



Dental Laboratory Registration Form

PO Box 6330

Tallahassee, FL 32314

Phone: (850) 245-4474

Fax: (850) 921-5389

REGISTRATION FEE: \$200.00 NON-REFUNDABLE

This is the official application for registration form referenced pursuant to Chapter 466.033, Florida Statutes. Failure to complete this application for registration or failure to provide the requested documents will prevent any further consideration of your registration request. Make check for the registration fee payable to Florida Department of Health and mail with your application to the address above. You will be notified of the status of your application within 30 days of receipt. Once the application is complete our office will schedule an inspection. Please allow a minimum of 30 days for the inspection to be scheduled and completed.

PART I – PROFILE DATA

Laboratory Name:

Laboratory Address:

Owner's Name:

Owner's Telephone: Office () Home ()

Date of Birth: _____

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 this office and contact this office by telephone or in writing.

Have you ever registered a dental lab? If yes, please provide the registration number: _____

Business type: Please mark the appropriate box. (*Must submit certified copies of all articles of incorporation).

Sole Proprietorship:

Partnership:

Corporation:

Fictitious Name Statement: If the laboratory is operating under a name other than the owner, please provide a copy of the "fictitious name" registration from the Secretary of State – (850) 488-9000. Please attach to this completed application.

PART II – CRIMINAL HISTORY AND HEALTH CARE FRAUD QUESTIONS

Has any owner, partner, officer, director, stockholder or employee 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 misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Yes No

If you answered "Yes" to the question above 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 documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

PART II - Continued

As required by section 456.0635(2), F.S., please answer Yes or No to the following questions below. If you answer 'YES' to any of the following questions, please send a written explanation for each such question, including the county and state of each termination, plea, or conviction, the date of each termination, plea, or conviction, and copies of supporting documentation, to Dental Laboratory Registration, PO Box 6330, Tallahassee, FL 32314. Supporting documentation may include court dispositions or agency orders.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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.)** Yes No
 - A. If "yes" to 1, did the arrest or felony charge resulting in the conviction or plea occur before July 1, 2009? **(If you responded "yes," skip to question 2.)** Yes No
 - B. 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? Yes No
 - C. 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), F.S.) Yes No
 - D. If "yes" to 1, for the felonies of the third degree under section 893.13(6)(a), F.S., 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? Yes No
 - E. If "yes" to 1, is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently enrolled in a pretrial diversion or drug court program that allows for the withdrawal of the plea or dismissal of the charges for the felony offense upon successful completion of that program? (If "yes," please provide supporting documentation). Yes No
2. Since July 1, 2009, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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.)** Yes No

If "yes" to 2, did the sentence and any subsequent period of probation for such conviction or plea end more than 15 years before the date of this application? Yes No
3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, F.S.? **(If you responded "no," skip to question 4.)** Yes No
 - A. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has that person been in good standing with the Florida Medicaid Program for the most recent 5 years? Yes No
4. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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.)** Yes No
 - A. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the application been in good standing with a state Medicaid program for the most recent five years? Yes No
 - B. Did the termination occur at least 20 years prior to the date of this application? Yes No
5. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Yes No

PART III - PERSONAL AND LICENSURE HISTORY

Has any owner, partner, officer, director, stockholder or employee ever been a party to any civil, criminal or administrative proceeding involving any violation of Chapter 466, Florida Statutes, or any regulation governing the practice of the dental profession? Yes No

Has any owner, partner, officer, director, stockholder or employee ever had a professional license or registration revoked, suspended, or disciplined? Yes No

Does the laboratory meet the requirements for sanitation and safety as outlined in Florida Administrative Code Rule 64B27-1.001? Yes No

PART IV – OWNER APPLICANT STATEMENT

THE FOLLOWING STATEMENT MUST BE COMPLETED:

I, _____, state that I am the person referred to in the foregoing Dental Laboratory application for registration and supporting documentation, and that said application and any supporting documentation are true and accurate.

I understand it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the Department of Health and which takes place between the initial filing of the application and the final granting or denial of opening the dental laboratory.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of the dental laboratory under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Florida Administrative Code Chapter 64B27, in the state of Florida.

I have read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Florida Administrative Code Chapter 64B27, and acknowledge that I must abide by them.

OWNER NAME (PRINT OR TYPE)

SIGNATURE OF OWNER

DATE

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health Dental Laboratory Registration

Applicant/Owner Name:			Social Security Number:
_____	_____	_____	_____
Last	First	Middle	

This page is exempt from public records disclosure. The Department of Health is required to collect Social Security Numbers relating to applications for professional licensure pursuant to the Social Security Act, 42 U.S.C. 666(a)(13). Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.