

**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  
Clinical Laboratory Personnel**

**ADDING SPECIALTY  
(to an existing licensure level)**

**DIRECTOR, SUPERVISOR  
TECHNOLOGIST AND TECHNICIAN**

**PLEASE NOTE: REVIEW THE RELEVANT BOARD RULE TO DETERMINE YOUR ELIGIBILITY FOR LICENSURE**

**1. FLORIDA LAWS & RULES:**

You may download a copy of Chapter 483, Part II, Florida Statutes at <http://floridasclinicallabs.gov/resources/>. 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 to add a specialty.

**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 the board office. Section 456.013(1)(a), F.S., provides that an incomplete application expires one (1) year after the initial filing date with the department.

**3. YES/NO QUESTIONS:**

All questions with a "Yes or No" answer must be marked with either a "Yes" or "No" unless otherwise indicated. No other response is acceptable. For questions that require a brief explanation or description to "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 that took the disciplinary or other action (e.g., probation, limitation, suspension, revocation, denial, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). **HOWEVER, IF A QUESTION IS NOT APPLICABLE, ANSWER "N/A" IN THE "NO" COLUMN.**

**4. 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. The fees are required by law and include the following:

**Adding Specialty to Existing Licensure Level:**

Application Fee: (non-refundable)

Director	\$ 90.00
Supervisor	\$ 70.00
Technologist	\$ 50.00
Technician	\$ 25.00
Licensure Fee (all levels):	\$ 25.00
Unlicensed Activity Fee:	\$ 5.00

(Section 456.065(3), Florida Statutes, requires the Department of Health to charge a fee of \$5 per licensee or applicant to fund efforts to combat unlicensed activity)

<b>Total Fee (application, licensure, and unlicensed activity fee):</b>	<b>Director</b>	<b>\$120.00</b>
	<b>Supervisor</b>	<b>\$100.00</b>
	<b>Technologist</b>	<b>\$ 80.00</b>
	<b>Technician</b>	<b>\$ 55.00</b>

**5. REQUIRED NATIONAL EXAMS:**

Below are the national certification bodies that you must contact to request verification of your National Certification. **The verified certification must be mailed directly from the national certifying body to the Board of Clinical Laboratory Personnel.**

**Directors:**

American Board of Bioanalysis (Hematology)  
(314) 241-1445

American Board of Clinical Chemistry  
(202) 420-7601

American Board of Histocompatibility & Immunogenetics  
(856) 380-6814

American Board of Medical Microbiology  
(202) 942-9281

American Board of Medical Laboratory Immunology  
(Serology)  
(202) 942-9281

National Registry of Certified Chemists (Clinical  
Chemistry and Toxicology)  
(610) 322-0657

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**Supervisors, Technologists & Technicians:**

American Association of Bioanalysts  
(314) 241-1445

American Board of Histocompatibility & Immunogenetics  
(856) 380-6814

American Medical Technologists  
(847) 823-5169

American Society for Clinical Pathology  
(800) 267-2727

National Registry of Certified Chemists (**Supervisor ONLY**)  
(610) 322-0657

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

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**6. EMPLOYMENT HISTORY: (Please refer to Rule 64B3-2.003, F.A.C.)**

**Do not include testing done in research, physician office laboratories, or veterinary work. Observation in a laboratory setting when the applicant does not have a Florida license is not pertinent clinical laboratory experience.**

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. **PLEASE NOTE:** If you an applicant from Cuba and are unable to obtain employment verification, you may submit written documentation from a Florida licensed Clinical Laboratory Personnel or Medical Doctor, describing your clinical laboratory experience.

**7. FINAL OFFICIAL TRANSCRIPT:**

Official transcripts must be sent directly to the board office from your college or university. If you were educated at an institution outside of the United States, it is your responsibility to have your education evaluated to determine U.S. equivalency.

**8. VOCATIONAL/TRAINING PROGRAMS:**

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

It is the responsibility of the applicant to know the requirements for licensure before an application is submitted. Determine what documentation 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

**9. 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.

**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 for 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.**

**Director: General Qualifications**

For a description of the licensure qualifications and requirements, please reference Rule 64B3-5.007, Florida Administrative Code, which can be reviewed by clicking this link: [https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS FOR LICENSURE&ID=64B3-5.007](https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS%20FOR%20LICENSURE&ID=64B3-5.007)

**Supervisor: General Qualifications**

For a description of the licensure qualifications and requirements, please reference Rule 64B3-5.002, Florida Administrative Code, which can be reviewed by viewing this link: <https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS%20FOR%20LICENSURE&ID=64B3-5.002>

**Technologist and Technician: General Qualifications**

For a description of the licensure qualifications and requirements, please reference:

**Technologist:** Rule 64B3-5.003, Florida Administrative Code, which can be reviewed by viewing this link:

<https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS%20FOR%20LICENSURE&ID=64B3-5.003>

**Technician:** Rule 64B3-5.004, Florida Administrative Code, which can be reviewed by viewing this link:

<https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS%20FOR%20LICENSURE&ID=64B3-5.004>

# BOARD OF CLINICAL LABORATORY PERSONNEL

## ADDING SPECIALTY

(to an existing licensure level)

### DIRECTOR, SUPERVISOR TECHNOLOGIST AND TECHNICIAN

#### APPLICATION CHECKLIST

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\_\_\_ 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

**PLEASE NOTE:** 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 the board office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application expires one (1) year after the initial filing date with the department.

\_\_\_ 2. **Fees:**

Please make cashier check or money order payable to the Department of Health-Clinical Laboratory Personnel.

Return application and fees to:  
Department of Health  
Revenue Services  
P.O. Box 6330  
Tallahassee, FL 32314-6330

\_\_\_ 3. **Official College Transcript** (sent directly to the board office from the educational institute)

\_\_\_ 4. **Verification of National Certification** (sent directly to the board office from the national examiners)

**Technicians, Technologists & Supervisors:**

- American Association of Bioanalysts
- American Medical Technologists
- American Board of Histocompatibility & Immunogenetics
- American Society for Clinical Pathology
- National Registry of Certified Chemists (**Supervisor ONLY**)

**Directors:**

- American Board of Bioanalysis (Hematology)
- American Board of Histocompatibility & Immunogenetics
- American Board of Medical Laboratory Immunology
- American Board of Clinical Chemistry
- American Board of Medical Microbiology

\_\_\_ 5. **Verification of Employment/Experience form** (must be signed by your Laboratory Supervisor/Director or Personnel Director)

**If you have any additional documents to submit after your application has been mailed, please send to:**  
(supporting documents/correspondence with 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: \_\_\_\_\_

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**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 5 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 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? [ ] 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 within the last five years? [ ] YES [ ] NO



CLINICAL LABORATORY LICENSURE
ADDING SPECIALTY (Client 6601)

ADDING SPECIALTIES (to an existing licensure level): (Fees include: application (non-refundable), additional specialty, and unlicensed activity).
Please select only one licensure level per application.

(3045)[ ] Technician \$ 55.00 (3046)[ ] Technologist \$ 80.00 (3047)[ ] Supervisor \$100.00 (3048)[ ] Director \$120.00

PROFILE DATA: (PLEASE TYPE OR PRINT IN BLACK INK)

1. NAME:

(Last) (First) (Middle)

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

IF YES, provide:

(Last) (First) (Middle)

2. ADDRESS:

a. MAILING ADDRESS:

(Street and Number) (Apt. #) (City) (State) (Zip)

b. PRIMARY ADDRESS:

(Street and Number) (Apt.#) (City) (State) (Zip)

c. TELEPHONE: ( ) ( )

Primary: Area Code/Phone Number

Business: Area Code/Phone Number

d. EMAIL ADDRESS:

Email Notification: If you want to be notified of the status of your application by email, please check the "YES" box and write your email address on the line provided above. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office info@floridaclinicallabs.gov. 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 the board office. Instead, contact the board office by telephone or in writing. [ ] YES [ ] NO

3. PERSONAL DATA

a. Date of Birth (optional):

(Month/Day/Year)

b. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR 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.

RACE: [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other
SEX: [ ] Male [ ] Female

c. 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 disasters?

[ ] YES [ ] NO

4. ADDING SPECIALTIES: (to an existing licensure level)

Please Note: YOU MAY SELECT ONLY ONE LICENSURE LEVEL PER APPLICATION. You must indicate the OPTION under which you are applying by reviewing the rule MATRIX. Failure to select an OPTION will result in delaying the process and you will be notified of that deficiency.

Director: OPTION:

[ ] Microbiology [ ] Serology/Immunology [ ] Clinical Chemistry [ ] Hematology [ ] Histocompatibility
[ ] Andrology [ ] Embryology [ ] Molecular Pathology [ ] Cytogenetics

Supervisor: OPTION:

[ ] Microbiology [ ] Serology/Immunology [ ] Clinical Chemistry [ ] Hematology [ ] Immunohematology
[ ] Histocompatibility [ ] Andrology [ ] Embryology [ ] Molecular Pathology
[ ] Histology [ ] Cytology [ ] Cytogenetics [ ] Blood Banking/Donor Processing

Technologist: OPTION:

[ ] Microbiology [ ] Serology/Immunology [ ] Clinical Chemistry [ ] Hematology [ ] Immunohematology
[ ] Histocompatibility [ ] Andrology [ ] Embryology [ ] Molecular Pathology
[ ] Histology [ ] Cytology [ ] Cytogenetics [ ] Blood Banking (Donor Processing)
[ ] Generalist (Microbiology, Serology/Immunology, Clinical Chemistry, Hematology, and Immunohematology)

Technician: OPTION:

[ ] Histology [ ] Molecular Pathology [ ] Andrology [ ] Embryology
[ ] Generalist (Microbiology, Serology/Immunology, Clinical Chemistry, Hematology and Immunohematology)

NAME: \_\_\_\_\_

**PLEASE USE ADDITIONAL PAGES, as necessary**

**5. EDUCATION INFORMATION:**

Please provide college/university education information, whether completed or not, in chronological order:

(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)

**6. VOCATIONAL/TRAINING PROGRAM:**

Did you complete a training program in the area of applying for licensure:  YES  NO

(If YES, please provide the following):

(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)
(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)
(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)

**7. NATIONAL CERTIFICATION EXAMINATION:**

Did you successfully pass a National Certification Examination in the area applying for licensure:  YES  NO

If YES, please provide the following:

(Name of National Certification Examination)	(Examination Date)
(Name of National Certification Examination)	(Examination Date)

**8. EMPLOYMENT HISTORY:**

List in chronological order all clinical laboratory employment, as defined in Rule 64B3-2.003(8), F.A.C.

(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)



NAME: \_\_\_\_\_

**ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET.  
DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.**

**PROCEEDINGS and/or ACTIONS**

**9. APPLICANT HISTORY:**

- a. 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 or country? [ ] YES [ ] NO
- b. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Clinical Laboratory Personnel practice act, unprofessional or unethical conduct? [ ] YES [ ] NO

If YES, please complete the following:

(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
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(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
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**10. LICENSURE ACTIONS:**

- a. 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
- b. 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
- c. Have you been refused a license to practice, or the renewal thereof in any state? [ ] YES [ ] NO

**11. CRIMINAL INFORMATION:**

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 YES, 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

(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)
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(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)
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**12. LICENSURE INFORMATION:** Do you hold or have you ever held a STATE license to practice as a Clinical Laboratory Personnel in this state or any other state? [ ] YES [ ] NO

License Number	State/Country	Original Date Issued	Expiration Date
License Number	State/Country	Original Date Issued	Expiration Date
License Number	State/Country	Original Date Issued	Expiration Date

**PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.**

NAME: \_\_\_\_\_

**13. 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, Section 456.013(1)(a), Florida Statutes, provides that an incomplete application expires one (1) year after the initial filing date with the department.**

**Board of Clinical Laboratory Personnel**  
**4052 Bald Cypress Way, Bin #C07**  
**Tallahassee, FL 32399-3257**

**VERIFICATION OF CLINICAL LABORATORY EXPERIENCE**

**APPLICANT SECTION: (Complete only the APPLICANT SECTION. Do not fill out EMPLOYER SECTION).**

**APPLICANT NAME:** \_\_\_\_\_  
(Last) (First) (Middle)

**EMPLOYER NAME:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_  
(Street and Number) (Apt.#) (City) (State) (Zip)

**TELEPHONE:** ( ) \_\_\_\_\_ **CLIA#** \_\_\_\_\_  
Business: Area Code/Phone Number

Please forward to your laboratory Supervisor/Director or Personnel Director for completion. The form must be signed. Do not write over/white-out information, or fill in the list of tests or the form will be returned to you.

**EMPLOYER SECTION: (Please complete the information below)**

**Do not include testing done in research, physician office laboratories or veterinary work. Observation in a laboratory setting when the Applicant does not have a Florida license is not pertinent clinical laboratory experience.**

Employment period performing tests in the laboratory: From: \_\_\_\_\_ To: \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_  
MM/YYYY MM/YYYY (hrs. per wk) (hrs. per wk)

**Please indicate an "X" in each SPECIALTY worked:**

X	SPECIALTY AREA WORKED	TESTS PERFORMED	APPROX. DATES PERFORMED
	Microbiology		/ to /
	Serology/Immunology		/ to /
	Clinical Chemistry		/ to /
	Hematology		/ to /
	Immunohematology/Blood Banking (Donor Processing)		/ to /
	Cytogenetics		/ to /
	Molecular Pathology		/ to /
	Histocompatibility		/ to /
	Histology		/ to /
	Cytology		/ to /
	Andrology		/ to /
	Embryology		/ to /

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

\_\_\_\_\_  
**Print Name (Laboratory Supervisor/Director/Personnel Director)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature (Laboratory Supervisor/Director/Personnel Director)**

\_\_\_\_\_  
**Title**



**LICENSE VERIFICATION**

**INSTRUCTIONS TO THE APPLICANT;**

- 1. Complete the information in Part I only.
- 2. This form must be returned by the state Board or agency that issued your license.

**PART I: TO BE COMPLETED BY APPLICANT: (PRINT OR TYPE)**

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip/Postal Code)

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ License No. \_\_\_\_\_ Title of License \_\_\_\_\_

**PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE: (PRINT OR TYPE)**

The individual listed above has applied for licensure in Florida as a Clinical Laboratory Personnel. Before further consideration is given to this application, we require the information requested on this form. The Board may submit your standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Clinical Laboratory Personnel, 4052 Bald Cypress Way, Bin C#07, Tallahassee, Florida 32399-3257.**

Licensee Name: \_\_\_\_\_  
(Last) (First) (Middle)

State: \_\_\_\_\_ Title of License: \_\_\_\_\_ License No: \_\_\_\_\_ Original Issue Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**THIS LICENSE IS CURRENTLY:**

Active  Inactive  Temporary  Other (Explain)

**THIS LICENSE WAS OBTAINED BY:**

Examination  Grandfathering  Reciprocity/Endorsement

**ACTION TAKEN AGAINST LICENSE:**

No Disciplinary Action Taken  Disciplinary Action Taken

\_\_\_\_\_  
Print Name (Completing Form) Title

**PLEASE AFFIX BOARD SEAL**

\_\_\_\_\_  
Signature

**If disciplinary action has been taken against this licensee; please provide certified copies of documentation regarding any disciplinary actions directly to the Florida Board of Clinical Laboratory Personnel.**