Florida Department of Health (Department)
License Renewal Application
(Active and Inactive Status)

Expedite your application by applying online at www.flhealthsource.gov

Your license expires at midnight on the expiration date. Renewal notification postcards are mailed to the last known mailing address on record 90 days prior to the expiration date.

General Renewal Requirements:

- Must pay the biennial renewal fee required by the board or Department when there is no board. Active duty members of the Armed Forces whose license is currently in a "military status" are not required to pay a renewal fee.
- Must pay $5.00 unlicensed activity fee as required in section 456.065(3), Florida Statutes (F.S.). Active duty members of the Armed Forces whose license is currently in a "military status" are not required to pay an unlicensed activity fee.
- Must have met the continuing education requirements required by the board or Department when there is no board by the license expiration date. Your continuing education credits must be reported to the Department's Continuing Education Tracking system on or before the day you submit your renewal application. To view continuing education requirements for your profession, visit www.flhealthsource.gov. To view your course history and report hours please register for a Free Basic Account by visiting http://www.flhealthsource.gov/AYRR.
- If you are registered with the U.S. Drug Enforcement Administration and authorized to prescribe controlled substances you must complete a board-approved 2-hour continuing education course on prescribing controlled substances offered by a statewide professional association of physicians by January 31, 2019 and at each subsequent renewal unless your applicable practice act requires a minimum of 2 hours of continuing education on the safe and effective prescribing of controlled substances.
- Must submit your renewal application, any applicable fees, and any supplemental documentation to the Department of Health online at www.flhealthsource.gov or by US Mail to P.O. Box 6320, Tallahassee, Florida 32314-6320. Applications mailed must be postmarked by midnight on the license expiration date.

Note: If you are renewing your license after the expiration date, you are required to pay the appropriate delinquency fee in addition to your renewal fees.

Profession Specific Requirements:

Background Screening: If you are licensed in one of the following professions and received your license prior to January 1, 2013, you are required to submit information necessary to conduct a statewide criminal history check, along with a fee required by the Florida Department of Law Enforcement to process the statewide criminal history check:

- Medical Doctors (Chapter 458, F.S.)
- Osteopathic Physicians (Chapter 459, F.S.)
- Chiropractic Physicians (Chapter 460, F.S.)
- Nurses (Chapter 464, F.S.)
- Podiatric Physicians & Podiatric X-Ray Assistants (Chapter 461, F.S.)
- Orthotists, Prosthetists & Pedorthists (Chapter 468, F.S.)

Financial Responsibility: If you are licensed in one of the following professions, you must demonstrate compliance with financial responsibility as a part of licensure renewal process:

- Acupuncturists (Chapter 457, F.S.)
- Medical Doctors (Chapter 458, F.S.)
- Osteopathic Physicians (Chapter 459, F.S.)
- Chiropractic Physicians (Chapter 460, F.S.)
- Podiatric Physicians (Chapter 461, F.S.)
- Autonomous Advanced Practice Registered Nurse
- Advanced Practice Registered Nurse (Chapter 464, F.S.)
- Dentists (Chapter 466, F.S.)
- Licensed Midwives (Chapter 467, F.S.)
- Anesthesiologist Assistant (Chapters 458, 459, F.S.)

Practitioner Profiling: If you are licensed in one of the following professions, you are required to maintain information as specified in sections 456.039 and 456.0391, F. S., for publication on the Department's website. As part of the renewal process, you will be asked to review and verify the information published online is correct.

- Medical Doctors (Chapter 458, F.S.)
- Osteopathic Physicians (Chapter 459, F.S.)
- Chiropractic Physicians (Chapter 460, F.S.)
- Podiatric Physicians (Chapter 461, F.S.)
- Autonomous Advanced Practice Registered Nurse
- Advanced Practice Registered Nurse (Chapter 464, F.S.)

Workforce Survey: If you are licensed as a medical doctor, osteopathic physician, or physician assistant you are required to complete the workforce survey as a condition of renewal pursuant to sections 458.3191, 459.0081, 458.347, and 459.022, F.S.

Dispensing Registration: If you are currently registered to dispense medicinal drugs to your patients, you are required to renew your registration at the same time you are renewing your license. If you are no longer interested in dispensing medicinal drugs, you can cancel your registration by checking the appropriate box on the renewal application. If you are not currently registered to dispense medicinal drugs and would like to register, you can complete the registration process at the time you are renewing your license by checking the appropriate box on the renewal application and paying the dispensing registration fee. The registration fee will be in addition to your renewal fee.

Prescribing Privileges: If you are a Physician Assistant currently registered with prescribing privileges, you are required to renew your registration at the same time you are renewing your license. If you are no longer interested in prescribing privileges, you can cancel your registration by checking the appropriate box on the renewal application. If you are not currently registered to prescribe and would like to register, you can complete the registration process at the time you are renewing your license by checking the appropriate box on the renewal application and paying the prescribing registration fee. The registration fee will be in addition to your renewal fee.

Letter of Recommendation or Employment: If you currently hold a certificate as a Medical Doctor Public Psychiatry, Medical Doctor Public Health, Medical Doctor Limited to Mayo Clinic, Limited License Medical Doctor or Medical Doctor Area of Critical Need, you will be required to submit the following letters:

1. Medical Doctor Public Psychiatry - Letter from the State Surgeon General recommending renewal of the certificate; and letter from the chair of the department of psychiatry at one of the public medical schools or the chair of the department of psychiatry at the accredited medical school at the University of Miami recommending renewal of the certificate.
2. Medical Doctor Public Health - Letter from the State Surgeon General recommending renewal of the certificate.
3. Medical Doctor Limited to Mayo Clinic, Limited License Medical Doctor or Medical Doctor Area of Critical Need - Letter of Employment.

Note: Limited License Medical Doctors and Medical Doctor Area of Critical Need who do not receive compensation for services will be required to submit a statement of non-compensation from the employing agency or institution pursuant to section 458.317(3), F.S.

National Advance Practice Certification: If you are renewing your Advanced Practice Registered Nurse license, and you were required to be nationally certified at the time of original licensure, you must submit a copy of your current national certification.

Criminal Conviction Sworn Statement: If you are renewing your Certified Chiropractic Physician Assistant (section 460.4165(13), F. S.) or Anesthesiologist Assistant (section 458.3475(6)(b)2., F.S.) license, you will be required to submit a sworn statement relating to felony convictions in the previous two years.

Emergency Care Plan: Pursuant to section 467.017, F.S., if you are renewing your midwife license, you will be required to submit an example of the emergency care plan you have developed which must address the following: consultation with other health care providers, emergency transfer, and access to neonatal intensive care units and

obstetrical units or other patient care areas. Patient specific information should not be included in the general emergency care plan.

Florida Center for Nursing Donation: The Florida Center for Nursing is the definitive source for information, research, and strategies addressing the dynamic nurse workforce needs in our state. The Center conducts multiple annual and biennial research projects to provide a comprehensive look at Florida's nurse population. This research is used to address issues of supply and demand, utilization of scarce nurse workforce resources throughout the state, and to make recommendations to influence health policy decisions.

Research has shown that increasing production of new nurses alone will not resolve the shortage. Efforts must be taken to retain the experiential knowledge of our existing nurses. It is through donations, such as we are asking you to consider today, that the Center can offer small grants aimed at improving the work environment to enhance retention and recruitment of nurses in Florida.

To learn more about the Center and to make a donation, please log onto your account at www.flhealthsource.gov. The Center's operating revenues are derived in part from your donations. In order for the Center to continue its work on behalf of nurses, please donate.

Nursing Student Loan Forgiveness: Pursuant to section 1009.66(6) F.S., and Florida Administrative Code Rule 64B9-7.001(11), a $5 Student Loan Forgiveness fee will be assessed for nurses renewing their Florida license.

Change of Status Requirements:

Active Status Options:

- **INACTIVE STATUS**: To change your license from active status to inactive status **during the renewal cycle**, you must complete the renewal application and pay the inactive status fee required by the board or department when there is no board. To change your license from active status to inactive status **after the renewal cycle ends**, you must complete the renewal application and pay the inactive status fee, plus the change of status and delinquent fees, required by the board or department when there is no board.
- **RETIRED STATUS**: To change your license from active status to retired status **during the renewal cycle**, you must complete the renewal application and pay the retired status fee required by the board or department when there is no board. To change your license from active status to retired status **after the renewal cycle ends**, you must complete the renewal application and pay the retired status fee, plus the change of status and delinquent fees, required by the board or department when there is no board.
- **MILITARY ACTIVE STATUS**: To change your license from active status to military active status, complete the renewal application and attach a copy of your current active duty orders or a letter from your Commanding Officer. There is no fee for military active status.
- **MILITARY SPOUSE STATUS**: To change your license from active status to military because you are the spouse of a member of the Armed Forces of the United States and will be absent from Florida due to your spouse's military duties, complete the renewal application and attach a copy of your spouse's active duty order or a letter from their Commanding Officer. There is no fee for military active status.

Inactive Status Options:

- **ACTIVE STATUS**: To change your license from inactive status to active status **during the renewal cycle**, you must complete the renewal application and pay the active status fee required by the board or Department when there is no board. Additionally, you must have met the continuing education requirements required by the board or Department when there is no board, to change your inactive license to active status. Your continuing education credits must be reported to the Department's Continuing Education Tracking system on or before the day you submit your renewal application.
- **REACTIVATE**: To change your license from inactive status to active status **after the renewal cycle ends**, you must complete the renewal application and pay the active status fee, plus the change of status and delinquent fees, required by the board or Department when there is no board. Additionally, you must have met the continuing education requirements required by the board or Department when there is no board, to reactivate your inactive license. Your continuing education credits must be reported to the Department's Continuing

Education Tracking system on or before the day you submit your renewal application. (Note: Additional requirements may be applicable.)

- **RETIRED STATUS**: To change your license from inactive status to retired status **during the renewal cycle**, you must complete the renewal application and pay the retired status fee required by the board or Department when there is no board. To change your license from active status to retired status **after the renewal cycle ends**, you must complete the renewal application and required supplemental forms and pay the retired status fee, plus the change of status and delinquent fees, required by the board or Department when there is no board.
- **MILITARY INACTIVE STATUS**: To change your license from inactive status to military inactive status, complete the renewal application and attach a copy of your current active duty orders or a letter from your Commanding Officer. There is no fee for military inactive status.
- **MILITARY SPOUSE STATUS**: To change your license from inactive status to military because you are the spouse of a member of the Armed Forces of the United States and will be absent from Florida due to your spouse's military duties, complete the renewal application and attach a copy of your spouse's active duty order or a letter from their Commanding Officer. There is no fee for Military Inactive status.

Note:

1. A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate their license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.
2. This status does not apply to Medical Doctor Public Psychiatry Certificate, Medical Doctor Public Health Certificate, Medical Doctor Limited to Mayo Clinic, Certified Nurse Assistant, Health Access Dentist, and Registered Chiropractic Assistant.

Military Status Options:

- **ACTIVE STATUS**: To remove military status from your license and receive an active license, you must complete the renewal application and pay the active status fee required by the board or Department when there is no board. Additionally, you must provide a copy of your DD214 or a letter from your Commanding Officer.
- **INACTIVE STATUS**: To remove military status from your license and receive an inactive license, you must complete the renewal application and pay the inactive status fee required by the board or Department when there is no board. Additionally, you must provide a copy of your DD214 or a letter from your Commanding Officer.
- **RETIRED STATUS**: To remove military status from your license and retire your license, you must complete the renewal application and pay the retired status fee required by the board or Department when there is no board. Additionally, you must provide a copy of your DD214 or a letter from your Commanding Officer.

License Renewal Application

Active and Inactive Status

Expedite your application-renew online at: www.flhealthsource.gov

License Number: _____

List the profession for which you renewing: _____

(Examples: Medical Doctor, Osteopathic Physician, Registered Nurse, Licensed Practical Nurse, etc.)

General Information:

Name: _____

Last/Surname First Middle

Do you wish to change your name? ☐ **YES** ☐ **NO**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the Department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation. If the name change cannot be completed, your license will be renewed using the current name.

Mailing Address: The address where your correspondence and license should be mailed.

Do you wish to update your mailing address? ☐ **YES** ☐ **NO**

_____

Street and #/P.O. Box Suite/Apt#

_____

City State/Province ZIP/Postal Code Country

Physical Address: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. If you do not have a current practice address your mailing address will be used.

Do you wish to update your physical address? ☐ **YES** ☐ **NO**

_____

Street and number Suite/Apt #

_____

City State/Province ZIP/Postal Code Country

Do you wish to update your physical address to 'Not Practicing'? ☐ **YES** ☐ **NO**

By checking the 'YES' box, you are indicating that you do not practice. The Department website will reflect 'Not Practicing' and your mailing address will be printed on your license.

Other Contact Information:

Do you wish to update or add a telephone or email address to your record? ☐ **YES** ☐ **NO**

Telephone: _____

Primary Alternate

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.

Criminal History and Medicaid / Medicare Fraud Questions:

As required by section 456.0635(3), F.S., please answer Yes or No to the following questions below. If you answer 'YES' to any of the following questions, please send a written explanation for each such question, including the county and state of each termination, plea, or conviction, the date of each termination, plea, or conviction, and copies of supporting documentation, to the address below. Supporting documentation may include court dispositions or agency orders.

Department of Health
Division of Medical Quality Assurance - Bureau of Operations
4052 Bald Cypress Way, Bin #C-10
Tallahassee, FL 32399-3260

1. ☐ Yes ☐ No 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 question 2.)**

- **a.** ☐ Yes ☐ No If "yes" to 1, did the arrest or felony charge resulting in the conviction or plea occur before July 1, 2009? **(If you responded "yes", skip to question 2.)**
- **b.** ☐ Yes ☐ No 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 or conviction, and completion of any sentence or subsequent period of probation?
- **c.** ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation? (This question does not apply to felonies of the third degree under section 893.13(6) (a), F.S.)
- **d.** ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree under section 893.13(6)(a), F.S., has it been more than 5 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?
- **e.** ☐ Yes ☐ No If "yes" to 1, are you currently enrolled in a pretrial diversion or drug court program that allows the withdrawal of the plea or dismissal of the charges for the felony offense upon successful completion of the program? (If yes, please provide supporting documentation.)

2. ☐ Yes ☐ No Since July 1, 2009, 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)? **(If you responded "no," skip to question 3.)**

- **a.** ☐ Yes ☐ No If "yes" to 2, did the sentence and any subsequent period of probation for such conviction or plea end more than 15 years before the date of this application?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, Florida Statutes? **(If you responded "no," skip to question 4.)**

- **a.** ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no," skip to question 5.)**

- **a.** ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?
- **b.** ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. Yes No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Please check the OIG website if you do not know if you are listed.

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

b. Yes No If you responded "Yes" to question 5a, is the student loan default or delinquency the only reason you are listed on the LEIE?

General Renewal Questions:

Do you wish to change your current license status? Yes No

If yes, please select from the list provided below:

- Active to Inactive Status
- Active to Retired Status
- Active to Military Active Status
- Inactive to Active Status
- Inactive to Retired Status
- Military to Active Status
- Military to Inactive Status
- Military to Retired Status

Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

How would you like to be notified concerning the renewal of your license?

a. By email? Yes No
b. By text? Yes No
c. By mail? Yes No

Profession Specific Renewal Questions:

This question ONLY applies to Medical Doctors, Osteopathic Physicians, Advanced Practice Registered Nurse, Podiatric Physicians, Optometrists and Dentists:

Are you currently registered to dispense medicinal drugs to your patients? Yes No

a If YES, do you want to continue dispensing medicinal drugs? Yes No
b If NO, would like to register to dispense medicinal drugs? Yes No
c. Are you registered with DEA to prescribe controlled substances? Yes No

This question ONLY applies to Physician Assistants:

I acknowledge that I have not been convicted of a felony in the previous two years. Yes No

Are you a physician assistant who has registered for prescribing privileges? Yes No

a. If YES, do you want to renew your prescribing privileges? Yes No
b. If YES, I acknowledge that I have completed a minimum of 10 medical education hours in the specialty practice for which I have prescriptive privileges. Yes No
c. Are you registered with DEA to prescribe controlled substances? Yes No

This question ONLY applies to Chiropractic Physicians:

Are you a chiropractic physician certified to supervise certified chiropractic physician assistants? ☐ Yes ☐ No

a. If YES, do you want to renew your supervising physician certification? ☐ Yes ☐ No

This question ONLY applies to Advanced Practice Registered Nurse, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Psychiatric Nurse:

Were you licensed as an Advanced Practice Registered Nurse, Certified Registered Nurse Anesthetist, Certified Nurse Midwife or Psychiatric Nurse in Florida after July 1, 2006? ☐ Yes ☐ No

a. If YES, provide the following information:

Certifying Board: _____
Certification: _____
Certification Number: _____
Expiration Date: _____

This question ONLY applies to Hearing Aid Specialists:

1. Do you perform audiometric tests in a testing room, certified by a manufacturer or independent testing agent that meets the requirements set forth in Section 484.0501(6), F.S.? ☐ Yes ☐ No ☐ Not Applicable

a. If NO, do you provide the Certified Testing Room Waiver to your patients notifying them that you are not testing them in an environment that meets statutory requirements?**.** ☐ Yes ☐ No

2. Do you possess a certificate from a manufacturer or independent testing agent stating that all audiometric testing equipment used by the licensee has been calibrated acoustically to American National Standards Institute Standards on an annual basis? ☐ Yes ☐ No

This question ONLY applies to Athletic Trainers:

Are you currently certified by the Board of Certification or its successor agency? ☐ Yes ☐ No

a. If YES, please provide the following information:

BOC Certification Number: _____
Certification Date: _____
Expiration Date:_____

b. If NO, licensee acknowledges initial license was held prior to January 1, 1998.

This question ONLY applies to Pharmacists:

1. To provide services under a collaborative pharmacy practice agreement, a pharmacist must maintain at least $250,000 of professional liability insurance coverage. A pharmacist who maintains professional liability insurance coverage as a requirement of the Test and Treat Certification, pursuant to section 465.1895, Florida Statutes, satisfies this requirement.

a. Do you maintain at least $250,000 of professional liability insurance? ☐ Yes ☐ No

2. To test or screen for and treat minor, nonchronic health conditions within the framework of a written protocol, a pharmacist must maintain at least $250,000 of professional liability insurance coverage. A pharmacist who maintains professionals liability coverage as a requirement of their Collaborative Practice Certification satisfies this requirement.

a. Do you maintain at least $250,000 of professional liability insurance? ☐ Yes ☐ No

This question ONLY applies to Registered Nurses and Licensed Practical Nurses with Multi-State Licenses (MSL):

As required by Section 464.0095, Article III (3), F.S., please answer Yes or No to the questions below. If you answer "Yes" to any of the questions, please send a written explanation for each question, including the county and state of each conviction, the date of each alternative program or conviction and copies of supporting documentation. Supporting documentation may include court dispositions or agency orders.

1. Have you been convicted or found guilty, or entered into an agreed disposition other than a disposition that results in nolle prosequi, of a felony offense under applicable state or federal criminal law that has not been reported since MSL approval or your last renewal? ☐ **YES** ☐ **NO**

2. Have you been convicted or found guilty, or have entered into an agreed disposition other than a disposition that results in nolle prosequi, of a misdemeanor offense related to the practice of nursing that has not been reported since MSL approval or your last renewal? ☐ **YES** ☐ **NO**

3. Are you currently enrolled in an alternative to discipline program in any state? An alternative to discipline program is a non-disciplinary monitoring program approved by a licensing board. ☐ **YES** ☐ **NO**

Statement of Applicant:

By submitting the appropriate renewal fees to the Department, I certify compliance with all requirements for renewal. 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 disciplinary action against my license, or criminal penalties. 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 department within 30 days.

_____ _____

Signature **Date**

Criminal Conviction Sworn/Affirmation Statement at Renewal

Have you been convicted of a felony in any jurisdiction with the past two years preceding this application for renewal? ☐ **YES** ☐ **NO**

If yes, provide a list of any felony convictions received with the past two years preceding this application for renewal and attach copies of all court documents related to your conviction(s) and any materials documenting successful completion of your sentence or other legal obligations.

_____
_____
_____
_____
_____
_____

I have carefully read the question above and swear that the answer provided is true and correct. I recognize that providing false information may result in disciplinary action against my license, or criminal penalties pursuant to sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

_____ _____
Signature Date

_____
License Number

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this ___day of _____, _____, by

_____

_____
Signature of Notary Public

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known_____ OR Produced Identification
_____

Type of Identification Produced _____

LIMITED LICENSE FEE WAIVER STATEMENT

(TO BE COMPLETED BY EMPLOYER OF VOLUNTEER PHYSICIAN)

Pursuant to section 458.317(1)(a)1., Florida Statutes, if a person applying for a Limited License submits a statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of medicine, the licensure fees shall be waived.

STATEMENT

I,_____, state that the following physician:

(TYPE OR PRINT PHYSICIAN'S NAME)

will NOT receive monetary compensation for any service involving the practice of medicine from:

Employing Agency/Institution:_____

Address:_____

Signed: _____

(Name – Type or Print)

Title: _____

FINANCIAL RESPONSIBILITY - Acupuncture Only

Please select **only one** of the following statements that best describes your liability coverage:

CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- ☐ I hereby certify that I have professional liability coverage in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.
- ☐ I hereby certify that I have an irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount not less than $10,000 per claim, with a minimum aggregate availability of credit no less than $30,000.
- ☐ I hereby certify that I have obtained a surety bond in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- ☐ I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- ☐ I practice only in conjunction with my teaching duties at an accredited acupuncture school.
- ☐ I do not practice in Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in sections 456.067, 456.072, 775.082, 775.083, and 775.084, F.S.

_____

Name (printed)

_____ _____

Signature (required) Date

FINANCIAL RESPONSIBILITY - Medical Doctors Only
(Page 1 of 2)

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

Category I: Financial Responsibility Coverage

- ☐ 1. I do not have hospital staff privileges, I do **not** perform surgery at an ambulatory surgical center and I have established an irrevocable letter of 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 or I perform surgery at an ambulatory surgical center 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 section 625.52, F.S., for an escrow account.
- ☐ 3. I do not have hospital staff privileges, I do **not** perform surgery at an ambulatory surgical center 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 section 624.09, F.S., from a surplus lines insurer as defined under section 626.914(2), F.S., from a risk retention group as defined under section 627.942, F.S., from the Joint Underwriting Association established under section 627.351(4), F.S., or through a plan of self-insurance as provided in section 627.357, F.S.
- ☐ 4. I have hospital staff privileges or I perform surgery at an ambulatory surgical center 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 section 624.09, F.S., from a surplus lines insurer as defined under section 626.914(2), F.S., from a risk retention group as defined under section 627.942, F.S., from the Joint Underwriting Association established under section 627.351(4), F.S., or through a plan of self-insurance as provided in section 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 section 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 in section 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 section 458.317, F.S., and practice only under the scope of the limited license.
- ☐ 8. I do not practice medicine in 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 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-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 be subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of 3 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.
- ☐ 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 - Medical Doctors Only

(Page 2 of 2)

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 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-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 10 years of practice, to license revocation, suspension, or probation for a period of 3 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

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

FINANCIAL RESPONSIBILITY - Osteopathic Physicians Only
(Page 1 of 3)

The Financial Responsibility options are divided into 2 categories: coverage and exemptions. Check only **1** of the 10 options provided as required by section 459.0085, F.S.

CATEGORY I: Financial Responsibility Coverage for Florida Practice Only

- ☐ 1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center 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 section 624.09 F.S., from a surplus lines insurer as defined under section 626.914(2) F.S., from a risk retention group as defined under section 627.942 F.S., from the Joint Underwriting Association established under section 627.351(4) F.S., or through a plan of self-insurance as provided in section 627.357 F.S.

- ☐ 2. I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have obtained and maintain 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 section 624.09 F.S., from a surplus lines insurer as defined under section 626.914(2) F.S., from a risk retention group as defined under section 627.942 F.S., from the Joint Underwriting Association established under section 627.351(4) F.S., or through a plan of self-insurance as provided in section 627.357 F.S., or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in section 766.110 F.S.

- ☐ 3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with section 625.52, F.S, in the per-claim amounts specified above.

- ☐ 4. I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with section 625.52, F.S., in the per-claim amounts specified above.

- ☐ 5. I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in section 459.0085(5)(g), F.S. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

CATEGORY II: Financial Responsibility Exemptions

- ☐ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
- ☐ 7. I hold a limited license issued pursuant to section 459.0075, F.S., and practice only under the scope of such limited license.
- ☐ 8. I practice only in conjunction with my teaching duties at a college of osteopathic medicine. (Residents do not qualify for this exemption.)
- ☐ 9. I do not practice osteopathic medicine in Florida. I will notify the department immediately before commencing practice in the state.
- ☐ 10. I am exempt from demonstrating financial responsibility due to meeting all of the following criteria** See note below.
  - (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 1,000 patient contact hours per year.
  - (c) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-year period.
  - (d) I have not been convicted of, or pled nolo contendere to any criminal violation specified in Chapter 459, F.S., or the practice act of any other state.
  - (e) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of Chapter 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

_____ _____

Signature Printed Name

****If you select an exemption based on based on number 10, you must also complete the affidavit on the following page.**

DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an exemption based on number 10 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 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 459, F.S. or the medical practice act in any other state; and

(e) I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of 3 years or longer, or a fine of $500 or more for a violation of Chapter 459, 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 459.0085(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

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

Personally Known _____ OR Produced Identification _____

Type of Identification Produced_____

FINANCIAL RESPONSIBILITY - Chiropractic Medicine Only

- ☐ I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, and in compliance with Florida Administrative Code Rule 64B2-17.009(1),. (Proof of coverage must come directly from the company)
- ☐ I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000, and in compliance with Florida Administrative Code Rule 64B2-17.009(2).
- ☐ I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.
- ☐ I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited chiropractic medicine school/college or its main teaching hospital.
- ☐ I am exempt from demonstrating financial responsibility because I do not practice in Florida.
- ☐ I am exempt from demonstrating financial responsibility because I have no malpractice exposure in Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in sections 456.066, 456.067, 456.072, 775.082, 775.083, and/or 775.084, F.S.

Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY - Podiatric Medicine Only

- ☐ I have professional liability coverage in an amount of not less than $100,000 with the following company _____. (Proof of coverage must come directly from the company)
- ☐ I have established and will maintain an escrow account consisting of cash or securities eligible for deposit in accordance with section 625.52, F.S., in an amount of not less than $100,000.
- ☐ I have an irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than $100,000 per claim.
- ☐ I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.
- ☐ I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited podiatric medicine school/college or its main teaching hospital.
- ☐ I am exempt from demonstrating financial responsibility because I do not practice in Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in sections 456.066, 456.067, 456.072, 461.012, 461.013, 775.082, and/or 775.083 and/or 775.084, F.S.

Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY - Dentistry Only

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only **1** option of the 6 provided pursuant to Florida Administrative Code Rule 64B5-17.011.

CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

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

- ☐ I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F. S., in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000.

- ☐ I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government or of the state or its agencies or subdivisions.

- ☐ I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

- ☐ I am exempt from demonstrating financial responsibility because I do not practice in Florida.

- ☐ I am exempt from demonstrating financial responsibility because I have no malpractice exposure in Florida.

Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY - Licensed Midwifery Only

Please choose one of the following:

- ☐ I hereby certify that I have 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.

- ☐ I hereby certify that I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below (circle):
  (a) I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
  (b) I have an inactive license, and do not practice in Florida.
  (c) I practice only in conjunction with my teaching duties at an approved midwifery school.
  (d) I do not practice in Florida, but I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state
  (e) I have no malpractice exposure in Florida.

Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY - Advanced Practice Registered Nurse Only

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option that best describes your situation. If you provided financial responsibility information to a hospital or elsewhere, please be consistent when choosing an option below.

Please be advised that failing to choose an option or choosing more than one option will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding choosing an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

- ☐ I have obtained and will maintain professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under section 624.09, F.S., a surplus lines insurer under section 626.914(2), F.S., a joint underwriting association under section 627.351(4), F.S., a self-insurance plan under section 627.357, F.S., or a risk retention group under section 627.942, F.S.

- ☐ I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, F.S. which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

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

- ☐ I hold a limited license issued pursuant to s. 456.015, F.S. and practice only under the scope of the limited license.

- ☐ My Florida license is inactive and I do not practice in the State of Florida.

- ☐ I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

- ☐ My Florida license is active, but I do not practice in the State of Florida.

- ☐ I have just completed my Advanced Practice Registered Nurse Program and/or I am not yet practicing in Florida.

Section 456.067, F.S. Penalty for giving false information.—In addition to, or in lieu of, any other discipline imposed pursuant to section 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license from the department, or any board thereunder, with intent to mislead a public service in the performance of his or her official duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable as provided in sections 775.082, 775.083, 775.084, F.S.

_____	_____
Name (printed)	Florida APRN Number
_____	_____
Signature of Licensee	Date

FINANCIAL RESPONSIBILITY – Autonomous Advanced Practice Registered Nurse Only

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option that best describes your situation. If you provided financial responsibility information to a hospital or elsewhere, please be consistent when choosing an option below.

Please be advised that failing to choose an option or choosing more than one option will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding choosing an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ I have obtained and will maintain professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under section 624.09, F.S., a surplus lines insurer under section 626.914(2), F.S., a joint underwriting association under section 627.351(4), F.S., a self-insurance plan under section 627.357, F.S., or a risk retention group under section 627.942, F.S.

☐ I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, F.S. which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

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

☐ My Florida license is inactive, and I do not practice in the state of Florida.

☐ I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ My Florida license is active, but I do not practice in the state of Florida.

Section 456.067, F.S. Penalty for giving false information— In addition to, or in lieu of, any other discipline imposed pursuant to section 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license from the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her official duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable as provided in s. 775.082, 775.083, or 775.084, F.S.

_____ _____

Name (printed) Florida APRN Number

_____ _____

Signature of Licensee Date

FINANCIAL RESPONSIBILITY - ANESTHESIOLOGIST ASSISTANTS ONLY

Financial Responsibility options are divided into 2 categories, coverage and exemptions. Choose only 1 option provided pursuant to section 456.048, F.S.

FINANCIAL RESPONSIBILITY COVERAGE:

❒ I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/ $300,000, in accordance with Chapter 675, F. S., for a letter of credit and section. 625.52, F. S., for an escrow account.

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

FINANCIAL RESPONSIBILITY EXEMPTIONS:

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

❒ I do not practice medicine in Florida.

❒ I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.

_____ _____

Signature of Anesthesiologist Assistant Date