Florida | Council of Licensed Midwifery

Rules Workshop Meeting

February 5, 2026
2:00 p.m., EST

By Web:

https://meet.goto.com/fldoh-clm/councilmeeting

By Phone:

1-877-309-2073

Participation Code: 985-532-741

Board Chair: Charlie Young
Vice Chair: Melissa Conord-Morrow
Executive Director: Stephanie Webster

AGENDA

Thursday, February 5, 2026

I. CALL TO ORDER

II. ROLL CALL

III. RULE DISCUSSIONS

A. 64B24-2

a. 64B24-2.001 Licensure to Practice Midwifery
b. 64B24-2.003 Licensure by Examination
c. 64B24-2.004 Licensure by Endorsement

B. 64B24-4

a. 64B24-4.001 Definitions
b. 64B24-4.002 Approval of Training Program
c. 64B24-4.003 Acceptance into Training Program
d. 64B24-4.006 Curriculum Guidelines and Educational Objectives
e. 64B24-4.007 Clinical Training
f. 64B24-4.008 Administrative Procedures

C. 64B24-7

a. 64B24-7.004 Risk Assessment
b. 64B24-7.005: Informed Consent
c. 64B24-7.006: Preparation for Home Delivery
d. 64b24-7.007: Responsibilities of Midwives During the Antepartum Period
e. 64B24-7.008: Responsibilities of Midwives During Intrapartum
f. 64B24-7.009: Responsibilities of the Midwife During Postpartum
g. 64B24-7.010: Collaborative Management
h. 64B24-7.011: Administration of Medicinal Drugs
i. 64B24-7.013: Requirement for Insurance
j. 64B24-7.014: Records and Reports

IV. PUBLIC COMMENT

V. ADJOURN

CHAPTER 64B24-2
REQUIREMENTS FOR LICENSURE

64B24-2.001 Licensure to Practice Midwifery
64B24-2.002 Examination
64B24-2.003 Licensure by Examination
64B24-2.004 Licensure by Endorsement

64B24-2.001 Licensure to Practice Midwifery.

(1) Applications for a midwife license by examination shall be submitted to the department on Form DH-MQA 1051, (07/2020), Application for Midwifery License by Examination, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=RefXXXX ~~https://www.flrules.org/Gateway/reference.asp?No=Ref-14373~~. ~~Applications for a midwife license by endorsement shall be submitted to the department on Form DH-MQA 5058 (08/2020), Application for Midwifery License by Endorsement, incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-14374~~.

(2) Applicants must demonstrate that they:

(a) Are 21 years of age or older;

(b) Meet the requirements for licensure by examination as outlined in section 467.011, F.S.; ~~or endorsement;~~

(c) Have completed a one-hour educational course on HIV/AIDS that meets the substantive specifications set forth in section 381.0034, F.S., as it pertains to the practice of midwifery, unless an affidavit showing good cause has been submitted allowing the applicant 6 months to complete the course;

(d) Have completed a two-hour course relating to the prevention of medical errors; and,

(e) Have successfully completed an approved four-month prelicensure course, if required.

Rulemaking Authority 409.908(12)(c), 456.004(5), 456.013, 456.38, 467.005, 467.0135 FS. Law Implemented 381.0034, 409.908(12)(c), 456.013, 456.0135, 456.38, 456.048, 456.0635, 456.065, 467.011, 467.0125, 467.017 FS. History–New 1-26-94, Formerly 61E8-2.001, 59DD-2.001, Amended 10-29-02, 12-26-06, 2-7-08, 5-17-09, 8-10-10, 4-26-16, 3-27-17, Amended 6-21-22,_____.

64B24-2.002 Examination.

The department hereby designates the North American Registry of Midwives' (NARM) written examination as the midwifery licensure examination. Any person desiring to be licensed as a midwife shall apply and pay the examination fee to the NARM.

Rulemaking Authority 456.004, 467.005, 456.017 FS. Law Implemented 467.011, 456.017 FS. History–New 1-26-94, Formerly 61E8-2.002, Amended 9-3-95, Formerly 59DD-2.002, Amended 9-26-02, 4-26-16.

64B24-2.003 Licensure by Examination.

In addition to the application, persons seeking licensure as a midwife by examination shall submit the following:

(1) An official transcript from an approved midwifery training program specifically setting forth all courses successfully completed, the date of the applicant's graduation and the degree, certificate, or diploma awarded;

(2) A general emergency care plan which meets the requirements of section 467.017(1), F.S.;

(3) Documentation of a passing score on the licensure examination sent directly to the department from the NARM; and

(4) An official transcript sent direct from an approved midwifery four-month prelicensure accredited and approved program demonstrating successful completion of the program, which shall include courses successfully completed and the date of the applicant's completion of the course.

(5)(a) In addition to the application and requirements set forth above, foreign-trained applicants for licensure as a midwife by examination shall submit the following:

1. A valid certificate or diploma from either a foreign institution of medicine or a foreign school of midwifery,

2. A certified translation of the certificate or diploma earned from a foreign institution of medicine or foreign school of midwifery, and

3. Explanation of different names on documents submitted with the application, if applicable.

(b) In determining whether the requirements to hold a certificate or diploma from a foreign institution of medicine or a foreign school of midwifery are substantially equivalent to the requirements established under chapter 467, F.S., and these rules, the department shall consider whether:

1. The applicant has a high school diploma, or its equivalent, and passed the College-Level Academic Skills Test (CLAST), or has taken and received a passing grade in three college level credits each of Math and English, or can demonstrate competencies in communication and computation by passing the College-Level Examination Program (CLEP) test in communication and computation.

2. The completed midwifery or medical program equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required course work and practicum areas as demonstrated by use of the Form DH-MQA 1111, Foreign-Trained Midwife Applicant Evaluation Tool (08/2015), incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-06541.

3. The applicant has received a determination of substantial equivalency through the use of this evaluation tool by an approved foreign education credentialing agency.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 456.017, 456.0135, 467.011, 467.017 FS. History–New 1-26-94, Formerly 61E8-2.003, 59DD-2.003, Amended 10-24-02, 2-2-06, 4-26-16,_____.

64B24-2.004 Licensure by Endorsement and Temporary Certificate in Areas of Critical Need

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-2.004, F.A.C. FOR CURRENT TEXT)

(1) Applications for licensure by endorsement pursuant to section 456.0145(2), F.S., shall submit form DH-MQA 5103 (04/2025), Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=RefXXXX. Applicants for licensure by endorsement shall meet and comply with all requirements in Section 456.0145(2), F.S.

(2) Applications for temporary certification to practice midwifery in areas of critical need pursuant to section 467.0125, F.S., shall submit form DH-MQA 5013 (04/2025), Application for Temporary Midwifery Certificate in Areas of Critical Need, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=RefXXXX. The application shall submit the name of the individual who will serve as the midwife's supervisor, who shall be a physician currently licensed pursuant to chapter 458 or 459, F.S., a certified nurse midwife licensed pursuant to chapter 464, F.S., or a midwife licensed pursuant to chapter 467, F.S., who has a minimum of 3 years of professional experience.

(3) A temporary certificate issued under this section shall be valid only as long as an area for which it is issued remains an area of critical need, but no longer than 2 years. A temporary certificate is not renewable, nor shall a person be granted a temporary certificate more than once.

Rulemaking Authority 456.38, 467.005 FS. Law Implemented 456.0145, 456.38, 467.0125 FS. History–New 1-26-94, Formerly 61E8-2.004, 59DD-2.004, Amended 10-24-02, 2-7-08, 4-22-09, 4-26-16, 6-21-22,_____.

Application for Midwifery License by Examination

Department of Health/Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridaHealth.gov/licensing-and-regulation/midwifery/
Email: MQA.Midwifery@FLHealth.gov
Phone: (850) 245-4161
Fax: (850) 412-2681

DH-MQA 1051, Revised 5/2025, Rule 64B24-2.001, F.A.C.

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.

DH-MQA 1051, Revised 5/2025, Rule 64B24-2.001, F.A.C.

Application for Midwifery License by Examination

Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 412-2681
Email: MQA.Midwifery@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

More information about the licensing process and requirements is available at www.floridahealth.gov/licensing-and-regulation/midwifery/.

Certified Nurse Midwives (CNM) should not apply with the Council of Licensed Midwifery. CNMs must apply with the Board of Nursing at https://floridasnursing.gov/.

Midwife (3201) by **Examination** (1010) **$705.00**

Total fee of $705.00 includes the following:

Application Fee (non-refundable)	$200.00
Initial Licensure Fee (refundable)	$500.00
Unlicensed Activity Fee (refundable)	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

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

_____ _____ _____
Street (Place of Employment) 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 council 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 Disclosure 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.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Include **all** names which may appear on documents submitted in support of your application. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice midwifery 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

For any license(s) listed, you may be required to submit official license verification.
Council staff will attempt to verify all licenses listed using available primary-source verification tools (i.e. online verification portals). If primary-source verification is not available, you will be notified in writing that official license verification is required. A copy of your license will not be accepted in lieu of official verification.

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.

5. EDUCATION AND TRAINING HISTORY

A. **Midwifery Education and Training:** List the midwifery or other training program you attended.

Program Name	Program State or Country	Graduation Date (MM/DD/YYYY)

☐ **Applicants who completed their midwifery education and training in Florida must have an official transcript sent directly to the council office from their Florida council approved midwifery program. Unofficial transcripts and copies submitted by applicants are not acceptable.**

If you attended a Florida council approved midwifery program:
☐ I authorize the Florida council approved midwifery program listed above to release my transcript.

☐ **Applicants educated in another state must have their education and training evaluated by a Florida council approved midwifery program.**

☐ **Applicants educated in another country must have their education and training evaluated by an education credentialing service.**

Uncredentialed education documents and copies of education credentialing documents submitted by applicants will not be accepted.

Credentialing must be completed on Form DH-MQA 5071, "Licensed Midwife Education and Training Evaluation," available online at https://www.floridahealth.gov/licensing-and-regulation/midwifery/resources.

B. **Prelicensure Course:** Applicants educated in another state or country must complete a prelicensure course with a Florida council approved midwifery program.

If you completed your midwifery education in another state or country, list the Florida council approved midwifery program where you completed your prelicensure course.

Approved Midwifery Program Name	Completion Date (MM/DD/YYYY)
☐ I authorize the approved midwifery program listed above to release my prelicensure transcript.	

6. EXAMINATION HISTORY

North American Registry of Midwives (NARM) - Examination Results:

☐ I have not yet taken the required NARM examination.

☐ I have taken the required NARM examination.

☐ **All applicants must request that their NARM results be sent directly to the council office. NARM results submitted by applicants will not be accepted.**

For additional information about the NARM examination, visit narm.org.

Requests for agency authorization to test made directly by applicants will not be accepted.
If you require authorization to test, contact the Florida council approved midwifery program where you completed your prelicensure course.

7. GENERAL EMERGENCY CARE PLAN

☐ **All applicants are required to provide a general emergency care plan pursuant to s. 467.017(1), Florida Statutes.**

Submit your general emergency care plan on Form DH-MQA 1077, "General Emergency Care Plan for Licensed Midwives." The form is available online at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources. **The form required in this section may be submitted with your application.**

After submission of this application, the required form may be submitted by:

- uploading the form using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the form to MQA.Midwifery@flhealth.gov, or
- mailing the form to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

This information is exempt from public records disclosure.

8. 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 council office:

☐ **A written self-explanation** which identifies the medical condition(s) or occurrence(s) and current status.

☐ **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 your ability to practice the profession with reasonable skill and safety. The letter must specify that you are safe to practice the profession without restrictions, or indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

9. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or jurisdiction? ☐ Yes ☐ No

B. Have you ever had any application for a license to practice a profession, including midwifery, denied by any state board/council or the licensing authority of any state, territory, or jurisdiction? ☐ Yes ☐ No

C. Are you currently under investigation or is any disciplinary action pending against you in any state, territory, or jurisdiction that would constitute a violation of s. 467.203, Florida Statutes? ☐ Yes ☐ No

D. Have you ever been notified to appear before any licensing agency for a hearing on a compliant of any nature, including, but not limited to, a charge of violation of the midwifery and/or medical practice act(s), for unprofessional or unethical conduct? ☐ Yes ☐ No

If you responded "Yes" to any of the questions above, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to question A, B, C, or D, you must provide the following:

☐ **A written self-explanation**, which describes in detail the circumstances surrounding each disciplinary action, denial, investigation, or hearing.

☐ A copy of the **Administrative Complaint** and **Notice of Intent to Deny or Final Order**.

☐ **Any other relevant filings** entered by the licensing agency related to the action taken.

E. Have you ever had any judgements entered against you related to the practice of midwifery or any other health care profession? ☐ Yes ☐ No

F. Have you ever been sued for malpractice? ☐ Yes ☐ No

If you responded "Yes" to question E or F, you must provide the following:

☐ **A written self-explanation** which describes in detail your involvement in each case.

☐ A copy of the **Complaint** and **Disposition** for each case.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the documents to MQA.Midwifery@flhealth.gov, or
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

10. CRIMINAL HISTORY

*For the questions 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.*

A. 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

B. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? ☐ Yes ☐ No

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

Offense	Jurisdiction/State	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

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

☐ **A written self-explanation** which describes in detail the circumstances surrounding each offense and includes the date of the offense, where the offense occurred (city and state), the charge(s), and the final disposition(s).

☐ **Arrest Records and Final Dispositions** for all offenses. The Clerk of Court in the jurisdiction where the offense took place will provide you with these documents. *If records are unavailable*, documentation of the unavailability of records must come from the Clerk of Court in the jurisdiction where the offense took place, in the form of a letter which states that the records are unavailable.

☐ **Completion of Sentencing Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the sentence was completed.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- emailing the documents to MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

11. 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), 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 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), 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. 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 "Yes" response which describes in detail the circumstances surrounding the termination or conviction and includes the county and state of each termination or conviction and the date of each termination or conviction.

☐ **Copies of supporting documentation** includes court dispositions or agency orders, if applicable.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- emailing the documents to MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

12. LIVESCAN PRIVACY STATEMENT

☐ 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.

☐ **Electronic Fingerprinting:** **(Required for ALL applicants)**

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 council's ORI number is **EDOH4620Z**. The council 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.

13. FINANCIAL RESPONSIBILITY

Midwives are required to carry professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 through an authorized insurer as defined under s. 624.09, Florida Statutes, a surplus lines insurer as defined under s. 626.914., Florida Statutes, a risk retention group as defined under s. 627.942, Florida Statutes, the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or a plan of self-insurance as provided in s. 627.357, Florida Statutes, unless exempt from financial responsibility coverage for one of the reasons below.

Council staff cannot advise as to your financial responsibility or malpractice insurance coverage. If you have questions regarding your financial responsibility, insurance coverage, or requirements for exemption, consult your legal counsel, insurance company, or financial institution.

Choose only one option that describes your professional liability insurance coverage status or exemption from financial responsibility.

☐ **I have obtained and will maintain professional liability insurance coverage** in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 from a provider as described herein.

☐ **I am exempt from financial responsibility coverage** because I practice exclusively as an officer, employee, or agent of the federal government, or of the state of Florida or its agencies or subdivisions.

☐ **I am exempt from financial responsibility coverage** because I will be practicing exclusively in conjunction with my teaching duties with an approved midwifery program.

☐ **I am exempt from financial responsibility coverage** because I will not be practicing in the state of Florida upon issuance of my midwifery license and will submit proof of professional liability coverage at least 15 days prior to beginning practice in the state of Florida.

☐ **I am exempt from financial responsibility coverage** because I have no malpractice exposure in the state of Florida.

14. 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, Florida Statutes.

Florida law requires me to immediately inform the council 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 this application and sign it or sign digitally. MM/DD/YYYY

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.

Council of Licensed Midwifery
Electronic Fingerprinting

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/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Council of Licensed Midwifery is **EDOH4620Z**.
- You must provide accurate 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#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: -_____ Sex: -_____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Application for Midwifery License by Examination

Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: http://www.floridahealth.gov/licensing-and-regulation/midwifery/
Email: MQA.Midwifery@flhealth.gov
Phone: (850) 245-4161
Fax: (850) 412-2681

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.

Application for Midwifery License by Examination

Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 412-2681
Email: MQA.Midwifery@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

More information about the licensing process and requirements is available at www.floridahealth.gov/licensing-and-regulation/midwifery/.

Certified Nurse Midwives (CNM) should not apply with the Council of Licensed Midwifery. CNMs must apply with the Board of Nursing at https://floridasnursing.gov/.

Midwife (3201) by **Examination** (1010) **$705.00**

Total fee of $705.00 includes the following:

Application Fee (non-refundable)	$200.00
Initial Licensure Fee (refundable)	$500.00
Unlicensed Activity Fee (refundable)	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

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

_____ _____ _____
Street (Place of Employment) 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	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

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 council 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 Disclosure 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.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Include **all** names which may appear on documents submitted in support of your application. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice midwifery 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

For any license(s) listed ~~in question C~~, you may be required to submit official license verification. Council staff will attempt to verify all licenses listed using available primary-source verification tools (i.e. online verification portals). If primary-source verification is not available, you will be notified in writing that official license verification is required. A copy of your license will not be accepted in lieu of official verification.

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.

5. EDUCATION AND TRAINING HISTORY

A. **Midwifery Education and Training:** List the midwifery or other training program you attended.

Program Name	Program State or Country	Graduation Date (MM/DD/YYYY)

Applicants who completed their midwifery education and training in Florida must have an official transcript sent directly to the council office from their Florida council approved midwifery program. Unofficial transcripts and copies submitted by applicants are not acceptable.

If you attended a Florida council approved midwifery program:
I authorize the Florida council approved midwifery program listed above to release my transcript.

Applicants educated in another state must have their education and training evaluated by a Florida council approved midwifery program.

Applicants educated in another country must have their education and training evaluated by an education credentialing service.

Uncredentialed education documents and copies of education credentialing documents submitted by applicants will not be accepted.

Credentialing must be completed on Form DH-MQA 5071, "Licensed Midwife Education and Training Evaluation," available online at https://www.floridahealth.gov/licensing-and-regulation/midwifery/resources.

B. **Prelicensure Course:** Applicants educated in another state or country must complete a prelicensure course with a Florida council approved midwifery program.

If you completed your midwifery education in another state or country, list the Florida council approved midwifery program where you completed your prelicensure course.

Approved Midwifery Program Name	Completion Date (MM/DD/YYYY)
I authorize the approved midwifery program listed above to release my prelicensure transcript.	

6. EXAMINATION HISTORY

North American Registry of Midwives (NARM) - Examination Results:

I have not yet taken the required NARM examination.

I have taken the required NARM examination.

All applicants must request that their NARM results be sent directly to the council office. NARM results submitted by applicants will not be accepted.

For additional information about the NARM examination, visit narm.org.

Requests for agency authorization to test made directly by applicants will not be accepted.
If you require authorization to test, contact the Florida council approved midwifery program where you completed your prelicensure course.

7. GENERAL EMERGENCY CARE PLAN

All applicants are required to provide a general emergency care plan pursuant to s. 467.017(1), Florida Statutes.

Submit your general emergency care plan on Form DH-MQA 1077, "General Emergency Care Plan for Licensed Midwives." The form is available online at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources. **The form required in this section may be submitted with your application.**

After submission of this application, the required form may be submitted by:

- uploading the form using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the form to MQA.Midwifery@flhealth.gov, or
- mailing the form to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

This information is exempt from public records disclosure.

8. 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 council office:

A written self-explanation which identifies the medical condition(s) or occurrence(s) and current status.

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 your ability to practice the profession with reasonable skill and safety. The letter must specify that you are safe to practice the profession without restrictions, or indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

9. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or jurisdiction? Yes No

B. Have you ever had any application for a license to practice a profession, including midwifery, denied by any state board/council or the licensing authority of any state, territory, or jurisdiction? Yes No

C. Are you currently under investigation or is any disciplinary action pending against you in any state, territory, or jurisdiction that would constitute a violation of s. 467.203, Florida Statutes? Yes No

D. Have you ever been notified to appear before any licensing agency for a hearing on a compliant of any nature, including, but not limited to, a charge of violation of the midwifery and/or medical practice act(s), for unprofessional or unethical conduct? Yes No

If you responded "Yes" to any of the questions above, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to question A, B, C, or D, you must provide the following:

A written self-explanation, which describes in detail the circumstances surrounding each disciplinary action, denial, investigation, or hearing.

A copy of the **Administrative Complaint** and **Notice of Intent to Deny or Final Order**.

Any other relevant filings entered by the licensing agency related to the action taken.

E. Have you ever had any judgements entered against you related to the practice of midwifery or any other health care profession? Yes No

F. Have you ever been sued for malpractice? Yes No

If you responded "Yes" to question E or F, you must provide the following:

A written self-explanation which describes in detail your involvement in each case.

A copy of the **Complaint** and **Disposition** for each case.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the documents to MQA.Midwifery@flhealth.gov, or
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

10. CRIMINAL HISTORY

*For the questions 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.*

A. 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 (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.~~ Yes No

B. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? Yes No

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

Offense	Jurisdiction/State	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

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

A written self-explanation which describes in detail the circumstances surrounding each offense and includes the date of the offense, where the offense occurred (city and state), the charge(s), and the final disposition(s).

Arrest Records and Final Dispositions for all offenses. The Clerk of Court in the jurisdiction where the offense took place will provide you with these documents. *If records are unavailable*, documentation of the unavailability of records must come from the Clerk of Court in the jurisdiction where the offense took place, in the form of a letter which states that the records are unavailable.

Completion of Sentencing Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the sentence was completed.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- ~~uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),~~
- emailing the documents to ~~MQA.Midwifery@flhealth.gov~~ MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

~~Council of Licensed Midwifery~~
~~4052 Bald Cypress Way, Bin C-06~~
~~Tallahassee, FL 32399-3255~~

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

11. 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), 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 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), 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 ~~(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 (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. 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
Name: _____

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 "Yes" response which describes in detail the circumstances surrounding the termination or conviction and includes the county and state of each termination or conviction and the date of each termination or conviction.

Copies of supporting documentation includes court dispositions or agency orders, if applicable.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- ~~uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),~~
- emailing the documents to ~~MQA.Midwifery@flhealth.gov~~ MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

~~**Council of Licensed Midwifery**~~
~~**4052 Bald Cypress Way, Bin C-06**~~
~~**Tallahassee, FL 32399-3255**~~

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

12. LIVESCAN PRIVACY STATEMENT

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.

Electronic Fingerprinting: (Required for ALL applicants)

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 council's ORI number is **EDOH4620Z**. The council 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.

Name: _____

13. FINANCIAL RESPONSIBILITY

Midwives are required to carry professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 through an authorized insurer as defined under s. 624.09, Florida Statutes, a surplus lines insurer as defined under s. 626.914., Florida Statutes, a risk retention group as defined under s. 627.942, Florida Statutes, the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or a plan of self-insurance as provided in s. 627.357, Florida Statutes, unless exempt from financial responsibility coverage for one of the reasons below.

Council staff cannot advise as to your financial responsibility or malpractice insurance coverage. If you have questions regarding your financial responsibility, insurance coverage, or requirements for exemption, consult your legal counsel, insurance company, or financial institution.

Choose only one option that describes your professional liability insurance coverage status or exemption from financial responsibility.

I have obtained and will maintain professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 from a provider as described herein.

I am exempt from financial responsibility coverage because I practice exclusively as an officer, employee, or agent of the federal government, or of the state of Florida or its agencies or subdivisions.

I am exempt from financial responsibility coverage because I will be practicing exclusively in conjunction with my teaching duties with an approved midwifery program.

I am exempt from financial responsibility coverage because I will not be practicing in the state of Florida upon issuance of my midwifery license and will submit proof of professional liability coverage at least 15 days prior to beginning practice in the state of Florida.

I am exempt from financial responsibility coverage because I have no malpractice exposure in the state of Florida.

~~**Providing false information in response to this question may result in denial of licensure or disciplinary action against your license once issued, and/or criminal penalties as provided in s. 456.067, 456.072, 467.201(5), 456.203(1)(a), 775.082, 775.083, and 775.084, Florida Statutes.**~~

14. 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, Florida Statutes.

Florida law requires me to immediately inform the council 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 this application and sign it or sign digitally. MM/DD/YYYY

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.

Council of Licensed Midwifery
Electronic Fingerprinting

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/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Council of Licensed Midwifery is **EDOH4620Z**.
- You must provide accurate 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#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Mobile Opportunity by Interstate Licensure 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 64B24-2.004, 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.

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.

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				

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: - _____ Sex: - _____

(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (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

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

Mobile Opportunity by Interstate Licensure Endorsement

(MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: http://www.flhealthsource.gov
Phone: (850) 488-0595

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 ~~three~~ 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. ~~Certain professions require Livescan screening. Refer to page 10 for a list of screened professions.~~

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

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.

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 ~~in a U.S. jurisdiction or~~ 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 ~~to practice~~ 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 ~~with a similar scope of practice as defined in s. 456.0145(2)(a)2., Florida Statutes,~~ for which you are applying for at least two ~~three~~ years during the four-year period immediately preceding the date of submission of the ~~this~~ 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.

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 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.

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. ~~Refer to and complete the appropriate "Florida Birth-Related Neurological Injury Compensation Association (NICA) Form" on page 17 or 18 for your profession.~~

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: _____ Sex: _____

(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (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.

This form is required for all Medical Doctors.

Board *of* Medicine
Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

All applicants must choose one of the three options described below. Check only one.

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

Exempt- $0.00	Non-participating- $250.00	Participating- $5,000.00

Amount Enclosed: $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

Participating and Non-participating applicants must complete and attach this form and appropriate fees to the application or submit to the Board of Medicine at:

Board *of* Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330

Applicants claiming exemption must complete this form, and return it with proof of qualification for the exemption to:

Board *of* Medicine		**NICA**
4052 Bald Cypress Way Bin C-03	**AND**	P.O. Box 14567
Tallahassee, FL 32399-3253		Tallahassee, FL 32317-4567

Exemptions Include:

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, Florida Statutes, who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

I have read the information provided by NICA at www.nica.com and I have selected the option above.

Applicant Signature _____ Date _____
MM/DD/YYYY

This form is required for all Osteopathic Physicians.

Board *of* Osteopathic Medicine
Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

All applicants must choose one of the three options described below. Check only one.

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

☐ Exempt $0.00	☐ Non-participating $250.00	☐ Participating $5,000.00

Amount Enclosed: $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

Participating and Non-participating applicants must complete and attach this form and appropriate fees to the application or submit to the Board of Osteopathic Medicine at:

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

Applicants claiming exemption must complete this form, and return it with proof of qualification for the exemption to:

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

AND

NICA
P.O. Box 14567
Tallahassee, FL 32317-4567

Exemptions Include:

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Osteopathic Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, Florida Statutes, who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state-owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

I have read the information provided by NICA at www.nica.com and I have selected the option above.

Applicant Signature _____ Date _____
MM/DD/YYYY

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

Medical Doctors ONLY

Board of 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 6** 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 **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

2. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

3. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, 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.

4. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 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.

5. I have elected not to carry medical malpractice insurance; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, Florida Statutes. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), Florida Statutes.

6. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category on the following page).***

Medical Doctors ONLY

Board *of* Medicine
Financial Responsibility

Name: _____

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I hold a limited license issued pursuant to s. 458.317, Florida Statutes, and practice only under the scope of such limited license.
3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents **do not** qualify for this exemption.)
4. I have no malpractice exposure because I do not practice in the state of Florida. I will notify the Department of Health immediately before commencing practice in the state.
5. I am exempt from demonstrating financial responsibility due to meeting **all** the following criteria (if you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):
   a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
   b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
   c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
   d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, Florida Statutes, or the medical practice act in any other state.
   e. I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of ch. 458, Florida Statutes, or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See s. 458.320(5)(f), Florida Statutes, for specific notice requirements.

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

Medical Doctors ONLY

Board *of* Medicine

Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming exemption based on #5 on the preceding page.

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.

b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.

c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.

d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, Florida Statutes, or the medical practice act in any other state.

e. I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of ch. 458, Florida Statutes, or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See section 458.320(5)(f), Florida Statutes, for specific notice requirements.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the form and sign it before a notary public.

(SEAL)

Osteopathic Physicians ONLY

Board *of* Osteopathic 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 6** 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 do not have hospital privileges and 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 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 hospital staff privileges and I have obtained and maintain liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, 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, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110, Florida Statutes.

3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to 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. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, Florida Statutes, in the per-claim amounts specified above.

4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, Florida Statutes, in an amount no less than $250,000 per claim, with a minimum aggregate availability of credit not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, Florida Statutes, in the per-claim amounts specified above.

5. I have decided to not carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgements pursuant to the terms and conditions contained in s. 459.0085(5)(g), Florida Statutes. I understand that I shall be required to either post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided to pursuant to Florida law.

Osteopathic Physicians ONLY

Board *of* Osteopathic Medicine
Financial Responsibility

Name: _____

6. 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 medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

2. I hold a limited license issued pursuant to s. 459.0075, Florida Statutes, and practice only under the scope of such limited license.

3. I practice only in conjunction with my teaching duties at a college of osteopathic medicine (residents **do not qualify** for this exemption).

4. I have no malpractice exposure because I do not practice in the state of Florida. I will notify the Department of Health immediately before commencing practice in the state.

5. I am exempt from demonstrating financial responsibility due to meeting all the following criteria (if you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):

    a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
    b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
    c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
    d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, Florida Statutes, or the practice act of any state.
    e. I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, Florida Statutes, or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

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 an option out of options one through four in the "Financial Responsibility Coverage" section, proof of liability coverage must be sent directly by the insuring company to the board at:

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

Osteopathic Physicians ONLY

Board of Osteopathic Medicine
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming exemption based on #5 on the preceding page.

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, Florida Statutes, or the practice act of any state.
e. I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, Florida Statutes, or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the application and sign it before a notary public.

(SEAL)

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

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

Advanced Practice Registered Nurses ONLY

Board *of* Nursing
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. 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 maintain professional liability coverage in an amount not less than $100,000 per claim, 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, or a risk retention group under s. 627.942, Florida Statutes.

2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by ch. 675, Florida Statutes, which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000, and which is payable to the APRN as beneficiary.

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 medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I hold a limited license issued pursuant to s. 456.015, Florida Statutes, and practice only under the scope of the limited license.
3. My Florida license is inactive, and I do not practice in the state of Florida.
4. I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.
5. My Florida license is active, but I do not practice in the state of Florida.
6. I have just completed my Advanced Practice Registered Nurse Program and/or I am not yet practicing in 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* Nursing
4052 Bald Cypress Way Bin C 02
Tallahassee, FL 32399-3252

Anesthesiologist Assistants ONLY

Board of Medicine
Anesthesiologist Assistant
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. 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 established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.
2. I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, 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.
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 medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I do not practice medicine in the state of Florida.
3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals.

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

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)

7. 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

64B24-2.001 Licensure to Practice Midwifery.

(1) Applications for a midwife license by examination shall be submitted to the department on Form DH-MQA 1051, (07/2020), Application for Midwifery License by Examination, incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-14373. Applications for a midwife license by endorsement shall be submitted to the department on Form DH-MQA 5058 (08/2020), Application for Midwifery License by Endorsement, incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-14374.

(2) Applicants must demonstrate that they:

(a) Are 21 years of age or older;

(b) Meet the requirements for licensure by examination or endorsement;

(c) Have completed a one-hour educational course on HIV/AIDS that meets the substantive specifications set forth in section 381.0034, F.S., as it pertains to the practice of midwifery, unless an affidavit showing good cause has been submitted allowing the applicant 6 months to complete the course;

(d) Have completed a two-hour course relating to the prevention of medical errors; and,

(e) Have successfully completed an approved four-month prelicensure course, if required.

Rulemaking Authority 409.908(12)(c), 456.004(5), 456.013, 456.38, 467.005, 467.0135 FS. Law Implemented 381.0034, 409.908(12)(c), 456.013, 456.38, 456.048, 456.0635, 456.065, 467.011, 467.0125, 467.017 FS. History–New 1-26-94, Formerly 61E8-2.001, 59DD-2.001, Amended 10-29-02, 12-26-06, 2-7-08, 5-17-09, 8-10-10, 4-26-16, 3-27-17, Amended 6-21-22.

64B24-2.003 Licensure by Examination.

In addition to the application, persons seeking licensure as a midwife by examination shall submit the following:

(1) An official transcript from an approved midwifery training program specifically setting forth all courses successfully completed, the date of the applicant's graduation and the degree, certificate, or diploma awarded;

(2) A general emergency care plan which meets the requirements of Section 467.017(1), F.S.; and,

(3) Documentation of a passing score on the licensure examination sent directly to the department from the NARM.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 456.017, 467.011, 467.017 FS. History–New 1-26-94, Formerly 61E8-2.003, 59DD-2.003, Amended 10-24-02, 2-2-06, 4-26-16.

64B24-2.004 Licensure by Endorsement.

(1)(a) In addition to the application, foreign-trained applicants for licensure as a midwife by endorsement shall submit the following:

1. A valid certificate or diploma from either a foreign institution of medicine or a foreign school of midwifery,

2. A certified translation of the certificate or diploma earned from a foreign institution of medicine or foreign school of midwifery,

3. The document which renders the foreign trained applicant eligible to practice medicine or midwifery in the country in which that document was issued,

4. A certified translation of the certificate, diploma or license which renders the foreign trained applicant eligible to practice medicine or midwifery in the country from which the diploma or certificate was awarded,

5. Explanation of different names on documents submitted with the application,

6. Evidence of successful completion of an approved four-month prelicensure course,

7. Evidence of a passing score on the licensure examination; and,

8. A general emergency care plan which meets the requirements described in section 467.017, F.S.

(b) In determining whether the requirements to hold a certificate or diploma from a foreign institution of medicine or a foreign school of midwifery are substantially equivalent to the requirements established under chapter 467, F.S., and these rules, the department shall consider whether:

1. The applicant has a high school diploma, or its equivalent, and passed the College-Level Academic Skills Test (CLAST), or has taken and received a passing grade in three college level credits each of Math and English, or can demonstrate competencies in communication and computation by passing the College-Level Examination Program (CLEP) test in communication and computation.

2. The completed midwifery or medical program equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required course work and practicum areas as demonstrated by use of the Form DH-MQA 1111, Foreign-Trained Midwife Applicant Evaluation Tool (08/2015), incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-06541.

3. The applicant has received a determination of substantial equivalency through the use of this evaluation tool by an approved foreign education credentialing agency.

(2)(a) In addition to the application, persons trained in another state seeking licensure as a midwife by endorsement shall submit the following:

1. Evidence of successful completion of the approved four-month prelicensure course,

2. Evidence of a passing score on the licensure examination; and,

3. A general emergency care plan which meets the requirements described in section 467.017, F.S.

(b) In determining whether the requirements to hold a certificate or license to practice midwifery in another state are substantially equivalent to the requirements established under chapter 467, F.S., and these rules, the applicant shall submit:

1. A current valid unrestricted certificate or license to practice midwifery in another state,

2. A certificate or diploma awarded by a midwifery program which was approved by the certifying body of the state in which it was located, or an authenticated copy of that certificate or diploma,

3. A copy of the other state's laws and rules under which the applicant's certificate or license was issued; and,

4. Official transcripts from the midwifery program which document classroom instruction and clinical training equivalent to the requirements in these rules.

(c) In determining whether the requirements to practice midwifery in another state are substantially equivalent to the requirements established under chapter 467, F.S., and these rules, the department shall consider whether:

1. The applicant has a high school diploma, or its equivalent, and passed the College Level Academic Scholastic Test (CLAST), or has taken and received a passing grade in three college level credits each of Math and English, or can demonstrate competencies in communication and computation by passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.

2. The completed midwifery or medical program equivalent to a three-year program, offered the equivalent to 90 credit hours, and included minimum required course work and practicum areas as demonstrated by use of the Form DH-MQA 1112, Out-of-State Midwife Applicant Evaluation Tool (08/2015), incorporated by reference and available at

https://www.flrules.org/Gateway/reference.asp?No=Ref-06542.

3. The applicant has received a determination of substantial equivalency through the use of this evaluation tool by an approved education credentialing agency.

(3) A temporary certificate to practice midwifery in areas of critical need may be issued to any applicant who is qualifying for licensure by endorsement. The applicant shall submit to the department a completed application on Form DH-MQA 5013, Application for Temporary Midwifery Certificate in Areas of Critical Need (07/2020), incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-14375; the temporary certificate fee documentation of the area of critical need pursuant to section 467.0125(2)(a), F.S.; and the name of the individual who will serve as the midwife's supervisor. This individual shall be a physician currently licensed pursuant to chapter 458 or 459, F.S., a certified nurse midwife licensed pursuant to chapter 464, F.S., or a midwife licensed pursuant to chapter 467, F.S., who has a minimum of 3 years of professional experience.

(4) A temporary certificate issued under this section shall be valid only as long as an area for which it is issued remains an area of critical need, but no longer than 2 years. A temporary certificate is not renewable, nor shall a person be granted a temporary certificate more than once.

Rulemaking Authority 456.38, 467.005 FS. Law Implemented 456.38, 467.0125 FS. History–New 1-26-94, Formerly 61E8-2.004, 59DD-2.004, Amended 10-24-02, 2-7-08, 4-22-09, 4-26-16, 6-21-22.

CHAPTER 64B24-4
TRAINING PROGRAMS

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64B24-4.001 Definitions.

~~(1) "Clinical expertise" means demonstrated proficiency in a specialized area of direct patient care.~~

~~(2) "Clinical learning experience" means faculty planned and supervised instruction of students during which students function in a midwifery capacity with patients.~~

(1) "Course of Study" means all courses and clinical practicum required to complete midwifery training at an approved midwifery program, which meets or exceeds the requirements of Rules 64B24-4.006 and 64B24-4.007, F.A.C.

(2)~~(3)~~ "Credit hour" means one hour of credit representing 15 hours of classroom teaching or 30 hours of clinical learned experience.

(3) "Direct Supervision" means the physical presence within the patient care unit of a preceptor as defined in Section 467.003(12), F.S., or faculty member, who assumes clinical responsibility for the practice of the student midwife being supervised, and who provides direction and consultation for the actions of such student midwife in the preceptor's or faculty member's area of clinical expertise.

(4) "Educational Objective" means a competency expected of a graduate of an approved midwifery program, stated as an expected student behavioral outcome.

(5)~~(4)~~ "Facility" means any establishment or institution in which students in an approved program obtain clinical learning or observational experiences.

~~(5) "Faculty" means the teaching staff in an educational institution who are qualified by education and experience in the areas which they teach.~~

~~(6) "Observational experience" means learning experience planned and directed by program faculty during which students do not function in a midwife capacity.~~

~~(7) "Supervision" means the physical presence within the patient care unit of a preceptor as defined in Section 467.003(12), F.S., or faculty member, who assumes clinical responsibility for the practice of the student midwife being supervised, and who provides direction and consultation for the actions of such student midwife in the preceptor's or faculty member's area of clinical expertise.~~

~~(8) "Three year training program" means not less than 90 credit hours.~~

~~(9) "Two year reduced training program" means not less than 60 credit hours.~~

(6)~~(10) "Four month P~~p~~re-licensure course" means a course of study offered by an approved midwifery program which meets the requirements of Chapter 64B24-4, F.A.C. ~~an approved program of not less than 15 credit hours which meets the requirements of these rules.~~

~~(11) "Approved program" means a midwifery school or a midwifery training program which is approved by the department pursuant to Section 467.205, F.S.~~

Rulemaking Authority 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.001, Amended 7-25-96, Formerly 59DD-4.001, Amended 10-11-04, 4-26-16.

64B24-4.002 Approval of Midwifery Programs ~~Training Program~~.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.002, F.A.C. FOR CURRENT TEXT)

(1) APPROVAL OF MIDWIFERY PROGRAMS. The department shall approve a midwifery program which:

(a)1. demonstrates that it is currently accredited pursuant to s. 467.205(1)(c), F.S. and is licensed by the Commission for Independent Education pursuant to Chapter 1005, F.S. and the rules promulgated thereunder; or,

2. is a public institution in the state of Florida, operating in compliance with Chapter 1004, F.S. and the rules promulgated thereunder; and,

(b) demonstrates that the education and training to be offered meets or exceeds the education and clinical training requirements of s. 467.009, F.S. and Rules 64B24-4.006, F.A.C. and 64B24-4.007, F.A.C.; and,

(c) demonstrates that the program is in compliance with the administrative and non-curricular requirements of Rule 64B24-4.008, F.A.C.; and,

(d) submits a completed application on form DH-MQA XXXX, "Appliction for Midwifery Program Approval," (04/2022) incorporated herein by reference, which may be obtained from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399, or from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/licensing or at https://www.flrules.org/Gateway/reference.asp?No=XXXX. To complete this application online, visit https://flhealthsource.gov/mqa-services.

(2) PROVISIONAL APPROVAL OF MIDWIFERY PROGRAMS. The department shall provisionally approve a midwifery program for a period not exceeding five years, which:

(a)1. demonstrates that it is currently seeking accreditation pursuant to s. 467.205(1)(c), F.S.; and,

a. is licensed or provisionally licensed by the Commission for Independent Education pursuant to Chapter 1005, F.S. and the rules promulgated thereunder; or,

b. is a public institution in the state of Florida, operating in compliance with Chapter 1004, F.S. and the rules promulgated thereunder; and,

(b) demonstrates that the education and training to be offered meets or exceeds the education and clinical training requirements of s. 467.009, F.S. and Rules 64B24-4.006, F.A.C. and 64B24-4.007, F.A.C.; and,

(c) demonstrates that the program is in compliance with the administrative and non-curricular requirements of Rule 64B24-4.008, F.A.C.; and,

(d) Submits a completed application on form DH-MQA XXXX, "Application for Provisional Midwifery Program Approval."

(e) A provisionally approved midwifery program may be granted full approval upon demonstration that the program:

1. has remained in compliance with Rules 64B24-4.006, 64B24-4.007, and 64B24-4.008, F.A.C.; and,

2. has attained a passage rate on an approved licensing examination of within three percent of the national average passage rate for first-time test takers in their first graduating class; and,

3. demonstrates that it has been accredited, pursuant to s. 467.205(1)(c), F.S.; and,

4. submits a completed application on form DH-MQA XXXX, "Application for Midwifery Program Approval."

(3) APPROVED MIDWIFERY PROGRAM REVIEW; PROBATIONARY STATUS; RESCISSION OF MIDWIFERY PROGRAM APPROVAL. The department shall periodically review approved and provisionally approved midwifery programs, and may take corrective action by placing the school on probationary status or rescinding approval pursuant to s. 467.205, F.S.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.002, 59DD-4.002, Amended 10-11-04, 4-26-16, _____.

64B24-4.003 Acceptance into Approved Midwifery ~~Training~~ Programs.

(1) An approved midwifery program may accept for training students who:

(a) Have a high school diploma or it's equivalent; and,

(b) Demonstrate competency in communication and computation by:

1. Having taken and passed three college-level credits each of math and English; or,

2. Passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.

(2) An approved midwifery program may reduce the required period of training for a student pursuant to Section 467.009(3), F.S., for a student who can demonstrate their prior qualifications or training, as follows:

(a) For a student who is licensed under Chapter 464, F.S. as a registered nurse or licensed practical nurse, courses taken to be so licensed from an accredited program as defined in Section 464.003(1), F.S. or an approved program as defined in Section 464.003(4), F.S. may be considered by the approved midwifery program.

(b) For a student who has completed all, or a portion of a course of study in nursing, courses from an accredited program as

defined in Section 464.003(1), F.S. or an approved program as defined in Section 464.003(4), F.S. may be considered by the approved midwifery program.

(c) For a student who has completed all or a portion of a course of study in midwifery, courses completed with a midwifery training program in another state which is accredited by an accrediting body pursuant to s. 467.205(1)(c), F.S. may be considered by the approved midwifery program.

(3) An approved midwifery program must ensure that the overall education and training of any graduate from a course of study that has been reduced for for prior qualification or training has met or exceeded the education and clinical training requirements of s. 467.009, F.S. in order to graduate.

~~To be accepted into a department approved midwifery training program, the program shall evidence that the applicant has taken and received a passing grade in three college level credits each of math and English, or can demonstrate competencies in communication and computation by passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.~~

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.009(3), 467.205 FS. History–New 1-26-94, Formerly 61E8-4.003, 59DD-4.003, Amended 4-26-16,_____.

64B24-4.005 Faculty.

The faculty of each approved midwifery training program shall be comprised of, at a minimum, a licensed midwife who is actively teaching, and either a certified nurse midwife, or a board certified physician licensed under Chapter 458 or 459, F.S., who has actively practiced obstetrics within the last 4 years.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.005, 59DD-4.005, Amended 4-26-16, Repealed.

64B24-4.006 Minimum Education Statndards for Approved Midwifery Programs ~~Curriculum Guidelines and Educational Objectives.~~

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.006, F.A.C. FOR CURRENT TEXT)

(1) A course of study offered by an approved midwifery program must evidence the development of knowledge, skills, and professional behavior in the following areas:

(a) Primary management, collaborative management, referral and medical consultation, pursuant to Section 467.009(1)(b)1., F.S.;

(b) Antepartal, intrapartal, postpartal, and neonatal care, pursuant to Section 467.009(1)(b)2., F.S.;

(c) Family planning and gynecological care, pursuant to Section 467.009(1)(b)3., F.S.;

(d) Common complications of in the antepartum, intrapartum, and postpartum periods, pursuant to Section 467.009(1)(b)4.; F.S., and,

(e) Professional responsibilities of the midwife, pursuant to Section 467.009(1)(b)5., F.S.

(2) A course of study offered by an approved midwifery program must include classroom instruction in the following subject areas:

(a) Obstetrics, pursuant to Section 467.009(1)(a)1., F.S.;

(b) Neonatal pediatrics, pursuant to Section 467.009(1)(a)2., F.S.;

(c) Basic sciences, pursuant to Section 467.009(1)(a)3., F.S.;

(d) Female reproductive anatomy and physiology, pursuant to Section 467.009(1)(a)4., F.S.;

(e) Behavioral sciences, pursuant to Section 467.009(1)(a)5., F.S.;

(f) Childbirth education, pursuant to Section 467.009(1)(a)6., F.S.;

(g) Community care, pursuant to Section 467.009(1)(a)7., F.S.;

(h) Epidemiology, pursuant to Section 467.009(1)(a)8., F.S.;

(i) Genetics, pursuant to Section 467.009(1)(a)9., F.S.;

(j) Embryology, pursuant to Section 467.009(1)(a)10., F.S.;

(k) Neonatology, pursuant to Section 467.009(1)(a)11., F.S.;

(l) Applied pharmacology, pursuant to Section 467.009(1)(a)12., F.S.;

(m) Medical and Legal aspects of midwifery, pursuant to Section 467.009(1)(a)13., F.S.;

(n) Gynecology and women's health, pursuant to Section 467.009(1)(a)14., F.S.;

(o) Family planning, pursuant to Section 467.009(1)(a)15., F.S.;

(p) Nutrition during pregnancy and lactation, pursuant to Section 467.009(1)(a)16., F.S.;

(q) Breastfeeding, pursuant to Section 467.009(1)(a)17., F.S.; and,

(r) Basic nursing skills, pursuant to Section 467.009(1)(a)18, F.S.

(3) A course of study offered by an approved midwifery program must include clinical training which meets the requirements of Rule 64B24-4.007, F.A.C.

(4) A course of study offered by an approved midwifery program must be based on a curriculum which:

(a) Is consistent with principles of learning and educational practices;

(b) Reflects the stated philosophy and objectives of the midwifery training program;

(c) Has stated educational objectives which ensure minimum education standards are met;

(d) Integrates the development of knowledge, skills and professional behavior required by Rule 64B24-4.006(1), F.A.C., the classroom instruction required by Rule 64B24-4.006(2), and the clinical training required by Rule 64B24-4.006(3), F.A.C. into a logical sequence which leads students to the attainment of competency in the practice of midwifery, as evidenced by the attainment of educational objectives;

(e) Incorporates the core competencies of the Midwives Alliance of North America, "The Midwives Alliance Core Competencies" (12/2014), incorporated herein by reference and available at http://mana.org/about-us/core-competencies and http://www.flrules.org/Gateway/reference.asp?No=Ref-06687; and,

(f) Incorporates the core competencies of the American College of Nurse Midwives, "Core Competencies for Basic Midwifery Practice" (03/2020), incorporated herein by reference and available at http://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000050/ACNMCoreCompetenciesMar2020_final.pdf and http://www.flrules.org/Gateway/reference.asp?No=RefXXXXXX, insofar as they relate to collaborative management, referral and consultation with Certified Nurse Midwives.

(5) A course of study offered by an approved midwifery program must be comprised of at least 90 credit hours.

(6) A course of study offered by an approved midwifery program must be reviewed annually by program administration, faculty, and students to ensure that the curriculum and educational objectives are sufficient at ensuring the competency of graduates completing the course of study.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.009, 467.205 FS. History–New 1-26-94, Formerly 61E8-4.006, 59DD-4.006, Amended 9-10-02, 10-11-04, 4-26-16,_____.

64B24-4.007 Minimum Clinical Training Standards for Approved Midwifery Programs.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.007, F.A.C. FOR CURRENT TEXT)

(1) PROGRAM REQUIREMENTS. Approved midwifery programs must:

(a) Integrate clinical training as a part of the curriculum and offered course of study, pursuant to Rule 64B24-4.006(3)(d), F.A.C.

(b) Conduct clinical training in hospitals or alternative birth settings, pursuant to Section 467.009(6)(a), F.S. Alternative birth settings may include homes, birth centers, clinics, and offices.

(c) Obtain and maintain current contractual agreements with each hospital or alternative birth setting in which clinical training is to be conducted.

(d) Designate a faculty member to be available for student consultation during clinical training.

(e) Ensure an adequate number of preceptors are available for clinical training, such that no preceptor provides direct supervision for more than two students during any training where direct supervision is required.

(2) REQUIRED TRAINING. Clinical training must include:

(a) Student demonstration of competency in the assessment and differentiation between low-risk and high risk pregnancies, pursuant to 467.009(6)(b), F.S. Risk assessment and differentiation must be demonstrated in accordance with Rule 64B24-7.004, F.A.C.

(b) Observation of 25 patients in the intrapartal period, pursuant to s. 467.009(5)(b), F.S.

(c) Fifty (50) neonatal examinations.

(d) Five (5) vaginal sutures.

(e) The management and care of patients under the direct supervision of a preceptor pursuant to Section 467.009(5)(a), F.S.,

including 50 patients in the prenatal period, 50 patients in the intrapartal and immediate postpartum period, and 50 patients in the postpartal period. No more than five percent (5%) of the required management and care resulting in required transfer under Rule 64B24-7.004, F.A.C. may be counted toward meeting these requirements. The patients need not be different in each period.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.007, 59DD-4.007, Amended 9-10-02, 10-11-04, 4-26-16, _____.

64B24-4.008 Administration of Approved Midwifery Programs ~~Administrative Procedures.~~

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.008, F.A.C. FOR CURRENT TEXT)

(1) FACULTY AND ADMINISTRATION. Approved midwifery programs must:

(a) specify the lines of authority in the organizational structure governing the program;

(b) specify the duties and responsibilities of the director of the program;

(c) employ adequate faculty to teach all subjects within the course of study pursuant to Rule 64B24-4.006, F.A.C. and supervise clinical training required by Rule 64B24-4.007, F.A.C. Faculty must include a midwife licensed under Chapter 467, F.S., and either a certified nurse midwife licensed under Chapter 464, F.S. or a physician licensed under Chapter 458 or 459, F.S., who has actively practiced obstetrics within the past four years;

(d) demonstrate adequate fiscal accountability for the operation of the program; and,

(e) develop and maintain clear admission, enrollment, promotion, and retention policies.

(2) FACILITIES AND RESOURCES. Approved midwifery programs must demonstrate that they have and continuously maintain:

(a) adequate classroom, laboratory, library, and office space;

(b) adequate equipment for instructional and clinical use;

(c) library holdings which include current professional journals and other appropriate holdings; and,

(d) education materials which shall include a variety of current teaching aids for both group and self instructional use.

(3) RECORDKEEPING. Approved midwifery programs must have an organized system of record making and record keeping which includes, at a minimum:

(a) information on student acceptance, enrollment, and progress through the course of study and clinical training; and

(b) faculty preceptor assignment relative to classroom instruction and clinical training.

(c) Upon request of a student or a graduate, the program shall furnish a copy of the student's final record to the department.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.008, 59DD-4.008, Amended 4-26-16,_____.

CHAPTER 64B24-4
TRAINING PROGRAMS

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64B24-4.008 Administration of Approved Midwifery Programs ~~Administrative Procedures~~

64B24-4.001 Definitions.

~~(1) "Clinical expertise" means demonstrated proficiency in a specialized area of direct patient care.~~

~~(2) "Clinical learning experience" means faculty planned and supervised instruction of students during which students function in a midwifery capacity with patients.~~

(1) "Course of Study" means all courses and clinical practicum required to complete midwifery training at an approved midwifery program, which meets or exceeds the requirements of Rules 64B24-4.006 and 64B24-4.007, F.A.C.

(2)~~(3)~~ "Credit hour" means one hour of credit representing 15 hours of classroom teaching or 30 hours of clinical learned experience.

(3) "Direct Supervision" means the physical presence within the patient care unit of a preceptor as defined in Section 467.003(12), F.S., or faculty member, who assumes clinical responsibility for the practice of the student midwife being supervised, and who provides direction and consultation for the actions of such student midwife in the preceptor's or faculty member's area of clinical expertise.

(4) "Educational Objective" means a competency expected of a graduate of an approved midwifery program, stated as an expected student behavioral outcome.

(5)~~(4)~~ "Facility" means any establishment or institution in which students in an approved program obtain clinical learning or observational experiences.

~~(5) "Faculty" means the teaching staff in an educational institution who are qualified by education and experience in the areas which they teach.~~

~~(6) "Observational experience" means learning experience planned and directed by program faculty during which students do not function in a midwife capacity.~~

~~(7) "Supervision" means the physical presence within the patient care unit of a preceptor as defined in Section 467.003(12), F.S., or faculty member, who assumes clinical responsibility for the practice of the student midwife being supervised, and who provides direction and consultation for the actions of such student midwife in the preceptor's or faculty member's area of clinical expertise.~~

~~(8) "Three year training program" means not less than 90 credit hours.~~

~~(9) "Two year reduced training program" means not less than 60 credit hours.~~

(6)~~(10) "Four month P~~p~~re-licensure course" means a course of study offered by an approved midwifery program which meets the requirements of Chapter 64B24-4, F.A.C. ~~an approved program of not less than 15 credit hours which meets the requirements of these rules.~~

~~(11) "Approved program" means a midwifery school or a midwifery training program which is approved by the department pursuant to Section 467.205, F.S.~~

Rulemaking Authority 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.001, Amended 7-25-96, Formerly 59DD-4.001, Amended 10-11-04, 4-26-16.

64B24-4.002 Approval of Midwifery Programs ~~Training Program~~.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.002, F.A.C. FOR CURRENT TEXT)

(1) APPROVAL OF MIDWIFERY PROGRAMS. The department shall approve a midwifery program which:

(a)1. demonstrates that it is currently accredited pursuant to s. 467.205(1)(c), F.S. and is licensed by the Commission for Independent Education pursuant to Chapter 1005, F.S. and the rules promulgated thereunder; or,

2. is a public institution in the state of Florida, operating in compliance with Chapter 1004, F.S. and the rules promulgated thereunder; and,

(b) demonstrates that the education and training to be offered meets or exceeds the education and clinical training requirements of s. 467.009, F.S. and Rules 64B24-4.006, F.A.C. and 64B24-4.007, F.A.C.; and,

(c) demonstrates that the program is in compliance with the administrative and non-curricular requirements of Rule 64B24-4.008, F.A.C.; and,

(d) submits a completed application on form DH-MQA XXXX, "Appliction for Midwifery Program Approval," (04/2022) incorporated herein by reference, which may be obtained from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399, or from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/licensing or at https://www.flrules.org/Gateway/reference.asp?No=XXXX. To complete this application online, visit https://flhealthsource.gov/mqa-services.

(2) PROVISIONAL APPROVAL OF MIDWIFERY PROGRAMS. The department shall provisionally approve a midwifery program for a period not exceeding five years, which:

(a)1. demonstrates that it is currently seeking accreditation pursuant to s. 467.205(1)(c), F.S.; and,

a. is licensed or provisionally licensed by the Commission for Independent Education pursuant to Chapter 1005, F.S. and the rules promulgated thereunder; or,

b. is a public institution in the state of Florida, operating in compliance with Chapter 1004, F.S. and the rules promulgated thereunder; and,

(b) demonstrates that the education and training to be offered meets or exceeds the education and clinical training requirements of s. 467.009, F.S. and Rules 64B24-4.006, F.A.C. and 64B24-4.007, F.A.C.; and,

(c) demonstrates that the program is in compliance with the administrative and non-curricular requirements of Rule 64B24-4.008, F.A.C.; and,

(d) Submits a completed application on form DH-MQA XXXX, "Application for Provisional Midwifery Program Approval."

(e) A provisionally approved midwifery program may be granted full approval upon demonstration that the program:

1. has remained in compliance with Rules 64B24-4.006, 64B24-4.007, and 64B24-4.008, F.A.C.; and,

2. has attained a passage rate on an approved licensing examination of within three percent of the national average passage rate for first-time test takers in their first graduating class; and,

3. demonstrates that it has been accredited, pursuant to s. 467.205(1)(c), F.S.; and,

4. submits a completed application on form DH-MQA XXXX, "Application for Midwifery Program Approval."

(3) APPROVED MIDWIFERY PROGRAM REVIEW; PROBATIONARY STATUS; RESCISSION OF MIDWIFERY PROGRAM APPROVAL. The department shall periodically review approved and provisionally approved midwifery programs, and may take corrective action by placing the school on probationary status or rescinding approval pursuant to s. 467.205, F.S.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.002, 59DD-4.002, Amended 10-11-04, 4-26-16, _____.

64B24-4.003 Acceptance into Approved Midwifery ~~Training~~ Programs.

(1) An approved midwifery program may accept for training students who:

(a) Have a high school diploma or it's equivalent; and,

(b) Demonstrate competency in communication and computation by:

1. Having taken and passed three college-level credits each of math and English; or,

2. Passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.

(2) An approved midwifery program may reduce the required period of training for a student pursuant to Section 467.009(3), F.S., for a student who can demonstrate their prior qualifications or training, as follows:

(a) For a student who is licensed under Chapter 464, F.S. as a registered nurse or licensed practical nurse, courses taken to be so licensed from an accredited program as defined in Section 464.003(1), F.S. or an approved program as defined in Section 464.003(4), F.S. may be considered by the approved midwifery program.

(b) For a student who has completed all, or a portion of a course of study in nursing, courses from an accredited program as

defined in Section 464.003(1), F.S. or an approved program as defined in Section 464.003(4), F.S. may be considered by the approved midwifery program.

(c) For a student who has completed all or a portion of a course of study in midwifery, courses completed with a midwifery training program in another state which is accredited by an accrediting body pursuant to s. 467.205(1)(c), F.S. may be considered by the approved midwifery program.

(3) An approved midwifery program must ensure that the overall education and training of any graduate from a course of study that has been reduced for for prior qualification or training has met or exceeded the education and clinical training requirements of s. 467.009, F.S. in order to graduate.

~~To be accepted into a department approved midwifery training program, the program shall evidence that the applicant has taken and received a passing grade in three college level credits each of math and English, or can demonstrate competencies in communication and computation by passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.~~

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.009(3), 467.205 FS. History–New 1-26-94, Formerly 61E8-4.003, 59DD-4.003, Amended 4-26-16,_____.

64B24-4.005 Faculty.

The faculty of each approved midwifery training program shall be comprised of, at a minimum, a licensed midwife who is actively teaching, and either a certified nurse midwife, or a board certified physician licensed under Chapter 458 or 459, F.S., who has actively practiced obstetrics within the last 4 years.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.005, 59DD-4.005, Amended 4-26-16, Repealed.

64B24-4.006 Minimum Education Statndards for Approved Midwifery Programs ~~Curriculum Guidelines and Educational Objectives.~~

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.006, F.A.C. FOR CURRENT TEXT)

(1) A course of study offered by an approved midwifery program must evidence the development of knowledge, skills, and professional behavior in the following areas:

(a) Primary management, collaborative management, referral and medical consultation, pursuant to Section 467.009(1)(b)1., F.S.;

(b) Antepartal, intrapartal, postpartal, and neonatal care, pursuant to Section 467.009(1)(b)2., F.S.;

(c) Family planning and gynecological care, pursuant to Section 467.009(1)(b)3., F.S.;

(d) Common complications of in the antepartum, intrapartum, and postpartum periods, pursuant to Section 467.009(1)(b)4.; F.S., and,

(e) Professional responsibilities of the midwife, pursuant to Section 467.009(1)(b)5., F.S.

(2) A course of study offered by an approved midwifery program must include classroom instruction in the following subject areas:

(a) Obstetrics, pursuant to Section 467.009(1)(a)1., F.S.;

(b) Neonatal pediatrics, pursuant to Section 467.009(1)(a)2., F.S.;

(c) Basic sciences, pursuant to Section 467.009(1)(a)3., F.S.;

(d) Female reproductive anatomy and physiology, pursuant to Section 467.009(1)(a)4., F.S.;

(e) Behavioral sciences, pursuant to Section 467.009(1)(a)5., F.S.;

(f) Childbirth education, pursuant to Section 467.009(1)(a)6., F.S.;

(g) Community care, pursuant to Section 467.009(1)(a)7., F.S.;

(h) Epidemiology, pursuant to Section 467.009(1)(a)8., F.S.;

(i) Genetics, pursuant to Section 467.009(1)(a)9., F.S.;

(j) Embryology, pursuant to Section 467.009(1)(a)10., F.S.;

(k) Neonatology, pursuant to Section 467.009(1)(a)11., F.S.;

(l) Applied pharmacology, pursuant to Section 467.009(1)(a)12., F.S.;

(m) Medical and Legal aspects of midwifery, pursuant to Section 467.009(1)(a)13., F.S.;

(n) Gynecology and women's health, pursuant to Section 467.009(1)(a)14., F.S.;

(o) Family planning, pursuant to Section 467.009(1)(a)15., F.S.;

(p) Nutrition during pregnancy and lactation, pursuant to Section 467.009(1)(a)16., F.S.;

(q) Breastfeeding, pursuant to Section 467.009(1)(a)17., F.S.; and,

(r) Basic nursing skills, pursuant to Section 467.009(1)(a)18, F.S.

(3) A course of study offered by an approved midwifery program must include clinical training which meets the requirements of Rule 64B24-4.007, F.A.C.

(4) A course of study offered by an approved midwifery program must be based on a curriculum which:

(a) Is consistent with principles of learning and educational practices;

(b) Reflects the stated philosophy and objectives of the midwifery training program;

(c) Has stated educational objectives which ensure minimum education standards are met;

(d) Integrates the development of knowledge, skills and professional behavior required by Rule 64B24-4.006(1), F.A.C., the classroom instruction required by Rule 64B24-4.006(2), and the clinical training required by Rule 64B24-4.006(3), F.A.C. into a logical sequence which leads students to the attainment of competency in the practice of midwifery, as evidenced by the attainment of educational objectives;

(e) Incorporates the core competencies of the Midwives Alliance of North America, "The Midwives Alliance Core Competencies" (12/2014), incorporated herein by reference and available at http://mana.org/about-us/core-competencies and http://www.flrules.org/Gateway/reference.asp?No=Ref-06687; and,

(f) Incorporates the core competencies of the American College of Nurse Midwives, "Core Competencies for Basic Midwifery Practice" (03/2020), incorporated herein by reference and available at http://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000050/ACNMCoreCompetenciesMar2020_final.pdf and http://www.flrules.org/Gateway/reference.asp?No=RefXXXXXX, insofar as they relate to collaborative management, referral and consultation with Certified Nurse Midwives.

(5) A course of study offered by an approved midwifery program must be comprised of at least 90 credit hours.

(6) A course of study offered by an approved midwifery program must be reviewed annually by program administration, faculty, and students to ensure that the curriculum and educational objectives are sufficient at ensuring the competency of graduates completing the course of study.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.009, 467.205 FS. History–New 1-26-94, Formerly 61E8-4.006, 59DD-4.006, Amended 9-10-02, 10-11-04, 4-26-16,_____.

64B24-4.007 Minimum Clinical Training Standards for Approved Midwifery Programs.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.007, F.A.C. FOR CURRENT TEXT)

(1) PROGRAM REQUIREMENTS. Approved midwifery programs must:

(a) Integrate clinical training as a part of the curriculum and offered course of study, pursuant to Rule 64B24-4.006(3)(d), F.A.C.

(b) Conduct clinical training in hospitals or alternative birth settings, pursuant to Section 467.009(6)(a), F.S. Alternative birth settings may include homes, birth centers, clinics, and offices.

(c) Obtain and maintain current contractual agreements with each hospital or alternative birth setting in which clinical training is to be conducted.

(d) Designate a faculty member to be available for student consultation during clinical training.

(e) Ensure an adequate number of preceptors are available for clinical training, such that no preceptor provides direct supervision for more than two students during any training where direct supervision is required.

(2) REQUIRED TRAINING. Clinical training must include:

(a) Student demonstration of competency in the assessment and differentiation between low-risk and high risk pregnancies, pursuant to 467.009(6)(b), F.S. Risk assessment and differentiation must be demonstrated in accordance with Rule 64B24-7.004, F.A.C.

(b) Observation of 25 patients in the intrapartal period, pursuant to s. 467.009(5)(b), F.S.

(c) Fifty (50) neonatal examinations.

(d) Five (5) vaginal sutures.

(e) The management and care of patients under the direct supervision of a preceptor pursuant to Section 467.009(5)(a), F.S.,

including 50 patients in the prenatal period, 50 patients in the intrapartal and immediate postpartum period, and 50 patients in the postpartal period. No more than five percent (5%) of the required management and care resulting in required transfer under Rule 64B24-7.004, F.A.C. may be counted toward meeting these requirements. The patients need not be different in each period.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.007, 59DD-4.007, Amended 9-10-02, 10-11-04, 4-26-16, _____.

64B24-4.008 Administration of Approved Midwifery Programs ~~Administrative Procedures.~~

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-4.008, F.A.C. FOR CURRENT TEXT)

(1) FACULTY AND ADMINISTRATION. Approved midwifery programs must:

(a) specify the lines of authority in the organizational structure governing the program;

(b) specify the duties and responsibilities of the director of the program;

(c) employ adequate faculty to teach all subjects within the course of study pursuant to Rule 64B24-4.006, F.A.C. and supervise clinical training required by Rule 64B24-4.007, F.A.C. Faculty must include a midwife licensed under Chapter 467, F.S., and either a certified nurse midwife licensed under Chapter 464, F.S. or a physician licensed under Chapter 458 or 459, F.S., who has actively practiced obstetrics within the past four years;

(d) demonstrate adequate fiscal accountability for the operation of the program; and,

(e) develop and maintain clear admission, enrollment, promotion, and retention policies.

(2) FACILITIES AND RESOURCES. Approved midwifery programs must demonstrate that they have and continuously maintain:

(a) adequate classroom, laboratory, library, and office space;

(b) adequate equipment for instructional and clinical use;

(c) library holdings which include current professional journals and other appropriate holdings; and,

(d) education materials which shall include a variety of current teaching aids for both group and self instructional use.

(3) RECORDKEEPING. Approved midwifery programs must have an organized system of record making and record keeping which includes, at a minimum:

(a) information on student acceptance, enrollment, and progress through the course of study and clinical training; and

(b) faculty preceptor assignment relative to classroom instruction and clinical training.

(c) Upon request of a student or a graduate, the program shall furnish a copy of the student's final record to the department.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.008, 59DD-4.008, Amended 4-26-16,_____.

64B24-4.001 Definitions.

(1) “Clinical expertise” means demonstrated proficiency in a specialized area of direct patient care.

(2) “Clinical learning experience” means faculty planned and supervised instruction of students during which students function in a midwifery capacity with patients.

(3) “Credit hour” means one hour of credit representing 15 hours of classroom teaching or 30 hours of clinical learned experience.

(4) “Facility” means any establishment or institution in which students in an approved program obtain clinical learning or observational experiences.

(5) “Faculty” means the teaching staff in an educational institution who are qualified by education and experience in the areas which they teach.

(6) “Observational experience” means learning experience planned and directed by program faculty during which students do not function in a midwife capacity.

(7) “Supervision” means the physical presence within the patient care unit of a preceptor as defined in Section 467.003(12), F.S., or faculty member, who assumes clinical responsibility for the practice of the student midwife being supervised, and who provides direction and consultation for the actions of such student midwife in the preceptor’s or faculty member’s area of clinical expertise.

(8) “Three year training program” means not less than 90 credit hours.

(9) “Two year reduced training program” means not less than 60 credit hours.

(10) “Four month pre-licensure course” means an approved program of not less than 15 credit hours which meets the requirements of these rules.

(11) “Approved program” means a midwifery school or a midwifery training program which is approved by the department pursuant to Section 467.205, F.S.

Rulemaking Authority 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.001, Amended 7-25-96, Formerly 59DD-4.001, Amended 10-11-04, 4-26-16.

64B24-4.002 Approval of Training Program.

(1) Provisional approval for a term not to exceed five years shall be granted by the department to an organization to initiate a midwifery training program when it has presented documentation satisfactory to the department that it meets the accreditation requirements of Chapter 467, F.S., and the requirements for faculty, curriculum, clinical training and administration as set forth in these rules.

(2) Training programs which have been granted provisional approval may be granted full approval upon demonstration to the department they are in compliance with established standards of the department, and at least 80 percent of the first graduating class who took the licensing examination achieved a passing score.

(3) A training program may be placed on probationary status if at any time the department determines that the program falls below established standards, or fewer than 80 percent of the midwifery students in the most recent graduating class who took the licensing examination achieved a passing score. Probationary status shall be on an individual basis for a specified period of time not to exceed 12 months.

(4) The department shall rescind approval of any training program which fails to meet standards established in Chapter 467, F.S., or these rules, or fails to make satisfactory progress for corrections of deficiencies within the probationary period.

(5) The department shall, at least once every three (3) years, audit the program to determine compliance with Chapter 467, F.S., and these rules.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.002, 59DD-4.002, Amended 10-11-04, 4-26-16.

64B24-4.003 Acceptance into Training Program.

To be accepted into a department approved midwifery training program, the program shall evidence that the applicant has taken and received a passing grade in three college level credits each of math and English, or can demonstrate competencies in communication and computation by passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.009(3), 467.205 FS. History–New 1-26-94, Formerly 61E8-4.003, 59DD-4.003, Amended 4-26-16.

64B24-4.005 Faculty.

The faculty of each approved midwifery training program shall be comprised of, at a minimum, a licensed midwife who is actively teaching, and either a certified nurse midwife, or a board certified physician licensed under Chapter 458 or 459, F.S., who has actively practiced obstetrics within the last 4 years.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.005, 59DD-4.005, Amended 4-26-16.

64B24-4.006 Curriculum Guidelines and Educational Objectives.

(1) The curriculum shall be an organized pattern of classroom instruction and clinical training consistent with principles of learning and educational practices which reflects the stated philosophy and objectives of the training program.

(2) Standards for midwifery programs shall include: the core competencies established by the American College of Nurse Midwives, "Core Competencies for Basic Midwifery Practice" (effective 12/2012), and the Midwives Alliance of North America, "The Midwives Alliance Core Competencies" (effective 12/2014), incorporated herein by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06686, and http://www.flrules.org/Gateway/reference.asp?No=Ref-06687, respectively; and a component on the law and rules which govern the practice of midwifery in Florida.

(3) The administration and faculty of the training program shall formulate and adopt educational objectives that ensure curriculum guideline requirements will be met.

(4) Training program objectives shall identify competencies expected of graduates from the program and serve as the basis of program development. Course objectives shall state expected behavioral outcomes of the student, serve as the basis for course development and student evaluation, and evidence direct relationship to training program objectives.

(5) All training program objectives shall be reviewed annually by the administration, faculty and students and revised if necessary.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.009, 467.205 FS. History–New 1-26-94, Formerly 61E8-4.006, 59DD-4.006, Amended 9-10-02, 10-11-04, 4-26-16.

64B24-4.007 Clinical Training.

(1) Clinical learning experiences shall be planned and assigned to be sequential to, or simultaneous with classroom instruction.

(2) Clinical learning experiences shall include a variety of clinical settings and facilities within the State of Florida such as homes, birth centers, clinics, offices and hospitals.

(3) Clinical experiences shall be conducted under the direct supervision of a preceptor. No preceptor shall be assigned more than two students during any clinical experience.

(4) It shall be the responsibility of the program to obtain and maintain current contractual agreements with each facility utilized for clinical training to insure provision of the appropriate clinical experience necessary to fulfill the requirements of this chapter.

(5) The student midwife shall undertake the care of 50 women in each of the antepartal, intrapartal and postpartal periods, but the same women need not be seen through all 3 periods. The intrapartum period includes labor, birth, and the immediate postpartum. No more than five percent (5%) of the required intrapartal managements shall include transfers in active labor.

(6) The student midwife shall undertake the neonatal examination of 50 newborns.

(7) The student midwife shall observe an additional 25 women in the intrapartal period.

(8) Each student midwife shall have a designated program faculty member available for periodic consultation during preceptorship.

(9) The student shall perform 5 vaginal sutures.

Rulemaking Authority 467.005, 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.007, 59DD-4.007, Amended 9-10-02, 10-11-04, 4-26-16.

64B24-4.008 Administrative Procedures.

(1) The midwifery school shall specify the lines of authority in the organizational structure governing the program, define its placement within the institution where the training program is conducted, and demonstrate:

(a) Duties and responsibilities of the director of the program;

(b) Admission, promotion, and retention policies for students;

(c) Fiscal accountability for the effective operation of the training program;

(d) Provisions for classroom space, laboratories, equipment, library, office space for instructors and administrators;

(e) Library holdings which shall consist of current professional journals and other appropriate holdings as determined by the midwifery school;

(f) Education materials which shall include a variety of current teaching aids for both group and self instructional use; and,

(g) An organized system of record making and record keeping which includes, but is not limited to, information on students, faculty, preceptors, and facilities relative to classroom instruction and clinical training.

(2) Upon request of a student or a graduate, the program shall furnish a copy of the student's final record to the department.

Rulemaking Authority 456.004(5), 467.205(2) FS. Law Implemented 467.205 FS. History–New 1-26-94, Formerly 61E8-4.008, 59DD-4.008, Amended 4-26-16.

64B24-4.010 Four-month Pre-licensure Course.

(1) Four month pre-licensure programs must be approved by the department and shall include, at a minimum:

(a) Content review and demonstration of proficiency in the core competencies established by the American College of Nurse Midwives and the Midwives Alliance of North America;

(b) A Florida Laws and Rules Component;

(c) Provisions for five supervised labor and deliveries and ten supervised prenatal visits by each course participant.

(2) Upon completion, the applicant shall provide the department an official transcript sent directly from the approved program which shall include course titles, grades received, dates of attendance and date of completion.

Rulemaking Authority 456.004(5) FS. Law Implemented 467.0125 FS. History–New 1-26-94, Formerly 61E8-4.010, 59DD-4.010, Amended 10-11-04, 4-26-16.

64B24-7.001 Definitions.

Rulemaking Authority 467.005 FS. Law Implemented 467.005 FS. History–New 7-14-94, Formerly 61E8-7.001, 59DD-7.001, Amended 9-11-02. Repealed _____.

64B24-7.005 Informed Consent for Licensed Midwifery Services.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-7.005, F.A.C. FOR CURRENT TEXT)

(1) Before providing midwifery services or accepting a patient into care, a licensed midwife must obtain the informed consent of the patient. To obtain informed consent, the midwife must provide to the patient:

(a) their educational background, training and experience in the practice of midwifery;

(b) the current status of their financial responsibility pursuant to Rule 64B24-7.013, F.A.C. and the amount of professional liability insurance coverage carried;

(c) an explanation of requirements for acceptance into care and for continuing care, including a description of normal pregnancy, labor and delivery, that consultation, referral, transfer of care or collaborative management for prenatal and postpartum services may be required pursuant to Rule 64B24-7.004, F.A.C., and that transfer of care may result in delay in treatment or an increase of the severity of medical problems or complications arising during pregnancy, labor, and delivery;

(d) an explanation of the benefits of natural childbirth related to avoiding potential injury from invasive procedures, anesthesia, or surgical intervention;

(e) the nature, benefits, and risks of the care to be provided;

(f) the necessity of a complete medical, health, obstetrical and maternity history;

(g) the requirement for risk assessment on an ongoing basis;

(h) the requirement of regular prenatal visits; and,

(i) the requirement to develop an Individual Emergency Care Plan.

(2) Documentation of the patient's informed consent, made on form DH-MQA 1047, "Informed Consent for Licensed Midwifery Services" (11/2021), incorporated herein by reference, must be included in the patient's record. A copy of the form may be obtained from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399 or from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/ or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.014, 467.015(1)(a), 467.016 FS. History–New 7-14-94, Formerly 61E8-7.005, 59DD-7.005, Amended 5-31-01, 9-11-02, .

64B24-7.006 Planned Out-of-Hospital Births Occuring at Home.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-7.006, F.A.C. FOR CURRENT TEXT)

(1) For out-of-hospital births which are planned to occur at the home of the patient, the licensed midwife must:

(a) encourage the patient to have medical care available from a health care practitioner experienced in obstetrics throughout the prenatal, intrapartal and postpartal periods;

(b) visit the home of the patient by 36 weeks of pregnancy to ensure that:

1. the home is safe, clean and conducive to the health of the patient and newborn;
2. the area used for labor and delivery is sufficiently lighted, ventilated, and free from drafts;
3. the area used for labor and delivery is near restroom facilities, including handwashing facilities and a toilet, and that restroom facilities are in working order;
4. the area to be used for labor and delivery is clear of obstruction, and is large enough to allow ample work space;
5. the area to be used for labor and delivery is free from insects;
6. the home has safe, clean sleeping arrangements for the newborn; and,

(c) ensure that appropriate supplies are on hand for use at the time of delivery and early postpartum; and,

(d) furnish and ensure the following are clean and ready for use during labor and delivery:

1. sterile obstetrical pack;

2. bulb syringe;
3. oxygen;
4. eye prophylaxis, pursuant to Section 383.04, F.S.; and,
5. vitamin K prophylaxis.

(2) The licensed midwife must document the patient's choice for at-home birth, the date of completion of the home visit, and the outcome of the home visit in the patient's record.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.006, 59DD-7.006, Amended 9-11-02, _____.

64B24-7.007 Responsibilities ~~of Midwives~~ During the Antepartum Period.

~~(1)~~ During the antepartum period, ~~T~~the licensed midwife ~~shall~~must:

(~~a~~1) ~~Require each patient to have a complete history and physical examination which includes:~~Complete an initial risk assessment, pursuant to Rule 64B24-7.004(3), F.A.C.;

(2) ensure that each patient has had appropriate diagnostic testing or screening and document testing or screening in the patient's record, which includes:

~~1.~~(a) a ~~P~~pap smear current within the last three years;~~.~~

~~2. Serological screen for syphillis.~~

~~3. Ghonorrhea and clamydia screening.~~

~~4.~~ (b) ~~B~~blood group testing, including Rh factor and antibody screening;~~.~~

~~5.~~ (c) a ~~C~~complete blood count (CBC);~~.~~

~~6.~~ (d) a ~~R~~rubella titer;~~.~~

~~7.~~ (e) a ~~U~~urinalysis with culture;~~.~~

~~8.~~ (f) ~~S~~sickle cell screening, ~~for~~ if the patient is part of an at-risk population; and,~~.~~

~~9. Screen for hepatitis B surface antigen (HBsAG).~~

~~10. Screen for HIV/AIDS.~~

(g) screening for chlamidya, gonnorrhea, hepatitis B, HIV/AIDS, and syphillis, pursuant to Rule 64D-3.042, F.A.C., or document the patient's objection to screening in the patient's record;

(~~b~~3) inform the patient of prenatal screening requirements for metabolic disorders, other hereditary and congenital disorders, and enviornmental risk factors pursuant to ss. 383.14(1)(b) and 383.011(1)(e), F.S., and:

(a) ~~Conduct~~ complete the Healthy Start Prenatal Risk Screening procedures pursuant to Rule 64C-7.009(2), F.A.C. and document the screning in the patient's record pursuant to 64C-7.010(2), F.A.C.; or,~~interview or assure that each patient has been previously screened.~~

(b) document the patient's objection to the Healthy Start prenatal risk screening in the patient's record, pursuant to 64C-7.008, F.A.C.;

(~~c~~4) ~~Provide counseling and~~ offer screening and counseling, and document screening or counseling in the patient's record related to ~~the following~~:

~~1.~~ (a) ~~N~~neural tube defects;~~.~~

~~2.~~ (b) Group B Streptococcus;~~.~~

~~3.~~ (c) Chroinic villus sampling (CVS) or genetic amniocentesis ~~for women~~, if the patient is 35 years of age or older at the time of delivery;~~.~~

~~4.~~ (d) ~~N~~nutritional counseling;~~.~~

~~5.~~ (e) ~~C~~childbirth preparation;~~.~~

~~6.~~ (f) ~~R~~risk assessment ~~F~~factors as defined in Rule 64B24-7.004, F.A.C.;~~.~~

~~7.~~ (g) ~~C~~common discomforts of pregnancy; and,~~.~~

~~8.~~ (h) ~~D~~danger signs of pregnancy;~~.~~

(~~d~~5) ensure that each patient has had appropriate follow-up testing, screening, and counseling and document the testing, screening or counseling in the patient's record, which includes:

~~1.~~(a) ~~H~~hematocrit or hemoglobin testing ~~levels~~ at 28 and 36 weeks gestation;~~.~~

~~2.~~(b) ~~D~~diabetic screening between 24 and 28 weeks gestation; and,~~.~~

~~3.~~(c) If the patient is Rh negative:

1. ~~A~~antibody screening ~~for Rh negative mothers,~~ at 28 weeks gestation;

2. ~~C~~counseling ~~and~~ to encourage RhoGAM prophylaxis, and,~~.~~

3. ~~In those clients~~if the patient declines~~ing~~ RhoGAM prophylaxis, an ~~repeat~~ antibody screening at 36 weeks.

(~~e~~6) ~~R~~require prenatal visits:

1. every four weeks until 28 weeks gestation;~~,~~

2. every two weeks from 28 to 36 weeks gestation; and,

3. weekly from 36 weeks until delivery, which include the following procedures and examinations, and the documentation of those procedures and examinations in the patient's record:.

(a.)Wweight;.

(b.)Bblood pressure;.

(c.)Uurine dip stick for protein and glucose earch visit with leukocytes, ketones, and nitrites as indicated;.

(d.)Ffundal height measurements;.

(e.)Ffetal heart tones and rate;.

(f.)Aassessment of edema and patellar reflexes, when indicated;.

(g.)Indication of weeks' gestational age and size correlation;.

(h.)Determination of fetal presentation, for visits occuring during or after 29 weeks gestational age;.

(i.)Nnutritional assessment;.

(j.)Aassessment of subjective symptoms of pregnancy induced hypertension (PIH), urinary tract infection (UTI), and preterm labor.

(37) An assessment of thedocument the Eexpected Ddate of Ddelivery (EDD) and gestational age in the patient's record shall be done by 20 weeks, if practical, according tobased on:

(a) the patient's Last normal menstrual period;.

(b) the date of conception, if known;

(bc) Reference to the statement of uuterine sizeenlargement determined by recorded measurements of the uterine fundus;recorded during the initial exam.

(ed) Hearing detection of fetal heart tones at eleven weeks with a Doppler ultrasound; or,unit, if one is available, and patient gives consent.

(d) Recording of quickening date.

(e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.

(fe) Hearing the detection of fetal heart tones at twenty weeks with a fetoscope;.

(48) Ifprovide counseling and encourage the use of ultrasound to determine a reliable EDD, if the EDD cannot be established by the above criteria; and,then the licensed midwife shall encourage the patient to have an ultrasound for EDD.

(59) consult, refer, or transfer care of patients presenting with certain conditions during the antepartum period as required by Rule 64B24-7.004(5), F.A.C.The midwife shall refer a patient for consultation to a physician with hospital obstetrical priveleges if any of the following conditions occur during the pregnancy:

(a) Hematocrit of less than 33% at 37th week gestation or hemoglobin less than 11gms/100mL.

(b) Unexplained vaginal bleeding.

(c) Abnormal weight change defined as less than 12 or more than 50 pounds at term.

(d) Non-vertex presentation persisting past 37th week of gestation.

(e) Gestational age between 41 and 42 weeks.

(f) Genital herpes confirmed clinically or by culture at term.

(g) Documented asthma attack.

(h) Hyperemesis not respondive to supportive care.

(i) Any other severe obstetrical, medical, or surgical proglem.

(6) The midwife shall transfer a patient if any of the following conditions occur during the pregnancy:

(a) Genetic or congenital abnormalities or fetal chromosomal disorder.

(b) Multiple gestation.

(c) Pre-eclampsia.

(d) Intrauterine growth retardation.

(e) Thrombophlebitis.

(f) Pyelonephritis.

(g) Gestational diabetes confirmed by abnormal glucose tolerance test.

(h) Laboratory evidence of Rh sensitization.

(7) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and the midwife deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall continue with the licensed midwife.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.007, 59DD-7.007, Amended 9-11-02, 7-21-03, 9-18-06, _____.

64B24-7.008 Responsibilities ~~of Midwives~~ During the Intrapartum Period.

(1) ~~Upon initial assessment, the midwife shall make an assessment of the patient which includes~~ During the intrapartum period, the licensed midwife must:

(a) ~~D~~determine the onset of labor and document the onset of labor in the patient's record;~~.~~

(b) ~~R~~review the patient's prenatal records;~~.~~

(c) ~~A~~assess the condition of the patient~~mother~~ and fetus;~~.~~

(d) ~~A~~assess the delivery environment. If the patient is to deliver at home, the assessment must confirm requirements for home delivery are met, pursuant to Rule 64B24-7.006, F.A.C.; and,~~.~~

(e) ~~Perform~~complete a sterile vaginal examination~~s~~ to ~~initially~~ assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of membranes.

(2) ~~Throughout~~ During active labor, the midwife ~~shall~~must:

(a) ~~M~~maintain a safe and hygenic delivery environment;~~.~~

(b) ~~P~~provide nourishment, ~~rest~~ and support to the patient as indicated by the patient's condition, and facilitate rest;~~.~~

(c) ~~M~~monitor, assess and ~~record~~document the ~~status~~ of labor and the ~~maternal~~patient and fetal condition, as follows:~~.~~

~~(d) Measure~~ 1. Monitor the patient's blood pressure and document the patient's blood pressure ~~every~~ hourly, or more frequently if indicated by ~~unless~~ significant change~~s~~ in patient contidition or additional symptoms present; ~~require more frequent assessments~~.

~~(e) Take~~ 2. Monitor the patient's pulse and document the patient's pulse in the patient's record every 2 hours while membranes are intact and temperature is normal~~, then~~ and every hour after ruptrure of membranes;~~.~~

~~(f) Take~~ 3. Monitor the patient's temperature and document the patient's record every 4 hours, ~~or more frequently if maternal condition warrants, and~~ every hour if elevated to 100~~º F~~ degrees Farenheit or above, or more frequently if indicated by significant change in patient condition or additional symptoms present;~~.~~

~~(g)~~ 4. Monitor and document in the patient's record ~~E~~estimated fluid intake and urinary output ~~at least~~ every 2 hours, or more frequently if indicated by significant changes in patient condition or additional symptoms present;~~.~~

~~(h)~~ 5. Assess for ~~hydration and~~ edema and document abnormal edema in the patient's record;~~.~~

~~(3) The midwife shall assess and record the status of labor as follows:~~

~~(a) Measure~~ 6. Monitor and document in the patient's record the frequency, duration, and intensity of ~~the~~ contractions every half hour, ~~and~~ or more frequently if indicated by significant change in patient condition or additional symptoms present;~~.~~

~~(b) Observe and record~~ 7. Monitor vaginal discharge and document any abnormality in discharge in the patient's record;~~.~~

~~(c)~~ 8. Monitor fetal heart tones ~~during and following contractions to assess fetal condition according to the following schedule after admission to care for labor~~:

~~1.~~ a. Every hour during the latent phase;~~.~~

~~2.~~ b. Every 30 minutes during the active phase of the first stage;~~.~~

~~3.~~ c. Every 15 minutes during transition;~~.~~

~~4.~~ d. Every 5 minutes during the second stage; and,~~.~~

~~5.~~ e. Immediately after the appearance of amniotic fluid in the vaginal discharge; and,~~.~~

~~(d)~~ 9. Palpate the abdomen for the position and level of the presenting part;~~.~~

~~(e)~~ 10. ~~Perform sterile vaginal examinations to assess~~ Monitor cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

(~~4~~3) The licensed midwife must consult, refer or transfer care of patients presenting with certain conditions during the intrapartum period, as required by Rule 64B24-7.004(6), F.A.C. ~~Risk factors shall be assessed throughout labor to determine the need for phsyician consultation or emergency transport. The midwife, shall consult, refer or transfer to a physician with hospital obstetrical priveleges if the following occur during labor, delivery or immediately thereafter:~~

~~(a) Premature labor, meaning labor occurring at less than 37 weeks of gestation.~~

~~(b) Premature rupture of membranes, meaning rupture occuring more than 12 hours before onset of regular active labor.~~

~~(c) Non-vertex presentation.~~

~~(d) Evidence of fetal distress.~~

~~(e) Abnormal heart tones.~~

~~(f) Moderate or severe meconium staining.~~

~~(g) Estimated fetal weight less than 2,500 grams or greater than 4,000 grams.~~

~~(h) Pregnancy induced hypertension which is defined as 140/90, or an increase of 30 mm hg systolic or 15 mm~~

~~hg diastolic above baseline.~~

~~(i) Failure to progress in active labor:~~

~~1. First stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara.~~

~~2. Second stage: more than 2 hours without progress in descent.~~

~~3. Third stage: more than 1 hour.~~

~~(j) Severe vulvar varicosities.~~

~~(k) Marked edema of cervix.~~

~~(l) Active bleeding.~~

~~(m) Prolapse of the cord.~~

~~(n) Active infectious process.~~

~~(o) Other medical or surgical problems.~~

(~~5~~4) The licensed midwife may perform the following operative procedures, and must document any operative procedure completed in the patient's record:~~The midwife shall not perform any operative procedure other than:~~

(a) ~~Artificial rupture of the membranes~~ an amniotomy, when the fetal head is engaged and well applied to the cervix in active labor and four or more centimeters dilated;~~.~~

(b) ~~Clamping and cutting the umbilical cord~~an omphalotomy;~~.~~

(c) an ~~E~~episiotomy, when indicated; and,~~.~~

(d) ~~S~~suturing~~e to repair~~ of first and second degree lacerations.

(~~6~~5) The licensed midwife ~~shall~~must not perform any other operative procedures, attempt to correct fetal presentations by external or internal version, or

~~(7) The midwife shall use only prescription drugs pursuant to Rule 64B24-7.011, F.A.C.~~

~~(8) The midwife shall not~~ use artificial, forcible or mechanical means to assist the birth.

(6) The licensed midwife may administer medicinal and prescription drugs pursuant to Rule 64B24-7.011, F.A.C.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.008, 59DD-7.008, Amended 9-11-02, 7-21-03, _____.

64B24-7.009 Responsibilities During the Postpartum Period.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-7.009, F.A.C. FOR CURRENT TEXT)

(1) IMMEDIATE POST-DELIVERY RESPONSIBILITIES. Immediately following delivery, the licensed midwife must:

(a) clear the airway of the newborn;

(b) perform an omphalotomy;

(c) obtain a cord blood sample for diagnostic testing, with the patient's consent;

(d) complete Apgar testing and document the Apgar score of the newborn at one minute and five minutes in the patient's record;

(e) weigh and document the weight of the newborn in the patient's record;

(f) instill prophylactic for the prevention of neonatal opthamalia into each eye and document that the prophylactic was instilled in the patient record, or document that prophylactic was not instilled and retain the written objection of the parent, pursuant to Section 383.04, F.S.;

(g) administer vitamin K prophylaxis and document the administration in the patient's record, or document that the patient declined the administration of vitamin K prophylaxis in the patient's record;

(2) IMMEDIATE POSTPARTUM OBSERVATION AND RESPONSIBILITIES. The licensed midwife must remain with the patient and newborn for at least two hours following delivery, and until the conditions of the conditions of the patient and newborn are stable, as evidenced by normal blood pressure, pulse, respiration, and bladder function, a firm uterine fundus, and normal lochial discharge of the patient and established respirations, normal temperature, and sucking of the newborn. During this observation period, the licensed midwife must:

(a) examine the newborn and report any abnormalities or problems to the physician, including low Apgar score, and document any abnormalities or problems in the patient's record;

(b) observe for signs of hemorrhaging in the patient and document any signs in the patient's record;

(c) inspect the expelled placenta to ensure that it is intact and free from abnormalities and document the condition of the expelled placenta in the patient's record;

(d) palpate the uterine fundus of the patient to ensure that it is firm and document in the patient's record;

(e) provide for infant bonding with parent; and,

(f) instruct the patient in self-care and care of the newborn, including feeding and cord care.

(3) GENERAL POSTPARTUM RESPONSIBILITIES AND FOLLOW-UP CARE. During the antepartum period, the licensed midwife must:

(a) complete a follow-up visit between 24 and 48 hours following delivery, unless conditions warrant an earlier visit, or arrange for such a visit to be made by a physician, certified nurse midwife, registered nurse, or another licensed midwife and document the visit or arranged visit in the patient record;

(b) instruct the patient to have a postpartum examination within 6 to 8 weeks after delivery, or sooner if any abnormalities exist or problems arise;

(c) ensure laboratory testing of the cord blood sample is ordered if the patient consented to the sample, including blood group testing, Rh factor and antibody screening, and a direct Coombs test, if the mother is Rh negative;

(d) obtain the results of the laboratory tests of the cord blood sample if the patient consented and is Rh negative, and ensure that the patient received RHo immune globulin within 72 hours of delivery if the newborn is Rh positive, and document in the patient's record;

(e) inform the patient of postnatal screening requirements for metabolic disorders, other hereditary and congenital disorders, and enviornmental risk factors pursuant to Sections 383.14(1)(b) and 383.011(1)(e), F.S.;

(f) complete the Healthy Start Postnatal Risk Screening procedures pursuant to Rule 64C-7.009(2), F.A.C. and:

1. document the screening, pursuant to 64C-7.010(2), F.A.C., in the patient's record; or,
2. record the objection of the parent to the Healthy Start postnatal risk screening, pursuant to Rule 64C-7.008, F.A.C., in the patient's record;

(g) collect and transmit a blood specimen pursuant to Rule 64C-7.002, F.A.C., or record and report the objection of the patient to collection of a blood specimen for screening pursuant to s. 383.14(4), F.S.

(h) register the birth of the child pursuant to Rule 64V-1.006, F.A.C., if the birth occurred outside a facility and document in the patient's record;

(i) ensure the patient has been rescreened for sexually transmitted diseases if required by Rule 64D-3.042, F.A.C., and document in the patient's record; and,

(j) report any inflammation or discharge in the eyes occuring within two weeks of birth, pursuant to s. 383.06, F.S. and document in the patient's record; and,

(k) for planned out-of-hospital births, ensure that the informational pamphlet on infant and childhood eye and vision disorders has been provided to the patient, pursuant to s. 456.0496, F.S.

(4) A licensed midwife must refer, consult or transfer care of patients or newborns presenting with certain conditions as required by Rule 64B24-7.004(7), F.A.C .

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 382.013, 383.04, 383.06, 383.14(1)(b), 383.011(1)(e), 467.015 FS. History–New 7-14-94, Formerly 61E8-7.009, Amended 3-20-96, Formerly 59DD-7.009, Amended 9-11-02, _____.

64B24-7.010 Collaborative Management for Prenatal and Postpartum Care.

(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-7.010, F.A.C. FOR CURRENT TEXT)

(1) A collaborative management agreement to provide prenatal and postpartum care must be documented in the patient's record, and must contain at a minimum:

(a) The name, license number, practice address, and phone number of the licensed midwife;

(b) The name, license number, practice address, and phone number of the physician;

(c) The name, address, and phone numbers of the hospital where the physician holds obstetrical privileges;

(d) The name, age, address, and phone number of the patient;

(e) All parts of the risk assessment required by Rule 64B24-7.004(2), F.A.C.; and

(f) Explanation of any required discontinuation of care, if care was discontinued pursuant to the criteria established in the agreement.

(2) A midwife entering a collaborative management agreement may use Form DH-MQA 1057, "Collaborative Management Agreement for Prenatal and Postpartum Care," (11/2021), to meet the requirements of this section. The form is incorporated herein by reference, and may be obtained from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399, or via the web at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources, or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX.

(3) A midwife may enter into a collaborative management agreement to provide prenatal and postpartum care within a specific healthcare facility or under the supervision of a physician group. Any such collaborative management agreement must be documented in writing, and must:

(a) Be maintained on the premises of the health care facility;

(b) Be updated at least annually;

(c) Be readily accessible to the licensed midwife and the physician or physicians responsible for supervision;

(d) Provide for supervision of the licensed midwife and direction of the care of patients by the facility or physician group; and,

(e) Include a plan for access to complete obstetrical services.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015(2) FS. History–New 7-14-94, Formerly 61E8-7.010, 59DD-7.010, Amended 9-11-02, _____

64B24-7.011 Administration of Medicinal and Prescription Drugs.

(1) ~~A midwife licensed prior to October 1, 1992 may administer certain medicinal drugs during intrapartal, postpartal, and neonatal care, if prior to administering such drugs, the licensee has successfully completed a course in the practice of administering medicinal drugs with an approved training program.~~

~~(2) A midwife may administer only those drugs which have been prescribed by a physician licensed under Chapter 458 or 459, F.S., pursuant to Chapter 499, F.S., and dispensed at a pharmacy permitted by Chapter 465, F.S. and by a pharmacist licensed pursuant to Chapter 465, F.S.~~

~~(3) The~~ A licensed midwife may administer the following:

(a) ~~P~~postpartum oxytocics;~~.~~

(b) ~~P~~prophylactic ompthalmic medication;~~.~~

(c) ~~O~~oxygen;~~.~~

(d) ~~V~~vitamin K;~~.~~

(e) RhO Immune Globulin;~~.~~

(f) ~~L~~local anesthetic; and,~~.~~

(g) medicinal drugs not requiring a prescription pursuant to Ch. 499, F.S.

(4~~2~~) ~~Other medications as prescribed by the physician.~~ A licensed midwife may administer drugs requiring prescription pursuant to Ch. 499, F.S., when they are:

(a) prescribed to the patient by a physician who is licensed under Ch. 458 or 459, F.S.; and,

(b) dispensed at a pharmacy and by a pharmacist which are licensed under Ch. 465, F.S.

(4~~3~~) ~~After administering any medicinal drug, the~~A licensed midwife ~~shall~~must document administration of any medicinal or prescription drug in the ~~medical record of the patient~~patient's record. At a minimum, documentation of each administration must include:

(a) the date and time of administration;

(b) the type of medicinal or prescription drug~~(s)~~ administered;~~.~~

(c) the name of the medicinal or prescription drug administered;~~.~~

(d) the prescribing physician, dispensing pharmacy, and prescribed dosage, if administering a prescription drug;

(e) the dosage administered;~~.~~

(f) the method of administration;~~.~~

(g) the location of the injection site or topical application, if applicable; ~~the date and time~~and,

(h) the ~~drug's~~ effect of the drug on the patient.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.006(2), 467.015(3) FS. History-New 7-14-94, Formerly 61E8-7.011, 59DD-7.011, Amended 9-11-02, _____.

64B24-7.012 Requirement for Insurance; Financial Responsibility of Midwives

(1) ~~Except as provided herein, applicants for licensure, applicants for licensure reactivation, and applicants for licensure renewal shall at the time of application submit proof of~~ Licensed midwives must carry professional liability insurance coverage pursuant to s. 456.048(1), F.S., in an amount not less than $100,000.00 per claim, with a minimum aggregate of not less than $300,000.00, ~~from~~through:

(a) an authorized insurer as defined under ~~Section~~s. 624.09, F.S.;~~,~~

(b) ~~from~~ a surplus lines insurer as defined under ~~Section~~s. 626.914, F.S.;~~,~~

(c) ~~from~~ a risk retention group as defined under ~~Section~~s. 627.942, F.S.;~~,~~

(d) ~~from~~ the Joint Underwriting Association established under 627.351(4), F.S.;~~,~~ or,

(e) ~~through~~ a plan of self-insurance as provided in ~~Section~~s. 627.357, F.S.

(2) A licensed midwife ~~who~~ is exempt from the requirement to carry professional liability insurance pursuant to s. 456.048(2), F.S., if the licensed midwife:

(a) practices exclusively as an officer, employee, or agent of the Federal Government or the state or its agencies or subdivisions, who ~~shall submit proof to the department that coverage equivalent to or exceeding this section is maintained by her employer on her behalf~~ maintains insurance coverage for the licensed midwife that is equivalent to or exceeds the requirements of this section. For the purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of ~~Section~~s.768.28(15), F.S., or who is a volunteer under ~~Section~~s.110.501(1), F.S.; or,

(b) holds a license in inactive status and is not practicing; or,

(~~3~~c) ~~A licensed midwife who~~ practices only in conjunction with a teaching ~~duties~~ position at an approved midwifery school ~~shall submit proof to the department that~~ and to the extent that such practice is incidental and necessary to teaching duties, provided the approved midwifery school maintains coverage for the licensed midwife that is equivalent to or exceeds the requirements of this section; or, ~~equivalent to or exceeding this section is maintained by her employer on her behalf. A licensed midwife may engage in the practice of midwifery only to the extent that such practice is incidental to and a necessary part of duties in conjunction with the teaching position in the school unless the midwife provides proof of coverage as provided by subsection (1) or (2).~~

(4d) ~~A licensed midwife who~~ does not practice midwifery in ~~this state~~Florida; or,

(e) Does not have malpractice exposure in Florida. ~~shall submit written proof to the department that the licensed midwife does not practice midwifery and shall be required to submit proof of professional liability coverage as required by this section to the department at least 15 days prior to practicing midwifery in this state.~~

(3) A licensed midwife must submit attestation of professional liability insurance coverage or exemption from the requirement for insurance on Form DH-MQA 5074, "Financial Responsibility Attestation for Licensed Midwives," (04/2022), incorporated herein by reference and available from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399, or from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX or by online submission via the website located at https://flhealthsource.gov/mqa-services, when the licensee is no longer exempt from the requirement to carry professional insurance pursuant to this rule, when the licensee becomes exempt from the requirement to carry insurance pursuant to this rule, and at each license renewal.

Rulemaking Authority 409.908(12)(c), 456.048(1), 456.004(5) FS. Law Implemented 456.048, ~~409.908(12),~~ 467.014 FS. History-New 7-14-94, Formerly 59DD-7.013, 61E8-7.013, Amended 5-4-98, 4-26-99, 911-02, _____.

64B24-7.014 Records and Reports

(1) CREATION OF PATIENT RECORDS. ~~The~~ A licensed midwife ~~shall keep~~must make a patient record for each patient that receives midwifery services. Patient records must be current while the patient is under the care of the licensed midwife.

(a) DEMOGRAPHIC INFORMATION; RISK ASSESSMENT; EMERGENCY CARE; CONSULTATION, REFERRAL AND TRANSFER. Each patient record must include the following:

1. ~~of each patient served which shall contain~~ the name, address and telephone number of the patient;~~,~~

2. the informed consent ~~form,~~ of the patient, pursuant to Rule 64B24-7.005, F.A.C.;

3. a copy of the patient's Individual Emergency Care Plan, pursuant to Rule 64B24-7.005, F.A.C.;

4. a copy of the patient's collaborative management agreement to provide prenatal and postpartum care, if the midwife entered into a collaborative management agreement pursuant to 64B24-7.010(1), F.A.C.

5. documentation of initial and ongoing risk assessment, pursuant to Rule 64B24-7.004, F.A.C.;

6. documentation of any consultation, referral, or transfer of care when required by Rule 64B24-7.004, F.A.C.;

and,

7. documentation of the administration of any medicinal or prescription drug, pursuant to Rule 64B24-7.011(4), F.A.C.

(b) ANTEPARTAL RECORDS. Records kept during the antepartum period must include:

1. documentation of appropriate diagnostic screening during the antepartum period, pursuant to Rule 64B24-7.007(2), F.A.C.;

2. a copy of the Healthy Start Prenatal Risk Screening or the patient's objection to screening, pursuant to Rule 64B24-7.007(3), F.A.C.;

3. documentation of screening or counseling provided pursuant to Rule 64B24-7.007(4), F.A.C.

4, documentation of all required follow-up testing, screening, and counseling pursuant to Rule 64B24-7.007(5), F.A.C.

5. documentation of all prenatal visits, pursuant to Rule 64B24-7.007(6), F.A.C.; and,

6. Documentation of the expected date of delivery (EDD) and gestational age, pursuant to Rule 64B24-7.007(7), F.A.C..

(c) INTRAPARTAL RECORDS. Records kept during the intrapartum period must include:

1. documentation of the onset of labor, pursuant to Rule 64B24-7.008(1)(a), F.A.C>;

2. documentation of the status of labor and the patient and fetal condition, pursuant to Rule 64B24-7.008(2), F.A.C.; and,

3. documentation of any operative procedure performed, pursuant to Rule 64B24-7.008(4), F.A.C.

(d) POSTPARTAL RECORDS. Records kept during the postpartum period must include:

1. documentation that a blood cord sample was taken for diagnostic testing or documentation that the patient did not consent to testing, pursuant to Rule 64B24-7.009(1)(b), F.A.C.;

2. the Apgar scores of the newborn taken at one and five minutes, pursuant to Rule 64B24-7.009(1)(a), F.A.C.;

3. the weight of the newborn, pursuant to Rule 64B24-7.009(1)(e), F.A.C.;

4. documentation that prophylactic for the prevention of neonatal ophthalmia was instilled, or the written objection of the patient, pursuant to Rule 64B24-7.009(1)(f), F.A.C.;

5. documentation that vitamin K prophylaxis was administered, or documentation that the patient declined the administration, pursuant to Rule 64B24-7.009(1)(f), F.A.C.;

6. documentation of abnormalities observed immediately postpartum, pursuant to Rule 64B24-7.009(2), F.A.C.;

7. documentation of a completed follow-up visit, pursuant to Rule 64B24-7.009(3)(a), F.A.C.;

8. documentation that laboratory testing of the blood cord sample was ordered, the results of that laboratory testing, and documentation of the administration of Rho immune globulin, if required, pursuant to Rule 64B24-7.009(3)(c) and (d), F.A.C.;

9. documentation that the patient was informed of postnatal screening requirements for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors, pursuant to Rule 64B24-7.009(3)(e), F.A.C., and that the Healthy Start Postnatal Risk Screening was completed or that the parent objected, pursuant to Rule 64B24-7.009(3)(f), F.A.C.;

10. documentation that the birth of the child was registered, pursuant to 64B24-7.009(3)(h), for births occurring outside a facility;

11. documentation of any required screening for sexually transmitted disease, pursuant to Rule 64B24-7.009(3)(i), F.A.C.; and,

12. documentation of any discharge in the eyes occurring within two weeks of birth, pursuant to Rule 64B24-7.009(3)(j), F.A.C. ~~a copy of the Certificate of Live Birth; and an emergency care plan for delivery specific to each patient. The emergency care plan shall be completed by the midwife and the patient at initial consultation or before 36 weeks of pregnancy on Form DH MQA 1077, Emergency Care Plan for Delivery (08/15), incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref_06544.~~

(2) REQUIRED REPORTING OF PRENATAL AND POSTNATAL RISK SCREENING, NEWBORN SCREENING. Licensed midwives must report healthy start prenatal and postnatal risk screening results or patient objection(s), and newborn screening specimen collection(s) or patient objection to newborn screening, pursuant to Rule 64C-7, F.A.C.

(3) PATIENT RECORD RETENTION AND TRANSFER.

(a) Each ~~The~~ patient~~'s~~ record~~s~~ ~~shall~~must be retained for ~~a minimum of~~ 5 years ~~from~~following the date of last entry in the record~~s~~.

(b) Copies of a patient's record must be made available to that patient upon request. If the patient is a minor, copies of a patient's record must be made available to that patient's parent or guardian, pursuant to s. 1014.04(1)(f), F.S.

(c) In the event of the death of a licensed midwife:

1. Within 90 days of ~~a midwife's~~ the death, the licensed midwife's estate or agent ~~shall~~must ~~place~~transfer all patient records of the deceased ~~midwife in~~ to ~~the care of~~ another Florida licensed midwife who will act as the custodian of records.

2. Within 30 days of the transfer of patient records, the licensed midwife acting as the custodian ~~shall~~must notify the department and each patient in writing of ~~the death~~ the transfer of records, and that they have assumed custodianship. ~~and~~ Patient notification must include the name, address, and telephone number of the person from whom copies of patient records may be obtained.

~~1.~~ 3. The licensed midwife acting as custodian must retain each patient record in their custodianship for a period of 5 years following the date custodianship is assumed. ~~The original patient records of the deceased midwife shall be maintained~~

4. Copies of retained patient records must be made available by the licensed midwife acting as custodian to that patient upon request. If the patient is a minor at the time of request, copies of a patient's record must be made available to that patient's parent or guardian, pursuant to s. 1014.04(1)(f), F.S. ~~and copies made available to patients for a period of 5 years from receipt.~~

(~~4~~d) ~~Medical records of~~ In the event a licensed midwife ~~who is~~ terminate~~s~~~~ing~~ or relocate~~s~~~~ing~~ their private practice outside the service area, the licensed midwife must:

1. retain patient records and notify each patient in writing within 30 days of the termination or relocation. Patient notification must include the name, address, and telephone number where copies of patient records may be obtained; or,

2, transfer all patient records within 30 days to another practicing, licensed midwife in the service area who will act as the custodian of records. The licensed midwife must notify the department and each patient in writing of the transfer of records. Patient notification must include the name, address, and telephone number of the licensed midwife assuming custodianship, from whom copies of patient records may be obtained, and records must be retained for a period of 5 years following the date custodianship is assumed; or,

3. for licensed midwives whose records were retained by a facility or group practice prior to termination of practice or relocation, ensure that patient records were retained by the facility or group practice and notify patients of record retention by the facility or group practice prior to termination of practice or relocation. Patient notification must include the name, address, and telephone number of the facility or group practice where records may be obtained. ~~(5) Within one month of a licensed midwife's termination of practice or relocation of practice outside the service area, the midwife shall advise patients in writing of the termination or relocation and the name, address and telephone number of the person from whom copies of records may be obtained.~~

(~~6~~4) ANNUAL REPORT OF MIDWIFERY PRACTICE. ~~Each~~ ~~l~~Licensed midwive~~s~~~~fe, temporary certificate holding midwife, and midwife supervising a student midwife in assisting in childbirth that occurs in an out-of-hospital setting, shall~~ must submit ~~file~~ an annual report no later than July 31 of each year for each preceding year, ~~for the prior fiscal year~~ on Form DH-MQA 5011, "Annual Report of Midwifery Practice," (~~06/2017,~~11/2021). The form is incorporated herein by reference and available from the council office at 4052 Bald Cypress Way, Bin C-06, Tallahassee, FL 32399, or from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources or ~~available~~ at https://www.flrules.org/Gateway/reference.asp?No=Ref-xxxxx

~~(7) The Department shall send a notice of noncompliance to each licensee who fails to meet the reporting requirement.~~

(5) ADVERSE INCIDENT REPORTING FOR PLANNED OUT-OF-HOSPITAL BIRTHS. Each licensed midwife must report adverse incidents occurring in planned out-of-hospital births pursuant to Rule 64-5.001, F.A.C. and s. 456.0495, F.S.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 456.0495, 467.004, 467.019 FS. History-New 7-14-94, Formerly 61E8-7.014, Amended 3-20-96, Formerly 59DD-7.014, Amended 9-11-02, 3-22-16, 10-5-17, _____.

THE FULL TEXT OF THE PROPOSED RULE IS:
(SUBSTANTIAL REWRITE OF THE RULE; SEE 64B24-7.004, F.A.C. FOR CURRENT TEXT)

64B24-7.004 Risk Assessment; Emergency Care; Consultation, Referral, and Transfer.

(1) DEFINITIONS.

(a) "Consultation" means communication between a licensed midwife and a physician with hospital obstetrical privileges for the purposes of assessing whether the patient may be expected to have a normal pregnancy, labor, and delivery.

(b) "General Emergency Care Plan" means a written plan developed pursuant to Section 467.017(1), F.S. made on form DH-MQA 1077, "General Emergency Care Plan for Licensed Midwives," (06/2025), incorporated herein by reference, which may be obtained from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/ or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX. which is effective until the development of an Individual Emergency Care Plan. The General Emergency Care Plan must be submitted to the Department with any application for license, renewal, or reinstatement, pursuant to Section 467.017, Florida Statutes.

(c) "Individual Emergency Care Plan" means a written plan developed with and for a specific patient pursuant to Section 467.017(1), F.S., which shall be made on form DH-MQA 5075, "Individual Emergency Care Plan" (06/2025), incorporated herein by reference, which may be obtained from the website located at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/ or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX. An Individual Emergency Care Plan must be complete and documented in the patient's record by 36 weeks of pregnancy.

(d) "Referral" means a request made by a licensed midwife to a physician with hospital obstetrical privileges for the purposes of assessing whether a patient may be expected to have a normal pregnancy, labor, and delivery.

(e) "Risk assessment factors" means the factors which determine whether a patient may be expected to have a normal labor and childbirth as defined in Section 467.003(9), F.S. These factors are enumerated in Section II: Risk Assessment Factors, on form DH-MQA 5072, "Initial and Ongoing Risk Assessment for Midwifery Care" (06/2025), incorporated herein by reference, which may be obtained at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/ or at https://www.flrules.org/Gateway/reference.asp?No=XXXXX.

(f) "Risk assessment score" means the score obtained by using the risk assessment factors, which determines whether a patient may be expected to have a normal pregnancy, labor, and delivery. The risk assessment scoring is specified in Section II: Risk Assessment Factors, on form DH-MQA 5072, "Initial and Ongoing Risk Assessment for Midwifery Care" (06/2025).

(g) "Transfer" or "transfer of care" means a required discontinuation of care by a licensed midwife when a patient can no longer be expected to have a normal pregnancy, labor, delivery, or the patient or neonate is not expected to stabilize postpartum, where care is assumed by another health care provider. Transfer of a patient is completed by executing the General Emergency Care Plan or the Individual Emergency Care Plan of the patient if completed or any time after 36 weeks of pregnancy.

(2) INITIAL RISK ASSESSMENT. A licensed midwife must complete a risk assessment upon acceptance of a patient into care. The initial assessment must include obtaining the patient's detailed medical history, performing a physical examination, and determining the patient's risk assessment score.

(a) Initial risk assessment must be documented in the patient's record immediately following acceptance into care.

(b) A patient with a risk assessment score of less than three may be expected to have a normal pregnancy, labor, and delivery and may continue in the midwife's care.

(c) A patient with a risk assessment score of three or higher may not continue in the midwife's care without consultation or referral. For the patient to continue in the midwife's care, the midwife and physician must reach a joint decision that the patient may be expected to have a normal pregnancy, labor, and delivery, and document the consultation or referral in the patient's record.

(3) RISK ASSESSMENT FOR PRENATAL AND POSTPARTUM COLLABORATIVE MANAGEMENT. A licensed midwife may assess risk and enter into a collaborative management agreement with a physician with hospital obstetrical privileges to provide prenatal and postpartum care to patients, including patients with a risk assessment score of three or higher, pursuant to Section 467.015(2), F.S. and Rule 64B24-7.010, F.A.C. A collaborative

management agreement to provide prenatal and postpartum care must assess risk to the patient, and contain at a minimum:

(a) the number of pregnancies and live births of the patient;

(b) identification of risks to the patient;

(c) rationale for deviation from risk assessment factors and scoring;

(d) the plan to manage the patient's care;

(e) the expected outcome; and,

(f) the criteria which would require discontinuation prenatal and postpartum care.

(4) ONGOING RISK ASSESSMENT. Licensed midwives must continue assessing risk for patients in their care.

(a) Ongoing risk assessment must be documented in the patient's record using risk assessment factors as defined in Rule 64B24-7.004(1)(e), F.A.C.

(b) A patient with a cumulative risk assessment score of three or higher may not continue in the midwife's care without consultation or referral. The patient may continue in the midwife's care if the midwife and physician reach a joint decision that the patient may be expected to have a normal pregnancy, labor, and delivery, and the midwife documents the consultation or referral and determination in the patient's record.

(5) ANTEPARTAL RISK ASSESSMENT; CONSULTATION, REFERRAL, AND TRANSFER. Licensed midwives must assess for specific risks associated with conditions presenting antepartum, and are required to consult, refer, or transfer upon presentation of certain conditions.

(a) A licensed midwife must transfer care of the patient if any of the following conditions present antepartum:

1. known or suspected genetic or congenital abnormalities;
2. fetal chromosomal disorders;
3. multiple gestation;
4. pre-eclampsia;
5. intrauterine growth restriction;
6. gestational age exceeding 42 weeks;
7. thrombophlebitis; or
8. laboratory evidence of Rh sensitization.

(b) A patient presenting any of the following during the antepartum period may not continue in the midwife's care without consultation or referral. The patient may continue in the midwife's care if the midwife and physician reach a joint decision that the patient may be expected to have a normal pregnancy, labor, and delivery, and the midwife documents the consultation or referral and determination in the patient's record.

1. hematocrit of less than 33% at 37 weeks gestational age;
2. hemoglobin less than 11g/100ml at 37 weeks gestational age;
3. unexplained vaginal bleeding;
4. weight change of less than 12 or more than 50 pounds at term;
5. non-vertex presentation persisting past 37 weeks gestational age;
6. gestational age between 41 and 42 weeks;
7. genital herpes confirmed clinically or by culture at term;
8. documented asthma attack;
9. gestational diabetes confirmed by an abnormal finding on a glucose tolerance test;
10. hyperemesis that does not respond to supportive care; or
11. other obstetrical, medical, or surgical complications not requiring transfer under Rule 64B24-7.004(5)(a), F.A.C.

(6) INTRAPARTAL RISK ASSESSMENT; CONSULTATION, REFERRAL AND TRANSFER. Licensed midwives must assess for specific risks associated with conditions presenting intrapartum, and are required to consult, refer, or transfer upon presentation of certain conditions.

(a) If any of the following conditions present intrapartum, the licensed midwife must transfer care of the patient:

1. onset of labor at less than 37 weeks gestational age;
2. non-vertex presentation in labor;
3. evidence of fetal distress that is non-responsive to intrauterine resuscitative measures;
4. moderate to severe meconium staining;
5. particulate meconium staining;

6. pregnancy induced hypertension (140/90, or an increase of 30 mm/hg of systolic or 15mm/hg diastolic above baseline); or,
7. cord prolapse.

(b) A patient presenting any of the following during the intrapartum period my not continue in the midwife's care without consultation or referral. The patient may continue in the midwife's care if the midwife and physician make a joint determination that the patient may be expected to have a normal labor and childbirth as defined in s. 467.003(9), F.S., and the midwife documents the consultation or referral and determination in the patient's record.

1. rupture of membranes occurring more than 12 hours before onset of regular active labor;
2. abnormal fetal heart tones;
3. fetal weight estimated at less than 2,500 grams or greater than 4,000 grams;
4. failure to progress (first stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara; second stage: more than two hours without progress in descent; third stage: more than one hour during active labor);
5. severe vulvar varicosity;
6. marked edema of the cervix;
7. active bleeding;
8. active infectious process; or
9. other obstetrical, medical, or surgical complications not requiring transfer under Rule 64B24-7.004(6)(a), F.A.C.

(7) POSTPARTAL RISK ASSESSMENT; CONSULTATION, REFERRAL AND TRANSFER. Licensed midwives must assess for specific risks associated with conditions presenting postpartum, and are required to consult, refer, or transfer upon presentation of certain conditions.

(a) If any of the following conditions present postpartum, the licensed midwife must transfer care pursuant to the patient's Individual Emergency Care Plan:

1. an Apgar score of less than seven at five minutes;
2. fetal weight of less than 2,500 grams;
3. signs of prematurity;
4. signs of jaundice;
5. persistent hypothermia (a body temperature of less than 97 degrees Fahrenheit by rectal measurement after two hours of life);
6. respiratory problems;
7. exaggerated tremors;
8. major congenital anomaly;
9. retained placenta; or,
10. postpartum hemorrhage.

(b) A patient or neonate presenting any of the following conditions may not continue in the midwife's care without consultation or referral. For the patient and neonate to continue in the midwife's care, the midwife and physician must make a joint determination that the condition of the patient and neonate may be expected to stabilize, and the midwife must document the consultation or referral in the patient's record.

1. signs of postmaturity;
2. any condition requiring more than four hours of postdelivery observation; or,
3. other obstetrical, medical, or surgical complications not requiring transfer under Rule 64B24-7.004(7)(a), F.A.C.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.004, 59DD-7.004, Amended 9-11-02, 2-2-06, 4-1-09, _____.

64B24-7.001 Definitions.

As used in this rule chapter, the term:

(1) “Consultation” means communication between a licensed midwife and a health care provider for the purpose of assessing a potential or actual problem relevant to the patient.

(2) “Referral” means a request made by a licensed midwife to a physician, or ARNP for an assessment of a patient to determine management for or a resolution to a problem relating to the health of the patient.

(3) “Transfer” means a formal dissolution of care to the patient by a licensed midwife which results in such care being assumed by another health care provider.

Rulemaking Authority 467.005 FS. Law Implemented 467.005 FS. History–New 7-14-94, Formerly 61E8-7.001, 59DD-7.001, Amended 9-11-02.

64B24-7.004 Risk Assessment.

(1) For each patient, the licensed midwife shall assess risk status criteria for acceptance and continuation of care. The general health status and risk assessment shall be determined by the licensed midwife by obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances along with social and psychological factors. The licensed midwife shall risk screen potential patients using the criteria in this section. If the risk factor score reaches 3 points the midwife shall consult with a physician who has obstetrical hospital privileges and if there is a joint determination that the patient can be expected to have a normal pregnancy, labor and delivery the midwife may provide services to the patient. When a client has a risk score of 3 or higher and has previously had a physician consultation for the identical risk factors in a prior pregnancy with no current changes in health or risk factors another consultation is not required.

(2) The licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the cumulative risk score reaches three points or higher and the patient is not expected to have a normal pregnancy, labor and delivery, the midwife shall transfer such patient out of his or her care. The midwife may provide collaborative care to the patient pursuant to Rule 64B24-7.010, F.A.C.

(3) The risk factors shall be scored as follows:	Score
(a) Socio-Demographic Factors.	
1. Chronological age under 16, or older than 40.	1
2. Residence of anticipated birth more than 30 minutes from emergency care.	3
(b) Documented Problems in Maternal Medical History.	
1. Cardiovascular System.	
a. Chronic hypertension.	3
b. Heart disease.	3
c. Heart disease assessed by a cardiologist which places the mother or fetus at no risk.	1
d. Pulmonary embolus.	3
e. Congenital heart defects.	3
(i) Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk.	1
2. Urinary System.	
a. Renal disease.	3
b. History of pyelonephritis.	1
3. Psycho-Neurological.	
a. History of psychotic episode adjudged by psychiatric evaluation and which required use of drugs related to its management, but not currently on medication.	1
b. Current mental health problems.	
Requiring drug therapy.	3
c. Epilepsy or seizures in the last two years.	3
d. Required use of anticonvulsant drugs.	3
e. During the current pregnancy, drug or alcohol addiction, use of addicting drugs.	3
f. Severe undiagnosed headache.	3
4. Endocrine System.	
a. Diabetes mellitus.	3
b. History of gestational diabetes.	1
c. Current thyroid disease.	
(I) Euthyroid.	1
(II) Non-Euthyroid.	3
5. Respiratory System.	
a. Chronic bronchitis.	1
(I) Current or chronic or with medication.	3
(II) Without medication or current problems.	1
b. Smoking.	
(I) 10 or less cigarettes per day.	1

(II) More than 10 cigarettes per day. 3
6. Other Systems.
a. Bleeding disorder or hemolytic disease. 3
b. Cancer of the breast in the past five years. 3
7. Documented Problems in Obstetrical History
a. Expected Date of Delivery (EDD) less than 12 months from date of previous delivery. 1
b. Previous Rh sensitization. 3
c. 5 or more term pregnancies. 3
d. Previous abortions.
(I) 3 or more consecutive spontaneous abortions. 3
(II) Two consecutive spontaneous abortions or more than three spontaneous abortions. 1
(III) 1 septic abortion. 3
e. Uterus.
(I) Incompetent cervix, with related medical treatment. 3
(II) Prior uterine surgery. 3
(III) Prior uterine surgery followed by an uncomplicated vaginal birth. 2
f. Previous placenta abruptio. 3
g. Previous placenta previa. 1
h. Severe pregnancy induced hypertension during last pregnancy. 2
i. Postpartum hemorrhage apparently unrelated to management. 3
8. Physical Findings of Previous Births
a. Stillbirth occurring at more than 20 weeks gestation or neonatal loss (other than cord accident). 3
b. Birthweight.
(I) Less than 2500 grams or two or more previous premature labors without a subsequent low risk pregnancy and full term appropriate for gestational age (AGA) infant. 3
(II) Less than 2500 grams or two or more previous premature labors with one or more full term AGA infant(s) subsequently delivered, after a low risk pregnancy. 1
(III) More than 4000 grams. 1
c. Major congenital malformations, genetic, or metabolic disorder. 3
9. Maternal Physical Findings.
a. Gestation.
(I) Of more than 22 weeks in the patient's first pregnancy (nullipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
(II) Of more than 28 weeks if the patient has had at least one previous viable birth (multipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
b. Prepregnant weight is not within the range of the following weights by height: 2

Height in Inches Without Shoes	Prepregnant Minimum Weight in Pounds	Prepregnant Maximum Weight in Pounds
56	83	143
57	85	146
58	86	150
59	89	153
60	92	157
61	95	161
62	97	166
63	100	170

64	103	175
65	106	180
66	110	185
67	113	190
68	117	196
69	121	202
70	124	208
71	128	212
72	131	217
73	135	222

c. Evidence of clinically diagnosed pathological uterine myoma or malformations, abdominal or adnexal masses. 3

d. Polyhydramnios or oligohydramnios.

(I) Prior pregnancy. 2

(II) Current pregnancy. 3

e. Cardiac diastolic murmur, systolic murmur grade III or above, or cardiac enlargement. 3

10. Current Laboratory Findings.

a. Hematocrit/Hemoglobin.

(I) Less than 31% or 10.3 gm/100 ml. 1

(II) Less than 28% or 9.3 gm/100 ml. 3

b. Sickle cell anemia. 3

c. Pap smear suggestive of dysplasia. 3

d. Evidence of active tuberculosis. 3

e. Positive serologic test for syphilis confirmed active. 3

f. HIV positive. 3

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.004, 59DD-7.004, Amended 9-11-02, 2-2-06, 4-1-09.

64B24-7.005 Informed Consent.

(1) A licensed midwife shall obtain a patient's consent for the provision of midwifery services. Such consent shall be recorded on the Informed Consent for Licensed Midwifery Services, Form DH-MQA 1047, revised 3/01, which is hereby adopted and incorporated by reference, and can be obtained from the Council of Licensed Midwifery, 4052 Bald Cypress Way, BIN #C06, Tallahassee, Florida 32399-3256.

(2) To complete the consent form, the licensed midwife shall inform the patient of:

(a) The licensee's qualifications to perform the services rendered.

(b) The nature and risks of the procedures to be used.

(c) The advantages of the procedures to be used.

(d) Professional liability insurance status.

(3) A signed copy of the consent form shall be placed in the patient's record.

Rulemaking Authority 467.005 FS. Law Implemented 467.014, 467.015(1)(a), 467.016 FS. History–New 7-14-94, Formerly 61E8-7.005, 59DD-7.005, Amended 5-31-01, 9-11-02.

64B24-7.006 Preparation for Home Delivery.

(1) For home births, the licensed midwife shall:

(a) Encourage each patient to have medical care available by a health care practitioner experienced in obstetrics throughout the prenatal, intrapartal and postpartal periods; and,

(b) Make a home visit by 36 weeks of pregnancy. The licensed midwife shall ensure that the setting in which the infant is to be delivered is safe, clean and conducive to the establishment and maintenance of health.

(2) The midwife shall prepare or cause to be prepared the following facilities to be used for delivery:

(a) The area used for labor shall be cleaned, well lighted, well ventilated and close to the toilet.

(b) The delivery area should be large enough to allow ample work space and provide privacy.

(c) The delivery area must be organized, well lighted, clean, free from drafts and insects, near handwashing facilities and clear of unnecessary furnishings.

(d) A safe, clean sleeping arrangement for the infant.

(3) The midwife shall instruct the expectant parents and ensure that appropriate supplies are on hand for use by the mother and infant at the time of delivery and early postpartum.

(4) The midwife shall have the following equipment and supplies clean and ready for use at delivery:

(a) Sterile obstetrical pack.

(b) Bulb syringe.

(c) Oxygen.

(d) Eye prophylaxis pursuant to Section 383.04, F.S.

Rulemaking Authority 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.006, 59DD-7.006, Amended 9-11-02.

64B24-7.007 Responsibilities of Midwives During the Antepartum Period.

(1) The licensed midwife shall:

(a) Require each patient to have a complete history and physical examination which includes:

1. Pap smear.
2. Serological screen for syphilis.
3. Gonorrhea and chlamydia screening.
4. Blood group including Rh factor and antibody screen.
5. Complete blood count (CBC).
6. Rubella titer.
7. Urinalysis with culture.
8. Sickle cell screening for at risk population.
9. Screen for hepatitis B surface antigen (HBsAG).
10. Screen for HIV/AIDS.

(b) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.

(c) Provide counseling and offer screening related to the following:

1. Neural tube defects.
2. Group B Streptococcus.
3. CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.
4. Nutritional counseling.
5. Childbirth preparation.
6. Risk Factors.
7. Common discomforts of pregnancy.
8. Danger signs of pregnancy.

(d) Follow-up screening:

1. Hematocrit or hemoglobin levels at 28 and 36 weeks gestation.
2. Diabetic screening between 24 and 28 weeks gestation.
3. Antibody screen for Rh negative mothers, at 28 weeks gestation. Counsel and encourage RhoGAM prophylaxis. In those clients declining RhoGAM prophylaxis repeat antibody screen at 36 weeks.

(e) Require prenatal visits every four weeks until 28 weeks gestation, every two weeks from 28 to 36 weeks gestation and weekly from 36 weeks until delivery.

(2) The following procedures and examinations shall be completed and recorded at each prenatal visit:

(a) Weight.

(b) Blood pressure.

(c) Urine dip stick for protein and glucose each visit with leukocytes, ketones, and nitrites as indicated.

(d) Fundal height measurements.

(e) Fetal heart tones and rate.

(f) Assessment of edema and patellar reflexes, when indicated.

(g) Indication of weeks' gestation and size correlation.

(h) Determination of fetal presentation after 28 weeks of gestation.

(i) Nutritional assessment.

(j) Assessment of subjective symptoms of PIH, UTI and preterm labor.

(3) An assessment of the Expected Date of Delivery (EDD) and gestational age shall be done by 20 weeks, if practical, according to:

(a) Last normal menstrual period.

(b) Reference to the statement of uterine size recorded during the initial exam.

(c) Hearing fetal heart tones at eleven weeks with a Doppler unit, if one is available, and patient gives consent.

(d) Recording of quickening date.

(e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.

(f) Hearing the fetal heart tones at twenty weeks with a fetoscope.

(4) If a reliable EDD cannot be established by the above criteria, then the licensed midwife shall encourage the patient to have an ultrasound for EDD.

(5) The midwife shall refer a patient for consultation to a physician with hospital obstetrical privileges if any of the following conditions occur during the pregnancy:

(a) Hematocrit of less than 33% at 37th week gestation or hemoglobin less than 11 gms/100 ml.

(b) Unexplained vaginal bleeding.

(c) Abnormal weight change defined as less than 12 or more than 50 pounds at term.

(d) Non-vertex presentation persisting past 37th week of gestation.

(e) Gestational age between 41 and 42 weeks.

(f) Genital herpes confirmed clinically or by culture at term.

(g) Documented asthma attack.

(h) Hyperemesis not responsive to supportive care.

(i) Any other severe obstetrical, medical or surgical problem.

(6) The midwife shall transfer a patient if any of the following conditions occur during the pregnancy:

(a) Genetic or congenital abnormalities or fetal chromosomal disorder.

(b) Multiple gestation.

(c) Pre-eclampsia.

(d) Intrauterine growth retardation.

(e) Thrombophlebitis.

(f) Pyelonephritis.

(g) Gestational diabetes confirmed by abnormal glucose tolerance test.

(h) Laboratory evidence of Rh sensitization.

(7) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and midwife deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall continue with the licensed midwife.

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.007, 59DD-7.007, Amended 9-11-02, 7-21-03, 9-18-06.

64B24-7.008 Responsibilities of Midwives During Intrapartum.

(1) Upon initial assessment, the midwife shall:

(a) Determine onset of labor.

(b) Review patient's prenatal records.

(c) Assess condition of the mother and fetus.

(d) Assess delivery environment.

(e) Perform sterile vaginal examinations to initially assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

(2) Throughout active labor the midwife shall:

(a) Maintain a safe and hygienic environment.

(b) Provide nourishment, rest and support as indicated by patient's condition.

(c) Monitor, assess and record the status of labor and the maternal and fetal condition.

(d) Measure the blood pressure every hour unless significant changes or symptoms require more frequent assessments.

(e) Take the patient's pulse every 2 hours while membranes are intact and temperature is normal, then every hour after rupture of membranes.

(f) Take the temperature every 4 hours, or more frequently if maternal condition warrants, and every hour if elevated to 100º F or above.

(g) Estimate fluid intake and urinary output at least every 2 hours.

(h) Assess for hydration and edema.

(3) The midwife shall assess and record the status of labor as follows:

(a) Measure the frequency, duration and intensity of the contractions every half hour and more frequently if indicated.

(b) Observe and record vaginal discharge.

(c) Monitor fetal heart tones during and following contractions to assess fetal condition according to the following schedule after admission to care for labor:

1. Every hour during the latent phase.

2. Every 30 minutes during the active phase of the first stage.

3. Every 15 minutes during transition.

4. Every five minutes during the second stage.

5. Immediately after the appearance of amniotic fluid in the vaginal discharge.

(d) Palpate the abdomen for the position and level of the presenting part.

(e) Perform sterile vaginal examinations to assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

(4) Risk factors shall be assessed throughout labor to determine the need for physician consultation or emergency transport. The midwife shall consult, refer or transfer to a physician with hospital obstetrical privileges if the following occur during labor, delivery or immediately thereafter:

(a) Premature labor, meaning labor occurring at less than 37 weeks of gestation.

(b) Premature rupture of membranes, meaning rupture occurring more than 12 hours before onset of regular active labor.

(c) Non-vertex presentation.

(d) Evidence of fetal distress.

(e) Abnormal heart tones.

(f) Moderate or severe meconium staining.

(g) Estimated fetal weight less than 2,500 grams or greater than 4,000 grams.

(h) Pregnancy induced hypertension which is defined as 140/90, or an increase of 30 mm hg systolic or 15 mm hg diastolic above baseline.

(i) Failure to progress in active labor:

1. First stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara.

2. Second stage: more than 2 hours without progress in descent.

3. Third stage: more than 1 hour.

(j) Severe vulvar varicosities.

(k) Marked edema of cervix.

(l) Active bleeding.

(m) Prolapse of the cord.

(n) Active infectious process.

(o) Other medical or surgical problems.

(5) The midwife shall not perform any operative procedure other than:

(a) Artificial rupture of the membranes when the fetal head is engaged and well applied to the cervix in active labor and four or more centimeters dilated.

(b) Clamping and cutting the umbilical cord.

(c) Episiotomy when indicated.

(d) Suture to repair first and second degree lacerations.

(6) The midwife shall not attempt to correct fetal presentations by external or internal version.

(7) The midwife shall use only prescription drugs pursuant to Rule 64B24-7.011, F.A.C.

(8) The midwife shall not use artificial, forcible or mechanical means to assist the birth.

Rulemaking Authority 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.008, 59DD-7.008, Amended 9-11-02, 7-21-03.

64B24-7.009 Responsibilities of the Midwife During Postpartum.

(1) Care of the newborn shall include:

(a) Clearing the airway of mucus.

(b) Clamping and cutting the umbilical cord.

(c) Obtaining a cord blood sample for laboratory testing for type, Rh Factor, and direct Coombs test when the mother is Rh negative.

(d) Assessing the newborn's condition according to Apgar scoring at one (1) minute and five (5) minutes and record the results of each assessment.

(e) Weighing the infant.

(f) Instilling prophylaxis into each eye or retain the written objection pursuant to Sections 383.04 and 383.06, F.S.

(g) Administering vitamin K prophylaxis.

(h) Examining the newborn and reporting any abnormalities or problems to the physician including low Apgar score.

(i) Providing for infant bonding with parent.

(2) The midwife shall consult, refer or transfer the infant to a physician if any of the following conditions occur:

(a) Apgar score less than 7 at 5 minutes.

(b) Signs of pre- or post-maturity.

(c) Weight: if less than 2,500 grams.

(d) Jaundice.

(e) Persistent hypothermia, meaning a body temperature of less than 97º F rectal after 2 hours of life.

(f) Respiratory problem.

(g) Exaggerated tremors.

(h) Major congenital anomaly.

(i) Any condition requiring more than 4 hours of postdelivery observation.

(3) Care of the mother shall include:

(a) Observation for signs of hemorrhage.

(b) Inspection of the expelled placenta to insure that it is intact and free from defects or abnormalities.

(c) Palpation of the fundus to insure that it is firm.

(d) The midwife shall instruct the mother in self care and care of the infant including feeding and cord care.

(4) The midwife must remain with the mother and infant for at least 2 hours postpartum, or until both the mother's and infant's conditions are stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse, respirations, bladder functioning, fundus firm and lochia normal. Infant stability is evidenced by established respirations, normal temperature, and strong sucking.

(5) If any complications arise, such as a retained placenta or postpartum hemorrhage, the midwife shall consult with a physician, or transport the patient for emergency medical care dependent upon the urgency of the situation.

(6) A follow-up visit shall be made between 24 and 48 hours following delivery, unless conditions warrant an earlier visit. The midwife may arrange for such a visit to be made by a physician, certified nurse midwife, registered nurse, or another licensed midwife. The patient shall be instructed to have a postpartum examination within 6 to 8 weeks after delivery or sooner if any abnormalities exist or problems arise.

(7) If the mother is Rh negative, the midwife shall obtain the laboratory tests results of the cord blood studies, and if the infant is Rh positive, assure and document that the mother receives Rho immune globulin within 72 hours of the delivery.

(8) The midwife shall instruct the parents regarding the requirement for the infant screening blood test for metabolic disorders. If arrangements for this screening have not been made, the midwife shall notify the county health unit or retain the written objection pursuant to Section 383.14, F.S.

(9) The midwife shall conduct the Healthy Start Postnatal Screening for the infant or assure that it will be done.

(10) Within 5 days following each birth, form DH 511, Certificate of Live Birth, available from the local county health department, must be completed and submitted to the local registrar of vital statistics.

(a) For births occurring in a hospital, birth center or other health care facility, or en route thereto, the person in charge of the facility is responsible for the preparation and filing of the certificate, and for certifying the facts of the birth therein. Within 48 hours of the birth, the midwife shall provide the facility with the medical information required for the birth certificate.

(b) For births occurring outside a facility wherein a licensed midwife is in attendance during or immediately after the delivery, the midwife shall prepare and file the certificate.

Rulemaking Authority 467.005 FS. Law Implemented 382.013, 467.015 FS. History–New 7-14-94, Formerly 61E8-7.009, Amended 3-20-96, Formerly 59DD-7.009, Amended 9-11-02.

64B24-7.010 Collaborative Management.

(1) A midwife may provide collaborative prenatal and postpartal care to women not expected to have a normal pregnancy, labor and delivery with a physician who holds hospital obstetrical privileges maintaining supervision for directing the specific course of medical treatment.

(2) Prior to engaging in collaborative management, the licensed midwife shall:

(a) Provide and document to the department that the midwife successfully completed a course on collaborative management within an approved training program.

(b) Enter into a written protocol with a physician licensed under Chapter 458 or 459, F.S., who is actively practicing obstetrics and has hospital obstetrical privileges. The protocol shall be made on the Collaborative Management Agreement form which is incorporated by reference herein, effective 7-14-94, and can be obtained from the Council of Licensed Midwifery, Department of Health, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399-3256, and shall at a minimum contain:

1. Name, address and telephone number of patient.

2. Name, address and telephone number of midwife.

3. Name, address and telephone number of physician who will maintain supervision for directing the specific plan of medical treatment as outlined in the protocol.

4. Identification of factors.

5. Rationale of the deviation from the low-risk criteria.

6. Specific course of management and expected outcome.

7. Criteria for the discontinuance of the collaborative agreement.

(c) The protocol shall be signed and dated by the patient, licensed midwife and physician. A copy of the collaborative agreement shall be placed and maintained in the patient's record.

(d) The midwife shall provide the physician with a complete copy of all patient records pertaining to this pregnancy.

(3) A licensed midwife practicing within a health care facility or under the supervision of a physician group shall establish a written collaborative management protocol prior to providing prenatal and postnatal care to women not expected to have a normal pregnancy, labor, or delivery. The written protocol shall:

(a) Be maintained on the premises of the health care facility;

(b) Be updated at least annually;

(c) Be readily accessible to the midwife and physician;

(d) Include a plan for access to complete obstetrical services; and,

(e) Be acceptable in lieu of a patient's specific collaborative management agreement.

Rulemaking Authority 467.005 FS. Law Implemented 467.015(2) FS. History–New 7-14-94, Formerly 61E8-7.010, 59DD-7.010, Amended 9-11-02.

64B24-7.011 Administration of Medicinal Drugs.

(1) A midwife licensed prior to October 1, 1992, may administer certain medicinal drugs during intrapartal, postpartal and neonatal care, if prior to administering such drugs, the licensee has successfully completed a course in the practice of administering medicinal drugs within an approved training program.

(2) A midwife may administer only those drugs which have been prescribed by a physician licensed under Chapter 458 or 459, F.S., pursuant to Chapter 499, F.S., and dispensed at a pharmacy permitted by Chapter 465, F.S., and by a pharmacist licensed pursuant to Chapter 465, F.S.

(3) The midwife may administer the following:

(a) Postpartum oxytocics.

(b) Prophylactic ophthalmic medication.

(c) Oxygen.

(d) Vitamin K.

(e) RhO Immune Globulin.

(f) Local anesthetic.

(g) Other medications as prescribed by the physician.

(4) After administering any medicinal drug, the midwife shall document in the medical record of the patient the type of drug(s) administered, name of drug, dosage, method of administration, injection site, or topical, the date and time, and the drug's effect.

Rulemaking Authority 467.005 FS. Law Implemented 467.006(2), 467.015(3) FS. History–New 7-14-94, Formerly 61E8-7.011, 59DD-7.011, Amended 9-11-02.

64B24-7.014 Records and Reports.

(1) The midwife shall keep a record of each patient served which shall contain the name, address and telephone number of patient; the informed consent form, documentation of all care given during the prenatal, intrapartum and postpartum period relevant to midwifery services; a copy of the Certificate of Live Birth; and an emergency care plan for delivery specific to each patient. The emergency care plan shall be completed by the midwife and the patient at initial consultation or before 36 weeks of pregnancy on Form DH-MQA 1077, Emergency Care Plan for Delivery (08/15), incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06544.

(2) The patient's records shall be retained for a minimum of 5 years from date of last entry in records.

(3) Within 90 days of a midwife's death, the midwife's estate or agent shall place all patient records of the deceased midwife in the care of another Florida licensed midwife who shall notify the department and each patient in writing of the death, the transfer of records, and the name, address and telephone number of the person from whom copies of records may be obtained. The original patient records of the deceased midwife shall be maintained and copies made available to patients for a period of 5 years from receipt.

(4) Medical records of a licensed midwife who is terminating or relocating their private practice shall be retained by the licensed midwife or authorized agent, which may be a successor-owner midwife, and copies made available to patients for 5 years from the date of the last entry in the records.

(5) Within one month of a licensed midwife's termination of practice or relocation of practice outside the service area, the midwife shall advise patients in writing of the termination or relocation and the name, address and telephone number of the person from whom copies of records may be obtained.

(6) Each licensed midwife, temporary certificate holding midwife, and midwife supervising a student midwife in assisting in childbirth that occurs in an out-of-hospital setting, shall file an annual report no later than July 31 for the prior fiscal year on Form DH-MQA 5011, Annual Report of Midwifery Practice (06/2017), incorporated by reference and available at https://www.flrules.org/Gateway/reference.asp?No=Ref-08601.

(7) The Department shall send a notice of noncompliance to each licensee who fails to meet the reporting requirement.

Rulemaking Authority 467.005 FS. Law Implemented 467.004, 467.019 FS. History–New 7-14-94, Formerly 61E8-7.014, Amended 3-20-96, Formerly 59DD-7.014, Amended 9-11-02, 3-22-16, 10-5-17.

64B24-7.013 Requirement for Insurance.

(1) Except as provided herein, applicants for licensure, applicants for licensure reactivation, and applicants for licensure renewal shall at the time of application submit proof of professional liability insurance coverage in an amount not less than $100,000.00 per claim, with a minimum annual aggregate of not less than $300,000.00 from an authorized insurer as defined under Section 624.09, F.S., from a surplus lines insurer as defined under Section 626.914, F.S., from a risk retention group as defined under Section 627.942, F.S., from the Joint Underwriting Association established under Section 627.351(4), F.S., or through a plan of self-insurance as provided in Section 627.357, F.S.

(2) A licensed midwife who practices exclusively as an officer, employee, or agent of the Federal Government or the state or its agencies or subdivisions shall submit proof to the department that coverage equivalent to or exceeding this section is maintained by her employer on her behalf. For purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of Section 768.28(15), F.S., or who is a volunteer under Section 110.501(1), F.S.

(3) A licensed midwife who practices only in conjunction with teaching duties at an approved midwifery school shall submit proof to the department that coverage equivalent to or exceeding this section is maintained by her employer on her behalf. A licensed midwife may engage in the practice of midwifery only to the extent that such practice is incidental to and a necessary part of duties in conjunction with the teaching position in the school unless the midwife provides proof of coverage as provided by subsection (1) or (2).

(4) A licensed midwife who does not practice midwifery in this state shall submit written proof to the department that the licensed midwife does not practice midwifery and shall be required to submit proof of professional liability coverage as required by this section to the department at least 15 days prior to practicing midwifery in this state.

Rulemaking Authority 409.908(12), 467.005 FS. Law Implemented 409.908(12), 467.014 FS. History–New 7-14-94, Formerly 59DD-7.013, 61E8-7.013, Amended 5-4-98, 4-26-99, 9-11-02.