Department of Health
Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

GENERAL INFORMATION/INSTRUCTIONS

Application for Podiatric Examination & Initial Licensure

HOW TO APPLY FOR FLORIDA PODIATRIC MEDICINE LICENSURE

*** PLEASE TYPE OR PRINT IN BLACK INK - PLEASE READ CAREFULLY ***

1. **FLORIDA LAWS & RULES:**
Section 461, Florida Statutes and Chapter 64B18, Florida Administrative Code can be downloaded from the boards web site http://floridaspodiatricmedicine.gov/resources/ It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statute and board rules regarding your application for licensure and the practice of podiatric medicine within the State of Florida.

2. **APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:**
Within thirty (30) days after we receive your application and fee, we will send you an acknowledgment letter informing you of any deficiencies in your application and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date you mailed it, or if you have questions concerning the requirements for licensure, please do not hesitate to contact this office. If you have questions concerning whether or not we have received items, which we require you to arrange to be sent to this office by a third party (such as official transcripts, licensure verifications from state licensing agencies); please check with the third party first to see if the required documentation has been sent. As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

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

4. **FEE SCHEDULE:**
A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the check or money order to the application on the upper left part of the form. These fees are required by law and include the following:

Application fee:	$ 100.00
Examination fee:	($200.00) (if applicable)
Dispensing fee	($100.00) (if applicable)
Unlicensed Activity fee:	$ 5.00
Initial Licensure fee:	$ 350.00
TOTAL:	**$ 755.00**

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

a. **Proof of Passing Parts I and II of the National Board of Podiatric Medical Examiners.** Results/score reports provided by applicants will not be accepted. Verification must be sent to this office directly from the National Board of Podiatric Medical Examiners.

b. **Proof of Passing Part III:** Results/score reports provided by applicants will not be accepted. Verification must be sent to this office directly from the National Board of Podiatric Medical Examiners.

6. **FINGERPRINT CARD/BACKGROUND CHECK - 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.

7. CLINICAL EXPERIENCE

In order to be eligible for licensure, an applicant must have completed one of the following:

a. Verification of one year of residency in a residency program approved by the Council on Podiatric Medical Education must be sent directly from the residency program director; or

b. Proof of ten years of continuous, active licensed practice of podiatric medicine in another state immediately preceding the submission of the application and completion of at least the same number of hours of continuing education required during those ten years as is required of doctors of podiatric medicine licensed in this state. You are required to show proof of completion of continuing education by submitting copies of the certificates of completion or by written verification by the state licensing authority.

8.FINAL OFFICIAL TRANSCRIPT:

A final official transcript must be sent directly from the educational institution/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable; a copy of your diploma will not be accepted in lieu of an official transcript. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests.

9.LICENSURE VERIFICATION:

The licensure verification form included with this application package must be sent to each state where you currently have or have held a license to practice. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

10.FINANCIAL RESPONSIBILITY/PROFESSIONAL LIABILITY COVERAGE:

The Professional Liability section must be completed by selecting the appropriate option and submitting the required documentation. Proof of liability coverage is not required until your license is issued and must be sent directly from the company to the board office.

11.REPORTS OF PROFESSIONAL LIABILITY CLAIMS AND ACTIONS:

Please complete Exhibit 1 for each occurrence within the past 10 years.

12.DISPENSING PRACTITIONER REGISTRATION:

Section 465.0276, Florida Statutes, requires that licensees, who dispense medicinal drugs for a fee or remuneration of any kind, whether direct or indirect in the State of Florida, shall be required to register with the Board and pay a fee of $100. Dispensing Practitioners are required to comply with all laws and rules applicable to pharmacists and pharmacies, including, but not limited to Chapter 465, Florida Statutes (Pharmacy Practice Act), Chapter 499, Florida Statutes (Florida Drug and Cosmetic Act), and Chapter 893, Florida Statutes (Controlled Substance Act), and all federal laws and federal regulations. Before dispensing any drug, the dispensing practitioner is required by Section 465.0276(2)(c), Florida Statutes, to give the patient a written prescription and orally or in writing advise the patient that the prescription may be filled in the practitioner's office or at any pharmacy. It is unlawful for any person to sell samples or complimentary packages of drug products. Practitioners who confine their activities to the dispensing of complimentary packages of medicinal drugs to their patients in the regular course of their practice shall not be required to register. If you register as a dispensing practitioner and choose to stop dispensing, you shall notify the Board that you are no longer dispensing. Please be advised that renewal of dispensing registration runs concurrent with your license.

13. 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 report, provide the Board office with a copy. A fee is charged to furnish this information.

NPDB
Post Office Box 10832
Chantilly, VA 22021
(800) 767-6732
www.npdb-hipdb.hrsa.gov

If the package that you are mailing to the Board Office contains money, mail to:

DEPARTMENT OF HEALTH
REVENUE SERVICES Post
Office Box 6330
Tallahassee, Florida 32314-6330

If the package that you, or anyone on your behalf, is mailing to the Board Office does NOT contain money, mail to:

Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

FEDERAL PRIVACY ACT:

Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. **In this instance, social security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654: and sections 456.013, 409.257(7) and 409.259(8), F. S.** Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for license verification pursuant to, unless exempt as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE
Florida Department of Health
Board of Podiatric Medicine

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

Name: _____ _____

Last **First** **Middle** **Social Security Number**

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

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO
2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO
4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? [ ] YES [ ] NO
5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO
6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug)disorder that has impaired your ability to practice within the last five years? [ ] YES [ ] NO

NATIONAL EXAMINATIONS: Please provide the examination information for Part I, II and III:

1. Part I (Integrated Basic Science Examination):

_____ _____/_____/_____
(State) (Date)

2. Part II (Clinical Science Examination):

_____ _____/_____/_____
(State) (Date)

3. Part III:

a. Have you passed the National Board of Podiatric Medical Examiners examination(s)? [ ] YES [ ] NO
(If **YES**, provide the State and date in which you successfully passed the examination(s).
If **NO**, provide the State and date where you plan to take the examination(s).)

_____ _____/_____/_____
(State) (Date)

_____ _____/_____/_____
(State) (Date)

b. Have you ever failed the National Board of Podiatric Medical Examiners examination(s)? [ ] YES [ ] NO
(If **YES**, please provide the State and date in which you failed the examination(s).)

_____ _____/_____/_____
(State) (Date)

_____ _____/_____/_____
(State) (Date)

BOARD OF PODIATRIC MEDICINE
APPLICATION FOR LICENSURE
(Client: 2101)

READ/DOWNLOAD APPLICATION INSTRUCTIONS FOR IMPORTANT INFORMATION

1. APPLICATION CATEGORY/APPLICABLE FEES: (TYPE OR PRINT LEGIBLY IN BLACK INK)

APPLICATION FEE:	**$ 100.00**
EXAMINATION FEE:	**$ (200.00) If Applicable**
DISPENSING FEE:	**$ (100.00) If Applicable**
Unlicensed Activity Fee:	**$ 5.00**
Initial Licensure Fee:	**$ 350.00**
Total:	**$ 755.00***

***(The total fee ($755.00) includes the examination and dispensing fee. If these fees do not apply to you, please subtract the fees from the $755.00 and submit the appropriate amount.)**

APPLICANT PROFILE:

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

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

_____
If yes, provide the following: (Last) (First) (Middle)

3. ADDRESS:

a. **MAILING ADDRESS** (where you receive mail):

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

b. **PRIMARY PRACTICE/PHYSICAL ADDRESS** (where you can be located-NO PO BOX):

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

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

d. **EMAIL ADDRESS:**

_____
Optional: Florida law provides that email addresses are public record. Do not provide an email address if you do not want it released pursuant to a public records request.

4. **PERSONAL DATA:**

BIRTH DATE: _____ BIRTH PLACE: _____
(MM/DD/YYYY) (City) (State/Province) (Country)

CITIZENSHIP: _____

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: White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other [ ]
SEX: Male [ ] Female [ ]

Would you be willing to provide health services in special needs to shelters or to help staff disaster medical assistance teams during time of emergency or major disaster? [ ] YES [ ] NO

NAME:_____

EMPLOYMENT:

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

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

EDUCATION and TRAINING:

6. **UNDERGRADUATE/GRADUATE/PROFESSIONAL EDUCATION:** Please provide undergraduate, graduate, and professional education, listing all schools, colleges and universities attended, whether completed or not, in chronological order.

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

7. **POSTGRADUATE TRAINING:** List in chronological order from date of graduation from the **Podiatric Medical School** to the present all professional/postgraduate training (Internship/Residency/Fellowship).

(Program Name)	(City/State/Country)	(Program Type)	(Specialty Area)	(From: MM/DD/YYYY–To: MM/DD/YYYY)	(Credit Received) Y/N
(Program Name)	(City/State/Country)	(Program Type)	(Specialty Area)	(From: MM/DD/YYYY–To: MM/DD/YYYY)	(Credit Received) Y/N

8. **ACADEMIC/FACULTY APPOINTMENTS:**
   a. Do you currently hold a faculty appointment at a medical school? [ ] YES [ ] NO
   b. Have you had responsibility for graduate medical education within the last 10 years? [ ] YES [ ] NO

If YES, please complete the following:

(Name of Institution)	(City/State)	(Title of Appointment)
(Name of Institution)	(City/State)	(Title of Appointment)

9. **STAFF PRIVILEGES:** Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (DO NOT LIST TRAINING PRIVILEGES) [ ] YES [ ] NO

If YES, please complete the following: **[ ] In-State Facility** **[ ] Out-of-State Facility**

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

NAME:_____

10. **SPECIALTY BOARD CERTIFICATION:** Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, or other similar national organization or from any specialty board recognized by the Florida Board of Podiatric Medicine? [ ] YES [ ] NO

(If YES, please complete the following and enclose a copy of each certification or letter of verification)

(Board Name)	(Certification/Specialty/Sub-Specialty)	(Date of Certification)
(Board Name)	(Certification/Specialty/Sub-Specialty)	(Date of Certification)

11. **LICENSURE INFORMATION:** Do you hold or have you ever held a license to practice Podiatric Medicine or any other profession in any U.S. State or territory, or foreign country? [ ] YES [ ] NO

(If YES, please list the year where you legally began to practice. This would be the date you began practicing podiatric medicine and could be the date you began your postgraduate training.)

_____
Year Began Practicing

(Also if yes, please provide the following information.)

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

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

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

PROCEEDINGS and/or ACTIONS

APPLICATION HISTORY:

12. **APPLICATION:**

a. Have you had any application for professional license or any application to practice Podiatric Medicine denied by any state board or other governmental agency of any state or country? [ ] YES [ ] NO

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

If YES, please complete the following:

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

NAME:_____

EDUCATION AND TRAINING HISTORY:

13. EDUCATION/POSTGRADUATE TRAINING:

Have you ever been placed on probation, restrictions, suspension, revocation modification, allowed to resign, requested to leave, temporarily or permanently or otherwise acted against by a Podiatric/Professional training program prior to completion of training? [ ] YES [ ] NO

If YES, list in chronological order from date of graduation from a Podiatric/Professional college all professional/postgraduate training **disciplinary actions** to the present.

(Program Name and full mailing address required)	(Institution/Hospital)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Program Name and full mailing address required)	(Institution/Hospital)	(From: MMDD/YY/YY To: MM/DD/YYYY)

CRIMINAL HISTORY:

14. CRIMINAL INFORMATION:

a. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? [ ] YES [ ] NO

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

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

b. 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

DISCIPLINE ACTIONS HISTORY:

15. SPECIALTY BOARD CERTIFICATION: Have you ever had any final disciplinary actions taken against you by a specialty board recognized by the department. [ ] YES [ ] NO

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

LICENSURE ACTIONS:

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

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

NAME:_____

The following questions are being asked below. A FACILITY is defined as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

17. FACILITY HISTORY:

a. 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

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

b. 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

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

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

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

EMPLOYMENT HISTORY:

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

DRUG ENFORCEMENT AGENCY (DEA):

19. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? [ ] YES [ ] NO

20. 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

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

NAME:_____

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

22. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded NO, skip to 23)** [ ] YES [ ] NO

a. If "yes" to 22, for 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 22, for 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 22, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

d. If "yes" to 22, 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

23. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? [ ] YES [ ] NO

a. If "yes" to 23, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

24. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 24a.)** [ ] 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

25. 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 25a or 25b.)** [ ] YES [ ] NO

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

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

26. 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

FINANCIAL RESPONSIBILITY:

27. STATEMENT OF FINANCIAL RESPONSIBILITY: (READ ALL OPTIONS/CHECK APPROPRIATE CATEGORY) PROVIDING FALSE INFORMATION MAY RESULT IN DISCIPLINARY ACTION OR CRIMINAL PENALTIES AS PROVIDED IN SECTIONS 456.066, 456.067, 456.072, 461.012, 461.013, 775.082, AND/OR 755.083 AND/OR 755.084, FLORIDA STATUTES)

NAME:_____

[ ] I have professional liability coverage in an amount of not less than $100,000 with the following company _____. (Proof of coverage must come directly from the company).

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

[ ] I have an irrevocable letter of credit, established pursuant to Chapter 675, in an amount of not less than $100,000 per claim.

[ ] I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.

[ ] I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited podiatric medicine school/college or its main teaching hospital.

[ ] I am exempt from demonstrating financial responsibility because I do not practice in the State of Florida.

28. LIABILITY CLAIMS:

a. Are you covered by an insurer required to report pursuant to s. 627.912 F.S.? [ ] YES [ ] NO

b. Have you been insured continuously during the last 10 years? [ ] YES [ ] NO

c. Within the last ten years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [ ] YES [ ] NO

If yes, please complete and attach a copy of EXHIBIT 1 for each occurrence.

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 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. 456.049, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Complete and attach a copy of EXHIBIT 1 for <u>each</u> occurrence. (NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire 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) (Age) (Sex)

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Name of Institution at which the injury occurred along with his/her license number:

_____

Location of Injury Occurrence:

____Patient's Room	____Physical Therapy Dept.	____Radiology
____Operating Suite	____Nursery	____Emergency Room
____Special Procedure Room	____Recovery Room	____Critical Care Unit
____Labor & Delivery Room	____Other _____	

List other defendants involved in this claim:

1. _____ 3. _____

2. _____ 4. _____

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

Final Claim Disposition Date: _____/_____/_____

Date and amount of judgment or settlement, if any: _____
Was there an itemized verdict? (If "**YES**", attach copy of settlement verdict) [ ] YES [ ] NO
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: _____

Under separate document titled **EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS.**
(Please **<u>type, list all five (5) questions,</u>** and **<u>provide a response for each of the following:</u>**

1. Final diagnosis for which treatment was sought or rendered.
2. Describe misdiagnosis made, if any, of the patient's actual condition.
3. 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.
4. 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.
5. 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 Statute.

Physician Signature: _____

NAME:_____

30. DISPENSING PRACTITIONER REGISTRATION: (Optional for podiatrists 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 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 **shall not** be required to register.

I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register pursuant to 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. [ ] YES [ ] NO

If yes, I will be dispensing medication at the following locations: (attach additional sheets if needed)

1st Practice Location: _____ / /
(Business Name) (Street and Number) (City) (State) (Zip) (Telephone Number)

2nd Practice Location: _____ / /
(Business Name) (Street and Number) (City) (State) (Zip) (Telephone Number)

3rd Practice Location: _____ / /
(Business Name) (Street and Number) (City) (State) (Zip) (Telephone Number)

31. APPLICANT SIGNATURE:

I understand that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 461.012, 461.013, 775.082, 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 Podiatric 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, and I declare under penalty of s. 461.012(2)(b), Florida Statutes, that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Podiatric Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 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 on it.

_____ _____
APPLICANT'S SIGNATURE **DATE**

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

Please make check payable to the Department of Health.
Return application and fees to:

Department of Health
Revenue Services
Post Office Box 6330
Tallahassee, Florida 32399-6330

Mail all supporting documents/correspondence to:
(Documents sent separate from application/no money)
Department of Health
Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

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.floridahealth.gov/licensing-and-regulation/background-screening/index.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 Podiatric Medicine is EDOH2017Z;
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 HEALTH

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:

1. Complete the information in Part I only.
2. This form must be returned by the state Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT: (PRINT or TYPE)

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

Address: _____
(Street) (City) (State) (Zip/Postal Code)

DOB: ___/___/____ License No.: _____ Title of License: _____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE: (PRINT or TYPE)

The individual listed above has applied for licensure in Florida as a Doctor of Podiatric Medicine. Before further consideration is given to this application, we require the information requested on this form. The Board may submit their standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Podiatric Medicine, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257**

Licensee Name:

(Last) (First) (Middle)

Licensing State: _____Title of License: _____License No.: _____Original Issue Date:_/_____/_____

THIS LICENSE IS CURRENTLY:
[ ] Active [ ] Inactive [ ] Temporary [ ] Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ] Examination [ ] Grandfathering [ ] Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ] No Disciplinary Action Taken [ ] Disciplinary Action Taken*

Do you have any additional relevant information concerning this licensee? [ ] NO [ ] YES
(If **YES**, please provide information on separate sheet.)

Please Affix Board Seal

_____ _____
Signature Title

If disciplinary action has been taken against this licensee, please provide certified copies of documentation regarding any disciplinary actions directly to the Florida Board of Podiatric Medicine.