State of Florida
Department of Health

Board of Osteopathic Medicine

Application for
Limited License

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

DH-MQA 1171, 07/16
64B15-12.005, F.A.C.

SECTION I:
APPLICATION INSTRUCTIONS

Please read the following IN ITS ENTIRETY before attempting to complete the application, as this information is provided to assist you in expediting the application process.

The Board of Osteopathic Medicine may be required to review your application at one of its quarterly meetings before a license can be issued. The Board's meeting schedule and agenda deadlines can be found on their website at http://floridasosteopathicmedicine.gov/meeting-information/. Please be advised that dates and locations are subject to change. It is recommended that you submit your application several months in advance of the meeting for which you wish to appear, as many of the documents necessary to complete your file can take several weeks to be received by the Board office and incorporated into your file.

FEE SCHEDULE

All fees must be made payable to the Department of Health and must be by cashiers check or money order. All fees must be encompassed in one check. Please do not send separate checks. The fees required for initial licensure are listed below. Please be advised that the fees listed below are subject to change.

Application processing fee (if compensated): (Application fee is waived if not compensated)	**$100.00** (NON-REFUNDABLE)
Fingerprint card processing fee:	**Paid directly to LiveScan vendor**

Where to send the APPLICATION: The original application and any documentation sent with it (in the same envelope) should be mailed to:

Department of Health
Board of Osteopathic Medicine
PO Box 6330
Tallahassee, FL 32314-6330

Where to send all SUPPORTING DOCUMENTATION: Any additional documents submitted (including all supplemental forms) that are mailed separately from the application should be mailed to:

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

List your name on all correspondence. When you receive any correspondence from the Board Office, please make sure that all information regarding your name and address is correct. If you find that it is not, please notify the Board Office in writing of any changes that need to be made.

APPEARANCES: Appearances before the Board may be required for a variety of reasons, such as length of time since practice, malpractice, criminal history or disciplinary action against you in another state. You will be notified via mail of the date, time and location if your appearance before the Board is necessary. The Chairman of the Board, not Board Office staff, determines the necessity of an appearance.

ELIGIBILITY REQUIREMENTS: If you are unsure as to your eligibility for limited licensure in Florida, please refer to sections 459.0055 and 459.0075, Florida Statutes.

REQUIRED BACKGROUND CHECK: All applicants for initial licensure must undergo a state and national criminal history background check. All fingerprinting is done through a LiveScan provider and all fingerprints are retained by the Florida Department of Law Enforcement. Please refer to the information provided later in this application for complete instructions on obtaining and submitting your fingerprints.

REQUIRED SUPPORTING DOCUMENTATION

The following is a list of supporting documentation that is REQUIRED in order to complete your application for limited licensure in Florida. Many of these documents take several weeks to arrive in the Board Office, so please do not panic should we inform you initially that they have not arrived.

A LETTER OF INTENT TO EMPLOY: This letter must be from the agency/institution that intends to employ you and must be addressed to the Board of Osteopathic Medicine. It must also indicate whether or not you will receive compensation for the medical services provided. If the applicant submits a statement from the employing agency or institution stating that he or she will not receive monetary compensation for any service involving the practice of osteopathic medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of osteopathic medicine. (See section 459.0075(1)(a), F.S.)

AOA PROFILE: Contact the American Osteopathic Association – (800) 621-1773 or Profile Services, 142 East Ontario Street, Chicago, IL 60611.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) DATA CHECK: Please visit the FSMB website at http://www.fsmb.org/fpdc_data_inquiry.html to obtain the Board Action Data Search Form.

NATIONAL PRACTITIONERS DATA BANK INQUIRY: This is a "self query". Please contact the National Practitioners Data Bank (NPDB) at (800) 767-6732. They will send a "Request for Information Disclosure" form to you. You must then send that from back to the NPDB. They will in return, send you a "Response". **You must then send the "Response" to the Board Office.**

VERIFICATION OF OTHER STATE LICENSES: You must request that verification of any state license that you now hold or have ever held be mailed directly from the other state licensing entity to the Board Office. A copy of your license is not considered verification. Some states are using www.Veridoc.org for verification. Please check to see if the state you are licensed in utilizes Veridoc.

PROOF OF CONTINUING EDUCATION: You must provide copies of certificates verifying that you completed the continuing education required pursuant to 64B15-13.001, F.A.C. within the preceding two year period:

FINANCIAL RESPONSIBILITY FORM: (Attached)

BACKGROUND CHECK: See instructions attached.

DOCUMENTATION CONFIRMING RETIREMENT: (If applicable)

MILITARY DISCHARGE FORM OR PROOF OF CURRENT ENLISTMENT: (If applicable) A copy of your DD214

COMPLETING THE APPLICATION

The following instructions are numbered so that they correspond with the numbered sections of the application. Each instruction will give specific information regarding the corresponding section of the application. We request that you keep the instructions and a copy of the completed application, as you may need to refer to them during the processing of your application. A response must be given in each section. If a question does not pertain to you, indicate "N/A" in that section. All questions with "YES/NO" answers must have either "YES" or "NO" marked. No other response is acceptable.

ADDITIONAL SPACE NOTE: If any of the sections in the application do not contain sufficient space for the requested information, use an additional page. Always number the additional information with the corresponding number of the question in the application.

1. **SOCIAL SECURITY NUMBER AND HEALTH HISTORY QUESTIONS**: List your social security number and answer the questions related to health history. Note- the additional documentation required based on affirmative answers is listed on the application page.

2. Check your method of application. Processing WILL BE DELAYED if you fail to list your method of application. You must also sign the statement regarding licensure in another jurisdiction if applicable. (See 459.0075, F.S.)

3. Pursuant to section 456.38 and 381.0303, Florida Statutes, we are required to ask all applicants if they would be willing to assist in the event of a disaster. Please answer yes or no.

4. List your FULL name.
a) Name changes: If you have ever had your name changed due to marriage, divorce or any other court action, this constitutes a name change and you must submit legal documentation of the change.

5. Mailing address: This is the address where you receive mail.

6. Facility Information: This should be the name, address, director's name, etc. where you plan to practice. No PO boxes.

7. Telephone numbers: Please list both your home and work numbers.

8. List your fax number.

9. List your e-mail address (optional). Staff may utilize e-mail to contact you about your application. ***Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing***

10. Response to this section is voluntary and self-explanatory.

11. Citizenship – Answer Yes or no. Provide additional information, if applicable.

12. You must answer yes or no and provide documentation (listed on page 4) if applicable.
a) You must answer Yes or No. If yes, please attach a letter of explanation as well as all documentation pertaining to the charge.

13. OTHER STATE LICENSES: You must answer yes or no. If yes, please list any license you hold or have EVER held (regardless of current status). Be sure to include the state, territory or foreign country, dates, type, license number and current status. <u>You must request that every state, territory or foreign country where you have ever held a license send the Board an OFFICIAL LICENSE VERIFICATION. Some states may require a fee for this service.</u>

14. List where and when you legally began to practice.

15. EXAM: Please indicate if you have passed all 3 parts of the NBOME. If you have taken any other licensure exams, please list those as well.

16. List the college where you obtained your Doctor of Osteopathy degree, as well as the address and the date your degree was awarded.

17. List ALL undergraduate and graduate schools, colleges and universities you attended (even if a degree was not awarded), in chronological order. Attach additional sheets if necessary.

18. TRAINING - Please list your entire postgraduate training sequence (internship, residency and fellowship). You must indicate whether that program was approved by the **AOA** or the **ACGME**. Please list ALL programs, regardless of completion.

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

20. Answer yes or no. If yes, please provide an explanation in your own words.
Answer yes or no. If yes, please provide an explanation in your own words.

21. PRACTICE EMPLOYMENT – List in chronological order from the date of graduation to the present, all practice employment, non-employment and/or unaccounted period of time. Attach additional sheets if necessary.

22. Answer yes or no.

23. Answer yes or no. If yes, list. Attach additional sheets if necessary.

24. STAFF PRIVILEGES – You must answer yes or no. If yes, list your privileges in the space provided.

25. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.

26. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.

27. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.

28. BOARD CERTIFICATION: Answer yes or no. If yes, list in the space provided.

29. Answer yes or no. If yes, explain on a separate sheet.

30. Answer yes or no. If yes, list in the space provided and direct the organization to submit a letter of explanation.

31. If none, list "N/A" in the space provided.

32. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.

33. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.

34. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.

35. ** MEDICAL MALPRACTICE JUDGMENTS OCCURRING AFTER NOVEMBER 2, 2004: Answer yes or no. If yes, you must provide the following documentation for **each** case:

- A detailed explanation in your own words listing your involvement in the case.
- The entire case record must be submitted in **electronic format** (either PDF or TIFF), preferably on a CD mailed to our office. The record must include:
    - Initial and/or amended complaint
    - Trial transcripts
    - Evidentiary exhibits
    - Final judgment

36. MALPRACTICE / LIABILITY CLAIMS: Answer yes or no. If yes, provide the following:

- A statement indicating how many malpractice case(s) you have been named in.
- A detailed explanation, in your own words, listing your involvement in each case.
- A copy of the complaint for each case.
- A copy of the disposition for each case.
- Complete the Exhibit 1 form attached.

37. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Additional documentation MAY be required.

38. Answer yes or no. Provide an explanation on a separate sheet.

39. Answer yes or no. Provide an explanation on a separate sheet.

40. Answer yes or no. If yes, please provide an explanation regarding the charges on a separate sheet. You must also submit copies of all pertinent court/arrest documents, including arrest report, official charges and current disposition.

41. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

42. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

43. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

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

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

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

47. Answer yes or no. Refer to the application for additional information required.

48. Answer yes or no. Refer to the application for additional information required.

49. Answer yes or no. Refer to the application for additional information required.

50. Answer yes or no. Refer to the application for additional information required.

51. Answer yes or no. Refer to the application for additional information required.

52. Answer yes or no. If yes, provide an explanation on a separate sheet

53. Answer yes or no. If yes, provide an explanation on a separate sheet

54. STATEMENT OF APPLICANT: Please read this section CAREFULLY then sign and date the application. If you fail to sign and/or date your application, it will be returned to you as incomplete.

PLEASE KEEP A COPY OF THE APPLICATION AND ALL SUPPORTING DOCUMENTS SENT TO THIS OFFICE AS YOU MAY BE REQUIRED TO REFERENCE YOUR APPLICATION IN THE FUTURE. ALSO KEEP ON FILE ANY FORMS NOT SUBMITTED TO THE BOARD OFFICE, AS APPLICATIONS ARE FREQUENTLY INCOMPLETE DUE TO REQUIRED FORMS BEING OVERLOOKED IN THE INITIAL APPLICATION PROCESS.

Florida Department of Health
Board of Osteopathic Medicine
Application for Limited License

1. Social Security Number and Health History Questions:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

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

Social Security Number:_____

If questions A-F are answered YES, explain in full on a separate sheet of paper. Your statement must include, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved. If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).	
A. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	Yes___ No____
B. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	Yes___ No____
C. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	Yes___ No____
D. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	Yes___ No____
E. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	Yes___ No____
F. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?	Yes___ No____

*** This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.**

APPLICATION FOR LIMITED LICENSE

FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256

2. APPLICATION CATEGORY: CLIENT 1903

[ ] I am NOT fully retired in all jurisdictions and will use this for NON-COMPENSATED practice.
[ ] I am fully retired in all jurisdictions and will use this for compensated practice.
[ ] I am fully retired in all jurisdictions and will use this for NON-COMPENSATED practice.

I have been licensed to practice osteopathic medicine in any jurisdiction in the United States for at least 10 years and intend to practice only pursuant to the restrictions of a limited license granted pursuant to Section 459.0075, Florida Statutes.

Signature_____ **Date**_____

3. Would you be able to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? [ ] YES [ ] NO

4. NAME: _____
(last) (first) (middle)

a. Have you ever changed your name through marriage or through action of a court? [ ] YES [ ] NO

_____
If "yes", list: Name(s) and date(s) of change(s) above

5. MAILING ADDRESS (where you receive mail): _____
(Street and number or PO Box)

_____
(City, State/Province, Zip/Postal Code, Country)

6. APPROVED FACILITY NAME/ ADDRESS: _____
(Facility Name)

_____
(Street and number) **NO PO BOX**

_____
(City, State/Province, Zip/Postal Code, Country)

_____
Facility Director's Name

_____
Anticipated Start Date / Facility Phone Number

7. TELEPHONE: (_____)_____ (_____)_____
Home **Work**

8. FAX NUMBER: _____ **9. E-MAIL ADDRESS:** _____

9a. E-Mail Notification: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing

10. PERSONAL DATA:

HEIGHT: _____ WEIGHT: _____ EYES: _____ HAIR: _____

BIRTH DATE: _____ (Month/Day/Year) BIRTH PLACE: _____ (City) (State/Province) (Country)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (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: Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other [ ]
SEX: Male [ ] Female [ ]

11. CITIZENSHIP:

Are you a citizen of the United States? [ ] YES [ ] NO

If you were not born in the U.S. but are a Naturalized citizen, please provide date and place of Naturalization:

_____ (Month/Day/Year) & _____ (City/State/Province/Country)

If you are not a U.S. citizen, please provide alien number: _____

12. Have you ever been in the United States Military or Public Health Service? [ ] YES [ ] NO

_____
If "yes", list branch of service, rank and dates of service.

a. Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States? [ ] YES [ ] NO
If "yes" see instructions for required documentation.

13. OTHER STATE LICENSES:

Do you now hold or have you ever held a license to practice Osteopathic 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	LICENSE NUMBER	ISSUE DATE	CURRENT STATUS	METHOD
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

14. List the year and state/province/country where you legally began to practice: _____

15. Have you passed all three parts of the National Board of Osteopathic Medical Examination? [ ] YES [ ] NO

If "no", list the dates and exams you HAVE taken: _____

16. POSTGRADUATE EDUCATION: Doctor of Osteopathic Medicine Degree was obtained from:

_____ (Name of School/College) (Dates of Attendance) (Degree Title)

17. UNDERGRADUATE/GRADUATE EDUCATION:

Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order:

_____ (College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

_____ (College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

_____ (College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

18. POSTGRADUATE TRAINING: List in chronological order from date of graduation from Osteopathic School all professional/postgraduate training (Internship/Residency/Fellowship).

Name of Training Program	Full Mailing Address	Specialty Area	AOA/ACGME Approved	Dates of Attendance		Credit Received
				Began	Ended	

19. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign from, or otherwise acted against by any school, college, university, internship, residency or other training program? [ ] YES [ ] NO
(If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

20. Was your attendance in Osteopathic Medical school or any postgraduate training program for a period of time other than the normal curriculum or established timeframe? [ ] YES [ ] NO
(If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

21. Were you required to repeat any part of your Osteopathic Medical education, internship, residency or other training program? [ ] YES [ ] NO
(If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

22. PRACTICE / EMPLOYMENT: List in chronological order from date of graduation to present, all practice employment, non-employment and/or any unaccounted for period of time. (Attach additional sheets if necessary.)

_____ _____ _____
(Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

_____ _____ _____
(Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

_____ _____ _____
(Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

_____ _____ _____
(Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

23. Have you had responsibility for graduate medical education within the last 10 years? [ ] YES [ ] NO

24. Do you currently hold a faculty appointment at an Osteopathic/health related institution of higher learning? [ ] YES [ ] NO
(If "yes", list below.)

_____ _____
(Name and mailing address of institution) (Title of Appointment)

_____ _____
(Name and mailing address of institution) (Title of Appointment)

25. STAFF PRIVILEGES: Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If "yes" list below.) DO NOT LIST TRAINING PRIVILEGES. [ ] YES [ ] NO
Attach additional sheets if necessary.

Name of Institution	Full Mailing Address	Type of Privileges	Chief of Staff	Dates of Service

26. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign, or take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [ ] NO
(If "yes", list below and see instructions for required documentation.)

(Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

(Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

27. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? [ ] YES [ ] NO
(If "yes", list below and see instructions for required documentation.)

(Name/Address of Facility) (Date: MM/DD/YY) (Circumstances) (Final Action)

28. Have you ever been asked, or allowed to resign, from any facility in lieu of disciplinary action or during any pending investigations into your practice? [ ] YES [ ] NO
(If "yes", list below and see instructions for required documentation.)

(Name/Address of Facility) (Date: MM/DD/YY) (Violation/Investigation) (Reason for Resignation)

29. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Osteopathic Association or other similar national organization? [ ] YES [ ] NO
(If "yes", list below and enclose a copy of each certification or letter of verification.)

(Board Name) (Certification/Specialty/Subspecialty) (Date of Certification)

(Board Name) (Certification/Specialty/Subspecialty) (Date of Certification)

30. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? [ ] YES [ ] NO
(If "yes", explain on a separate sheet, providing accurate details.)

31. Have you ever had any sanctions taken against you by a specialty board recognized by the AOA or other similar national organization? [ ] YES [ ] NO
(If "yes", list below and see instructions for required documentation.)

(Name of Specialty Board) (Date: MM/DD/YY) (Circumstances) (Final Action) (Under Appeal?)

32. List all Osteopathic/Professional Society or Association Memberships:

_____
(Name / Address) (Dates of Affiliation: From/To)

_____
(Name / Address) (Dates of Affiliation: From/To)

33. Have you ever had an application for membership denied by an Osteopathic/Professional Society or Organization? [ ] YES [ ] NO

34. Have you ever had an Osteopathic/Professional Society or Association membership suspended? [ ] YES [ ] NO

35. Have you ever been notified to appear before an Osteopathic/Professional Society or Association in regard to charges/complaints filed against you? [ ] YES [ ] NO

(If "yes" to 33-35, list below.)

_____
(Name of Society/Association) (Address) (Date of Action: MM/DD/YY)

MALPRACTICE / LIABILITY CLAIM HISTORY:

36. ☐ Yes ☐ No Have you had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after **November 2, 2004**?

37. ☐ Yes ☐ No Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000?

- A "yes" answer to either of the above two questions requires the following:
  - A self explanation listing your involvement in each case
  - Completed Exhibit 1 Form for each case (follows application)
  - A copy of the complaint and disposition for each case
  - **In addition to the above, for judgments occurring after November 2, 2004** the entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a DVD (don not send originals). The record must include:
    - Initial and/or amended complaint
    - Trial transcripts
    - Evidentiary exhibits
    - Final judgment

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 38-48 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

38. Have you had <u>any</u> application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or the licensing authority of any state territory or country? [ ] YES [ ] NO

39. 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 Osteopathic Medicine practice act, unprofessional or unethical conduct? [ ] YES [ ] NO

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

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

42. Have you ever been convicted of, or entered a plea of guilty, nolo contendre, or no contest to a crime in any jurisdiction other than a minor traffic offense? [ ] YES [ ] NO
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 s not considered a minor traffic offense for purposes of this question.

43. Have you ever received a letter of admonition or notice of administrative hearing from the Drug Enforcement Agency (DEA)? [ ] YES [ ] NO

44. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [ ] YES [ ] NO

45. Have you ever been denied, or surrendered a DEA Registration? [ ] YES [ ] NO

46. Have you ever been terminated for cause from participating in the Florida Medicaid Program? [ ] YES [ ] NO

47. Have you ever been sanctioned by any state Medicaid program? [ ] YES [ ] NO

48. Have you ever defaulted on any health education loan or scholarship obligation? [ ] YES [ ] NO

APPLICANT HISTORY – 456.0635(2), F.S.:

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.

49. 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 #51.) [ ] YES [ ] NO

a. If "yes" to 49, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

b. If "yes" to 49, 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

c. If "yes" to 49, 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

d. If "yes" to 49, 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

50. 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

a. If "yes" to 50, 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

51. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 51a.) [ ] 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

52. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? [ ] 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 the date of this application? [ ] YES [ ] NO

53. 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

54. STATEMENT OF APPLICANT:

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 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Osteopathic Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Signature of Applicant) (Date)

FINANCIAL RESPONSIBILITY FILING FORM

The Financial Responsibility options are divided into two categories: coverage and exemptions. Check only **one** of the ten options provided as required by s. 459.0085, Florida Statutes.

CATEGORY I: Financial Responsibility Coverage for Florida Practice Only

1. [ ] I do not have hospital staff privileges 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.

2. [ ] I have hospital staff privileges and I have obtained and maintain 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

5. [ ] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

CATEGORY II: Financial Responsibility Exemptions

6. [ ] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
7. [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
8. [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)
9. [ ] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
10. [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria**** See note below**:
    (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 1,000 patient contact hours per year.
    (c) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period.
    (d) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.
    (e) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

**** If you select an exemption based on based on #10, you must also complete the affidavit on the following page.**

_____ _____ _____
Signature Printed Name Date

DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an exemption based on #10 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 459, 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 459, 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 459.0085(5) (f), F.S., for specific notice requirements.

Dated:_____ Signature:_____

STATE OF FLORIDA
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_____

Electronic Fingerprinting

Take this form with you to the Live Scan 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 Osteopathic Medicine is **EDOH2015Z**;
- 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 11C8.001, 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 my 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.

Confirmation of Receipt of:

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

Name: _____ File # (if known) _____

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

Other last names: _____

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

☐ **Yes** ☐ **No**

Signature: _____ Date: _____
(MM/DD/YYYY)

Please send this form with your application and fees to:

Board of Osteopathic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330

If you send this form separate from your application please mail it to:

Board of Osteopathic Medicine
4052 Bald Cypress Way
Bin # C06
Tallahassee, FL 32399-3256

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION (NICA) FORM

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 proof of qualification for claimed exemption to NICA and to the Board of Osteopathic Medicine.

I have read the information at www.nica.com and I choose the option above.

_____
Name

_____
Signature Date

Street Address

_____
City, State, Zip

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

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256

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

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256

and 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.

EXHIBIT 1 FORM – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Practitioner's Name _____

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. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.0391, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

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 healthcare provider license number involved in this claim:
1. _____ 2._____
3. _____ 4._____

Date of final claim disposition: _____/_____/_____

Date and amount of judgment or settlement, if any:_____

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: $_____

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

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 knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty is a misdemeanor of the second degree, punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of Physician: _____ Date: _____