TEMPORARY CERTIFICATE FOR VISITING PHYSICIANS TO OBTAIN MEDICAL PRIVILEGES FOR INSTRUCTIONAL PURPOSES IN CONJUNCTION WITH PLASTIC SURGERY, MEDICAL OR SURGICAL TRAINING PROGRAMS AND EDUCATIONAL SYMPOSIUMS

SECTION 458.3137, FLORIDA STATUTES

DEPARTMENT OF HEALTH DIVISION OF
MEDICAL QUALITY ASSURANCE
BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C03
TALLAHASSEE, FLORIDA 32399
850-488-0595

64B8-4.009, F.A.C. DH-MQA 1079
Revised 06/2020

GENERAL INFORMATION

Section 456.013(1)(a), Florida Statutes, provides that a licensure application and application fee are valid for one year. Application fees are non-refundable.

- The State of Florida operates under Chapter 286, Florida Statutes, commonly referred to as the "Sunshine Law." This law requires that board meetings are public. All information that you provide to the Department is public record and shall be open to public inspection as required by 119.07 F. S., except financial information, examination records, and patient records.
- The Florida Board of Medicine general statutes require that you must have a valid Florida medical license to practice medicine in Florida.
- Read instructions before and while you complete the application. Failure to do so may result in delays in processing your application.
- Licenses will not be issued without the background check results and will be issued in date order. When issuing licenses, we have a strict policy of fairness. One application will not be accelerated at the expense of another. All applications will be handled equally and fairly. Also, the less time reviewers spend responding to duplicate e-mails and telephone calls, the faster applications can be reviewed.
- It could take up to 14 days to issue your license after completion of your application. It will take approximately 10 business days to receive your license in the mail after issuance. To view your license, you may access our license look-up screen at www.FLHealthSource.com. Your license number will appear on the web site 24 to 48 hours after it is issued.
- Before practicing medicine in Florida, read Chapter *456,* 458, and 766.301-.316 Florida Statutes (F. S.), and Rule Chapter 64B8, Florida Administrative Code (F.A.C). You must know and comply with the laws and rules as they pertain to your professional practice. Laws and rules are subject to change at any time. For updated information refer to the following web-sites www.leg.state.fl.us/ (statutes) and www.fac.dos.state.fl.us (Florida Administrative Code).
- Personal Appearances before the Credentials Committee or the Board of Medicine may be required for a variety of reasons: e.g., malpractice, disciplinary actions, etc. If an appearance is required, we will notify you by mail including the date, time, location, and reason(s) for the appearance. The Credentials Committee meets in conjunction with the full Board of Medicine meetings. In order for the Committee members to review all the information that is provided for this committee, other committee meetings at the same time, and for the full board meeting, a deadline for applications must be established and respected. The cut off for a complete application to be considered is six (6) weeks prior to the committee meeting. All Board and Committee meetings dates are posted on our web site at: www.flboardofmedicine.gov

- Document submitted in a language other than English must be accompanied by a literal translation. Acceptable translators are: An employee of a professional translating company, a member of a professional translation company, a member of the American Translators Association, a faculty member of the modern languages or linguistics department of a United States college or university. Translations must be prepared on letterhead paper or bear the translator's certification seal. All information appearing on the original document must also appear on the translation each time it appears on the original document. This includes pre- printed information. For example, the letterhead of the university, titles, etc.

- Submit your application, supporting documentation, and fees, to the following address: Department of Health/ HMQAM
  P.O. Box 6330
  Tallahassee, Florida 32314-6330

- Mail additional documentation or anything without a fee to the following address: Department of Health Medical Quality Assurance/Board of Medicine/HMQAM, 4052 Bald Cypress Way, BIN #C03 Tallahassee, Florida 32399-3253

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html.
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- The ORI number for the **Board of Medicine is EDOH2014Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, including your Social Security number (SSN);
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____. Social Security Number: _____

Aliases: _____ Date of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Place of Birth: _____

Race: _____ Sex: _____
W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown) (M=Male; F=Female)

Weight: _____ Height: _____

Eye Color:_____ Hair Color: _____

Address:_____Apt. Number: _____

City:_____State:_____Zip Code: _____

Transaction Control Number (TCN#):_____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided ins. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Completing the Application

Read instructions before and while you complete your application. Failure to do so may result in delays in processing your application. Type or legibly write your application. As we receive supporting documentation, we may need to ask you additional questions and require additional documentation.

Item-by Item Instructions

Social Security Number: List your social security number as in this example: 333-33-3333. 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 as required by Title 42 United States Code, Sections 653 and 654; and Sections 456.004(9), 456.013(1)(a), 409.2577, and 409.2598, Florida Statutes. Social security numbers are used to efficiently screen applicants and licensees by Title IV-D to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.
Certificate requirements/applicable fees: You must list the type of training program; the affiliated medical or osteopath school or teaching hospital; any symposium cosponsors; and the area of medicine in which you are a recognized expert. Fees for an unrestricted Florida medical license: Application fee: $300.00 (non-refundable) Initial license fee: $200.00 NICA fee: $250.00 or $5,000.00 (please read information at www.nica.com) Make one cashier's check or money order for the total amount payable to the Department of Health-Board of Medicine. Cash and credit card payments are not acceptable. Mail complete fee with your application to: Department of Health/ HMQAM, P.O. Box 6330, Tallahassee, Florida 32314-6330.
Name: list your name as it appears on your birth certificate and/or a legal name-change document. Nicknames or shortened versions are unacceptable. If you have a hyphenated last name, enter both names in the last name space. It will be recognized by the first letter of the first name; e.g., Diaz-Jones.
Mailing address: List your current mailing address. We will mail correspondence to you at this address unless you notify the board in writing of an address change. NOTE: If your address changes prior to the issuance of the license, it is your responsibility to notify your reviewer of your address change in writing.
Telephone: List your primary and alternate telephone numbers.
E-mail address (Optional): List your e-mail address. We will e-mail correspondence to you at this address instead of the mailing address when possible.
Citizenship: List the country where you are a citizen. Provide your date of birth.
Demographics (voluntary): Check your race and sex.

Education: List the medical school where you obtained your medical degree. The Medical School must be accredited by LCME or if an international medical graduate the medical school must be listed with the World Health Organization.

Provide the following documentation to support your education:

- Copy of the medical school or medical college diploma. If the diploma is from a school outside of the United States and is in a language other than English, a certified translation must accompany the diploma. In the event that such diploma has been lost or destroyed, then, submit a statement under the signature and seal of the dean of the medical school or medical college, which demonstrates that completes the prescribed course of study, the actual degree. Additionally, the applicant shall submit a written and signed statement fully and clearly stating the circumstances under which his diploma

- Complete the medical school verification request form and remit to the medical school. This form must be received directly from the medical school to the Board office with the school

- Licensure: List all state(s) or country where you hold or ever held a medical license regardless of the current status in any state in the United States or other country.
- Request verification of licensure status directly from the licensing entity or www.veridoc.org
- For items 10a-d, if yes, explain on a separate sheet providing accurate details; and request documentation directly from the licensing entity supporting your yes answers for items 10a-d.

MALPRACTICE: Check Yes or No.
If yes, provide the following:

- A statement indicating date of each incident and the number for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- An explanation of details for each case and your involvement for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 12, in addition to the documents listed above, submit the enclosed Exhibit 1form.
- A copy of complaint, judgments and/or settlements for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 11, in addition to submitting the above documents, submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.

Criminal Convictions: Check Yes or No.

If yes, explain on a separate sheet providing the date, accurate details and submit copies of charge(s), indictment(s), judgment(s} and sentence.

DENConvictions/Medicare/State Healthcare Programs: Check Yes or no.

If yes, explain on a separate sheet providing accurate details. Request that the entity send supporting documentation directly to the Board of Medicine.

Health History: Check Yes or No.

If yes, submit the following:

A statement providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment. A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary{s}.

You may be asked to submit to a current evaluation by a board-approved physician independent of your current treating physician and appear before the Credentials Committee.

Financial Responsibility: Check only one of the ten Financial Responsibility options to comply with §458.320, Florida Statutes. The options are divided into two categories: coverage and exemptions. If you are not licensed in Florida through another licensure provision, you may choose the exemption provision until you are licensed and began practicing in Florida.

- Complete the medical school verification request form and remit to the medical school. This form must be received directly from the medical school to the Board office with the school

- Licensure: List all state(s) or country where you hold or ever held a medical license regardless of the current status in any state in the United States or other country.
- Request verification of licensure status directly from the licensing entity or www.veridoc.org
- For items 10a-d, if yes, explain on a separate sheet providing accurate details; and request documentation directly from the licensing entity supporting your yes answers for items 10a-d.

MALPRACTICE: Check Yes or No.
If yes, provide the following:

- A statement indicating date of each incident and the number for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- An explanation of details for each case and your involvement for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 12, in addition to the documents listed above, submit the enclosed Exhibit 1form.
- A copy of complaint, judgments and/or settlements for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 11, in addition to submitting the above documents, submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.

Criminal Convictions: Check Yes or No.

If yes, explain on a separate sheet providing the date, accurate details and submit copies of charge(s), indictment(s), judgment(s) and sentence.

DENConvictions/Medicare/State Healthcare Programs: Check Yes or no.

If yes, explain on a separate sheet providing accurate details. Request that the entity send supporting documentation directly to the Board of Medicine.

Financial Responsibility: Check only one of the ten Financial Responsibility options to comply with §458.320, Florida Statutes. The options are divided into two categories: coverage and exemptions. If you are not licensed in Florida through another licensure provision, you may choose the exemption provision until you are licensed and began practicing in Florida.

Neurological Injury Compensation Association: If you are a participating or non-participating physician, or a physician claiming exemption, complete the Florida Birth Related Neurological Compensation Association {Item 46) form, sign and date it, and return it with your application.

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated compensation form (Item 46) with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, Fl32308

To complete the form, check one of the three boxes to choose your compensation option for Florida birth-related neurological compensation. Check only one. If you will submit payment, list the amount on the "Amount Enclosed" line and submit fee with your licensure application.

If you check "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

Sign your name on the Signature line to show that you have read the explanatory information provided by NICA at WWW.NICA.COM and have chosen a compensation option. list the date that you signed in mm/dd/yy. Print or type your name, street address, city, state, and zip on the lines provided.

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191. Statement of Applicant: Read the Statement of Applicant. If you agree with the content print or type your name, sign your name, and list the date that you signed as mm/dd/yy on the lines provided to show that you consent to the statement. You must sign and date the statement. If you have used any outside resources to assist you in completing this application, please remember only you are responsible for the contents of this application.

1509·SECTION 458.3137, FLORIDA STATUTES- TEMPORARY CERTIFICATE FOR VISITING PHYSICIANS To OBTAIN MEDICAL PRIVILEGES FOR INSTRUCTIONAL PURPOSES IN CONJUNCTION WITH CERTAIN PLASTIC SURGERY, MEDICAL OR SURGICAL TRAINING PROGRAMS AND EDUCATIONAL SYMPOSIUMS

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health Division of Medical

Quality Assurance Board of Medicine

Name:_____

Last First Middle

Social Security Number:_____

*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 (I)(a), Florida Statutes.

1509 ·SECTION 458.3137, FLORIDA STATUTES- TEMPORARY CERTIFICATE FOR VISITING PHYSICIANS TO OBTAIN MEDICAL PRIVILEGES FOR INSTRUCTIONAL PURPOSES IN CONJUNCTION WITH CERTAIN PLASTIC SURGERY, MEDICAL OR SURGICAL TRAINING PROGRAMS AND EDUCATIONAL SYMPOSIUMS

2. I state that I have been invited by a plastic surgery or other medical or surgical training program that is affiliated with a medical school in this state which is accredited by the ACGME, AOA, or a teaching hospital as defined in s. 408.07, Florida Statutes, or an educational symposium cosponsored by the American Society of Plastic Surgeons, the Plastic Surgery Education Foundation, the American Society for Aesthetic Plastic Surgery, or any other medical or surgical society in conjunction with a medical school or teaching hospital as defined in 408.07, Florida Statutes, and am a recognized expert in a specific area of plastic surgery, or another field of medicine or surgery as demonstrated by peer-review publications, invited lectureships, and academic affiliations. Please choose from the following affiliations.

List type of training program:

_____

List affiliated medical, osteopath school or teaching hospital in this state:

_____

Educational symposium cosponsor:

_____

Recognized expert in specific area of:

_____

3. Name: _____ _____
First Last

4. Mailing Address: _____
Street and Number or P.O. Box City State/Province Country

5. Telephone (___)_____ (___)_____
Primary: Area Code/Phone Number Alternate: Area Code/Phone Number

6. E-mail Address (Optional):_____

7. Date of Birth _____

8. Demographics: 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) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes on and will not affect your candidacy for licensure.

Race/Sex: Caucasian☐ Black☐ Hispanic☐ Asian☐ Native American☐ Other ☐ Male☐ Female☐

9. Medical Degree was obtained from: _____

10. List medical license(s) you hold or have ever held in any state of country:

Jurisdiction	Profession	License number

☐ Yes ☐ No 10a. Have you had any application for professional license denied by any state board or other governmental agency of any state or country?

☐ Yes ☐ No 10b. Have you had any application for professional license denied by any state board or other governmental agency of any state or country?

☐ Yes ☐ No 10c. 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 Medical Practice Act, unprofessional or unethical conduct?

☐ Yes ☐ No 11. Have you ever had any professional license revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state territory or country?

☐ Yes ☐ No 12. Have you ever committed an act or are you under investigation in any jurisdiction that would constitute a basis for imposing a disciplinary action specified in s. 456.072 or s. 458.331(2)(b), F.S.?

☐ Yes ☐ No 13. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☐ No 14. Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

(If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.)

☐ Yes ☐ No 15. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no", skip to #16.)**

☐ Yes ☐ No 15a. If "yes" to 15, 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 15b. If "yes" to 15, for the 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 Statues)

☐ Yes ☐ No 15c. If "yes" to 15, for the 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 15d. If "yes" to 15, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

☐ Yes ☐ No 16. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

☐ Yes ☐ No 16a. If "yes" to 16, 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 17. 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 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 18. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 18a.)

☐ Yes ☐ No 18a. 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 19. 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 19a or 19b)

☐ Yes ☐ No 19a. Have you been in good standing with a state Medicaid program for the most recent five years?

☐ Yes ☐ No 19b. Did the termination occur at least 20 years before the date of this application?

☐ Yes ☐ No 20. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List Excluded Individuals and Entities (LEIE)?

☐ Yes ☐ No 20a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?

☐ Yes ☐ No 20b. If you responded "Yes" to questions 20.a., is the student loan defaulted or delinquency the only reason you are listed on the LEIE?

☐ Yes ☐ No 21. Have you ever been warned or called before the Drug Enforcement Agency (DEA)?

☐ Yes ☐ No 22. Have you ever been made an offer to compromise or entered into any other arrangement for other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA?

☐ Yes ☐ No 23. Have you ever been denied, or surrendered, a DEA Registration?

☐ Yes ☐ No 24. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment for drug or alcohol abuse that occurred within the past five years?

☐ Yes ☐ No 25. 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 26. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

☐ Yes ☐ No 27. In 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 medicine?

☐ Yes ☐ No 28. 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 29. 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 medicine within the last five years?

30. Financial Responsibility

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐ 1. I do not have hospital staff privileges and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ 2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s.625.52, F. S., for an escrow account.

☐ 3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s.627.357, F. S.

☐ 4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided ins. 627.357, F. S.

☐ 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified ins. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐ 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐ 8. I do not practice medicine in the State of Florida.

☐ 9. I meet all of the following criteria:

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

b. I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

c. I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

e. I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception are of provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statues, for specific notice requirements.

☐ 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Financial Responsibility Form:

DEPARTMENT OF HEALTH
BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an exemption based on number 9 on the preceding page.

I, _____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), F.S., for specific notice requirements.

Dated:_____ Signature:_____

STATE OF_____
COUNTY OF_____

Sworn to (or affirmed) and subscribed before me this_____, day of_____, by

_____

_____
(Signature of Notary Public- State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known_____OR Produced Identification_____

Type of Identification Produced_____

31. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating

☐ $250 Non-participating

☐ $0 Exempt

_____ Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

_____ Signature Date

_____ Name

_____ Street Address

_____ City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850)488-8191

32. Statement of Applicant

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes, and Chapter 64B8, Florida Administrative Code.

I hereby 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 Medicine 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. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the Board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

_____

(Please print your name.)

_____

(Signature of applicant required.) **(Date signed required.)**