Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

GENERAL INFORMATION
Application for
Clinical Laboratory Personnel Trainee

PLEASE NOTE: Prior to enrolling in a Board approved Training Program, it is suggested that all applicants review the licensure requirements specific to the specialty for which you are seeking licensure. Approval of this trainee license does not ensure licensure upon completion.

1. **APPLICANT EDUCATION AND TRAINING DATA:** Complete your education and clinical laboratory training information. State the name, location, dates attended, and date of graduation from high school. If applicable, list the same information from any college attended. Technician applicants attach a notarized copy of your high school diploma if that is all that is required for entrance into the training program. If you will be a technologist trainee, you must have an official copy of your transcripts forwarded directly to this office from your college or university. The following items are needed to verify applicant education:
   (a) Official transcripts sent directly to this office from your college or university. Diplomas may not replace transcripts and student copies are unacceptable. Request that the college or university add the correct name to the transcripts and send them to the address on the front of this application.
   (b) If you were educated in an institution outside of the United States, it is your responsibility to have your education evaluated to determine the U. S. equivalent. Evaluations will be accepted from:
      1. An accredited U. S. college or university on an official transcript, or
      2. A credentials evaluation service. In addition, graduates of institutions from which official transcripts are not available may submit a certified copy of the original diploma, grade sheet or other educational documents. A subject breakdown is required. Copies of translations are not acceptable unless accompanied by a notarized copy of the original document.

   FOREIGN EDUCATION EQUIVALENCY REQUIREMENTS: All foreign graduates who intend to utilize credit earned in colleges or universities outside of the United States to qualify for licensure will need to provide evidence of U. S. equivalency of such credit hours. The credentials evaluation must be performed by one of the acceptable credential evaluation services and include a breakdown of all college level courses by subject. Credit hours must be listed in semester hours. The credentials evaluation should be sent directly to the board office from the evaluator. If transcripts cannot be ordered from the foreign institution, certified copies of the original documents used in the evaluation must be submitted to the agency. (Please review Rule 64B3-6.002, Florida Administrative Code).**NOTE: Bachelor's degrees from Puerto Rico and the Philippines do not need a credentials evaluation; however, official transcripts must be submitted from the institution.**

2. **YES/NO QUESTIONS:** All questions with "Yes or No" answer must be marked with either a "Yes or No", unless otherwise indicated. No other response is acceptable. For questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). HOWEVER, IF A QUESTION CONTAINED IS NOT APPLICABLE ANSWER "N/A" IN THE NO COLUMN. **Certified or civil notary documentation of final disposition to "Yes" answers is required.**

3. **TRAINING PROGRAM INFORMATION -** Enter the training program's license number. The approval number begins with TP and can be obtained from your program director. Enter the training program's name, address, and the educational coordinator or program director's name. Include your anticipated date of graduation, including the month and year.

4. **CLINICAL EXTERNSHIP: (If different from the training program) -** Indicate where you will receive your clinical internship if it is different from the training program. If it is not different, state N/A.

5. **FEES -** Enclose a $45.00 certified check or money order payable to the Department of Health. Applications without fees will be delayed.

6. **FEDERAL PRIVACY ACT:** Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. **In this instance, disclosure of a social security number is mandatory pursuant to Title 42 United States Code, Sections 653 and 654, and sections 456.013, 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 assure compliance with child support obligations. Barring any exemption under Florida law or federal law, social security numbers must be recorded on all professional and occupational licensure applications and will be used for license verification. **Note: If you do not fill in your social security number, your application may be delayed.**

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Clinical Laboratory Personnel

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.

Name: _____

Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (**If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)**

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO

2. 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

3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO

4. 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? [ ] YES [ ] NO

5. 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

6. 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 within the last five years? [ ] YES [ ] NO

FLORIDA DEPARTMENT OF HEALTH

CLINICAL LABORATORY TRAINEE

(Client 6602 – Transaction 1010)

FEES: $45.00

SELECT THE SPECIALTY AREAS TO BE INCLUDED IN TRAINING:

[ ] Microbiology [ ] Hematology [ ] Cytogenetics [ ] Molecular Pathology

[ ] Serology [ ] Immunohematology [ ] Clinical Chemistry [ ] Histocompatibility

[ ] Histology [ ] Cytology [ ] Blood Banking (Donor Processing)

[ ] Other _____

PROFILE DATA: (PLEASE PRINT OR TYPE IN BLACK INK)

1. NAME: _____
(Last) (First) (Middle)

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

If YES, list provide: _____
(Last) (First) (Middle)

2. ADDRESS:

a. **MAILING ADDRESS:** _____
(Street and Number) (Apt. #) (City) (State) (Zip)

b. **PRIMARY LOCATION:** _____
(Street and Number) (Apt. #) (City) (State) (Zip)

c. **TELEPHONE:** (____)_____ (____)_____
Primary: Area Code/Phone Number **Business: Area Code/Phone Number**

d. **EMAIL ADDRESS:** _____

3. TRAINEE LICENSE NUMBER: (If previously licensed) _____

4. PERSONAL DATA:

a. Date of Birth: _____
(Month/Day/Year)

b. Birth Place: _____

c. 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 FR 38296 (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

d. 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 disasters? [ ] YES [ ] NO

NAME: _____

5. EDUCATION INFORMATION:

High School (diploma or GED)/college/university – (Please provide high school(diploma or GED)/college/university education information, whether completed or not, in chronological order).

(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)

6. TRAINING PROGRAM INFORMATION: Florida Training Approval License Number: TP _____

(Name of Institution)	(Street and Number)	(City)	(State)	(Zip-code)

(Program Director/Education Coordinator)	(Date Enrolled)	(Date of Anticipated Graduation)

7. CLINICAL EXTERNSHIP: (If different from the training program)

(Name of Institution)	(Street and Number)	(City)	(State)	(Zip-code)

(Contact Person)	(Telephone Number)

8. APPLICANT HISTORY:

a. Have you had <u>any</u> application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state or country? [ ] YES [ ] NO

b. Have you ever been notified to appear before <u>any</u> licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Clinical Laboratory practice act, unprofessional or unethical conduct? [ ] YES [ ] NO

If YES, please complete the following:

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

NAME: _____

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

PROCEEDINGS and/or ACTIONS

9. LICENSURE ACTIONS:

a. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? [ ] YES [ ] NO

b. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? [ ] YES [ ] NO

c. Have you been refused a license to practice, or the renewal thereof in any state? [ ] YES [ ] NO

If YES, please complete the following:

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

10. CRIMINAL INFORMATION:

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? [ ] YES [ ] NO

If **YES**, you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

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

11. LICENSURE INFORMATION: Do you hold or have you ever held a **STATE** license to practice Clinical Laboratory Personnel in this state or any other state? [ ] YES [ ] NO

License Number	State/Country	Original Date Issued	Expiration Date
_____	_____	_____/_____/_____	_____/_____/_____
_____	_____	_____/_____/_____	_____/_____/_____
_____	_____	_____/_____/_____	_____/_____/_____

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

NAME: _____

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.

12. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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 felon offense(s) in another state or jurisdiction? **(If you responded NO, skip to 13)** [ ] YES [ ] NO

a. If "yes" to 12, for felonies of the first or second degree, has it been more than 15 years before the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

b. If "yes" to 12, for felonies of the third degree, has it been more than 10 years before 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). [ ] YES [ ] NO

c. If "yes" to 12, for 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? [ ] YES [ ] NO

d If "yes" to 12, 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)** [ ] YES [ ] NO

13. 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 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? [ ] YES [ ] NO

a. If "yes" to 13, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

14. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 14a.)** [ ] YES [ ] 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? [ ] YES [ ] NO

15. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If "No", do not answer 15a or 15b.)** [ ] YES [ ] NO

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

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

16. 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? [ ] YES [ ] NO

17. If "yes" to any of the questions 12 through 16 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? **(If "yes", please provide official documentation verifying your enrollment status.)** [ ] YES [ ] NO

NAME: _____

18. APPLICANT SIGNATURE:

I understand that these statements are true and correct and 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.

I 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 Clinical Laboratory Personnel 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 under penalty of perjury 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 Clinical Laboratory Personnel in the State of Florida.

***As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.**

_____ _____

(Applicant Signature) (Date)

_____ _____

(Program Director/Education Coordinator Signature) (Date)

Please make cashier check or money order payable to the Department of Health. Return application and fees to:

Department of Health
Revenue Services
P.O. Box 6330
Tallahassee, FL 32399-6330

(Documents sent separate from application/no money)

Mail all supporting documents/correspondence to:
Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257