FLORIDA BOARD OF MEDICINE
TEMPORARY CERTIFICATE TO PRACTICE IN AN AREA OF CRITICAL NEED APPLICATION

Apply for your license online at www.flboardofmedicine.gov

GENERAL INFORMATION

For a detailed list of licensure requirements please visit www.flboardofmedicine.gov

Mailing Information:
Submit your application, fees and any supplemental documentation you are sending with your application to the following address:

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

Mail additional documentation, not included with your application, to the following address:

Florida Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

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

Fees:
If applicable, make one cashier's check or money order for the total amount payable to the Department of Health-Board of Medicine.

An applicant who is denied licensure, or withdraws the application prior to licensure, is entitled to a refund of the initial licensure fee and NICA fee. A request to withdraw and receive a refund must be made in writing.

All fees are waived for non-compensated practice:
To receive the waiver of fees, the facility in which you intend to work must send a letter, addressed to the Florida Board of Medicine, stating you will not be receiving any compensation for your practice.

Fees for compensated practice:

Application fee:	$300.00 (non-refundable)
Initial license fee:	$350.00
NICA Fee:	$250.00 or $5,000.00 (please read information at www.nica.com)
Dispensing Practitioner fee:	$100.00 (optional this fee is for selling pharmaceuticals in your office)

QUALIFICATIONS FOR LICENSURE

Chapter 458.315, Florida Statutes:

- Be licensed to practice in any jurisdiction in the United States and whose license is currently valid.
- Only practice in certain designated, approved facilities located in communities of Florida where there is a critical need for physicians.

Submit the following supporting documentation:

- Applicable fees
- Letter of intent to employ
- Copy National Practitioner Data Bank
- Statement for all "Yes" answers and supporting documentation (if applicable)
- Copy of your military discharge document (if applicable)

Request the following to be sent directly to the Florida Board of Medicine:

- State license verification
- *Medical Degree Verification form

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

Important Contact Information:
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 response to the query, provide the Board office with a copy. A fee is charged to furnish this information.

NPDB
P.O. Box 10832
Chantilly, VA 22021
(800) 767-6732
http://www.npdb.hrsa.gov/

Electronic Fingerprinting

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

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.flhealthsource.gov/background-screening/ (Select Locate a Provider).
- 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;
- The ORI number for the **Board of Medicine is EDOH2014Z;**
- You must provide accurate 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 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: _____
(White; Latino; Black; Asian; Native American; Unknown)

SEX:_____WEIGHT:_____HEIGHT: _____

EYE COLOR:_____HAIR COLOR_____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

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

KEEP THIS FORM FOR YOUR RECORDS

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

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

NOTICE OF:

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

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

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

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

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

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

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

Privacy Statement

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

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

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may 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.

APPLICATION FOR TEMPORARY CERTIFICATE TO PRACTICE IN AN AREA OF CRITICAL NEED

Apply for your license online at http://flboardofmedicine.gov/licensing

CHOOSE YOUR APPLICATION METHOD: (check only one)

( ) I have a current license and will use this temporary certificate for COMPENSATED practice.
Application fee $300.00: Initial license fee: $350.00 - Total fee $650.00 plus NICA if applicable.
NICA Fee Exempt ( ) Non-Participating $250.00( ) Participating $5000.00( )

( ) I have a current license and will use this temporary certificate for NON-COMPENSATED practice.
(Application and Initial license fee waived)

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

Anticipated Employment Start Date:_____ Facility Director's Name: _____

Name of Approved Facility:_____ Facility Telephone Number: _____

Facility Address: _____
Street City State Zip

1. PERSONAL INFORMATION:

Name:_____ **Date of Birth**_____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: The address where mail and your license should be sent.

_____
Street/PO Box Suite/Apt. No City

_____
State Zip Country Phone Number

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.

_____
Street Suite/Apt. No City

_____
State Zip Country Alternate Phone Number

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 Procedure (1978) 43 CFR 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

Availability for Disaster: Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistant teams during time of emergency or major disaster? ( ) Yes ( ) No

MEDICAL EDUCATION HISTORY:
List in chronological order all medical schools attended, whether completed or not. Submit on separate sheet if needed.

Medical School Name and Address	From: (MM/YYYY)	To: (MM/YYYY)	Date Degree Received: (MM/DD/YYYY)

2. POSTGRADUATE TRAINING HISTORY:
In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Address	Specialty Area	From: (MM/YYYY)	To: (MM/YYYY)	Did You Receive Credit? (Yes/No)

LOAN HISTORY:

( ) Yes ( ) No Are you currently in default on any health education loan or scholarship obligation? (If "Yes", explain on a separate sheet providing accurate details and submit supporting documentation.)

3. LICENSURE HISTORY:
Request verification of licensure status directly from the licensing entity or https://www.veridoc.org/index.aspx .

( ) Yes ( ) No Do you now hold or have you ever held a license to practice medicine or any other profession in the United States or territory, or foreign country? List in the table below. Submit on a separate sheet if needed.

Jurisdiction	Profession	License Number

If you answer "Yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

( ) Yes ( ) No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

( ) Yes ( ) No Are you currently under investigation in any jurisdiction for an act or offense what would constitute a violation of Section 458.331, Florida Statutes?

( ) Yes ( ) No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

4. PRACTICE/EMPLOYMENT HISTORY:

List the year you legally first began to practice medicine,_____(YYYY). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

( ) Yes ( ) No Have you actively practiced medicine during the prior 3 years?

List in chronological order all employment, non-employment, and/or any unaccounted period of time from date you graduated medical school to present. If needed, continue on a separate sheet of paper.

Name and Address of Employment or Activity	Employment or Activity	From: MM/YYYY	To: MM/YYYY

( ) Yes ( ) No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name and Address of Facility

If you answer "Yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

( ) Yes ( ) No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you ever been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

( ) Yes ( ) No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

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

Name of Institution

( ) Yes ( ) No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Specialty Board Certification Name	Date of Certification (MM/YYYY)

If you answer "Yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

( ) Yes ( ) No Have you ever had any final disciplinary action taken against you by a specialty board of other similar national organization?

( ) Yes ( ) No Have you ever been denied or surrendered a DEA registration?

5. CRIMINAL HISTORY:

If you answer "Yes" to the following question you are required to send the following items:

- Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
- Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

( ) Yes ( ) No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanor and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

( ) 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.

6. MILITARY HISTORY:

( ) Yes ( ) No Have you ever been in the United States Military and/or Public Health Service?

( ) Yes ( ) No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service? If you answered "Yes" provide a detailed explanation and supporting documentation.

7. CRIMINAL 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. **If you answer "Yes" to any of the following questions, provide a detailed explanation and supporting documentation.**

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" to the question above, 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, sentence and completion of any subsequent probation?

b. ( )Yes ( )No If "Yes" to 1, 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.)

c. ( )Yes ( )No If "Yes" to 1, 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?

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 charges dismissed?

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" to the question above, 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 completion of 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" to the question above, 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" to the question above, 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*

8. HEALTH HISTORY:

If you answer "Yes" to any of the following questions 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 Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) codes(s), and admission and discharge summary(s).

( ) 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?

( ) 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?

( ) 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 medicine within the past five years?

( ) 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 medicine?

( ) 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?

( ) 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 medicine within the past five years?

Name: _____
Last/Surname First Middle

Social Security Number: _____

U.S. Social Security Information - * Under the Federal Privacy Act, disclosure of U.S. 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 Section 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.

9. MALPRACTICE HISTORY:

If you answer "Yes" to the following questions you are required to send the following items:

- A statement indicating the date of each incident and the number of each case.
- An explanation of details for each case and your involvement for each case.
- Submit the enclosed Exhibit 1 form.
- A copy of the complaint, judgments and/or settlements for each case.
- Submit a complete copy of the trial record(s) of each case, including the trial transcripts, evidentiary exhibits and final judgment in electronic format.

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

( ) Yes ( ) No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY:

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 of 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:
   - I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
   - I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
   - I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
   - 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
   - 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 number 9, you must also complete the affidavit on the following page.

FINANCIAL RESPONSIBILITY FORM

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

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

- I have held an active license to practice in this state or another state or some combination thereof for more than15 years;
- I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
- I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
- 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
- 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_____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOICATION:

You must choose one of the three options described below. Please be sure to view the information about each exemption at http://www.nica.com or call (850) 488-8191. Check only one.

( ) $5000.00 Participating ( ) $250.00 Non-participating ( ) $0.00 Exempt _____
Amount Enclosed

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

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

_____
Name

_____
Signature Date

_____
Street Address

_____
City, State, Zip

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

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

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

NICA
2360 Christopher Place
Tallahassee, FL 32308

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

12. STATEMENT OF APPLICANT:

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

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

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

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

_____

Print Name

_____

Signature Date

Medical Degree Verification Form

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

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: _____
Name of medical school

_____
Street address

_____
City - State - Zip - Country

2. Name: _____

3. Date of Birth:_____

4. Type of Degree:_____Date Degree Received: _____

Authenticate by signature and school seal.

_____
Verified by

SEAL

_____
Name

_____
Title

EXHIBIT 1–REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

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

Date of Occurrence:_____ Date Reported to Licensee:_____ Date Claim Reported to Insurer or Self-insurer: _____
MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

Injured Person's Name_____ Age_____ Sex_____

_____ Date of suit, if filed_____
Street Address, City, Sate, Zip MM/DD/YYYY

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

1._____ 2._____

3._____ 4._____

Date of final claim disposition:_____ Date and amount of judgment or settlement, if any: _____
MM/DD/YYYY MM/DD/YYYY

Was there an itemized verdict? ( ) Yes ( ) No **(If "Yes", attach copy of settlement verdict)**
Indemnity paid on behalf of this defendant: $_____
Loss of adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

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

_____

Name and address of institution at which the injury occurred: _____

_____

( ) Patient's Room ( ) Physical Therapy Dept. ( ) Radiology ( ) Labor & Delivery Room
( ) Operating Suite ( ) Nursery ( ) Emergency Room ( ) Special Procedure Room
( ) Recovery Room ( ) Critical Care Unit ( ) Other

Final diagnosis for which treatment was sought or rendered: _____

Describe misdiagnosis made, if any, of the patient's actual condition: _____

_____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration: _____

_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable: _____

_____

Safety management steps taken by the licensee to make similar occurrences less likely: _____

_____

I represent that these statements are true and correct pursuant to s. 837.06, F.S. 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, F.S.

_____
Signature Print First, Middle, Last