State of Florida
Department of Health

Board of Osteopathic Medicine

Application for Initial & Renewal of Registration as Resident/Intern/Fellow Osteopathic Physician in Training Pursuant to 459.021, F.S.

Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 488-0595

Application for Registration as a Resident/Intern/Fellow

Osteopathic Physician in Training
General Information and Instructions

The following instructions are numbered to correspond with the numbered sections of the application. Each numbered instruction will give specific information regarding filling out the corresponding section of the application.

A response must be given in each section. If a question does not pertain to you, indicate N/A in that section. All questions that require a Yes/No answer must be answered either YES or NO. NOTE: We strongly recommend that the forms you complete are forms received from this office or the medical education coordinator office. "

Your application should be received by the Board Office **AT LEAST 60 DAYS PRIOR** to your training start date or the expiration of an existing training license number previously issued by the Board of Osteopathic Medicine.

BACKGROUND CHECK: You must undergo a state/national criminal history background check. All fingerprinting is done through a LiveScan provider and all fingerprints are retained by the Florida Department of Law Enforcement. Complete instructions regarding fingerprinting are attached to this application.

FEE SCHEDULE:
All fees must be made payable to the Department of Health and must be by cashiers check or money order. All fees must be encompassed in one check. Please do not send separate checks.

Initial Registration Fee:	**$100.00**
Renewal of Registration:	**$100.00**

ADDITIONAL / SUPPLEMENTAL DOCUMENTS REQUIRED:

- A copy of your diploma verifying graduation from Osteopathic Medical School (for initial applications only). Your license can not be issued until the receipt of the diploma
- A letter from your program director or coordinator verifying registration/acceptance into their training program and your dates of training. Note to program coordinators – please submit a separate letter for each applicant.
- A list of all rotation sites where you will be training while in Florida. This can be included in the letter from the program director/coordinator. Please submit a separate letter for each applicant.
- If you currently hold, or have ever held any professional or medical license in any state, US territory or foreign country you must request that verification of the license be mailed directly from the issuing state licensing entity to the Board office. A copy of your license is not considered verification. Some states are using www.Veridoc.org for verification. Please check to see if the state you are licensed in utilizes Veridoc.
- Affirmative answers to application history or background questions require additional information as denoted in the application instructions.

BOARD APPEARANCES:
Certain applicants may be required to appear before the Board of Osteopathic Medicine (Board) to discuss his or her application before a determination of licensure can be made. An appearance may be required for a variety of reasons, such as:

- Criminal or disciplinary history
- Education or post-graduate training history
- Impairment
- Other reasons as deemed necessary by the Board

Appearances are determined on a case by case basis. Board office staff do not determine the necessity of an appearance. Should your appearance be required, you will be notified of the exact date, time and location of the meeting at which your appearance is necessary.

If you believe you may be required to appear before the Board it is recommended you submit your application several months in advance of the meeting for which you wish to appear. You may view the Board's meeting dates and locations on its website at: http://floridasosteopathicmedicine.gov/meeting-information/ .

APPLICATION COMPLETION INSTRUCTIONS:

1. **Social Security Number and Health History Questions:** List your social security number and answer the questions related to health history. Any additional documentation required based on an affirmative answer is listed directly on the application page.
2. **Registration Method:** Indicate if this is an initial registration or renewal of a registration. If a renewal, please provide your current or previous training number and the name and location of the previous Florida training program.
3. **Name:** List your full name.
4. **Telephone Numbers:** List both your primary and business numbers.
5. **Mailing Address:** List the address where you receive mail.
6. **Physical Address:** This should be the address where you reside. It may be the same as the mailing address. If so, please indicate. No PO Boxes.
7. **Email Address:** Please provide an email address if you would like to be contacted via email regarding this application. **Under Florida law, email addresses are public records. If you do not want your e-mail 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**
8. **Osteopathic Medical Degree:** List the name of your Osteopathic Medical School, the city, state and graduation date.
9. **Florida Postgraduate Training Program:**
   - **a)** List the name of the hospital or institution/program where you are going to commence training. This should be the hospital or institution in the **State of Florida** for which this form is being completed. Please include the name of the educational facility as well as the name of the hospital.
   - **b)** List the full mailing address of the institution/program, including; floor numbers, room numbers, specific program areas (i.e. anesthesiology etc.). This should be the address of your official place of practice.
   - **c)** List the name of the Program Director and/or person who is your immediate supervisor.
   - **d)** List the phone number where the program director/administrator may be contacted. Include extension, if applicable.
   - **e)** List your specialty area of training.
   - **f)** List the dates you plan to begin and end your training. PLEASE NOTE: All registration numbers expire after one year. If you plan to continue your training after one year, you must submit a new application and fee.
   - **g)** Select your program type (internship, residency or fellowship).

10. **Previous Postgraduate Training:** List all postgraduate training programs you have ever participated in.
11. **Practice / Employment History:** List type of employment or a description of any non-employment period, as well as the address and dates for all employment or non-employment periods since you graduated from medical school.
12. List any license you hold or have ever held in the space provided. Attach additional sheets if necessary. You must submit an official license verification (mailed directly from the state of licensure to the Board office) for any license you now hold or have ever held in any state.
13. Answer yes or no. If yes, please provide an explanation in your own words regarding the action or incident. You must also have the state licensing entity provide all pertinent documentation, including complaints, orders, current disposition, etc.
14. Answer yes or no. If yes, please provide an explanation in your own words regarding the action or incident. Additional information may be required.
15. Answer yes or no. If yes, please provide a letter of explanation in your own words regarding the incident. You must also direct the school or training program to send a letter of explanation
16. Answer yes or no. If yes, please provide an explanation in your own words. You must also have your school or training program send a letter providing applicable details to the Board office.
17. Answer yes or no. If yes, please provide an explanation in your own words. You must also have the state licensing entity provide all pertinent documentation, including complaints, orders, current disposition, etc.
18. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

19. Answer yes or no. If yes, please provide an explanation regarding the charges on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges and current disposition.

20. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also include any documents relevant to the investigation, included the allegations of the investigation and current status.

21. Answer yes or no.

22. Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit copies of all court/arrest documents, including arrest report, official charges, and disposition.

23. Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit copies of all court/arrest documents, including arrest report, official charges, and disposition.

24. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

25. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.

26. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the US HHS office to submit all pertinent documentation directly to the Board office.

27. **Demographics:** Response to this section is self-explanatory.

28. **Citizenship:** List the country where you hold citizenship, date of and place of birth.

29. **Statement of Applicant:** Please read this section carefully and sign where indicated. If your application is not signed and dated upon receipt, it will be returned to you as incomplete.

YOU MUST NOTIFY US IMMEDIATELY OF ANY OCCURRENCES WHICH WOULD CHANGE OR AFFECT IN ANY WAY, AN ANSWER OR RESPONSE YOU HAVE GIVEN IN THE APPLICATION. FAILURE TO DO SO COULD RESULT IN THE DENIAL OR REVOCATION OF YOUR REGISTRATION.

1. Social Security Number and Health History Questions:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Osteopathic Medicine
Application for Osteopathic Physician in Training

Name:____
Last First Middle

Social Security Number:________________________________

If questions A-F are answered YES, explain in full on a separate sheet of paper. Your statement must include, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved. If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).	
A. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	Yes___ No____
B. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	Yes___ No____
C. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	Yes___ No____
D. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	Yes___ No____
E. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	Yes___ No____
F. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?	Yes___ No____

*** This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.**

APPLICATION FOR REGISTRATION AS AN OSTEOPATHIC PHYSICIAN IN TRAINING

Mail completed application and fee to:

FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
PO Box 6330
Tallahassee, FL 32314-6330

2. Registration Method - Check only one – Client 1902
[ ] Initial Registration - $100 Fee Required
[ ] Renewal of Registration - $100 Fee Required
- List the training number to be renewed: ________________
- List the previous training program name/location: ________________

3. Name: ________________
(Last) (First) (Middle)

4. Telephone Number: ________________ ________________
(Primary – area code/number) (Business – area code/number)

5. Mailing Address: ________________
(Number and Street or PO Box)
____
(City, State and Zip)

6. Physical Address: ________________
(Number and Street - NO PO Box)
____
(City, State and Zip)

7. Email Address: ________________
Under Florida law, email addresses are public records. If you do not want your e-mail 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.

8. Osteopathic Medical Degree obtained from: ________________
(Name of School)
____
(City/State)
____
(Date of Graduation – MM/DD/YYYY)

9. FLORIDA Postgraduate Training Information:

a) Name of Hospital/Training Program: ________________
(Please list the hospital/training program in FLORIDA where you plan to train)

b) Full Mailing Address: ________________
(Number and Street)
____
(City, State and Zip)

c) Program Director/Administrator: ________________

d) Program Phone Number: ________________
(Area code/number)

e) Specialty Area: ________________

f) Dates of Training: ________________
(MM/DD/YY) through (MM/DD/YY)

g) Program Type (select only one): **[ ] Internship** **[ ] Residency** **[ ] Fellowship**

10. PREVIOUS POSTGRADUATE TRAINING: List in chronological order from date of graduation from osteopathic medical school to the present all postgraduate training (internship/residency/fellowship). Attach additional sheets if necessary.

NAME OF TRAINING PROGRAM	CITY & STATE	PROGRAM TYPE (internship, residency, fellowship)	SPECIALTY AREA	AOA OR ACGME APPROVED	DATES OF ATTENDANCE		CREDIT RECEIVED Y OR N
					Began	Ended	

11. PRACTICE / EMPLOYMENT HISTORY: List in chronological order from date of graduation from osteopathic medical school to the present, all employment, non-employment and/or any unaccounted for period of time. Do not list postgraduate training. (Attach additional sheets if necessary.)

EMPLOYMENT OR NON-EMPLOYMENT (select one)	TYPE OF EMPLOYMENT OR DESCRIPTION OF NON-EMPLOYMENT	FULL MAILING ADDRESS	DATES	
			Began	Ended
[ ] Employment [ ] Non-employment				
[ ] Employment [ ] Non-employment				
[ ] Employment [ ] Non-employment				

12. Do you now hold, or have you ever held a license to practice Osteopathic Medicine or any other profession in any US State, territory or foreign country? [ ] YES [ ] NO

____
(If Yes, list profession, state, license number and date of issuance)

13. Have you ever had any professional license or license to practice Osteopathic Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [ ] NO

14. Have you ever had employment terminated for cause? [ ] YES [ ] NO

15. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign or otherwise acted against by any school, college, university or training program? [ ] YES [ ] NO

16. Was attendance in Osteopathic Medical school or any postgraduate training program for a period other than the normal curriculum or established time frame? [ ] YES [ ] NO

17. Were you required to repeat any part of your Osteopathic Medical education, or postgraduate training program for any reason? [ ] YES [ ] NO

18. Have you ever had any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or licensing authority in any state, territory or country? [ ] YES [ ] NO

19. Have you ever been convicted of, or entered a plea of guilty, nolo contendere or no contest to a crime, regardless of adjudication, in any jurisdiction? [ ] YES [ ] NO

20. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s.459.015, F. S.? [ ] YES [ ] NO

21. Are you registered with the DEA to prescribe controlled substances? ________________ [ ] YES [ ] NO

APPLICANT HISTORY – 456.0635(2), F.S.: **Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written 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 to the address below. Supporting documentation includes court dispositions or agency orders where applicable.**	
22. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #23.)	[ ] YES [ ] NO
a. If "yes" to 22, 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 22, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	[ ] YES [ ] NO
c. If "yes" to 22, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	[ ] YES [ ] NO
d. If "yes" to 22, 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", please provide supporting documentation).	[ ] YES [ ] NO
23. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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
a. If "yes" to 23, 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
24. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 24a.)	[ ] YES [ ] NO
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
25. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	[ ] YES [ ] NO
a. Have you been in good standing with a state Medicaid program for the most recent five years?	[ ] YES [ ] NO
b. Did the termination occur at least 20 years before the date of this application?	[ ] YES [ ] NO
26. Are you currently listed on the United States Department of Health and Human Services Office of 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 26.a., is the student loan default or delinquency the only reason you are listed on the LEIE?	[ ] YES [ ] NO

27. Demographics: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38295 August 25, 1978. This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other: ___________
Sex: [ ] Male [ ] Female

28. CITIZENSHIP:

a. List the country where you hold citizenship: ____

b. Birth Date: ___________ Birth Place: ____
(Month/Day/Year) (City/State/Province/Country)

29. STATEMENT OF APPLICANT:

I,___________________________________, state that I am the person referred to in the foregoing registration application and supporting documentation.

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

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 Board of Osteopathic Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

____

Signature of Applicant Date

CONFIRMATION OF RECEIPT OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

Name: ____

Profession: ____ Date of Birth: ______________
(MM/DD/YYYY)

Other last names: ____

☐ Yes ☐ No 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.

STATEMENT OF APPLICANT

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

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 Board of Osteopathic Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature: ______________________________________ Date: ______________
(MM/DD/YYYY)

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please 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 to a fingerprint scan using the livescan method;
- You can find a Livescan service provider at: **www.floridahealth.gov/licensing-and-regulation/background-screening/index.html**;
- 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;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Osteopathic Medicine is **EDOH2015Z**;
- 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:_______________________________________ Social Security Number: _________________

Aliases:____

Date of Birth: _______________ Place of Birth: ____
(MM/DD/YYYY)

Citizenship: ________________ Race: _______ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: ____________ Weight: ________ Height: _____________
(M=Male; F=Female)

Eye Color:__________ Hair Color: ______________________

Address: ____ Apt. Number: ___________

City:____ State: ___________ Zip Code: _________

Transaction Control Number (TCN#):___________________________________
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD 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 that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to 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 Persons 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 as 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 the 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, F.S., 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 my 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, disclosures 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 you additional information pertinent 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.