



FLORIDA DEPARTMENT OF HEALTH BOARD OF PSYCHOLOGY

Mailing address for the laws and rules re-examination application:

*Department of Health
Board of Psychology
P.O. Box 6330
Tallahassee, FL 32314-6330*

PLEASE NOTE

EXAMINATION FEES FOR THE LAWS AND RULES EXAM WILL BE PAID TO THE DEPARTMENT AND TO THE TESTING VENDOR.

PLEASE SUBMIT \$85 TO THE DEPARTMENT FOR THE EXAM

NOTE: PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK.

RE-EXAMINATION APPLICATION / LAWS AND RULES EXAM

APPLICANT PROFILE DATA FORM

¹ List your full, legal NAME (no nicknames or shortened versions): First: _____ Middle: _____ Last: _____		
² Have you ever changed your name through marriage or action of a court, or have you been known by any other name? <i>If "YES", give the name(s) and date(s) of changes below:</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO
³ MAILING Address (street address, city, state, ZIP): _____		
⁴ Social Security Number: (required) ____ - ____ - ____	⁵ City/State/Country of Birth: _____	⁶ Date of Birth (mm/dd/yr) ____/____/____
^{7a} Work Telephone Number: () _____	^{8a} Fax Number: () _____	
^{7b} Alternative Telephone Number: () _____	^{8b} E-mail Address: _____	
⁹ Please indicate date(s) of previous examination(s): _____ mm/dd/yr		
¹⁰ We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR39298 (August 25, 1978). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure. Sex: <input type="checkbox"/> F <input type="checkbox"/> M Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give alien number _____ Ethnic Origin: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Other _____		
¹¹ Special Testing Accommodations		
Please indicate if you require special testing accommodations due to disability. If yes, contact the Bureau of Operations immediately for an application at (850) 245-4252. The "Application for Special Testing Accommodations" must be completed and returned to the Bureau of Operations no later than 60 days before the examination for which the applicant wishes to be scheduled.		<input type="checkbox"/> YES <input type="checkbox"/> NO

Name _____

Re-examination application date: _____
mm/dd/yr

HISTORY PURSUANT TO SECTION 456.0635(2) F.S.

¹² **IMPORTANT NOTICE:** Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written 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 to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. 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? <i>(If you responded “no”, skip to #2.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If “yes” to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. If “yes” to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> Yes <input type="checkbox"/> 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”, please provide supporting documentation).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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)? <i>(If you responded “no”, skip to #3.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? <i>(If “No”, do not answer 3a. and skip to #4.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? <i>(If “No”, do not answer 4a or 4b. and skip to #5.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you been in good standing with a state Medicaid program for the most recent five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Did the termination occur at least 20 years before the date of this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. If “yes” to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession’s licensing board or the Department of Health? <i>(If “yes”, please provide official documentation verifying your enrollment status.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name _____
 Re-examination application date: _____
 mm/dd/yr

HISTORY PURSUANT TO SECTION 456.013(1), F.S.

Note: Section 456.013(1), Florida Statutes, requires that licensure applicants must supplement the original licensure application form, if there is a material change in any circumstance or condition stated therein, prior to the final granting of a license. If you answer “yes” to this question, explain on a separate sheet providing accurate details and submit copies of supporting documentation. Please note that your "yes" answer would not be an automatic cause for denial.

<div>T3</div> <p>Since the submission of your initial application for psychologist licensure, has there been any material change in any circumstance or condition stated therein, which might affect the decision of the Board?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Name _____
Re-examination application date: _____
mm/dd/yr