State of Florida
Department of Health

Board of Osteopathic Medicine

Application for Registration as an Osteopathic Physician in Training

Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 488-0595

Application for Registration as an Osteopathic Physician in Training
General Information and Instructions

The following instructions are numbered to correspond with the numbered sections of the application. Each numbered instruction will give specific information regarding filling out the corresponding section of the application.

A response must be given in each section. If a question does not pertain to you, indicate N/A in that section. All questions that require a Yes/No answer must be answered either YES or NO. NOTE: We strongly recommend that the forms you complete are forms received from this office or the medical education coordinator office. "Unofficial" copies are frequently outdated.

Your application should be received by the Board Office **AT LEAST 30 DAYS PRIOR** to your training start date or the expiration of an existing training license number previously issued by the Board of Osteopathic Medicine. NOTE – Our fiscal year ends June 30 and the Board cannot process any applications for at least a week at the end of that month; therefore if your training begins on July 1, or shortly thereafter, your application must be received by the Board Office no later than June 1 to ensure that your number is issued prior to your anticipated start date.

IMPORTANT NOTICE!:

Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

FEE SCHEDULE:
All fees must be made payable to the Department of Health and must be by cashiers check or money order. All fees must be encompassed in one check. Please do not send separate checks.

Initial Registration Fee:	**$100.00**
Renewal of Registration:	**$100.00**

ADDITIONAL / SUPPLEMENTAL DOCUMENTS REQUIRED:
- A copy of your diploma verifying graduation from Osteopathic Medical School (for initial applications only).
- A letter from your program director or coordinator verifying registration/acceptance into their training program and your dates of training. Note to program coordinators – you may submit one cover letter listing all applicants if you send in a group of applications at once.
- A list of all rotation sites where you will be training while in Florida. This can be included in the letter from the program director/coordinator.
- If you currently hold, or have ever held any professional or medical license in any state, US territory or foreign country you must request that verification of the license be mailed directly from the issuing state licensing entity to the Board office. A copy of your license is not considered verification. Some states are using www.Veridoc.org for verification. Please check to see if the state you are licensed in utilizes Veridoc.
- Affirmative answers to application history or background questions require additional information as denoted in the application instructions.

BOARD APPEARANCES:

Certain applicants may be required to appear before the Board of Osteopathic Medicine (Board) to discuss his or her application before a determination of licensure can be made. An appearance may be required for a variety of reasons, such as:

- Malpractice
- Criminal Convictions
- Discipline
- Previous appearance before a licensing board or regulatory agency
- Unfavorable training evaluations or staff privilege verifications
- Drug/alcohol addiction/impairment
- Discrepancies in application information/materials
- Participation in an impaired practitioner program
- Other reasons as deemed necessary

The scenarios listed above are not an automatic appearance before the Board. Appearances are determined on an individual basis. The Board Chair, not office staff, determines the necessity of an appearance. The Board Chair may also require an application be presented to the Board for review, but not require the appearance of the applicant. Should your appearance be required, you will be notified of the exact date, time and location of the meeting.

In the event that you believe you MAY be required to appear before the Board based on a scenario listed above, it is recommended that you submit your application several months in advance of the meeting for which you wish to appear, as many of the documents necessary to complete your file can take several weeks to be received by the Board office and incorporated into your file. You can view the Board's meeting dates and locations on its website at: *www.doh.state.fl.us/mqa/osteopath/index.html.*

APPLICATION COMPLETION INSTRUCTIONS:

1. **Social Security Number and Health History Questions:** List your social security number and answer the questions related to health history. Any additional documentation required based on an affirmative answer is listed directly on the application page.
2. **Registration Method:** Indicate if this is an initial registration or renewal of a registration. If a renewal, please provide your current or previous training number and the name and location of the previous Florida training program.
3. **Name:** List your full name.
4. **Telephone Numbers:** List both your primary and business numbers.
5. **Mailing Address:** List the address where you receive mail.
6. **Physical Address:** This should be the address where you reside. It may be the same as the mailing address. If so, please indicate. No PO Boxes.
7. **Email Address:** Please provide an email address if you would like to be contacted via email regarding this application.
   a. Please answer yes or no. If you want to receive notices regarding your application deficiencies by e-mail only, please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through e-mail only. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board. Note- Additional notices regarding any required Board appearances or licensure decisions will be provided through the regular USPS mail system.
8. **Osteopathic Medical Degree:** List the name of your Osteopathic Medical School, the city, state and graduation date.
9. **Florida Postgraduate Training Program:**
   - **a)** List the name of the hospital or institution/program where you are going to commence training. This should be the hospital or institution in the **State of Florida** for which this form is being completed. Please include the name of the educational facility as well as the name of the hospital.
   - **b)** List the full mailing address of the institution/program, including; floor numbers, room numbers, specific program areas (i.e. anesthesiology etc.). This should be the address of your official place of practice.
   - **c)** List the name of the Program Director and/or person who is your immediate supervisor.
   - **d)** List the phone number where the program director/administrator may be contacted. Include extension, if applicable.
   - **e)** List your specialty area of training.
   - **f)** List the dates you plan to begin and end your training. PLEASE NOTE: All registration numbers expire after one year. If you plan to continue your training after one year, you must submit a new application and fee.
   - **g)** Select your program type (internship, residency or fellowship).

10. **Previous Postgraduate Training:** List all postgraduate training programs you have ever participated in.

11. **Practice / Employment History:** List type of employment or a description of any non-employment period, as well as the address and dates for all employment or non-employment periods since you graduated from medical school.

12. List any license you hold or have ever held in the space provided. Attach additional sheets if necessary. You must submit an official license verification (mailed directly from the state of licensure to the Board office) for any license you now hold or have ever held in any state.

13. Answer yes or no. If yes, please provide an explanation in your own words regarding the action or incident. You must also have the state licensing entity provide all pertinent documentation, including complaints, orders, current disposition, etc.

14. Answer yes or no. If yes, please provide an explanation in your own words regarding the action or incident. Additional information may be required.

15. Answer yes or no. If yes, please provide a letter of explanation in your own words regarding the incident. You must also direct the school or training program to send a letter of explanation

16. Answer yes or no. If yes, please provide an explanation in your own words. You must also have your school or training program send a letter providing applicable details to the Board office.

17. Answer yes or no. If yes, please provide an explanation in your own words. You must also have the state licensing entity provide all pertinent documentation, including complaints, orders, current disposition, etc.

18. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

19. Answer yes or no. If yes, please provide an explanation regarding the charges on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges, restoration of civil rights (if applicable) and current disposition.

20. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also include any documents relevant to the investigation, included the allegations of the investigation and current status.

21. Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges, restoration of civil rights (if applicable) and current disposition.

22. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

23. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.

24. **Physical Description:** Response to this section is self-explanatory.

25. **Citizenship:** List the country where you hold citizenship, date of and place of birth.

26. **Statement of Applicant:** Please read this section carefully and sign where indicated. If your application is not signed and dated upon receipt, it will be returned to you as incomplete.

YOU MUST NOTIFY US IMMEDIATELY OF ANY OCCURRENCES WHICH WOULD CHANGE OR AFFECT IN ANY WAY, AN ANSWER OR RESPONSE YOU HAVE GIVEN IN THE APPLICATION. FAILURE TO DO SO COULD RESULT IN THE DENIAL OR REVOCATION OF YOUR REGISTRATION.

FLORIDA DEPARTMENT OF HEALTH

1. Social Security Number and Health History Questions:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Osteopathic Medicine
Application for Osteopathic Physician in Training

Name:_____
Last **First** **Middle**

Social Security Number:_____

If questions A-F are answered YES, explain in full on a separate sheet of paper. Your statement must include, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved. If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).	
A. 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 of drug or alcohol abuse that occurred within the past five years?	Yes___ No____
B. 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____
C. 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____
D. During 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____
E. 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____
F. 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?	Yes___ No____

*** 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 (1)(a), Florida Statutes.**

APPLICATION FOR REGISTRATION AS AN OSTEOPATHIC PHYSICIAN IN TRAINING

Mail completed application and fee to:

FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
PO Box 6330
Tallahassee, FL 32314-6330

2. Registration Method - Check only one – Client 1902

[ ] Initial Registration - $100 Fee Required

[ ] Renewal of Registration - $100 Fee Required

- List the training number to be renewed: _____
- List the previous training program name/location: _____

3. Name: _____
(Last) (First) (Middle)

4. Telephone Number: _____ _____
(Primary – area code/number) (Business – area code/number)

5. Mailing Address: _____
(Number and Street or PO Box)

_____
(City, State and Zip)

6. Physical Address: _____
(Number and Street - NO PO Box)

_____
(City, State and Zip)

7. Email Address: _____

7a. E-Mail Notification: If you want to receive notices regarding your application deficiencies by **e-mail only**, please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through **e-mail only**. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board. **[ ] YES [ ] NO**

8. Osteopathic Medical Degree obtained from: _____
(Name of School)

_____
(City/State)

_____
(Date of Graduation – MM/DD/YYYY)

9. FLORIDA Postgraduate Training Information:

a) Name of Hospital/Training Program: _____
(Please list the hospital/training program in FLORIDA where you plan to train)

b) Full Mailing Address: _____
(Number and Street)

_____
(City, State and Zip)

c) Program Director/Administrator: _____

d) Program Phone Number: _____
(Area code/number)

e) Specialty Area: _____

f) Dates of Training: _____
(MM/DD/YY) through (MM/DD/YY)

g) Program Type (select only one): **[ ] Internship** **[ ] Residency** **[ ] Fellowship**

10. PREVIOUS POSTGRADUATE TRAINING: List in chronological order from date of graduation from osteopathic medical school to the present all postgraduate training (internship/residency/fellowship). Attach additional sheets if necessary.

NAME OF TRAINING PROGRAM	CITY & STATE	PROGRAM TYPE (internship, residency, fellowship)	SPECIALTY AREA	AOA OR ACGME APPROVED	DATES OF ATTENDANCE		CREDIT RECEIVED Y OR N
					Began	Ended	

11. PRACTICE / EMPLOYMENT HISTORY: List in chronological order from date of graduation from osteopathic medical school to the present, all employment, non-employment and/or any unaccounted for period of time. Do not list postgraduate training. (Attach additional sheets if necessary.)

EMPLOYMENT OR NON-EMPLOYMENT (select one)	TYPE OF EMPLOYMENT OR DESCRIPTION OF NON-EMPLOYMENT	FULL MAILING ADDRESS	DATES	
			Began	Ended
[ ] Employment [ ] Non-employment				
[ ] Employment [ ] Non-employment				
[ ] Employment [ ] Non-employment				

12. Do you now hold, or have you ever held a license to practice Osteopathic Medicine or any other profession in any US State, territory or foreign country? [ ] YES [ ] NO

_____
(If Yes, list profession, state, license number and date of issuance)

13. Have you ever had any professional license or license to practice Osteopathic Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [ ] NO

14. Have you ever had employment terminated for cause? [ ] YES [ ] NO

15. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign or otherwise acted against by any school, college, university or training program? [ ] YES [ ] NO

16. Was attendance in Osteopathic Medical school or any postgraduate training program for a period other than the normal curriculum or established time frame? [ ] YES [ ] NO

17. Were you required to repeat any part of your Osteopathic Medical education, or postgraduate training program for any reason? [ ] YES [ ] NO

18. Have you ever had any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or licensing authority in any state, territory or country? [ ] YES [ ] NO

19. Have you ever been convicted of, or entered a plea of guilty, nolo contendre or no contest to a crime, regardless of adjudication, in any jurisdiction? [ ] YES [ ] NO

20. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s.459.015, F. S.? [ ] YES [ ] NO

Pursuant to Section 456.0635(2), Florida Statutes, the following questions (21 – 23) are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of all supporting documentation. Please see instructions for required documentation.

21a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? [ ] YES [ ] NO
(If no, do not answer 21b.)

b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? [ ] YES [ ] NO

22a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, Florida Statutes? [ ] YES [ ] NO
(If no, do not answer 22b.)

b. 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

23a. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? [ ] YES [ ] NO
(If no, do not answer 23b and 23c.)

b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? [ ] YES [ ] NO

c. Did the termination occur at least 20 years prior to the date of this application? [ ] YES [ ] NO

24. PHYSICAL DESCRIPTION: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38295 August 25, 1978. This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other: _____
Sex: [ ] Male [ ] Female

25. CITIZENSHIP:

a. List the country where you hold citizenship: _____

b. Birth Date: _____ Birth Place: _____
(Month/Day/Year) (City/State/Province/Country)

26. STATEMENT OF APPLICANT:

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

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 Osteopathic Medicine any 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, and I declare 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 shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the 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 the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR 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 on it.

_____
Signature of Applicant Date