

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF MEDICINE
MEDICAL FACULTY CERTIFICATE
FOR ALLOPATHIC PHYSICIANS
Section 458.3145, Florida Statutes**



DEPARTMENT OF HEALTH-MEDICINE
4052 BALD CYPRESS WAY, BIN #C03
TALLAHASSEE, FL 32399
(850)488-0595

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Please keep these application instructions for your records. Do not return them to the board office with your application. You may be referred back to the instructions during your application process.

Make a copy of everything you send to the board office. You may need to refer to previously submitted documents during your application process.

IMPORTANT NOTICE:

Effective July 1, 2012, 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:

1. Has 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 unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed.

Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:

For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;

For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;

For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;

2. Has 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), 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;
3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;
4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;
5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

NOTE: This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in a educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

SECTION I GENERAL INFORMATION

Section 456.013(1)(a), Florida Statutes, and Chapter 64B8-4.016, Florida Administrative Code, provides that a licensure application and application fee are valid for one year. Application fees are non-refundable.

- o The State of Florida operates under Chapter 286, Florida Statutes, commonly referred to as the "Sunshine Law." This law requires that board meetings are public. All information that you provide to the Department is public record and shall be open to public inspection as required by 119.07 F. S., except financial information, examination records, and patient records.
- o The Florida Board of Medicine general statutes require that you must have a valid Florida medical license to practice medicine in Florida. We recommend that you do not make any commitments based upon expectation of licensure until you are actually licensed. Some applicants suffer significant costs by signing mortgages and committing to a start date prematurely. One application is not accelerated at the expense of another, particularly if there is a premature commitment to start practicing medicine. All applicants are handled equally and fairly. The application process may take between two to six months to complete depending on your credentials. You will not be able to start work until you have been granted a full medical license. Applicants can help expedite the application process by including all relevant materials with their application packets (medical school diploma, residency certificates, etc). We will mail you a deficiency letter approximately 30 days after receiving your application. Please refrain from contacting our office until after you have received your initial deficiency letter. E-mail contact is more efficient. Time spent on the telephone impacts time available for staff to process applications. Please direct questions or comments to MQA_Medicine@doh.state.fl.us. We process applications, mail, e-mails, and telephone calls in date order.
- o Read instructions before and while you complete the application. Failure to do so may result in delays in processing your application.
- o Licenses will not be issued without the background check results and will be issued in date order. When issuing licenses, we have a strict policy of fairness. One application will not be accelerated at the expense of another. All applications will be handled equally and fairly. Also, the less time reviewers spend responding to duplicate e-mails and telephone calls, the faster applications can be reviewed. The standard procedures for the reviewer is:
 - Return phone calls within 24 hours.
 - Check mail within one week from receipt date.
 - Respond to e-mails within one week.
- o It could take up to 14 days to issue your license after completion of your application. It will take approximately 10 business days to receive your license in the mail after issuance. To view your license, you may access our license look-up screen at www.FLHealthSource.com. Your license number will appear on the web site 24 to 48 hours after it is issued.
- o Federal Credentials Verification Services (FCVS): The Florida Board of Medicine encourages all applicants to use FCVS to assist with the licensure process. However, it is not a requirement for licensure. For more information about FCVS, visit their web-site at www.fcvs.org/. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, and ECFMG verification.

Note: If you have not completed the FCVS certification process prior to applying for license in Florida it could take longer to receive your Florida license.

- o Before practicing medicine in Florida, read Chapter 456, 458, and 766.301-.316 Florida Statutes (F. S.), and Rule Chapter 64B8, Florida Administrative Code (F.A.C). You must know and comply with the laws and rules as they pertain to your professional practice. Laws and rules are subject to change at any time. For updated information refer to the following web-sites www.leg.state.fl.us/ (statutes) and www.fac.dos.state.fl.us (Florida Administrative Code).
- o Personal Appearances before the Credentials Committee or the Board of Medicine may be required for a variety of reasons: e.g., malpractice, medical education, postgraduate training, disciplinary actions, etc. If an appearance is required, we will notify you by mail including the date, time, location, and reason(s) for the appearance. The Credentials Committee meets in conjunction with the full Board of Medicine meetings. In order for the Committee members to review all the information that is provided for this committee, other committee meetings at the same time, and for the full board meeting, a deadline for applications must be established and respected. The cut off for a complete application to be considered is six (6) weeks prior to the committee meeting. All Board and Committee meetings dates are posted on our web site at: <http://www.doh.state.fl.us/mqa/medical/>
- o Any document submitted in a language other than English must be accompanied by a literal translation. Acceptable translators are: An employee of a professional translating company, a member of a professional translation company, a member of the American Translators Association, a faculty member of the modern languages or linguistics department of a United States college or university. Translations must be prepared on letterhead paper or bear the translator's certification seal. All information appearing on the original document must also appear on the translation each time it appears on the original document. This includes pre-printed information. For example, the letterhead of the university, titles, etc.

All stamps and seals must be translated if legible. If not legible, state that it is not legible and cannot be translated.

All signatures and photos must be identified.

All numbers must be translated unless they appear as follows: 1 2 3 4 5 6 7 8 9 0. If they do not appear on the document as they do above, they must be accurately transcribed.

Any other information on the document must be translated.

Note: Translations prepared in international countries often have certifications on the translation. If a certification is in a language other than English, it must also be translated. Omissions or errors will cause a delay in the application process.

- o Submit your application, supporting documentation, and fees, to the following address:

Department of Health/ HMQAM
P.O. Box 6330
Tallahassee, Florida 32314-6330

Receiving your application and logging in your check usually takes about 7-10 days. Once the application is logged in, it is then forwarded to the board office. NOTE: The reason you are using this address is because it has fees enclosed.

- o Mail additional documentation or anything without a fee to the following address:

Department of Health
Medical Quality Assurance/Board of Medicine
HMQAM
4052 Bald Cypress Way, BIN #CO3
Tallahassee, Florida 32399-3253

All documents must have your name as listed on your application to ensure materials reach your application in a timely manner.

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please 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 to a fingerprint scan using the livescan method;
- You can find a Livescan service provider at: <http://www.doh.state.fl.us/mqa/background.html>;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**;
- The ORI number for the Board of Medicine is EDOH2014Z.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ Social Security Number: _____

Aliases: _____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

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

Sex: _____ Weight: _____ Height: _____
(M=Male; F=Female)

Eye Color: _____ Hair Color: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING 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 that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 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 Persons 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 as 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 the 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 Sections 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, disclosures 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 you additional information pertinent 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.

SECTION II

Completing the Application

Read instructions before and while you complete your application. Failure to do so may result in delays in processing your application.

Type or legibly write your application. As we receive supporting documentation, we may need to ask you additional questions and require additional documentation.

Item-by Item Instructions

1. **Social Security Number:** List your social security number as in this example: 333-33-3333. 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 as required by Title 42 United States Code, Sections 653 and 654; and Sections 456.004(9), 456.013(1)(a), 409.2577, and 409.2598, Florida Statutes. Social security numbers are used to efficiently screen applicants and licensees by Title IV-D to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

2. **Employing University:** Identify the employing University by marking the appropriate box. A Medical Faculty certificate may be issued to an individual who has been offered and accepted a full time faculty appointment to teach in a program of medicine at one of the medical schools listed. Submit an original letter from the Dean of the medical school stating that you have been offered and accepted a full-time faculty appointment to teach in a program of medicine listed in section 458.3145(1)(i) The letter must be addressed to the Florida Board of Medicine.

Fees for a Medical Faculty Certificate:

Application fee:	\$500.00 (non-refundable)
Initial license fee:	\$429.00
NICA fee:	\$250.00 or \$5,000.00 (please read information at www.nica.com)
Dispensing Practitioner fee:	\$100.00 (optional, this fee is for selling pharmaceuticals in your office)

Make one cashier's check or money order for the total amount payable to the Department of Health-Board of Medicine. Cash and credit card payments are not acceptable. Mail complete fee with your application to: Department of Health/ HMQAM, P.O. Box 6330, Tallahassee, Florida 32314-6330.

3. **Name:** List your name as it appears on your birth certificate and/or a legal name-change document. Nicknames or shortened versions are unacceptable. If you have a hyphenated last name, enter both names in the last name space. It will be recognized by the first letter of the first name; e.g., Diaz-Jones.

- List name(s). Name changes include marriage, naturalization, divorce, or by any other means.
- List your aliases or any of your other names that may appear on supporting documentation.

4. **Mailing address:** List your current mailing address. We will mail correspondence to you at this address unless you notify the board in writing of an address change. NOTE: If your address changes prior to the issuance of the license, it is your responsibility to notify your reviewer of your address change in writing.

5. **Physical location or address of employment:** List your physical location or address of employment. This address will be available to the public on the MQA License Verification web site. Post Office Box is not acceptable.

6. **Telephone:** List your primary and alternate telephone numbers.

7. **E-mail address:** List your e-mail address. We will e-mail correspondence to you at this address instead of the mailing address when possible.

8. **Citizenship:** List the country where you are a citizen. Provide your date and place of birth.

9. **Demographics:** Check your race and sex.

10. **Disaster Registry:** Check Yes or No. The Department of Health must maintain a healthcare practitioner registry for disasters and emergencies. Your response to this question will not affect processing your licensure application.

11. **Federation of Credentials Verification Services (FCVS):** Check Yes or No

12. United States military and/or Public Health: Check Yes or No. If yes, list the branch of service, rank, and dates of service. Provide a copy of your discharge documents indicating type of discharge.
- 12a. United States military charges: Check Yes or No. If yes, explain the circumstances and provide supporting documentation.
13. EDUCATION: LIST ALL UNDERGRADUATE, GRADUATE, MEDICAL AND PROFESSIONAL EDUCATION. LIST EACH INSTITUTION ATTENDEDEVEN IF YOU DID NOT RECEIVE A DEGREE.

Provide the following documentation to support your education:

A copy of your medical school diploma. *
 Undergraduate transcripts, if you graduated from medical school after October 1, 1992.
 Complete the medical school verification request form and remit to the medical school. This form must be received directly from the medical school to the Board office with the school seal. *

* If you are using FCVS do not submit the items identified with an *, as FCVS will submit these items for you.

14. Postgraduate Training: List chronologically each program that you attended after graduation from medical school. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training. For items 14a-c, if yes, explain on a separate sheet providing accurate details. In addition, request that your training program(s) submit supporting documentation directly to the Board of Medicine.

If you fail to disclose accurate information, you may have to personally appear before the Credentials Committee. If you are unsure as to whether you had any type of break or leave, extended medical education, or any type of probation, etc., contact your training program prior to completing these questions.

Provide the following documentation to support your postgraduate training:

A copy of all of your internship, residency, and fellowship training certificate(s). If you have not been issued a certificate, provide a current original letter from the training program director addressed to the Florida Board of Medicine that states the PGY levels completed and dates you attended each level.
 A completed postgraduate evaluation form and remit it to all postgraduate training programs you began, whether you completed or received credit for the training. We must receive this form directly from the training program with an original signature of the current program chairman or director.

15. List the year that you legally first began to practice medicine. This would be the year you began practicing medicine and could be the date you began your postgraduate training.
16. Licensure: List all state(s) license number(s) where you hold or ever held a medical or any other professional license regardless of the current status in any state in the United States, Canada, Guam, Puerto Rico, or the U.S. Virgin Islands.

For items 16a-e, if yes, explain on a separate sheet providing accurate details. Request verification of the following:

Licensure status directly from the licensing entity or www.veridoc.org
 International license verification(s) if you have practiced outside of the United States.
 Documentation directly from the licensing entity supporting your yes answers for items 16a-e

17. PRACTICE/EMPLOYMENT: List in chronological order all periods of time starting from the date you graduated from medical school to the present. Be specific, and give type of practice or non employment and address. Account for all activities more than 30 days. Include vacation, moonlighting and locum tenens. Unaccounted periods of time may cause a delay in the processing of your application. If sufficient space is not provided, submit on a separate sheet.

For items 17a-b, if yes, explain on a separate sheet providing accurate details and request supporting documentation be sent directly from the applicable entity.

18. Staff Privileges: Check Yes or No and list all hospital(s), health institution(s), clinics(s), or medical facilities where you currently hold staff privileges. Do not list training privileges.

For items 18a-b, if yes, explain on a separate sheet providing accurate details and request supporting documentation be sent directly from the applicable entity.

19. Graduate Medical Education: Check Yes or No, if yes, list all institutions where you have had responsibility for graduate medical education.

20. Faculty appointment: Check Yes or No, if yes, list any faculty appointment(s) you currently have at any medical school(s).

21. American Board of Medical Specialties: Check Yes or No.

If yes, list specialty board name, specialty/sub-specialty, and date of certification. For items 21a-b, if yes explain on a separate sheet providing accurate details. Request that the specialty board send supporting documentation directly to the Board of Medicine.

22-30 DEA/Convictions/Medicare/State Healthcare Programs/: Check Yes or no.

If yes, explain on a separate sheet providing accurate details. Request that the entity send supporting documentation directly to the Board of Medicine.

31-32. MALPRACTICE: Check Yes or No.

If yes, provide the following:

A statement indicating date of each incident and the number for each case where there was a judgment or settlement in an amount that exceeds \$100,000.00.

An explanation of details for each case and your involvement for each case where there was a judgment or settlement in an amount that exceeds \$100,000.00.

If you answered "yes" to question 34, in addition to the documents listed above, submit the enclosed Exhibit 1 form.

A copy of complaint, judgments and/or settlements for each case where there was a judgment or settlement in an amount that exceeds \$100,000.00.

If you answered "yes" to question 33, in addition to submitting the above documents, submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.

33. Criminal Convictions: Check Yes or No.

If yes, explain on a separate sheet providing the date, accurate details and submit copies of charge(s), indictment(s) and judgment(s).

34-39. Health History: Check Yes or No.

If yes, submit the following:

A statement providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.

A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

You may be asked to submit to a current evaluation by a board-approved physician independent of your current treating physician and appear before the Credentials Committee.

40. Continuing Medical Education:

Prevention of Medical Errors: Check the box to certify that you have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education since June 1, 2002. The education must meet requirements defined in § 456.013(7), Florida Statutes, and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312)464-5000 or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

Please note: You will be required by Chapter 456, F.S., to take an HIV/AIDS course approved by the board for your first renewal and a two (2) hour Domestic Violence Course approved by the board prior to your third renewal.

41. Dispensing Practitioner Registration: Check the box to register for dispensing medical drugs for profit from your private office. Checking the box shows that you understand that the dispensing fee is \$100.00 over and above your initial license fee, and you will submit it along with your license fee.

Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medical drugs pay a fee of \$100.00 when they register to dispense or when they renew their practitioner's license. It is unlawful to sell samples or complimentary packages of drug products. Physicians who dispense only complimentary packages of medicinal drugs to patients in the regular course of practice are not required to register. Do not check the box if you plan to dispense only samples or complimentary medical drugs.

The State of Florida does not have a separate prescribing number. However, if you are going to prescribe controlled substances you are required to obtain a number through the Drug Enforcement Agency. You may contact the DEA at www.dea.gov or (305) 994-4870.

42. **Financial Responsibility:** Check only one of the ten Financial Responsibility options to comply with §458.320, Florida Statutes. The options are divided into two categories: coverage and exemptions. If you are not licensed in Florida through another licensure provision, you may choose the exemption provision until you are licensed and began practicing in Florida.
43. **Neurological Injury Compensation Association:** If you are a participating or non-participating physician, or a physician claiming exemption, complete the Florida Birth Related Neurological Compensation Association (Item 46) form, sign and date it, and return it with your application.

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated compensation form (Item 46) with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

To complete the form, check one of the three boxes to choose your compensation option for Florida birth-related neurological compensation. Check only one. If you will submit payment, list the amount on the "Amount Enclosed" line and submit fee with your licensure application.

If you check "\$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

Sign your name on the Signature line to show that you have read the explanatory information provided by NICA at www.nica.com and have chosen a compensation option. List the date that you signed in mm/dd/yy. Print or type your name, street address, city, state, and zip on the lines provided.

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

44. **Statement of Applicant:** Read the Statement of Applicant. If you agree with the content print or type your name, sign your name, and list the date that you signed as mm/dd/yy on the lines provided to show that you consent to the statement. You must sign and date the statement. If you have used any outside resources to assist you in completing this application, please remember only you are responsible for the contents of this application.

SECTION III

1508 APPLICATION FOR MEDICAL FACULTY CERTIFICATE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine

Name: _____
Last First Middle

Social Security Number: _____

*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.

1508 APPLICATION FOR MEDICAL FACULTY CERTIFICATE

2. Check Employing University

- | | |
|---|--|
| <input type="checkbox"/> University of Florida | <input type="checkbox"/> University of Miami |
| <input type="checkbox"/> University of South Florida | <input type="checkbox"/> Florida State University |
| <input type="checkbox"/> The Florida International University | <input type="checkbox"/> The University of Central Florida |
| <input type="checkbox"/> The Mayo Medical School at the Mayo Clinic in Jacksonville | |

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

3a. Have you ever changed your name through marriage, naturalization or action of a court or have you been known by any other names? YES NO

If yes; list original name(s) _____
(Last) (First) (Middle)

3b. List any other names by which you have been known.

List name(s) (Last, First, Middle, and Suffix).

4. Mailing address:

(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

5. Physical location or address of employment – This address will be available to the public on the MQA License Verification website. Post Office Box is not acceptable.

(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

6. Telephone (_____) _____ (_____) _____
(Primary: Area Code/Phone Number) (Alternate: Area Code/Phone Number)

7. E-mail address: _____

8. List the country where you are citizen _____

Birth Date: _____ Birth Place: _____

9. Demographics: 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 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and will not affect your candidacy for licensure.

Race: Caucasian Black Hispanic Asian Native American Other

Sex: Male Female

10. Disaster Registry: As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? YES NO

11. Are you using the Federation Credentials Verification Service to verify your core credentials? YES NO

12. Have you ever been in the United States Military and/or Public Health Service? YES NO
- 12a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? YES NO
If yes, explain the circumstances on a separate sheet.

13. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received

13a. Have you ever defaulted on any health education loan or scholarship obligation? YES NO

14. Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No

For items 14a-c, if yes, explain on a separate sheet providing accurate details.

- 14a. Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from any postgraduate training program? YES NO
- 14b. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat any of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum? YES NO
- 14c. Did you take any type of break or leave of absence for any reason during your postgraduate training? (Including maternity/paternity, medical leave or any other type of break or leave.) YES NO

15. List the year you legally first began to practice medicine, this would be the year you began practicing medicine and could be the date you began your postgraduate training. _____

16. Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? [] YES [] NO
If "yes" list below (attach additional sheets if necessary).

State or Country	License number	Original date issued	Expiration date

For items 16a-e, if yes, explain on a separate sheet providing accurate details.

- 16a. Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country? [] YES [] NO
- 16b. Have you ever been allowed to withdraw an application for medical licensure or professional license for any reason or during a pending investigation in any jurisdiction in lieu of your license being denied? [] YES [] NO
- 16c. Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? [] YES [] NO
- 16d. Have you ever been notified, invited or 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 Medical Practice Act, involving unprofessional or unethical conduct? [] YES [] NO
- 16e. Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [] YES [] NO

17. Practice/Employment: In the table below, list in chronological order all employment, non-employment, and/or any unaccounted period of time from date you graduated medical school to present.
 If needed, continue on a separate sheet of paper.

Name and full mailing address of employment or activity	Type of employment or activity	From: mm/yy	To: mm/yy

For items 17a-b, if yes, explain on a separate sheet providing accurate details.

17a. Have you ever had employment terminated for cause? YES NO

17b. Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? YES NO

18. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? YES NO

Name/mailling address of facility	Type of privileges	From: mm/yy	To: mm/yy

For items 18a-b, if yes, explain on a separate sheet providing accurate details.

18a. 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

18b. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? YES NO

19. Have you had responsibility for graduate medical education within the last 10 years? (If yes, list in the table below.) YES NO

20. Do you currently hold a faculty appointment at a medical school? (If yes, list in the table below.) YES NO

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution	Full mailing address	Title of appointment

21. American Board of Medical Specialties: Are you certified by any specialty board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine. [] YES [] NO
 If yes, list in the table below.

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification mm/yy

For items 21a - 42, if yes, explain on a separate sheet providing accurate details.

- 21a. Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? [] YES [] NO

- 22. Have you ever been warned or called before the United States Drug Enforcement Administration (DEA)? [] YES [] NO

- 23. Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA? [] YES [] NO

- 24. Have you ever been denied or surrendered a DEA registration? [] YES [] NO

- 25. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #27.) [] YES [] NO

- 25a. If "yes" to 25, 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

- 25b. If "yes" to 25, 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) [] YES [] NO

- 25c. If "yes" to 25, 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? [] YES [] NO

- 25d. If "yes" to 25, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed? (If "yes", please provide supporting documentation) [] YES [] NO

- 26. 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)? [] YES [] NO

- 26a. If "yes" to 26, 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
27. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 27a.) YES NO
- 27a. 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
28. 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 28a or 28b) YES NO
- 28a. Have you been in good standing with a state Medicaid program for the most recent five years? YES NO
- 28b. Did the termination occur at least 20 years before the date of this application? YES NO
29. 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
30. If "yes" to any of the questions 25-39 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
31. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? YES NO
32. Within the last 10 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 \$100,000.00?
If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence. YES NO
33. 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 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. YES NO
34. 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
35. 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
36. 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
37. In 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
38. 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
39. 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

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

40. Prevention of Medical Errors:

I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

41. Dispensing Practitioner Registration:

This is optional and for physicians whose primary practice is in the State of Florida. Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit. Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of \$100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice is not required to register.

Check if applicable to you.

I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is \$100.00 over and above the required initial license fee and will submit it along with the license fee.

42. FINANCIAL RESPONSIBILITY FORM

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

Category I: Financial Responsibility Coverage

1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of \$100,000/\$300,000, in accord with Chapter 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
2. I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have established an irrevocable letter of credit or escrow account in an amount of \$250,000/\$750,000, in accord with Chapter 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
4. I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F.S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F.S.

Category II: Financial Responsibility Exemptions

6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.
7. I hold a limited license issued pursuant to s. 458.317, F.S., and practice only under the scope of the limited license.
8. I do not practice medicine in the State of Florida.
9. I meet all of the following criteria:
 - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
 - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
 - (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
 - (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F.S. or the medical practice act in any other state; and
 - (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.
10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on # 9, you must also complete the affidavit on the following page.

FINANCIAL RESPONSIBILITY FORM

This affidavit is only required if you are claiming an exemption based on number 9 on the preceding page.

I, _____, do hereby certify and attest that I meet all of the following criteria:

- (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
- (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
- (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
- (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F.S. or the medical practice act in any other state; and
- (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), F.S., for specific notice requirements.

Dated: _____

Signature: _____

STATE OF _____ COUNTY OF _____

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

(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public) Personally Known _____ OR

Produced Identification _____

Type of Identification Produced _____

43. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

\$5,000
Participating

\$250
Non-participating

\$0
Exempt

_____ Amount enclosed

If you choose "\$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature Date

Name

Street Address

City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191 .

44. Statement of Applicant

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

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 Medicine 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. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under 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 federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR 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 upon it.

(Please print your name.)

(Signature of applicant required.)

(Date signed required.)

SECTION IV

Important Addresses

National Practitioner Data Bank Self-Query: Applicants are required to complete a self query to the National Practitioner Data Bank (NPDB) and upon receipt of the query, provide the Board office with a copy. A fee is charged to furnish this information. www.npdb-hipdb.hrsa.gov

NPDB
P.O. Box 10832
Chantilly, VA 22021
(800)767-6732

AMA Physician Profile Sheet: Applicants are responsible for requesting an AMA Physician Profile be sent to the Board office directly from the American Medical Association. www.ama-assn.org/amaprofiles

American Medical Association
515 North State Street
Chicago, IL 60610
(800)621-8335

Licensure Verifications received from www.veridoc.org are acceptable.

Medical Degree Verification Form

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253
FAX (850) 412-1268

The physician listed below submitted an application for Florida licensure and is under investigation by this authority. Verify number 2 through 4 and return directly to the Board of Medicine. Thank you.

Applicant completes number 1 through 3.

1. To: _____
Name Name of medical school

Address of medical school

City - State - Zip - Country

2. Name: _____

3. Date of Birth: _____

4. Type of Degree: _____ Date Degree Received: _____

Authenticate by signature and school seal.

SEAL

Verified by

Name

Title

Florida Department of Health
 Board of Medicine
 4052 Bald Cypress Way, Bin C03
 Tallahassee, Florida 32399-3253
 (850) 245-4131
 (850) 412-1268 -Fax

Post-Graduate Training Evaluation Form

The physician listed in number 1 submitted an application for licensure and is under investigation by this authority. Please complete number 3 through 7 of this form and return directly to the Board of Medicine.

To: _____
 School _____

 Department _____

 Address _____

 City, State, Zip _____

1. Name: _____

2. Internship/Residency/Fellowship _____ To: _____ From: _____

3. Please verify: **If yes, explain on a separate sheet providing accurate details.**

- a. Matriculation Date _____ Completion Date _____ Specialty _____
- b. Levels completed: PGY I ___ PGY II ___ PGY III ___ PGY IV ___ PGY V ___
- c. Did this individual take any type of break or leave of absence for any reason? Yes ___ No ___
- d. Was this individual ever dropped, suspended, placed on probation, asked to resign or expelled? Yes ___ No ___
- e. Was attendance for a period other than the established timeframe or was he/she required to repeat any training? Yes ___ No ___

4. Professional Character: Evaluate compared to a physician or similar experience.

Poor Fair Good Superior Don't Know

a. Basic Medical Knowledge	_____	_____	_____	_____	_____
b. Diagnostic/Clinical Ability	_____	_____	_____	_____	_____
c. Teaching Ability	_____	_____	_____	_____	_____
d. Research Potential	_____	_____	_____	_____	_____
e. Fitness for Clinical Practice	_____	_____	_____	_____	_____
5. Personal Character:					
a. Motivation	_____	_____	_____	_____	_____
b. Initiative	_____	_____	_____	_____	_____
c. Responsibility	_____	_____	_____	_____	_____
d. Integrity	_____	_____	_____	_____	_____
e. Appearance	_____	_____	_____	_____	_____
f. Knowledge of English	_____	_____	_____	_____	_____
6. Professional Relationship With:					
a. Teaching Staff	_____	_____	_____	_____	_____
b. Colleagues	_____	_____	_____	_____	_____
c. Nursing Staff	_____	_____	_____	_____	_____
d. Patients	_____	_____	_____	_____	_____

7. Overall Evaluation: **If item C or D is checked, provide a written explanation on a separate sheet.**

- a. _____ Recommended as an outstanding applicant
- b. _____ Recommended as qualified and competent
- c. _____ Recommended with some reservation
- d. _____ Cannot Recommend

Signed: _____

Chairman or Program Director Only No stamped signatures please.

Licensure Verification Form

1. To: _____
State Board

Street Address

City/State/Zip

I, the physician listed below, has made application for licensure in the State of Florida. Please forward verification of licensure directly to the Florida Board of Medicine.

This form may be duplicated.

Physician: Complete number 1 through 8 and mail to applicable state board.

2. Date: _____

3. Name: _____
First Middle Last

4. Address: _____
City State Zip

5. Place of Birth: _____
City State Country

6. Date of Birth: _____
Month Day Year

7. Medical Education: _____
City State Country

8. Year of Graduation: _____
Month Day Year

State Board, please return your completed form to:

The Department of Health
Medical Quality Assurance/Board of Medicine/HMQAM
4052 Bald Cypress Way BIN #CO3
Tallahassee, Florida 32399-3253
Fax (850)412-1268 (850)245-4131

Practitioner's Name _____

EXHIBIT 1—REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: ___/___/___ Date reported to licensee: ___/___/___ Date claim reported to insurer or self-insurer ___/___/___

Injured person's name: (last, first, middle initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit, if filed: ___/___/___

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

1. _____ 2. _____
3. _____ 4. _____

Date of final claim disposition: ___/___/___

Date and reason for final disposition, if no judgment or settlement: _____

Was there an itemized verdict? Yes No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: \$ _____

Loss adjustment expense paid to defense counsel: \$ _____

All other loss adjustment expense paid: \$ _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

- Patient's Room Physical Therapy Dept. Radiology Labor & Delivery Room
- Operating Suite Nursery Emergency Room Special Procedure Room
- Recovery Room Critical Care Unit 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/or 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/or 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, Florida Statutes. I recognize that providing any false statements 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, Florida Statutes.

Signature of physician: _____

Application Checklist

Please ensure that you have submitted the following supporting documentation:

- Applicable fees
- Copy of your undergraduate transcripts
- *Copy of your medical school diploma
- Copy of your post graduate training certificate(s) or letter(s) from your program director
- Copy of your National Practitioners Data Bank and Healthcare Integrity and Protection Data Bank reports
- Statements for all yes answers and supporting documentation, (if applicable)

Please be sure you have requested the following be sent directly to the Florida Board of Medicine:

- *Medical Degree Verification Form.
- State License Verification(s)
- *Training Evaluation Form(s) from all training programs
- AMA Profile

* If you are using FCVS do not submit the items identified with an *, as FCVS will submit these items for you.