Temporary Certificate for Active Duty Military Health Care Practitioners Renewal Application

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: http://www.flhealthsource.gov
Phone: (850) 488-0595

Qualifications for Renewal

1. Must be a military health care practitioner who is serving on active duty in the United States Armed Forces, the United States Reserve Forces, the National Guard, or is on active duty in the United States Armed Forces and serving in the United States Public Health Services.

2. Must submit proof that you are continuing to practice pursuant to a military platform as defined in section (s.) 456.0241(1)(b), Florida Statutes (F.S.).

3. Must pay a $50.00 non-refundable application fee.

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Do Not Write in this Space
For Revenue Receipting Only

Temporary Certificate Renewal Fee **$50.00** (non-refundable)

Temporary Certification #: _____

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw must be made in writing.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

If your mailing address, practice location address, and/or email address have changed, provide the updated address information below.

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

_____ _____ _____
Street Suite No. City

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

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.

All renewal applicants must provide copies of:

Active duty orders

Proof of practicing pursuant to a military platform

Name: _____

2. 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 time frames 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. If "Yes" to 4, 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

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 that includes court dispositions or agency orders where applicable.

3. APPLICANT SIGNATURE

I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in denial of certification, disciplinary action against my certification, or criminal penalties. I have read ch. 456, F.S., the practice act governing the profession for which I am applying, and the Florida Administrative Code Chapter governing the profession for which I am applying.

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 Department of Health information which is material to my application for licensure.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocations of my license to practice the profession for which I am applying 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 Florida Department of Health within 30 days.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____
MM/DD/YYYY