FLORIDA
DEPARTMENT OF HEALTH

BOARD OF
ATHLETIC TRAINING

APPLICATION FOR LICENSURE

FLORIDA BOARD OF ATHLETIC TRAINING
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
Phone: (850) 245-4474 Facsimile: (850) 921-5389
www.floridasathletictraining.gov
Email: MQA.AthleticTraining@flhealth.gov

Rule 64B33-2.001
DOH-AT 001, Revised 02/2018

ATHLETIC TRAINING LICENSURE APPLICATION INSTRUCTIONS

You must read the laws and rules in order to determine your eligibility for licensure. Chapter 468, Part XIII, Florida Statutes (F.S.), and Rule Chapter 64B33, Florida Administrative Code (F.A.C.), can be found on our web site at http://floridasathletictraining.gov/.

LICENSURE REQUIREMENTS:

- Applicant must submit to the Department of Health a completed Florida Board of Athletic Training licensure application with required fees;
- Applicant must possess a baccalaureate or higher degree from a college or university professional athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education or its successor recognized and approved by the U.S. Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the Board, or recognized by the Board of Certification;
- Applicant must hold a current certification from the Board of Certification;
- Applicant must pass the Board of Certification national examination;
- Applicant must hold a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator at the professional rescuer levels as determined by the Board;
- Applicant must undergo a background screening pursuant to s. 456.0135, Florida Statutes.

APPLICATION INSTRUCTIONS

I. FEES

Attach a check or money order payable to the Department of Health. Do not submit cash with the application.

Application Fee:	$100.00
Licensure Fee:	$100.00
Unlicensed Activity Fee:	$5.00
TOTAL FEE:	**$205.00**

The Department will not process application without the required fees. Payment must be in the form of a check or money order made payable to the **Department of Health**. Please mail required fees with completed application, supporting documentation, and credentials to:

DEPARTMENT OF HEALTH
P.O. BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

Any supporting documentation and credentials mailed **separately** from the application should be mailed to:

DEPARMENT OF HEALTH
BOARD OF ATHLETIC TRAINING
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

REFUNDS:

The application fee is non-refundable.

II. OFFICIAL TRANSCRIPTS

Applicant must request **official** transcript(s) from the accredited institution(s) from which you received your degree or completed coursework. Transcript(s) must be sent directly to the Board Office from the accredited institution(s) under official seal. ALL final transcripts must indicate the graduation date and degree earned. The Board will not accept any transcript that has been stamped "issued to student." Any transcript, which does not abide by these standards, shall be deemed unofficial.

III. EXAMINATION AND CERTIFICATION INFORMATION

The Board of Certification Entry level Certification Examination is required for Florida licensure pursuant to Rule 64B33-2.001(1)(b), F.A.C. Applicants must submit a **CERTIFIED**

copy of his or her Board of Certification, Inc. (BOC) Certificate. For information on examination registration procedures, applicants may call (877) 262-3926, email BOC@bocatc.org, write BOC, 1415 Harney Street, Suite 200, Omaha NE 68102, or navigate to www.bocatc.org.

IV. CPR CERTIFICATION

Applicant must submit a copy of his or her current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator at the professional rescuer levels from the American Red Cross, the American Heart Association, American Safety and Health Institute, the National Safety Council, or an entity approved by the Board.

V. COMPLETION OF APPLICATION FORMS

All sections of the application must be completed. Fields left blank may delay processing and licensure. Print neatly in blue or black. All completed forms must be original, including signatures. If sufficient space is not included on the application, please attach additional sheets identifying the specific section of the application for which the information is provided. Please call (850) 245-4474 if you have questions.

1. APPLICANT PROFILE DATA: The Florida Department of Health's licensure database requires two addresses for each licensee. The mailing address is used by the Board to furnish documentation to the applicant/licensee. The practice location address is publicly displayed on the Department's license verification website. **NOTE:** The Department's license verification website provides the public with information on licensed health care practitioners in the State of Florida. The practice location address indicated on the application will be displayed as the address of record. If you provide one address only, it will be used for both the mailing address and the practice location address.

2. APPLICANT LICENSURE STATUS: List the names of all of the states, U.S. territories, and/or foreign countries in which he or she currently holds or has ever held a license, certificate, or registration to practice athletic training.

3. EDUCATION: List the name and location of the institution(s), the dates of attendance, type of degree earned, and date the degree was awarded.

4. APPLICANT HISTORY – PROFESSIONAL: If you answer "YES" to any questions in this section, please provide a complete and detailed statement of the circumstances which are the basis for such answer, as well as the names and addresses of all physicians, counselors, hospitals, facilities, treatment programs providing treatment and the dates of treatment. In addition, you must have each of the treatment providers submit a complete record of such treatment to include diagnosis, prognosis, admission and discharge summaries, etc. directly to: Department of Health, Board of Athletic Training, 4052 Bald Cypress Way, BIN C08, Tallahassee, FL 32399-3258.

5. APPLICANT HISTORY – GENERAL: If you answer "YES" to any question in this section, please provide a complete and detailed statement of the circumstances surrounding each event that is the basis for such answer. In addition, you must provide certified copies of any and all Complaints, Orders, Indictments, Judgments or other documents of disposition.

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

7. SOCIAL SECURITY NUMBER: Your social security number is required. The Department of Health is required and authorized to collect social security numbers relating to applications for professional licensure. This section is confidential and exempt from public records disclosure.

8. APPLICANT HISTORY – HEALTH: The board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. Please read these questions very carefully. If you answer "yes" to any question(s) in this section, you must provide the Board complete details.

9. CERTIFICATION: Read this section carefully. Your signature is required. By signing this statement you are attesting you have provided true and correct information on the application and supporting documents.

10. FINGERPRINT CARD/BACKGROUND CHECK AFFIRMATION – FLORIDA DEPARMENT OF LAW ENFORCEMENT: Applicant's signature in this section is required. By signing this section, the applicant provides affirmation that he or she has read and acknowledges the following information:

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

NOTICE OF:

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

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

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

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

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

US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division - <u>FBI's Privacy Statement:</u>

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 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.

11. LICENSE CERTIFICATION/VERIFICATION FORM: This form is **ONLY** required if you currently hold or have ever held a license in another state, U.S. Territory, or foreign country. Applicant must send this form to the office that issued the license or certification for completion. The completed form must be sent directly to the Board of Athletic Training from the issuing authority. **The license certification or verification will not be considered official if received from the applicant.**

STATE OF FLORIDA BOARD OF ATHLETIC TRAINING APPLICATION FOR LICENSURE (1001)

1. APPLICANT PROFILE DATA (PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
*Practice Location Address	Street and No.		Apt. No.
	City	State	Zip

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Date of birth:
_____/_____/_____

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
❑ YES ❑ NO If "YES" list names and dates of changes below:

Home Telephone:
area code ( )

Business Telephone:
area code ( )

Sex: ❑ Male ❑ Female

E-Mail Address:

Have you taken and passed the Board of Certification national examination? Are you currently certified by the Board of Certification? ❑ YES ❑ NO Please provide certification date: _____

We are required to ask that you furnish the information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR38295 and 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.

Race: ❑ white ❑ Black or African-American ❑ Hispanic ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or other Pacific Islander ❑ Two or More Races

* Your Practice Location Address Will Show On The Internet License Verification Screen

Our Internet license lookup provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

2. APPLICANT LICENSURE STATUS

Do you hold or have you ever held a license to practice athletic training in any state, U.S. territory, or foreign country?
❑ YES ❑ NO
If YES, list all licenses and the issuing state, territory, or foreign country:

APPLICANT NAME _____

3. EDUCATION

Name and Location of Institution	Dates of Attendance	Degree Earned	Graduation Date

4. APPLICANT HISTORY – PROFESSIONAL

A.	Have you ever been denied a license to practice as an athletic trainer or other health care practitioner or the renewal thereof by any state, U.S. territory or foreign country?	❑ YES ❑ NO
B.	Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?	❑ YES ❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES ❑ NO
D.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	❑ YES ❑ NO
E.	Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?	❑ YES ❑ NO

If you answered "YES" to any question in Section 5, you must provide the Board complete details. A "yes" answer does not mean the application will be denied; however, failure to provide the correct information may result in licensure denial.

5. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any 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 of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.

6. Applicant History – Pursuant to Section 456.0635, Florida Statutes:

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

1.	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 #2.)	❑ YES ❑ NO
a.	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?	☐ YES ☐ NO ☐ NA
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	☐ YES ☐ NO ☐ NA
c.	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, sentence and completion of any subsequent probation?	☐ YES ☐ NO ☐ NA
d.	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).	☐ YES ☐ NO ☐ NA
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑ YES ❑ NO
a.	If "yes" to 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?	☐ YES ☐ NO ☐ NA
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑ YES ❑ NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	☐ YES ☐ NO ☐ NA
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑ YES ❑ NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	☐ YES ☐ NO ☐ NA
b.	Did the termination occur at least 20 years before the date of this application?	☐ YES ☐ NO ☐ NA
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑ YES ❑ NO

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health

Board of Athletic Training

This page must be returned, but is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USC § 466 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a),

Name: _____

Last **First** **Middle**

7. Social Security Number: _____ - _____ - _____

8. APPLICANT HISTORY – HEALTH

If you answer "YES" to any of the following questions, please provide detailed information.

A.	In the last 5 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 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 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 5 years?	❑ YES ❑ NO
E.	During the last 5 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 your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

APPLICANT NAME _____

9. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them truthfully and completely without reservations of any kind. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

I hereby acknowledge that I have read the regulations in Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

_____

Applicant's Signature Date

10. FINGERPRINT CARD/BACKGROUND CHECK AFFIRMATION – FLORIDA DEPARMENT OF LAW ENFORCEMENT

ELECTRONIC FINGERPRINTING (LIVESCAN) / PRIVACY STATEMENT

All applicants are required to submit their fingerprints electronically. The Department of Health accepts fingerprinting offered by Livescan providers that are approved by the Florida Department of Law Enforcement (FDLE). Your provider will take prints and a photograph during the screening.

The Florida Department of Health retains fingerprints and a photograph in the Care Provider Clearinghouse, which allows sharing of criminal history information among specified agencies under s. 456.0135(4), F.S.

For more information on requirements and providers, please visit: http://www.flhealthsource.gov/background-screening

The Board will not receive your Livescan results if you do not affirm the statement by checking the box.

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

Applicant's Signature Date

Electronic Fingerprinting

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

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find an **approved** Livescan service provider at: http://www.flhealthsource.gov/background-screening
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)*;**
- **The ORI number for the Board of Athletic Training is EDOH4520Z;**
- If you have trouble with the ORI number, please contact the Division of Medical Quality Assurance Call Center at (850) 488-0595.
- 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: _____ (MM/DD/YYYY) Place of Birth: _____

Citizenship: _____ Race: _____ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ (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 Live Scan Service provider.)

Keep a copy of this form for your record.

LICENSE/CERTIFICATION VERIFICATION

(MAIL A COPY OF THIS FORM TO EACH STATE THAT YOU HOLD OR EVER HELD A LICENSE)

APPLICANT NAME _____

Print clearly in black ink or type the information.

Applicant's Address:	
Title of License:	License Number:

THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:

BOARD OF ATHLETIC TRAINING
4052 Bald Cypress Way, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.

Title of License:	License Number:
Original Issue Date:	Expiration Date:

License Status: ❑Active ❑Inactive ❑Temporary ❑Delinquent ❑Other (Explain)

Licensure Method: ❑ Grandfathering ❑ Reciprocity/Endorsement ❑Examination

If licensed by examination, please complete the following:

Name of Exam:	Date of Exam:
Level of Exam:	Score Achieved:

Has any disciplinary action been taken against this license? ❑ YES ❑ NO

If "YES", please provide our office with any documentation regarding the disciplinary action.

Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of:

If you have further questions you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

DISCLOSURE OF SOCIAL SECURITY NUMBER

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(12), 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 assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.