Podiatric Physician Application for Licensure and Examination

Board of Podiatric Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridaspodiatricmedicine.gov
Email: info@floridaspodiatricmedicine.gov
Phone: (850) 245-4292
FAX: (850) 413-6982

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armec Forces and their families online at

http://www.flhealthsource.gov/valor

Podiatric Physician Application for Licensure and Examination

Board of Podiatric Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 413-6982
Email: info@floridaspodiatricmedicine.gov

Do Not Write in this Space
For Revenue Receipting Only

Select one Podiatric application type (2101):

☐ **Initial License** (1010) **$455.00**

☐ **Examination** (1015) **$655.00**

Total fee includes the following:

Application Fee	$100.00
Initial Licensure Fee	$350.00
Unlicensed Activity Fee	$5.00
Examination Fee (if applicable)	$200.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $355.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

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

Mailing Address: (The address where mail and your license should be sent)

______________________ ______ ______________
Street/P.O. Box Apt. No. City

______________ ______ ______________ ______________
State ZIP Country Home/Cell Telephone (Input without dashes)

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

______________________ ______ ______________
Street (Place of Employment) Apt. No. City

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

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical ard reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: ______________________________

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statute (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: ____

First Name: ____

Middle Name: ____

Social Security Number: ____________________________________
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: ____________________

3. APPLICANT BACKGROUND

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

____

B. Do you hold, or have you ever held a license to practice podiatric medicine or any other health-related license(s)? ☐ Yes ☐ No

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

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D.

In order to be eligible for licensure, all applicants must have completed one of the following:
☐ **One year of residency** in a residency program approved by the Council on Podiatric Medical Education. **Verification must be sent directly from the residency program director.**
☐ **Ten years of continuous, active licensed practice** of podiatric medicine in another state immediately preceding the submission of the application, and completion of at least the same number of hours of continuing education required during those ten years as is required of doctors of podiatric medicine licensed in this state. **You are required to show proof of practice and completion of continuing education by submitting copies of the certificates of completion or by written verification by the state licensing authority.**

E. List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time.

Name of Business	Full Mailing Address	Type of Employment	Employment Dates: From-To (MM/DD/YYYY)
			to
			to
			to

F. Have you ever had employment terminated for cause? ☐ Yes ☐ No

G. Have you ever had an application for a professional license, or any application to practice podiatric medicine, denied by any state board or governmental agency (state or country)? ☐ Yes ☐ No

H. Have you ever been notified/required to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Podiatric Medicine Practice Act, unprofessional or unethical conduct? ☐ Yes ☐ No

If you responded "Yes" to questions F-H, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Name: ______________________________

4. DISASTER

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

5. EDUCATION HISTORY

A. List undergraduate, graduate, and professional education, listing all schools, colleges and universities attended whether completed or not, in chronological order.

School Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		
		to		
		to		
		to		

☐ **All applicants must have an official transcript forwarded directly to the board office from your educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

B. List in chronological order from date of graduation from the Podiatric Medical School to present, all professional/postgraduate training (Internship/Residency/Fellowship).

Program Name	City/State or Country	Program Type	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received?
				to	☐Y ☐N
				to	☐Y ☐N

C. Have you ever been placed on probation, restrictions, suspension, revocation, or modification, been allowed to resign, requested to leave, or otherwise acted against, whether temporarily or permanently, by a Podiatric/Professional training program prior to completion of training? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Program Name	Full Address	Institution/Hospital	From-To (MM/DD/YYYY)
			to
			to
			to

D. Are you certified by any specialty board recognized by the American Board of Medical Specialties or other similar national organization, or from any specialty board recognized by the Florida Board of Podiatric Medicine? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/DD/YYYY)

☐ **If certified, you must supply a copy of each certification or a letter of verification.**

Name: ___________________________________

6. ACADEMIC FACULTY APPOINTMENTS/STAFF PRIVILEGES

A. Do you currently hold a faculty appointment at a medical school? ☐ Yes ☐ No

B. Have you had the responsibility for graduate medical education with the last ten years? ☐ Yes ☐ No

If you responded "Yes" to question A or B, complete the following:

Name of Institution	City/State	Title of Appointment

C. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility (do not list training privileges)? ☐ Yes ☐ No

If you responded "Yes," complete the following: ☐ In-State Facility ☐ Out-of-State Facility

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

D. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N

E. Have you ever been asked or allowed to resign from any facility instead of facing disciplinary action or during any pending investigations into your practice? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N

F. Have you ever had any staff privileges restricted or not renewed by any facility instead of facing disciplinary action? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N

Name: ____________________________

7. EXAM INFORMATION

The following examinations are required for licensure: Part I (Basic Science examination), Part II (Clinical Science examination), and Part III of the National Board of Podiatric Medical Examiners examination.

A. **Part I (Basic Science examination)-** Provide the date of successful completion and the state in which the exam was taken.

Exam Date (MM/DD/YYYY)	State

B. **Part II (Clinical Science examination)-** Provide the date of successful completion and the state in which the exam was taken.

Exam Date (MM/DD/YYYY)	State

C. **Part III-** Have you passed the National Board of Podiatric Medical Examiners examination(s)? ☐ Yes ☐ No

If "Yes," provide the date of successful completion and the state in which the exam was taken.
If "No," provide the state and date on which you plan to take the examination(s).

Exam Date (MM/DD/YYYY)	State

D. Have you ever failed the National Board of Podiatric Medical Examiners examination(s)? ☐ Yes ☐ No

If "Yes," provide the date(s) of failure and the state(s) in which the exam was taken.

Exam Date (MM/DD/YYYY)	State

☐ **Verification of passing scores for all exam parts must be sent directly from the National Board of Podiatric Medical Examiners. Results/score reports provided by the applicant will not be accepted. Score verifications should be sent to the board office at:**

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

8. OTHER ITEMS REQUIRED

☐ **National Practitioner Data Bank (NPDB) Self-Query-** **All applicants** are required to complete a self-query to the NPDB and upon receipt of the report, provide the board office with a copy. A fee is charged by the NPDB to provide the self-query. You can contact NPDB at http://www.npdb.hrsa.gov/ or by telephone at (800) 767-6732.

NPDB self-query should be submitted to the board office at the above address or by email at info@floridaspodiatricmedicine.gov.

Name: ______________________________

This information is exempt from public records disclosure.

9. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Name: ____

10. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice podiatric medicine revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or country? ☐ Yes ☐ No

If you respond "Yes," complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

B. Have you ever had any final disciplinary actions taken against you by a specialty board recognized by the department? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Specialty Board	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
			☐ Y ☐ N
			☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

11. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? **You must include all misdemeanors and felonies, even if adjudication was withheld.**

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

☐ ***I understand that pursuant to s. 461.013(1)(a), F.S., and s. 461.013(2), F.S., attempting to obtain, obtaining, or renewing a license to practice podiatric medicine by bribery, by fraudulent misrepresentation, or through an error of the department or board constitutes grounds for suspension, revocation, or denial of licensure.***

If you responded "Yes" in this section, complete the following:

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

If you responded "Yes," you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: ____

12. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in 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. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

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

Name: ____

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

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

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

If you responded "Yes" to any of the 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** including court dispositions or agency orders where applicable.

Documentation for sections 9 and 10 must be sent to the board office at floridaspodiatricmedicine@flhealth.gov or mailed to: Board *of* Podiatric Medicine 4052 Bald Cypress Way Bin C-08 Tallahassee, FL 32399-3258	Documentation for sections 11 and 12 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL 32399

13. LIVESCAN PRIVACY STATEMENT

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

☐ **Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically, background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH2017Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

Because the Florida Department of Health retains fingerprints on any applicant, those prints are retained in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. You will be notified when your retention date is approaching and will be provided with instructions on how to retain your fingerprints to avoid having to submit a new background screening.

Name: ______________________________

14. DRUG ENFORCEMENT AGENCY

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

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

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

15. LIABILITY CLAIMS

A. Are you covered by an insurer required to report pursuant to s. 627.912 F.S.? ☐ Yes ☐ No

B. Have you been insured continuously during the last ten years? ☐ Yes ☐ No

C. Within the last ten years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? ☐ Yes ☐ No

☐ **If you responded "Yes" to any questions in this section, you must complete the Exhibit 1 form found following this application.**

16. APPLICANT SIGNATURE

I understand that these statements are true and correct and recognize that providing false information may results in disciplinary action against my license or criminal penalties pursuant to s. 456.067, 456.072, 461.012, 461.013, 775.082, 775.083, and 775.084, F.S.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instruments (local, state, federal, or foreign) to release to the Florida Board of Podiatric 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 reservation of any kind, and I declare under penalty of s. 461.012(2)(b), F.S., 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 podiatric 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.

As a reminder to all applicants, understand that s. 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature ______________________________ Date ______________

You may print out this application and sign it or sign digitally. MM/DD/YYYY

Florida Board *of* Podiatric Medicine

Financial Responsibility

This form is required for ALL applicants.

Name: ______________________________________

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 4** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.
Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000. (Proof of coverage must come directly from the company.)

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, F.S., in an amount no less than $100,000 per claim.

☐ 3. I have established and will maintain an escrow account consisting of cash or securities eligible for deposit in accordance with s. 625.52, F.S., in an amount of not less than $100,000.

☐ 4. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

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

☐ 2. I practice only in conjunction with my teaching duties at an accredited podiatric medicine school/college or in its main teaching hospitals.

☐ 3. I have no malpractice exposure, because 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 s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her 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 in s. 775.082, 775.083, or 775.08, F.S.

Applicant Signature ______________________________________ Date ________________
MM/DD/YYYY

If you selected options one or two in the "Financial Responsibility Coverage" section, provide proof of liability coverage sent directly by the insuring company to the board by email at info@floridaspodiatricmedicine.gov or by mail to:

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL REOCRDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREEING CLEARINGHOUSE

NOTICE OF:

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

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

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

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

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

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

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

PRIVACY STATEMENT

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

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

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

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

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

Board *of* Podiatric Medicine
Electronic Fingerprinting

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

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- A list of Livescan service providers is provided at: http://www.floridahealthsource.gov/background-screening/.
- Failure to submit background screening will delay application processing.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement.
- The correct Originating Agency Identification (ORI) must be provided to the Livescan service provider, or the board office will not receive the background screening results.
- The ORI for the Board of Podiatric Medicine is **EDOH2017Z**.
- Accurate demographic information must be provided to the Livescan service provider at the time of fingerprinting, including **Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.

Name: ____ SSN#: ____________________
Last First Middle

Aliases: ____

Address: ____ Apt. Number: _________

City: ______________________ State: ______________________ ZIP: ______________

Date of Birth: ______________ Place of Birth: ______________________________
MM/DD/YYYY

Weight: __________ Height: __________ Eye Color: ______________ Hair Color: ______________

Race: - __________
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown)

Sex: - ________
(M= Male; F=Female)

Citizenship: ______________________________

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

Keep this form for your records.

Exhibit I- Report on Professional Liability Claims and Actions

Include information relating to liability actions occurring within the previous ten years. The actions are required to be reported under s. 456.039, F.S. A form must be completed for each occurrence. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.049, F.S., may be submitted in lieu of this exhibit to satisfy the reporting requirement.

Date of occurrence: ______________ MM/DD/YYYY Date reported to licensee: ______________ MM/DD/YYYY Date claim reported to insurer or self-insurer: ______________ MM/DD/YYYY

Injured person's full name: ____

Street Address: ____

City: ______________________ State: ______________________ ZIP: __________

Age: __________ Sex: __________

List other defendants with their health care provider license number involved in this claim:

Defendant	Health Care Provider License #

Date suit was filed: ______________ MM/DD/YYYY Date of final claim disposition: ______________ MM/DD/YYYY

Date of judgement/settlement, if any: ______________ MM/DD/YYYY Amount of judgement/settlement, if any:$ __________

Was there an itemized verdict? ☐Yes ☐No **If you responded "Yes," attach a copy of the settlement verdict.**

Indemnity paid on behalf of the defendant: $______________ Loss

Adjustment expense paid to defense counsel: $______________

All other loss adjustment expense paid: $______________

If no judgement or settlement, provide the following: Date: ______________ MM/DD/YYYY Reason: ______________________

Name of institution where the injury occurred: ____

Location of injury occurrence:

☐ Critical Care Unit	☐ Emergency Room	☐ Labor & Delivery Room
☐ Nursery	☐ Operating Suite	☐ Patients Room
☐ Physical Therapy Dept.	☐ Radiology	☐ Recovery Room
☐ Special Procedures Room	☐ Other: ______________________	

Final diagnosis for which treatment was sought or rendered: ____

Describe misdiagnosis made, if any, of the patient's actual condition: ____

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

____

____

____

____

____

Describe the principal injury giving rise to the claim. Use nomenclature and descriptions of the injury. Include type of adverse effect from drugs where applicable.

____

____

____

____

____

Safety management steps taken by the licensee to make similar occurrences less likely.

____

____

I represent that these statements are true and correct pursuant to s. 837.06, F.S. I recognize that providing any false statement made in writing with the intent to mislead the department staff in the performance of their official duties shall be punishable as provided in s. 775.082 and 775.083, F.S.

Applicant Name ____

Applicant Signature ______________________________________ Date ____________
MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Board *of* Podiatric Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: ____

Address: ____

Name original license was issued under: ______________________________

License Number: ______________________ State: ______________________

I hereby authorize release of any information regarding my licensure status to the Florida Board of Podiatric Medicine.

Applicant Signature: ______________________________ Date: ______________
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- Typed on an official state form or letterhead
- Include an official board seal
- Signature and title of state board official

The following information must be included in all verifications:

- Licensee name
- License number
- State or jurisdiction of licensure
- Licensure status
- Is license in good standing?
- Date of issuance/expiration
- Licensure method (examination, grandfathering, reciprocity/endorsement)
- Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.