

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257
(850) 245-4355

GENERAL INFORMATION

Application for Public Health Laboratory Scientist (Director, Supervisor, Technologist and Technician)

HOW TO APPLY FOR FLORIDA CLINICAL LABORATORY PERSONNEL LICENSURE

1. **FLORIDA LAWS & RULES:** You may download a copy of Chapter 483, Part III, Florida Statutes at <http://www.floridasclinicallabs.gov/>. It is important to read this to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. **APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:**

Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after initial filing with the department.

3. **NATIONAL EXAM INFORMATION:**

Chapter 483, Part III, F. S., states that public health laboratory scientist applicants desiring licensure at the director, supervisor and technologist levels must take and pass a national examination. Personnel who meet the education requirements may become licensed if certified by one of these national examinations.

Director and Supervisor:

American Society of Microbiology
(202) 942-9281

National Registry of Certified Chemists
(703) 979-9001

Technologist:

American Society for Microbiology
(202) 942-9281

National Registry in Clinical Chemistry Certification
(703) 979-9001

National Registry of Microbiology Certification
in Public Health Microbiology
(202) 942-9281

If you are certified by organizations other than those listed, you may not be eligible for licensure.

4. **YES/NO QUESTIONS:**

All questions with "Yes or No" answer must be marked with either a "Yes or No". No other response is acceptable. For questions which require a brief explanation or description of "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). Certified or civil notary documentation of final disposition

to "Yes" answers is required.

5. FEDERAL PRIVACY ACT:

Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. **In this instance, disclosure of a social security number is mandatory pursuant to Title 42 United States Code, Sections 653 and 654, and sections 456.013, 409.2577 and 409.2598, F.S.** Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Barring any exemption under Florida law or federal law, social security numbers must be recorded on all professional and occupational licensure applications and will be used for license verification. **Note: If you do not fill in your social security number, your application may be delayed.**

SUPPORTING DOCUMENTS – THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:

1. Fee Schedule: A certified check, or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

Initial licensure level:

Application Fee	\$25.00
Licensure Fee	\$25.00
Unlicensed Activity Fee	\$ 5.00
Total Fee:	\$55.00

Additional Specialty to Existing Licensure Level:

Application Fee	\$25.00
Licensure Fee	\$25.00
Total Fee:	\$50.00

2. HIV/AIDS: Florida law requires that all initial licensure applicants to complete Florida Board approved courses in HIV/AIDS. In lieu of the course completion, you may submit an affidavit that the one (1) hour course will be completed within six months of licensure.

PLEASE NOTE: To obtain information for the HIV/AIDS course, contact CE Broker @ 1-877- 434-6323 or www.cebroker.com

3. Applicant Education and Training Data: Official transcripts must be sent directly to this office from your college or university. If you were educated in an institution outside of the United States, it is your responsibility to have your education evaluated to determine the U. S. equivalency.

If you have attended an accredited program or an approved technical training program that is not part of your college degree, submit a notarized copy of the training certificate you were issued or submit a notarized copy of your diploma or certificate of graduation. If you have completed a Florida training program, include the training program approval number.

NOTE: Even though you may have submitted these documents with a prior application, you may be required to resubmit them.

It is the responsibility of the applicant to know the requirements for licensure before an application is submitted. Determine what is necessary according to your own qualifications. Official transcripts must be sent directly from the school; student copies are not acceptable (see additional sections concerning foreign transcripts and U. S. equivalency). A copy of a diploma or a DD-214 (military) may document training, but the employer must verify experience. Applicants are advised to submit as much documentation of education, experience, and training with the original application.

4. Verification of Experience - (Do not include testing done in research, physician office laboratories or veterinary work.)

Forward the verification of experience form to your employer for completion. A letter from the employer may be used to document experience but it must contain all the information requested on the verification of employment form. Have your employer verify the tests you performed. This form is used to determine whether you have performed tests in the full range of each area of the laboratory.

5. Name Change: Notify the board office in writing of any change in name or address. If you have changed your name (by marriage, divorce or court order) since your last application (including license renewal), you must submit a certified copy of the marriage, divorce or court record to change your name for licensure purposes.

FOREIGN EDUCATION EQUIVALENCY REQUIREMENTS

All foreign graduates who intend to utilize credit earned in colleges or universities outside of the United States to qualify for licensure will need to provide evidence of U. S. equivalency of such credit hours. The credentials evaluation must be performed by one of the acceptable credential evaluation services and include a breakdown of all college level courses by subject. Credit hours must be listed in semester hours. The credentials evaluation should be sent directly to the board office from the evaluator. If transcripts cannot be ordered from the foreign institution, certified copies of the original documents used in the evaluation must be submitted to the agency.

NOTE: Bachelor's degrees from Puerto Rico and the Philippines do not need a credentials evaluation; however, official transcripts must be submitted from the institution.

ACCEPTABLE FOREIGN CREDENTIALS EVALUATION SERVICES:

1. JOSEF SILNY & ASSOCIATES
INTERNATIONAL EDUCATIONAL
CONSULTANTS
7101 SW 102 AVENUE
MIAMI, FL 33173
PHONE: (305) 273-1616
FAX: (305) 273-1338
2. FOUNDATION FOR INTERNATIONAL
SERVICES, INC.
14926 35th AVENUE WEST, SUITE 210
LYNWOOD, WA 98087
PHONE: (425) 248-2262
FAX: (425)248-2262
www.fis-web.com
3. EDUCATION CREDENTIAL
EVALUATORS, INC.
P. O. BOX 92970
MILWAUKEE, WI 53202-0970
PHONE: (414) 289-3400
FAX: (414) 289-3411
4. CENTER FOR APPLIED RESEARCH,
EVALUATION & EDUCATION, INC.
P.O. BOX 18358
ANAHEIM, CA 92817
PHONE: (714) 237-9272
FAX: (714) 237-9279
5. INTERNATIONAL EDUCATION
RESEARCH FOUNDATION, INC.
P. O. BOX 3665
CULVER CITY, CA 90231
PHONE: (310) 258-9451
FAX: (310) 342-7086
6. WORLD EDUCATION SERVICES, INC.
P.O. BOX 01-5060
MIAMI, FL 33101
PHONE: (305) 358-6688
www.wes.org
7. FOREIGN ACADEMIC CREDENTIALS
SERVICES, INC.
P. O. BOX 400
GLEN CARBON, IL 62034
PHONE: (618) 307-6036
(618) 656-5291
FAX: (618) 656-5292
8. WORLD EDUCATION SERVICES, INC.
BOWLING GREEN STATION
P.O. BOX 5087
NEW YORK, NY 10274-5087
PHONE: (212) 966-6311
FAX: (212) 739-6100
www.wes.org

BOARD OF CLINICAL LABORATORY PERSONNEL
-- PUBLIC HEALTH --
APPLICATION CHECKLIST

1. Application:

All questions answered on all pages and if question not applicable, mark with N/A All
"Yes" answers must be accompanied by an explanation, as instructed.
Public Records Disclosure Form SSN

2. Fees:

Please make certified check or money order payable to DOH-Board of Clinical Laboratory Personnel

3. Proof of HIV/AIDS or affidavit

4. Official College Transcript

5. Verification of National Certification

American Society of Microbiology providing Specialty

National Registry of Certified Chemists (**Supervisor ONLY**)

National Registry of Microbiology Certification in Public Health Microbiology providing Specialty

6. Verification of Employment/Experience

Please make cashier check or money order payable to the Department of Health. Return application and fees to:
Department of Health
Revenue Services
P.O. Box 6330
Tallahassee, FL 32314-6330

Mail all supporting documents/correspondence to: (documents sent separate from application/no money)
Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health Board of Clinical Laboratory Personnel

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.

Name: _____
 Last First Middle

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [] YES [] NO
2. 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
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice clinical laboratory personnel within the past five years? [] YES [] NO
4. 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 clinical laboratory personnel? [] YES [] NO
5. 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
6. 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 clinical laboratory personnel within the last five years? [] YES [] NO

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NAME: _____

6. APPLICANT EDUCATION AND TRAINING DATA:

a. Education: _____
(Name of School(s) you attended)

Did you Graduate? Yes No

Degree: _____ Year Graduated: _____

a. Name of accredited training program attended: _____

Did you complete the program? Yes No Year Completed: _____

7. NATIONAL CERTIFICATION:

American Society of Microbiology: Specialty: _____

National Registry of Clinical Chemistry Certification: Specialty: _____

National Registry in Microbiology Certification in Public Health Microbiology: Specialty: _____

8. EXPERIENCE – Use the enclosed verification form to verify experience.

9. APPLICANT HISTORY:

a. Regardless of adjudication, have you ever been convicted of a violation of, or pled nolo contendere to, any Federal, State, Local statute, regulation, or ordinance, or entered any plea, negotiated plea, bargain, or settlement relating to a misdemeanor or felony? Yes No

b. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Yes No

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

IMPORTANT NOTICE: 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.

10. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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 felon offense(s) in another state or jurisdiction? **(If you responded NO, skip to 11)** YES NO

a. If “yes” to 10, for 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 10, for 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 10, for 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

NAME: _____

- d. If "yes" to 10, 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
11. 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
- a. If "yes" to 11, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [] YES [] NO
12. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 12a.)** [] 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
13. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If "No", do not answer 13a or 13b.)** [] 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 to the date of this application? [] YES [] NO
14. 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? [] YES [] NO
15. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? [] Yes [] No
16. Have you had any application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state? [] Yes [] No
17. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? [] Yes [] No
18. Have you been refused a license to practice, or the renewal thereof in any state or other jurisdiction? (This question does not pertain to the failure of a previous examination) [] Yes [] No

NAME: _____

19. APPLICANT SIGNATURE:

I acknowledge that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083 and 775.084, Florida Statutes.

I 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 Clinical Laboratory Personnel 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 under penalty of perjury 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 Clinical Laboratory Personnel in the State of Florida.

APPLICANT'S SIGNATURE

DATE

State of _____
County of _____

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

by _____ whose identity is known to me by _____.

Notary Signature

Name of Notary Printed

Stamp Commissioned Name of Notary Public:

***As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.**

Please make cashier check or money order payable to the Department of Health. Return application and fees to:
Department of Health
Revenue Services
P.O. Box 6330
Tallahassee, FL 32399-6330

Mail all supporting documents/correspondence to: (documents sent separate from application/no money)
Department of Health
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VERIFICATION OF EMPLOYMENT

APPLICANT: Complete only the upper portion of this form. Do not fill out employer section. Forward to your laboratory Supervisor/Director or Personnel Director for completion. The form must be signed by both. Do not write over/white-out information, or fill in the list of tests or the form will be returned to you.

I _____, authorize you to verify my employment to the Board of Clinical Laboratory Personnel.

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____

EMPLOYER: Please complete the information below:

Dates of employment: Month/Year: _____ to Month/Year: _____ Full Time: _____ Part Time: _____

“X” SPECIALTY WORKED (You may use a separate sheet)

Microbiology _____
(Test performed)

Clinical Chemistry _____
(Test performed)

Did this person demonstrate competency in all areas of experience marked above? Yes No
(If “No” attach a separate sheet with an explanation)

The above information is correct to the best of my knowledge.

(Signature of Supervisor/Director or Personnel Director)

(Date)