



**FLORIDA DEPARTMENT OF HEALTH
COUNCIL OF MEDICAL PHYSICISTS**

APPLICATION FOR REACTIVATION

General Information:

This application is to be used by licensed medical physicists who wish to change their license from an inactive status to an active status. Before submitting this application, please be sure you have completed the required continuing education. The following documentation is required for reactivation:

- Submission of a completed Application for Reactivation
- Submission of appropriate fees
- Submission of proof of required continuing education into the Department's CE tracking system, CE Broker

Fees:

All fees must be made payable to the Department of Health and must be a cashier's check or money order. All fees must be encompassed in one check. The fees required for reactivation are listed below.

<p>Clear/Inactive to Clear/Active= \$255.00 Unlicensed Activity Fee- \$5.00 Active Renewal Fee- \$ 150 Change of Status Fee- \$100</p>	<p>Delinquent/Inactive to Clear/Active= \$405.00 Unlicensed Activity Fee- \$5.00 Active Renewal Fee- \$150 Delinquent Fee- \$150 Change of Status Fee- \$100</p>
	<p>Within 120 days of current expiration the fee will be:</p> <p>Delinquent/Inactive to Clear/Active= \$560.00 Past and Current Unlicensed Activity Fee- \$10.00 Active Renewal Fee- \$150 Past Inactive Renewal Fee- \$150 Delinquent Fee- \$150 Change of Status Fee- \$100</p>

Continuing Education Requirements:

Each medical physicist licensed pursuant to Chapter 483, F.S., whose license has been on inactive status for more than 1 year shall be required to complete continuing education hours as a condition for reactivating the inactive license. The requirements are:

- Twenty four (24) clock hours of department approved, clinically related continuing education for **each biennium** on inactive status
- This requirement is in addition to submitting evidence of the continuing education required for the previous biennium in which the licensee held an active license

**Department of Health
Council of Medical Physicists
Application for Reactivation**

Mail competed application and fee to:

**Department of Health
Council of Medical Physicists**
Post Office Box 6330
Tallahassee, Florida 32399-6330

Name: _____ **License Number:** _____
(last) (first) (middle)

Mailing Address: (the address where mail and your license should be sent)

Street and number or PO Box Suite/Apt #

City State/Province Zip/Postal Code Country

Physical Address: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. If you do not have a current practice address, your mailing address will be used. When you obtain a practice address you will be required to update your online practitioner profile.

Street and number or PO Box Suite/Apt #

City State/Province Zip/Postal Code Country

Telephone: _____
Primary Alternate Cell

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.

CRIMINAL HISTORY AND MEDICAID / MEDICARE FRAUD QUESTIONS:

As required by Section 456.0635(3), FS, please answer yes or no to the questions below. If you answer yes to any of the below questions, you must 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 Council office. Supporting documentation includes court dispositions or agency orders where applicable.

1. Yes No 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 offense(s) in another state or jurisdiction? **(If you responded "no", skip to question 2.)**
- a. Yes No Are you currently enrolled in a drug court program for a felony offense that allows the withdrawal of the plea or the dismissal of the charges? (If "yes", please provide supporting documentation.)
2. Yes No 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)?

[Note: The questions below refer to terminations as a provider, not as a recipient of services.]

3. Yes No Have you been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?
4. Yes No Have you been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?
5. Yes No 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?
- A "yes" answer to any of the above questions requires the following:
 - A self-explanation for each providing accurate details (including the county and state of each termination or conviction, date of each termination or conviction).
 - Copies of supporting documentation (including court dispositions or agency orders where applicable).

Signature

Date