Florida Department of Health
Active Military Spouse Licensure Application

Expedite your application by applying online at www.flhealthsource.gov

Qualifications for Licensure

1. Must be the spouse of a person serving on active duty in the U.S. Armed Forces. We will request a copy of your spouse's orders for duty and proof of marriage.

2. Must hold an active, unencumbered license in a U.S. jurisdiction, other than a dentist, or be a health care practitioner in a profession for which licensure in a state or jurisdiction is not required to practice. If your active, unencumbered license is not verifiable on-line, we will request that you have the licensing entity send official license verification to the department. If you are a health care practitioner in a profession for which licensure in another state or jurisdiction is not required, you must submit evidence of training or experience substantially equivalent to the requirements for licensure in Florida and evidence that you have obtained a passing score on the appropriate examination for licensure in this state, if required in Florida for that profession.

3. Must have had no disciplinary action taken against you in the five (5) years preceding the submission of this application if you hold an active, unencumbered license in a U.S. jurisdiction. Must have a National Practitioner Data Bank (NPDB) report with no disciplinary action that would constitute grounds for denial during the preceding five (5) years (we will obtain the NPDB report directly).

4. Must have actively practiced the profession for which you are applying for the three (3) years preceding the submission of this application.

5. Certain professions require Livescan screening. The professions requiring Livescan are listed below in *Additional Requirements*.

6. All initial licensure, application, unlicensed activity and NPDB fees are waived. Fees are required for the background screening (paid directly to the Livescan vendor) and Student Loan Forgiveness Fund (Nurses only). Medical Doctors and Osteopathic Physicians may be required to pay Fees for Florida Birth-Related Neurological Injury Compensation Association (NICA) participation. Please visit http://flboardofmedicine.gov/help-center/am-i-required-to-pay-the-florida-birth-related-neurological-injury-compensation-association-nica-fee/ to determine if you are required to pay this fee. Proof of qualification for a claimed exemption must be submitted to NICA, P.O. Box 14567, Tallahassee, FL 32317-4567. Please make your cashier's check or money order payable to the Department of Health (if applicable).

7. Submit your application, any applicable fees, and any supplemental documentation to the Department of Health, P.O. Box 6330, Tallahassee, Florida 32314-6330.

Additional Requirements

Background Screening: Please see the Electronic Fingerprinting Form in the application. **The following professions** must complete a Livescan screening:

- Medical Doctors (Ch. 458)
- Osteopathic Physicians (Ch. 459)
- Chiropractic Physicians (Ch. 460)
- Podiatric Physicians (Ch. 461)
- Nurses (Ch. 464)
- Certified Nurse Assistant (Ch. 464)
- Massage Therapists (Ch. 480)
- Physician Assistant (Ch. 458, 459)
- Orthotists, Prosthetists & Pedorthists (Ch. 468)
- Athletic Trainer (Ch.468, Part XIII)
- Anesthesiologist Assistant (Ch. 458, 459)

Financial Responsibility: The following professions must demonstrate compliance with financial responsibility as a part of licensure:

- Acupuncturists (Ch. 457)
- Medical Doctors (Ch. 458)
- Osteopathic Physicians (Ch. 459)
- Chiropractic Physicians (Ch. 460)
- Advanced Registered Nurse Practitioners (Ch. 464)
- Podiatric Physicians (Ch. 461)
- Licensed Midwives (Ch. 467)
- Anesthesiologist Assistant (Ch. 458, 459)

Practitioner Profiling: Sections 456.039 and 456.0391, Florida Statutes (F.S.) require practitioners to furnish specific information for publication on the Department's website. Required information must be submitted within 12 months from the date of initial licensure. **The following professions** are required to comply with the profiling requirements:

- Medical Doctors (Ch. 458)
- Chiropractic Physicians (Ch. 460)

- Osteopathic Physicians (Ch. 459)
- Podiatric Physicians (Ch. 461)
- Advanced Registered Nurse Practitioners (Ch. 464)

Active Military Spouse Licensure Application

Expedite your application- apply online at: www.flhealthsource.gov

Fees: **(Nurses only)** Student Loan Forgiveness- $ 5.00

(**Medical Doctors and Osteopathic Physicians Only**) NICA- Please visit www.nica.com to determine which amount below you must pay.

☐ $0.00 – Exempt ☐ $250.00 – Non-participating ☐ $5,000.00 - Participating

List the profession for which you are applying: _____

(Examples: Medical Doctor, Osteopathic Physician, Registered Nurse, Licensed Practical Nurse, etc.)

Personal Information:

Name: _____ **Date of Birth:** _____

Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where your correspondence and license should be mailed.)

_____

Street and #/P.O. Box Suite/Apt#

_____

City State/Province Zip/Postal Code Country

Physical Address: (A Post Office Box is not acceptable. This address will be posted of the Department of Health's website. If you do not have a current practice address your mailing address will be used.

_____

Street and number Suite/Apt #

_____

City State/Province Zip/Postal Code Country

Telephone: _____

Primary Alternate

Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email 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.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedures (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other:

Licensure History:

☐ Yes ☐ No Do you hold an active, unencumbered license in a U.S. jurisdiction or territory to practice the profession for which you are applying? If "Yes", list:

Jurisdiction/Territory: _____ **License #**: _____ **Date of Initial Licensure**: _____

☐ Yes ☐ No Are you a health care practitioner in a profession, excluding dentistry, for which licensure is not required to practice in another state or jurisdiction?

☐ Yes ☐ No Have you practiced the profession for which you are applying for the three (3) years preceding the submission of this application?

☐ Yes ☐ No Have you had disciplinary action taken against any license by the licensing authority in any state, jurisdiction or country within the last 5 years?

☐ Yes ☐ No Do you have disciplinary action currently pending against any license?

Criminal History and Medicaid / Medicare Fraud Questions:
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.

1. ☐ Yes ☐ No 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 question 2.)**

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?

b. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

c. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?

d. ☐ Yes ☐ No If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).

2. ☐ Yes ☐ No 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)? **(If you responded "no", skip to question 3.)**

a. ☐ Yes ☐ No If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If you responded "no", skip to question 4.)**

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no", skip to question 5.)**

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No 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?

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

The below health history section and social security number are confidential and exempt from public disclosure.

Health History:

If you answer "Yes" to any of the questions in this section, **you are required to send the following items:**

- A self-explanation providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Department of Health from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

A. ☐ Yes ☐ No 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?

B. ☐ Yes ☐ No 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?

C. ☐ Yes ☐ No 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 within the past five years?

D. ☐ Yes ☐ No 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?

E. ☐ Yes ☐ No 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?

F. ☐ Yes ☐ No 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 past five years?

Name: _____

Last First Middle

Social Security Number: _____

* **Social Security Information** - * 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(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure 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 identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

Availability for Disaster:

□ Yes □ No Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

Statement of Applicant:

I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties. I have read Chapter 456, the practice act governing the profession for which I am applying and the Florida Administrative Code Chapter governing the profession for which I am applying.

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 Department of Health information which is material to my application for licensure.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice the profession for which I am applying in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the department within 30 days.

_____ _____

Signature **Date (mm/dd/yyyy)**

Livescan Privacy Statement (for professions requiring background screening only):

- Medical Doctors (Ch. 458)
- Osteopathic Physicians (Ch. 459)
- Chiropractic Physicians (Ch. 460)
- Anesthesiologist Assistant
- Podiatric Physicians (Ch. 461)
- Nurses (Ch. 464)
- Athletic Trainer (Ch.468, Part XIII)
- Physician Assistant
- Orthotists, Prosthetists and Pedorthists (Ch. 468)
- Massage Therapists (Ch. 480)
- Certified Nursing Assistants

□ Yes □ No 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.

_____ _____

Signature **Date (mm/dd/yyyy)**

Electronic Fingerprinting

This form is only for the professions which require Livescan. See the list at the bottom of this form.

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method.
- You can find a Livescan service provider at: . http://www.flhealthsource.gov/background-screening/ *(Click on "Locate a Provider").*
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the department will not receive your background screening results; ORI #s are listed by profession below.
- You must provide demographic information to the Livescan service provider at the time your fingerprints are taken, including your Social Security number (SSN).
- Typically background screening results submitted through a Livescan service providers are received by the department 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**: _____
(MM/DD/YYYY)

Citizenship: _____ **Place of Birth**: _____

Race: _____ **Sex**: _____
(**W**-White/Latino(a); **B**-Black; **A**-Asian; **NA**-Native American; **U**-Unknown) (**M**=Male; **F**=Female)

Weight: _____ **Height:** _____ **Eye Color**: _____ **Hair Color**: _____

Address: _____ **Apt. Number**: _____

City: _____**State**: _____ **Zip Code**: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Profession	ORI Number	Profession	ORI Number
Medical Doctors	EDOH2014Z		
Osteopathic Physicians	EDOH2015Z	Orthotists, Prosthetists and Pedorthists	EDOH3451Z
Chiropractic Physicians	EDOH2016Z	Massage Therapists	EDOH4600Z
Podiatric Physicians	EDOH2017Z	Athletic Trainer	EDOH4520Z
Nurses(LPN/RN/ARNP)	EDOH4420Z	Anesthesiologist Assistant	EDOH4510Z
Certified Nursing Assistants	EDOH4400Z	Physician Assistant	EDOH4700Z

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

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

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as 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.

FINANCIAL RESPONSIBILITY FORM - Acupuncture Only

Please select **only one** of the following statements that best describes your liability coverage:

CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- ❑ I hereby certify that I have professional liability coverage in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.
- ❑ I hereby certify that I have an irrevocable letter of credit, established pursuant to Chapter 675, in an amount not less than $10,000 per claim, with a minimum aggregate availability of credit no less than $30,000.
- ❑ I hereby certify that I have obtained a surety bond in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- ❑ I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- ❑ I practice only in conjunction with my teaching duties at an accredited acupuncture school.
- ❑ I do not practice in Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in Sections 456.067, 456.072, 775.082, 775.083, and 775.084, Florida Statutes.

_____
Name (printed)

_____ _____
Signature (required) Date

FINANCIAL RESPONSIBILITY FORM - Medical Doctors Only
(Page 1 of 2)

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

Category I: Financial Responsibility Coverage

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

Category II: Financial Responsibility Exemptions

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

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

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

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

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

Dated: _____ Signature:_____

STATE OF _____ COUNTY OF _____
Sworn to (or affirmed) and subscribed before me this_____day of_____, by

_____

_____
(Signature of Notary Public)

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

Produced Identification _____

Type of Identification Produced _____

FINANCIAL RESPONSIBILITY FORM - Osteopathic Physicians Only
(Page 1 of 3)

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, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09 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 or I perform surgery at an ambulatory surgical center 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, I do not perform surgery at an ambulatory surgical center 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 or I perform surgery at an ambulatory surgical center 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 Section 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 Chapter 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 Chapter 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.

_____ _____

Signature Printed Name

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

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 _____

COUNTY OF _____

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

_____

_____
Signature of Notary Public

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced_____

FINANCIAL RESPONSIBILITY FORM - Chiropractic Medicine Only

- ❑ I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, and in compliance with Rule 64B2-17.009(1), F.A.C. (Proof of coverage must come directly from the company)
- ❑ I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000, and in compliance with Rule 64B2-17.009(2), F.A.C.
- ❑ 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 chiropractic medicine school/college or its main teaching hospital.
- ❑ I am exempt from demonstrating financial responsibility because I do not practice in Florida.
- ❑ I am exempt from demonstrating financial responsibility because I have no malpractice exposure in the State of Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in Sections 456.066, 456.067, 456.072, 775.082, 775.083, and/or 775.084, Florida Statutes.

_____	_____	_____
Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY FORM - Podiatric Medicine Only

- ❑ 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 Section 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 Florida.

I understand that 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 775.083 and/or 775.084, Florida Statutes.

_____	_____	_____
Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY FORM - Licensed Midwifery Only

Please choose one of the following:

- ❑ I hereby certify that I have 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. (I have attached a copy of my insurance certificate.)

- ❑ I hereby certify that I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below (circle):
  (a) I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
  (b) I have an inactive license, and do not practice in the State of Florida.
  (c) I practice only in conjunction with my teaching duties at an approved midwifery school.
  (d) I do not practice in Florida, but I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state
  (e) I have no malpractice exposure in Florida.

_____	_____	_____
Name (printed)	Signature (required)	Date

FINANCIAL RESPONSIBILITY - Advanced Registered Nurse Practitioners Only

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only one option that best describes your situation. If you provided financial responsibility information to a hospital or elsewhere, please be consistent when choosing an option below.

Please be advised, failing to choose an option or choosing more than one option will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding choosing an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under Section 624.09, F.S., a surplus lines insurer under Section 626.914(2), F.S., a joint underwriting association under Section 627.351(4), F.S., a self-insurance plan under Section 627.357, F.S., or a risk retention group under Section 627.942, F.S.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, F.S. which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. My Florida license is inactive and I do not practice in the State of Florida.

☐ 3. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ 4. My Florida license is active, but I do not practice in the State of Florida.

☐ 5. I have had no malpractice exposure in the state and can demonstrate to the board or department my lack of malpractice exposure.

☐ 6. I have just completed my Advanced Registered Nurse Practitioner Program and/or I am not yet practicing in Florida.

456.067 Penalty for giving false information.—In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, the act of knowingly giving false information in the course of applying for or obtaining a license from the department, or any board thereunder, with intent to mislead a public service in the performance of his or her official duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable as provided in s. 775.082, or s. 775.08.

_____

Name (printed)

_____ _____

Signature of Licensee Date

FINANCIAL RESPONSIBILITY FORM: ANESTHESIOLOGIST ASSISTANTS ONLY

Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only one option provided pursuant to s. 456.048, Florida Statutes.

FINANCIAL RESPONSIBILITY COVERAGE:

☐ **1**. I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/ $300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **2.** I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

FINANCIAL RESPONSIBILITY EXEMPTIONS:

☐ **3.** I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ **4.** I do not practice medicine in the State of Florida.

☐ **5.** I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.

_____ _____

Signature of Anesthesiologist Assistant Date