Public Health Laboratory Scientist Application

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

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

Select only ONE specialty:

☐ Microbiology ☐ Chemistry

Select application type:

Initial Licensure - $55.00

☐ Director (1057) ☐ Technologist (1055)
☐ Supervisor (1056) ☐ Technician (1050)

Additional Specialty to Existing License - $50.00

Current Florida License Number : ____________

Total fee of $55.00 includes the following:	
Application Fee	$25.00
Licensure Fee	$25.00
Unlicensed Activity Fee	$5.00

Total fee of $50.00 includes the following:	
Application Fee	$25.00
License Fee	$25.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the 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 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, Section 456.013(1)(a), 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, Section 653 and 654; and Sections 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. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

____

Do you hold, or have you ever held a license to practice as a Public Health Laboratory Scientist or any other health-related license(s)?
☐ Yes ☐ No

B. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued	Expiration Date	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.

4. EDUCATION HISTORY

A. Are you a graduate of an accredited school/college with a minimum of a bachelor's degree in Chemical or Biological Science? ☐ Yes ☐ No

B. 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	Degree Awarded

☐ **All applicants must have an official transcript forwarded directly to the board office from your 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

C. 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: ______________________________

D. 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

E. National Certification –

American Society of Microbiology - Specialty:

____

National Registry of Clinical Chemistry Certification - Specialty:

____

National Registry in Microbiology Certification in Public Health Microbiology Specialty:

____

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's 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.

F. 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

☐ 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 at:**

Board *of* Clinical Laboratory Personnel **OR** *MQA.ClinicalLab@flhealth.gov*
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

Name: ______________________________

This information is exempt from public records disclosure.

5. 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: ____________________

6. 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

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**.

7. 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. ☐ Yes ☐ No

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.

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date: MM/DD/YYYY	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" 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: ______________________________

8. 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 Section 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 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? ☐ 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 Section 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under Section 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," please 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 Section 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 following questions, 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 to the address listed on the first page of the application.

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

9. 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 ss. 456.067, 775.082, and 775.083, 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.

Complete verifications must be mailed directly from your Laboratory Supervisor/Director or Personnel Director to:

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

Board *of* Clinical Laboratory Personnel Verification of Employment

Do not write over/white out information or fill in the list of tests or the form will be returned as unacceptable.

Part I: To be completed by applicant

Employer: ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

I, ______________________, authorize you to verify my employment to the Board of Clinical Laboratory Personnel.
Your name

______________________________ ____________
Applicant Signature Date

Part II: To be completed by the employer

Dates of Employment: ________ to ________ ☐ Full Time ☐ Part Time

Specialty Worked:

☐ Microbilogy Test Performed: ______________________________

☐ Clinical Chemistry Test Performed: ______________________________

Did this person demonstrate competency in all areas of expertise for the specialty chosen above?

☐ Yes ☐ No

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

______________________________ ____________
Signature of Supervisor/Director or Personnel Director Date