for the professions that require a practitioner profile, listed below. This form must be submitted with your application. Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

Medical Doctor (ch. 458)	Chiropractic Physician (ch. 460)	Advanced Practice Registered Nurse (ch. 464)
Osteopathic Physician (ch. 459)	Podiatric Physician (ch. 461)	

1. BACKGROUND / EDUCATION AND TRAINING

A. List the year you legally began to practice your profession. Year: _____
YYYY

B. List in chronological order all schools or training programs attended, including graduate education, whether completed or not. Attach a separate sheet if necessary.

School / Training Program Name	School Address	Dates of Attendance: From-To (MM/DD/YYYY)	Date Degree Received (MM/DD/YYYY)
		to	
		to	
		to	
		to	

C. List in chronological order all professional and postgraduate training attended. List all programs you began, whether or not you completed or received credit for the training.

Program Name / Address	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received?
		to	☐ Y ☐ N
		to	☐ Y ☐ N
		to	☐ Y ☐ N

D. Are you certified by any specialty board recognized by the Florida board that regulates the profession you are applying for? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/YYYY)

2. ACADEMIC FACULTY APPOINTMENTS

A. Do you currently hold a faculty appointment at an accredited medical school? ☐ Yes ☐ No

B. Have you had the responsibility for graduate education within the last 10 years? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Institution	City/State	Title of Appointment

Name: _____

3. STAFF PRIVILEGES *(Not required for APRNs)*

A. Do you currently hold staff privileges in any hospital, health institution, clinic, or medical facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

B. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	☐ Y ☐ N
		to	☐ Y ☐ N

If you responded "Yes" to B, you must provide the following:

☐ **A written self-explanation** on a separate sheet describing in detail the circumstances.

☐ **Supporting documents** from the applicable entity.

4. DISCIPLINE HISTORY

A. Within the previous 10 years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, national nursing specialty board recognized by the Board of Nursing, or other similar national organization? ☐ Yes ☐ No

B. Within the previous 10 years, have you ever had any final disciplinary action taken against you by the licensing agency in this state or any jurisdiction? ☐ Yes ☐ No

C. Within the previous 10 years, have you ever had any final disciplinary action taken against you by an institution such as a licensed hospital, health maintenance organization, pre-paid health clinic, nursing home, or ambulatory surgical center in this state or any jurisdiction? ☐ Yes ☐ No

D. Within the previous 10 years, have you ever been asked to or allowed to resign from or had any staff privileges restricted or not renewed by any medical health-related institution in lieu of facing disciplinary action or during any pending investigation into your practice? ☐ 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**.

Name: _____

5. LIABILITY CLAIM HISTORY *(Allopathic and Osteopathic Physicians Only)*

Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** listing your involvement in each case

☐ **Completed Exhibit 1 form** for each case (found at the appropriate link below)
Allopathic Physicians: https://flboardofmedicine.gov/forms/exhibit-i-form.pdf
Osteopathic Physicians: https://floridasosteopathicmedicine.gov/forms/exhibit-I-form.pdf

☐ **A copy of the complaint and disposition for each case**

☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

6. LIABILITY CLAIM HISTORY *(Podiatric Physicians Only)*

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? ☐ Yes ☐ No

☐ **If you responded "Yes," complete the Exhibit 1 form** for each case (found at https://floridaspodiatricmedicine.gov/forms/Form_-_Exhibit_I.pdf)

2. PRACTITIONER SIGNATURE

I, the undersigned, state that I am the person referred to in this Florida Practitioner Profile. I have carefully read the profiling questions and have answered them completely. These statements are true and correct.

Applicant Signature _____ Date _____
MM/DD/YYYY