Clinical Laboratory Licensure - Adding Specialty

Board of Clinical Laboratory Personnel
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasclinicallabs.gov
Email: info@floridasclinicallabs.gov
Phone: (850) 245-4355
FAX: (850) 922-8876

Florida HEALTH
Medical Quality Assurance

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

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Do Not Write in this Space For Revenue Receipting Only

Clinical Laboratory Personnel- Adding Specialty:

Select Licensure Level:

- ☐ **Technician** (3045) - **$55.00**
- ☐ **Technologist** (3046) - **$80.00**
- ☐ **Supervisor** (3047) - **$100.00**
- ☐ **Director** (3048) - **$120.00**

Total fee includes the following:

Application Fee (non-refundable)-Based on Licensure Level	
Technician	$25.00
Technologist	$50.00
Supervisor	$70.00
Director	$90.00
Licensure Fee (refundable)	$25.00
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. Certain fees are refundable for up to three years from 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 (Input without dashes)

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

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

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 is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

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, F.S. 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.

Name: _____

3. QUALIFICATIONS FOR LICENSURE

A. Select specialty area(s):

Director:		
☐ Andrology	☐ Clinical Chemistry	☐ Cytogenetics
☐ Embryology	☐ Hematology	☐ Histocompatibility
☐ Molecular Pathology	☐ Microbiology	☐ Oral Pathology Laboratory
☐ Serology/Immunology	☐ All Specialties	

Supervisor:		
☐ Andrology	☐ Blood Banking/Donor Processing	☐ Clinical Chemistry
☐ Cytogenetics	☐ Cytology	☐ Embryology
☐ * Generalist	☐ Hematology	☐ Histocompatibility
☐ Histology	☐ Microbiology	☐ Molecular Pathology
☐ Immunohematology	☐ Serology/Immunology	

* Generalist (Blood Banking, Cytogenetics, Clinical Chemistry, Hematology, Immunohematology, Microbiology, and Serology/Immunology)

Technologist:		
☐ Andrology	☐ Blood Banking/Donor Processing	☐ Clinical Chemistry
☐ Cytogenetics	☐ Cytology	☐ Embryology
☐ * Generalist	☐ Hematology	☐ Histocompatibility
☐ Histology	☐ Immunohematology	☐ Microbiology
☐ Molecular Pathology	☐ Serology/Immunology	

* Generalist (Clinical Chemistry, Hematology, Immunohematology, Microbiology, and Serology/Immunology)

Technician:		
☐ Andrology	☐ Clinical Chemistry	☐ Embryology
☐ Hematology	☐ Histology	☐ Immunohematology
☐ Microbiology	☐ Molecular Pathology	☐ Serology/Immunology

The licensure qualifications and requirements are listed in Rule 64B3-5, Florida Administrative Code (F.A.C.). Find this rule at: https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B3-5.

B. You must identify the appropriate **option <u>number</u>** from the rule that identifies the qualifications you have to meet the licensure requirements.

Director Option Number: -_____ Supervisor Option Number: -_____

Technologist Option Number: -_____ Technician Option Number: -_____

Name: _____

4. 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, or have you ever held a license to practice as clinical laboratory personnel in this state or any other state? ☐ 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

☐ **Submit a License Verification** form to **ALL** your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license.

D. List in chronological order all clinical laboratory employment, as defined in Rule 64B3-2.003(7), 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 hold a Florida license is not pertinent experience.

Name of Business	Full Mailing Address	Employment Dates: To-From (MM/DD/YYYYY)
		to
		to
		to

☐ **All applicants must have their employer complete the "Verification of Clinical Laboratory Experience" form. Applicants from Cuba** who are unable to obtain employment verification may submit written documentation from a Florida Licensed Clinical Laboratory Personnel or Medical Doctor, describing your clinical laboratory experience.

5. 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

Name: _____

6. EDUCATION HISTORY

A. List college/university education, whether completed or not, in chronological order.

School Name	City/State or Country	Dates of Attendance (From-To) MM/DD/YYYY	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		
		to		
		to		
		to		

☐ **All applicants must have an official transcript forwarded directly to the board office from their educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

Board *of* Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

B. Did you complete a training program in the area you are applying for? ☐ Yes ☐ No

If you responded "Yes," provide the following:

Program Name	City/State	Dates of Attendance: From- To (MM/DD/YYYY)	Completion Date (MM/DD/YYYY)
		to	
		to	
		to	

☐ **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, copy of your diploma, or certificate of graduation.**

Applicants who were educated outside the United States must have their education evaluated to determine U.S. equivalency. Evaluations are acceptable from an accredited U.S. college or university on an official transcript, or a credentials evaluation service.

Credentials evaluations **must** be performed by one of the board accepted providers and **must** include a breakdown of all college level courses by subject. Credit hours **must** be listed in semester hours. Evaluations **must** be sent directly to the board from the evaluator. If transcripts cannot be ordered from the education institution, certified copies of the original documents used in the evaluation must be submitted to the board. Board accepted providers can be located at: https://floridasclinicallabs.gov/resources/.

Graduates of institutions where official transcripts are not available may submit a certified copy of the original diploma, grade sheet, or other educational documents. A subject breakdown is required. Copies of translations are not acceptable unless accompanied by a notarized copy of the original document.

Note: Bachelor's degrees from Puerto Rico and the Philippines do not require a credentials evaluation, instead official transcripts must be sent directly to the board from the educational program.

Name: _____

C. Did you successfully pass a national certification examination in the area you are applying for? ☐ Yes ☐ No

If you responded "Yes," provide the following:

Name of National Certification Exam	Exam Date (MM/DD/YYYYY)

☐ Below are the national certification bodies that you must contact to request verification of your national certification. **The verified certification must be sent directly from the national certifying body to the board by email at MQA.ClinicalLab@flhealth.gov or by mail at:**

Board *of* Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

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

Directors:

American Association of Bioanalysts
(314) 241-1445

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

American Board of Medical Laboratory Immunology (Serology)
(202) 945-9281

American Board of Clinical Chemistry
(202) 420-7601

American Board of Medical Microbiology
(202) 942-9281

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

Supervisors, Technologists & Technicians:

American Association of Bioanalysts
(314) 241-1445

American Board of Histocompatibility & Immunogenetics
(913) 895-4602

American Medical Technologists
(847) 823-5169

American Society for Clinical Pathology
(800) 267-2727

National Registry of Certified Chemists
(610) 322-0657

D. Have you completed the one-hour HIV/AIDS course that is required by Florida law prior to licensure?
☐ Yes ☐ No

☐ **If you have not completed this course, you can find information on the course at** www.cebroker.com. Applicants who have not completed the course may submit an affidavit, in lieu of a certificate of completion, that states they will complete the one-hour course within six months of licensure.

Name: _____

This information is exempt from public records disclosure.

7. 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.

Name: _____

8. DISCIPLINE HISTORY

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 ever been refused a license to practice, or the renewal thereof in any state? ☐ Yes ☐ No

D. Have you ever had an application for a professional license, or any application to practice, denied by any state board or governmental agency (state or country)? ☐ Yes ☐ No

E. Have you ever been notified/required 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 Practice Act, unprofessional or unethical conduct? ☐ 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.**

9. CRIMINAL HISTORY

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

If you responded "Yes" to any of the questions 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" 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.

☐ **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.

Name: _____

10. 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), F.S.?

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, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (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), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., 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 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, F.S.? ☐ 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 question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 7, 8, 9, and 10 must be mailed to:

Board *of* Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

11. 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, 775.082, 775.083, and 775.084, F.S.

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), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
MM/DD/YYYY

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 _____ Printed Name of Notary _____

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

You may request a temporary permit if your application is completed and you have submitted a copy of the approval letter from the certification agency stating the date of your examination. Your request must be in writing.

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

Board *of* Clinical Laboratory Personnel License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Clinical Laboratory Personnel.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- Typed on an official state form or letterhead
- Include an official board seal
- Signature and title of state board official

The following information must be included in all verifications:

- Licensee name * License number * State or jurisdiction of licensure
- Licensure status * Is license in good standing?
- Date of issuance/expiration
- Licensure method (examination, grandfathering, reciprocity/endorsement)
- Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

If your specialty requires it, complete verification(s) must be mailed directly from your employer to:

Board *of* Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

Board *of* Clinical Laboratory Personnel
Verification of Clinical Laboratory Experience

Part I: To be completed by applicant

Name: _____

Employer Name: _____

Mailing Address: _____

Telephone Number: _____ CLIA#: _____
Input without dashes

This form must be signed. ***Do not*** *write over/ white out information or fill in the list of tests or the form will be returned.*

Part II: To be completed by your employer

Do not include testing done in research, physician office laboratories or veterinary work. Observations 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 (hours per week) (hours per week)

X	Specialty Area Worked	Test Performed	Approx. Dates (From-To)
	Microbiology		to
	Serology/Immunology		to
	Clinical Chemistry		to
	Hematology		to
	Immunohematology		to
	Cytogenetics		to
	Molecular Pathology		to
	Histocompatibility		to
	Histology		to
	Cytology		to
	Andrology		to
	Embryology		to
	Blood Banking/Donor Processing		to

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

_____ _____
Print Name (Laboratory Supervisor/Director/Personnel Director) Date (MM/DD/YYYY)

_____ _____
Signature (Laboratory Supervisor/Director/Personnel Director) Title