State of Florida
Department of Health
Board of Osteopathic Medicine

Application for Temporary Certificate for Practice in an Area of Critical Need

Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
(850) 488-0595

Chapter 459.0076, Florida Statutes

Application for Temporary Certificate for Practice in an Area of Critical Need

This temporary and restricted licensure avenue is for osteopathic physicians who hold a current and valid license to practice in any state or have served as a physician in the United States Armed Forces for at least 10 years and received an honorable discharge, and who intend to practice in:

- an area of critical need as determined by the State Surgeon General;
- a county health department;
- a correctional facility;
- a Department of Veterans' Affairs clinic;
- a community health center funded by s. 329, s. 330 or s. 340 of the United States Public Service Act;
- another agency or institution approved by the State Surgeon General that provides health care to meet the needs of underserved populations in this state; or
- an area for a limited time to address critical physician-specialty, demographic or geographic needs for Florida's physician workforce as determined by the State Surgeon General.

GENERAL INFORMATION

Where to send the application: The original application accompanied by the applicable fee, should be addressed to the following:

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

Use of the above address will ensure appropriate receipt of the application and fee. After posting of the fee, your application will be forwarded to the Board of Osteopathic Medicine for processing.

Where to send any additional documentation: Any additional documentation, sent either by the applicant or by another source on behalf of the applicant, should be mailed to the following:

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

FEE SCHEDULE

All fees must be made payable to the Department of Health and must be by cashiers check or money order.

If compensation will be received:	If compensation will **not** be received:
$300.00 – Application Fee (non refundable) **$429.00** - Licensure fee * Additional background check fee will be paid directly to the LiveScan provider	* Background check fee will be paid directly to the LiveScan provider

SUPPLEMENTAL INFORMATION REQUIRED FOR LICENSURE

The following is a list of supporting documentation that is REQUIRED in order to complete this application. Many of these documents take several weeks to arrive in the Board Office, so please do not panic should we inform you initially that they have not arrived.

- **A LETTER OF INTENT TO EMPLOY AND AFFIDAVIT REGARDING COMPENSATION:** This letter must be from the agency/institution that intends to employ you and must be addressed to the Board of Osteopathic Medicine. It must also indicate whether or not you will receive compensation for the medical services provided. If you will not receive compensation for any service involving the practice of medicine, the agency/institution must submit an affidavit to that effect so that the application fee and all licensure fees, including the NICA fee, can be waived. (See section 459.0076(4), F.S.)

- **OSTEOPATHIC MEDICAL SCHOOL TRANSCRIPT:** Request that your osteopathic medical school submit an official transcript directly to the Board office.

- **AOA PROFILE:** Contact the American Osteopathic Association – (800) 621-1773; Profile Services, 142 East Ontario Street, Chicago, IL 60611; or www.do-online.org.

- **FEDERATION OF STATE MEDICAL BOARDS (FSMB) DATA CHECK:** Please visit the FSMB website at http://www.fsmb.org/fpdc_data_inquiry.html to obtain the Board Action Data Search Form.

- **NATIONAL PRACTITIONERS DATA BANK INQUIRY:** This is a "self query". Please contact the National Practitioners Data Bank (NPDB) at (800) 767-6732; PO Box 10832, Chantilly, VA 22021; or www.npdb-hipdb.com.

- **VERIFICATION OF OTHER STATE LICENSES:** You must request that verification of any state license that you now hold or have ever held be mailed directly from the other state licensing entity to the Board office. A copy of your license is not considered verification. Some states are using www.Veridoc.org for verification. Please check to see if the state you are licensed in utilizes Veridoc.

- **PREVENTION OF MEDICAL ERRORS COURSE:** Section 456.013(7), F.S. requires completion of a 2-hour course in the prevention of medical errors for initial licensure. Refer to the attached completion form or submit a copy of a certificate verifying completion of the course.

- **MILITARY DOCUMENTATION:** (If applicable) A copy of your DD214 or current orders.

- **REQUIRED BACKGROUND CHECK:** All applicants for initial licensure must undergo a state and national criminal history background check. All fingerprinting is done through a LiveScan provider and all fingerprints are retained by the Florida Department of Law Enforcement. Please refer to the information at the end of this application for complete instructions on obtaining and submitting your fingerprints.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

The below instructions are in direct correlation with the numbered questions on the application.

1. **Social Security Number and Health History Questions:** Please provide your name and social security number in the space provided. Additionally, you must answer questions A-F and provide the supporting documentation requested if you answer "yes" to any of the questions.

2. **Application Method:** Please check only one method and provide the appropriate fee as indicated.

3. **Name:** List first, middle and last name as it would appear on a birth certificate and/or legal name change document. Nicknames or shortened versions are unacceptable. If there is a discrepancy between the applicant's name on the application and supporting documentation, please submit a written clarification.

4. **Name Changes:** If you have ever had your name changed due to marriage, divorce or any other court action please list in the space provided.

5. **Mailing Address:** List the address where correspondence regarding your application should be received.

6. **Telephone Number(s):** Provide phone numbers at which you may be reached.

7. **Email Address:** Provide an email address where you can be reached.

8. **Facility Name:** Provide the name of the facility at which you intend to practice.

9. **Facility Address:** Provide the address of the facility at which you intend to practice.

10. **Facility Director and Phone Number:** Provide the facility director's name and phone number of the facility at which you intend to practice.

11. **Anticipated Employment Start Date:** Provide the date you intend to begin practicing at the facility. Note- you cannot practice in Florida until you have been issued a license/certificate number.

12. Facility Type: Please indicate the type of facility at which you will be practicing. Please refer to s. 459.0076, F.S. for facilities that qualify for area of critical need.

13. Personal Data: Response to this section is voluntary and self-explanatory.

14. Citizenship: Answer yes or no. Provide your date and place of birth. If you are naturalized, list your naturalization date.

15. Military / Public Health Service: Answer yes or no. If yes, list your branch, rank and dates of service. You must also provide a copy of your DD214 or current orders.
a. Answer yes or no. If yes, you must provide a letter of explanation and a copy of all documentation relevant to the charges.

16. List the year and state/province/country where you first practiced.

17. Answer yes or no. If you have not passed all parts of the NBOME, list the state exam(s) (and dates) you have taken.

18. Education: List all undergraduate/graduate and medical schools, colleges and universities attended. Provide institution address, dates of attendance (month/year) and the type of degree obtained (e.g. BA, BS, MA, MS, DO, MD). Request that your osteopathic medical school submit an official copy of your transcript directly to the Board office.

19. Practice / Employment: List in order from the date of graduation from medical school to the present all postgraduate training programs (internship, residency, fellowship), employment and non-employment periods. All periods of time must be accounted for.

20. Answer yes or no. If yes, provide a letter of explanation in your own words regarding the incident. You must also direct the school/program to send a letter of explanation.

21. Answer yes or no. If yes, provide a letter of explanation in your own words regarding the incident. You must also direct the school/program to send a letter of explanation.

22. Answer yes or no. If yes, provide a letter of explanation in your own words regarding the incident. You must also direct the school/program to send a letter of explanation.

23. Other State Licensure: Answer yes or no. If yes, please list any license you hold or have EVER held (regardless of current status). Be sure to include the state, territory or foreign country, dates, type, license number and current status. <u>You must request that every state, territory or foreign country where you have ever held a license send the Board an OFFICIAL LICENSE VERIFICATION. Some states may require a fee for this service.</u>

24. Board Certification: Answer yes or no. If yes, provide verification of your current certification.

25. Answer yes or no.

26. Answer yes or no.

27. Staff Privileges: Answer yes or no. If yes, list the name/address of the hospital, dates of service and the type of privileges you hold.

28. Answer yes or no. If yes, list the action in the space provided on the application (attach additional sheets, if necessary), to describe the action. Please direct the hospital to send a letter of explanation regarding the incident to the Board office.

29. Answer yes or no. If yes, list the action in the space provided on the application (attach additional sheets, if necessary), to describe the action. Please direct the hospital to send a letter of explanation regarding the incident to the Board office.

30. Answer yes or no. If yes, list the action in the space provided on the application (attach additional sheets, if necessary), to describe the action. Please direct the facility to send a letter of explanation regarding the incident to the Board office.

31. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

32. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

33. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

34. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.

35. Answer yes or no. If yes, please provide an explanation regarding the charges on a separate sheet. You must also submit copies of all pertinent court/arrest documents, including arrest report, official charges and current disposition.

36. ** MEDICAL MALPRACTICE JUDGMENTS OCCURRING AFTER NOVEMBER 2, 2004: Answer yes or no. If yes, you must provide the following documentation for each case:

- Complete the Exhibit 1 form.
- A detailed explanation in your own words listing your involvement in the case.
- The entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a CD mailed to our office. The record must include:
    - Initial and/or amended complaint
    - Trial transcripts
    - Evidentiary exhibits
    - Final judgment

37. MALPRACTICE / LIABILITY CLAIMS: Answer yes or no. If yes, provide the following:

- A statement indicating how many malpractice case(s) you have been named in.
- A detailed explanation, in your own words, listing your involvement in each case.
- A copy of the complaint for each case.
- A copy of the disposition for each case.
- Complete the Exhibit 1 form.

38. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

39. Answer yes or no**.** If yes, provide an explanation on a separate sheet. You must also submit all pertinent documentation directly to the Board office.

40. Answer yes or no**.** If yes, provide an explanation on a separate sheet. You must also submit all pertinent documentation directly to the Board office.

41. Answer yes or no. If yes, provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

42. Answer yes or no. If yes, provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

43. Answer yes or no. If yes, provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.

44. Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit copies of all court/arrest documents, including arrest report, official charges, and disposition.

45. Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit copies of all court/arrest documents, including arrest report, official charges, and disposition.

46. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

47. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.

48. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the US HHS office to submit all pertinent documentation directly to the Board office.

49. Answer yes or no. If yes, provide an explanation on a separate sheet.

50. Applicant Statement: Please read this section CAREFULLY then sign and date the application. If you fail to sign and/or date your application, it will be returned to you as incomplete.

51. Financial Responsibility Form: Please read the options carefully and select the option that best applies to you at the time of submission of your application. Note- you must notify the Board when your financial responsibility status changes.

52. NICA Form: Please read the form and select the option that applies to you. If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

53. Proof of Prevention of Medical Errors Course Completion: Section 456.013(7), F.S. requires completion of a 2-hour course in the prevention of medical errors for initial licensure.

54. Exhibit 1 Form (Liability Claims and Actions): If you answer yes to questions 36 or 37, you must complete this form.

1. Social Security Number and Health History Questions:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Osteopathic Medicine
Application for Temporary Certificate for Practice in an Area of Critical Need

Name: _____
Last **First** **Middle**

Social Security Number: _____

Applicant Health History Questions

If questions A-F are answered YES, explain in full on a separate sheet of paper. Your statement must include, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved. If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).	
A. 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____
B. 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____
C. 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____
D. 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____
E. 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____
F. 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 last five years?	Yes___ No____

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

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

Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

2. Application Method (Check only one)- Client 1905:

[ ] I have a current license in another state and will use this temporary certificate for COMPENSATED practice
NICA Fee: [ ] Exempt [ ] $250.00 [ ] $5,000.00

[ ] I have a current license in another state and will use this temporary certificate for NON-COMPENSATED practice

[ ] I served as a physician in the U.S. Armed Forces and I will use this temporary certificate for COMPENSATED practice
NICA Fee: [ ] Exempt [ ] $250.00 [ ] $5,000.00

[ ] I served as a physician in the U.S. Armed Forces and I will use this temporary certificate for NON-COMPENSATED practice

---

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

4. Have you ever changed your name through marriage or through action of a court? Yes____ No___

_____
(If yes, list name(s) and date(s) of name change(s))

5. Mailing address: _____
(No & Street) (City) (State) (Zip)

6. Telephone Numbers: _____ _____ _____
(Residence/Cell-area code/number) (Cell-area code/number) (Office-area code/number)

7. Email Address: _____

Approved Facility Information:

8. Name of Approved Facility:_____

9. Facility Address:_____
(No & Street) (City) (State) (Zip)

10. Facility Director's Name:_____ Facility Phone Number:_____
(area code/number)

11. Anticipated Employment Start Date:_____

12. Type of Facility (check one): ___ County Health Department ___ Correctional Facility ___ VA Clinic
___ Community Health Center ___ Other: _____

---

13. Personal Data:

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other [ ]
SEX: Male [ ] Female [ ]

14. Are you a citizen of the United States? Yes____ No___

If you are not a U.S. citizen, please provide alien number: _____

Birth Date: _____ Birth Place: _____ Naturalization Date: _____
(Month/Day/Year) (City/State/Province/Country) (Month/Day/Year)

15. Have you ever been in the United States Military or Public Health Service? Yes____ No___

_____
If "yes", list branch of service, rank and dates of service.

a. Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States? Yes____ No___
If "yes" see instructions for required documentation.

16. List the year and state/province/country where you legally began to practice:

_____

17. Have you passed all three parts of the National Board of Osteopathic Medical Examination? Yes____ No___

If "no", list the exams (and dates) tat you HAVE taken: _____

18. UNDERGRADUATE/GRADUATE MEDICAL EDUCATION: Starting with undergraduate degree, list ALL schools, colleges and universities attended, whether completed or not, in chronological order:

COLLEGE/UNIVERSITY NAME	COLLEGE/UNIVERSITY ADDRESS (CITY/STATE/COUNTRY)	ATTENDANCE DATES (MONTH/YEAR)		TYPE OF DEGREE DATE RECEIVED
		FROM	TO	

19. PRACTICE / EMPLOYMENT List in chronological order from date of graduation from medical school to the present all postgraduate training/employment/non-employment. Attach additional sheets if necessary.

PROGRAM/HOSPITAL/EMPLOYER NAME	ADDRESS (CITY/STATE/COUNTRY)	EMPLOYMENT DATES (MONTH/YEAR)		POSITION/TITLE
		FROM	TO	

20. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign from, or otherwise acted against by any school, college, university, internship, residency or other training program? Yes____ No___
(If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

21. Was your attendance in Osteopathic Medical school or any postgraduate training program for a period of time other than the normal curriculum or established timeframe? Yes____ No___
If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

22. Were you required to repeat any part of your Osteopathic Medical education, internship, residency or other training program? Yes____ No___
(If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

23. OTHER STATE LICENSES: Do you now hold or have you ever held a license to practice Osteopathic Medicine or any other profession in any US State or territory, or foreign country? Yes____ No___
If "yes" list below (attach additional sheets if necessary).

STATE	LICENSE NUMBER	ISSUE DATE	CURRENT STATUS	METHOD OF LICENSURE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

24. Are you certified by any specialty board recognized by the ABMS, AOA, AAPS or any other board certification organization? Yes_____ No____
If "yes" see instructions for required documentation.

25. Within the most recent 10 years have you had responsibility for graduate medical education? Yes_____No____

26. Do you currently hold a faculty appointment at a Medical/Health-related institution of higher learning? Yes____ No____

27. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? Yes____ No____
(If yes, list below.)

HOSPITAL/ INSTITUTION NAME	FULL MAILING ADDRESS	DATES OF SERVICE (MONTH/YEAR)		TYPE OF PRIVILEGES
		FROM	TO	

28. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign, or take a temporary leave of absence or otherwise acted against by any facility? Yes____ No____
(If "yes", list below and see instructions for required documentation.)

_____ _____ _____ _____ _____
(Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

_____ _____ _____ _____ _____
(Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

29. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? Yes____ No____
(If "yes", list below and see instructions for required documentation.)

_____
(Name/Address of Facility) (Date: MM/DD/YY) (Circumstances) (Final Action)

30. Have you ever been asked, or allowed to resign, from any facility in lieu of disciplinary action or during any pending investigations into your practice? Yes____ No____
(If "yes", list below and see instructions for required documentation.)

_____
(Name/Address of Facility) (Date: MM/DD/YY) (Violation/Investigation) (Reason for Resignation)

LICENSURE / DISCIPLINARY / CRIMINAL HISTORY **If your answer is "yes" to any of the following questions, additional information is required. Please refer to the application instructions for the specific information that you will need to submit or have submitted.**	
31. Have you had any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or the licensing authority of any state, territory or country?	Yes____ No____
32. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Osteopathic Medical Practice Act, unprofessional or unethical conduct?	Yes____ No____
33. Have you ever had any professional license or license to practice Osteopathic Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state territory or country?	Yes____ No____
34. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in section 459.015, F.S.?	Yes____ No____
35. 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 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 <u>not</u> a minor traffic offense for purposes of this question.*	Yes____ No____
36. 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____
37. 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?	Yes____ No____
38. Have you ever been terminated for cause from participating in the Florida Medicaid program or sanctioned by any state Medicaid program?	Yes____ No____
39. Have you ever defaulted on any health education loan or scholarship obligation?	Yes____ No____
40. Have you ever had employment terminated for cause?	Yes____ No____
41. Have you ever received a letter of admonition or notice of administrative hearing from the Drug Enforcement Agency (DEA)?	Yes____ No____
42. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA?	Yes____ No____
43. Have you ever been denied, or surrendered a DEA Registration?	Yes____ No____

APPLICANT HISTORY – 456.0635(2), F.S.:

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.

44. 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 #45.)	[ ] 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
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
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
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
45. 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
46. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 46a.)	[ ] 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
47. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	[ ] YES [ ] NO
a. Have you been in good standing with a state Medicaid program for the most recent five years?	[ ] YES [ ] NO
b. Did the termination occur at least 20 years before the date of this application?	[ ] YES [ ] NO
48. 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
49. If "yes" to any of the questions 44 through 48 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	[ ] YES [ ] NO

50. STATEMENT OF APPLICANT: I, _____, state that I am the person referred to in the foregoing registration application and supporting documentation, and that the attached photograph is a true likeness of myself.

I hereby authorized all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all government agencies and instrumentality's (local, state, federal or foreign) to release to the Florida Board of Osteopathic Medicine any information which is material to my application pursuant to 459.0076, F.S.

I have carefully read the questions in the foregoing registration application and have answered them completely, without reservations of any kind, and 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 shall constitute cause for denial, suspension or revocation of my license as a physician in the State of Florida.

I understand my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

_____

(Signature of Applicant) (Date)

51. Financial Responsibility Form:

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only **one** option of the ten provided as required by s. 459.0085, Florida Statutes.

Category I: Financial Responsibility Coverage

☐**1.** I do **not** have hospital staff privileges 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 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 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 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. 459.0085(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. 459.0085(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. 459.0075, F. S., and practice only under the scope of the limited license.

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

☐**9.** I meet all of the following criteria **(**see additional 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 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.

☐**10.** I practice only in conjunction with my teaching duties at an accredited osteopathic 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 and submit the affidavit on the following page.**

Signature of physician: _____ **Date:** _____

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 #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 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 FLORIDA
COUNTY OF _____

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

_____

_____
(Signature of Notary Public - State of Florida)

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

Personally Known _____ OR Produced Identification _____

Type of Identification Produced_____

52. Florida Birth Related Neurological Compensation Association (NICA) Form:

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

[ ] $5,000	[ ] $250	[ ] $0	**$**_____
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide proof of qualification for claimed exemption to NICA and to the Board of Osteopathic Medicine.

I have read the information at www.nica.com and I choose the option above.

_____ Name

_____ Signature Date

_____ Street Address

_____ City, State, Zip

If you are a participating or non-participating physician, you must complete, sign and date this form and return it with your payment to this address:

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256

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

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256

and 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.

53. Prevention of Medical Errors Form:

Board of Osteopathic Medicine
Proof of Compliance with Mandatory
Continuing Medical Education Requirements

_____ I hereby state that I have completed the required course entitled PREVENTION OF MEDICAL ERRORS in accordance with s. 456.013(7), Florida Statutes and that this course was a minimum of two (2) hours and included a study of root-cause analysis, error reduction and prevention and patient safety as well as information related to the 5 most misdiagnosed conditions of osteopathic physicians during the preceding biennium.

These statements are true and correct and I recognize that providing false information shall constitute cause for denial, suspension or revocation of my license to practice osteopathic medicine under Chapter 459, F.S., in the state of Florida or criminal penalties pursuant to sections 456.072, 459.013, 459.015, 775.082, 775.083, and 775.084, F.S.

_____	_____	_____
Printed Name	Signature	Date

Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256

54. EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Practitioner's Name _____

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.0391, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ___/___/___ Date reported to licensee: ____/____/____ Date claim reported to insurer or self-insurer ___/___/___

Injured person's name: (last, first, middle initial)_____
Street Address:_____
City: _____ State: _____Zip Code: _____
Age: _____ Sex: _____

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

List all defendants with their healthcare 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:_____

Was there an itemized verdict? ☐Yes ☐No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

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

Name of institution at which the injury occurred:_____
Location of injury occurrence:

____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, Florida Statutes. I recognize that knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty is a misdemeanor of the second degree, punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of Physician: 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 a Livescan service provider at: **http://www.doh.state.fl.us/mqa/background.html**;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Osteopathic Medicine is **EDOH2015Z**;
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ Social Security Number: _____

Aliases:_____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

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

Sex: _____ Weight: _____ Height: _____
(M=Male; F=Female)

Eye Color:_____ Hair Color: _____

Address: _____ Apt. Number: _____

City:_____ State: _____ Zip Code: _____

Transaction Control Number (TCN#):_____
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

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

NOTICE OF:

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

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

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

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

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

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

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

Privacy Statement

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

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

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

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Confirmation of Receipt of:

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

Name: _____ File # (if known) _____

Profession: _____ Date of Birth: _____
(MM/DD/YYYY)

Other last names: _____

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

☐ **Yes** ☐ **No**

Signature: _____ Date: _____
(MM/DD/YYYY)

Please send this form with your application and fees to:

Board of Osteopathic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330

If you send this form separate from your application please mail it to:

Board of Osteopathic Medicine
4052 Bald Cypress Way
Bin # C06
Tallahassee, FL 32399-3256