



Clinical Laboratory Personnel Licensure - Adding Specialty

Board of Clinical Laboratory Personnel
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridasClinicalLabs.gov
Email: MQA.ClinicalLab@FLHealth.gov
Phone: 850-245-4355
Fax: 850-922-8876



Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at FLHealthSource.gov/valor.



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Do Not Write in this Space
For Revenue Receipting Only

Clinical Laboratory Personnel - Adding Specialty:

Select Licensure Level:

Technician (3045) - \$50.00

Technologist (3046) - \$75.00

Supervisor (3047) - \$95.00

Director (3048) - \$115.00

Total fee includes the following:

Application Fee (non-refundable)-Based on Licensure Level

Technician	\$25.00
Technologist	\$50.00
Supervisor	\$70.00
Director	\$90.00
Licensure Fee (refundable)	\$25.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a refund (Licensure Fee and Unlicensed Activity Fee). Requests to withdraw or for a refund must be made in writing. Certain fees are refundable for up to three years from date of receipt.

1. PERSONAL INFORMATION

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

Street/P.O. Box _____ Apt. No. _____ City _____

State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

Street _____ Apt. No. _____ City _____

State ZIP County Work/Cell Telephone

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 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.

Gender: Male Race: Native Hawaiian or Pacific Islander Hispanic or Latino White
Female American Indian or Alaska Native Black or African American Asian
Two or More Races

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address:

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at ssa.gov or by calling 800-772-1213.

Name: _____

3. QUALIFICATIONS FOR LICENSURE

A. Select specialty area(s):

Director:		
Andrology	Clinical Chemistry	Cytogenetics
Embryology	Hematology	Histocompatibility
Microbiology	Molecular Pathology	Oral Pathology Laboratory
Serology/Immunology	All Specialties	

Supervisor:		
Andrology	Blood Donor Processing	Clinical Chemistry
Cytogenetics	Cytology	Embryology
* Generalist	Hematology	Histocompatibility
Histology	Immunohematology	Microbiology
Molecular Pathology	Serology/Immunology	

* Generalist (Blood Banking/Donor Processing, Clinical Chemistry, Cytogenetics, Hematology, Immunohematology, Microbiology, and Serology/Immunology)

Technologist:		
Andrology	Blood Donor Processing	Clinical Chemistry
Cytogenetics	Cytology	Embryology
* Generalist	Hematology	Histocompatibility
Histology	Immunohematology	Microbiology
Molecular Pathology	Serology/Immunology	

* Generalist (Clinical Chemistry, Hematology, Immunohematology, Microbiology, and Serology/Immunology)

Technician:		
Andrology	Clinical Chemistry	Embryology
Hematology	Histology	Immunohematology
Microbiology	Molecular Pathology	Serology/Immunology

The licensure qualifications and requirements are listed in Rule 64B3-5, Florida Administrative Code (F.A.C.).
Find this rule at: firules.org/gateway/ChapterHome.asp?Chapter=64B3-5.

B. You must identify the appropriate option number from the rule that identifies the qualifications you have to meet the licensure requirements.

Director Option Number: _____

Supervisor Option Number: _____

Technologist Option Number: _____

Technician Option Number: _____

Name: _____

4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

B. Do you hold, or have you ever held a license to practice as clinical laboratory personnel in this state or any other state? Yes No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

D. List in chronological order all clinical laboratory employment, as defined in rule 64B3-2.003(7), F.A.C.

Do not include testing done in research, physician office laboratories, or veterinary work. Observation in a laboratory setting when the applicant does not hold a Florida license is not pertinent experience.

Name of Business	Full Mailing Address	Employment Dates: From - To (MM/DD/YYYY)
		to
		to
		to

All applicants must have their employer complete the "Verification of Clinical Laboratory Experience" form found at the back of the application. Applicants from Cuba who are unable to obtain employment verification may submit written documentation from a Florida-licensed Clinical Laboratory Personnel or Medical Doctor, describing your clinical laboratory experience.

5. AVAILABILITY FOR DISASTER

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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

6. EDUCATION HISTORY

A. List college/university education, whether completed or not, in chronological order.

School Name	City/State or Country	Dates of Attendance: From - To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		

All applicants must have an official transcript forwarded directly to the board office from their educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:

Board of Clinical Laboratory Personnel

4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

B. Did you complete a training program in the area you are applying for? Yes No

If you responded "Yes," provide the following:

Program Name	City/State	Dates of Attendance: From - To (MM/DD/YYYY)	Completion Date (MM/DD/YYYY)
		to	
		to	
		to	

If you attended an accredited program or an approved technical training program that is not part of your college degree, submit a copy of the training certificate, copy of your diploma, or certificate of graduation.

Applicants who were educated outside the United States must have their education evaluated to determine U.S. equivalency. Evaluations are acceptable from an accredited U.S. college or university on an official transcript, or from a credentials evaluation service.

Credentials evaluations **must** be performed by one of the board-accepted providers and **must** include a breakdown of all college level courses by subject. Credit hours **must** be listed in semester hours. Evaluations **must** be sent directly to the board from the evaluator. If transcripts cannot be ordered from the education institution, certified copies of the original documents used in the evaluation must be submitted to the board. Board-accepted providers can be located at: FloridasClinicalLabs.gov/resources/.

Graduates of institutions where official transcripts are not available may submit a certified copy of the original diploma, grade sheet, or other educational documents. A subject breakdown is required. Copies of translations are not acceptable unless accompanied by a notarized copy of the original document.

Note: Bachelor's degrees from Puerto Rico and the Philippines do not require a credentials evaluation, instead official transcripts must be sent directly to the board from the educational program.

Name: _____

C. Are you nationally certified in the area for which you are applying? Yes No

If you responded "Yes," provide the following:

Name of National Certification	Expiration Date (MM/DD/YYYY)

Contact the appropriate national certification body listed below to request verification of your national certification. The verified certification must be sent directly from the national certifying body to the board by email at MQA.ClinicalLab@flhealth.gov or by mail at:

Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

If you are certified by any organization other than those listed below, you may not be eligible for licensure.

American Association of Bioanalysts
314-241-1445

American Board of Histocompatibility & Immunogenetics
856-380-6814

American Board of Medical
Laboratory Immunology (Serology)
202-945-9281

American Board of Clinical Chemistry
202-420-7601

American Board of Medical Microbiology
202-942-9281

National Registry of Certified Chemists
(Clinical Chemistry and Toxicology)
610-322-0657

American Medical Technologists
847-823-5169

American Society for Clinical Pathology
800-267-2727

D. Have you completed the one-hour HIV/AIDS course that is required by Florida law prior to licensure?

Yes No

If you have not completed this course, you can find information on the course at cebroker.com.
Applicants who have not completed the course may submit the "HIV/AIDS Affidavit" (found at the back of application), in lieu of a certificate of completion, that states they will complete the one-hour course within six months of licensure.

This information is exempt from public records disclosure.

7. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

8. DISCIPLINE HISTORY

A. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? Yes No

B. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? Yes No

C. Have you ever been refused a license to practice, or the renewal thereof in any state? Yes No

D. Have you ever had an application for a professional license, or any application to practice, denied by any state board or governmental agency (state or country)? Yes No

E. Have you ever been notified/required 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 Clinical Laboratory Practice Act, unprofessional or unethical conduct? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the Administrative Complaint and Final Order.

9. CRIMINAL HISTORY

For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.

Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? Yes No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written 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.

Name: _____

10. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

- 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 subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five 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? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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

If you responded "No" to the question above, skip to question 3.

- 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
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

If you responded "No" to the question above, skip to question 4.

- 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
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years?
Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-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.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 7 and 8 must be submitted to the board office via the online upload system at mqaonline.doh.state.fl.us/datamart/voservicesportal/, via email at MQA.ClinicalLab@FLHealth.gov, or mailed to:

Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

Documentation for sections 9 and 10 must be sent to the Background Screening Unit at MQA.BackgroundScreen@FLHealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

11. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print out the application and sign it or sign digitally. MM/DD/YYYY

Temporary Permit: You may submit a request in writing for a temporary permit if your application is complete and you have submitted a copy of the approval letter from the certification agency stating the date of your examination.

Failure of an examination will render you ineligible to receive a temporary permit or may render a previously issued permit void.

Complete verifications must be mailed directly from the licensing agency to:

Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258



Board of Clinical Laboratory Personnel License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Clinical Laboratory Personnel.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- * Typed on an official state form or letterhead
- * Include an official board seal
- * Signature and title of state board official

The following information must be included in all verifications:

* Licensee name	* License number	* State or jurisdiction of licensure
* Licensure status	* Is license in good standing?	
* Date of issuance/expiration		
* Licensure method (examination, grandfathering, reciprocity/endorsement)		
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?		
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.		

If your specialty requires it, complete verification(s) must be mailed directly from your employer to:



Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258

Board of Clinical Laboratory Personnel Verification of Clinical Laboratory Experience

Part I: To be completed by applicant

Name: _____

Employer Name: _____

Mailing Address: _____

Telephone Number: _____ CLIA#: _____

This form must be signed. Do not write over/ white out information or fill in the list of tests.

Part II: To be completed by your employer

Do not include testing done in research, physician office laboratories, or veterinary work. Observations in a laboratory setting when the applicant does not have a Florida license is not pertinent clinical laboratory experience.

Employment period performing tests in the laboratory:

From: _____ To: _____ Full Time: _____ Part Time: _____
MM/YYYY MM/YYYY (hours per week) (hours per week)

X	Specialty Area Worked	Test Performed	Approximate Dates (From-To)
	Microbiology		to
	Serology/Immunology		to
	Clinical Chemistry		to
	Hematology		to
	Immunohematology		to
	Cytogenetics		to
	Molecular Pathology		to
	Histocompatibility		to
	Histology		to
	Cytology		to
	Andrology		to
	Embryology		to
	Blood Banking/Donor Processing		to

The above information is accurate to the best of my knowledge.

Print Name (Laboratory Supervisor/Director/Personnel Director)

Date (MM/DD/YYYY)

Signature (Laboratory Supervisor/Director/Personnel Director)
DH-MOA 3012, Revised 5/2025, Rule 64B3-6.001, F.A.C.

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Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin C-07
Tallahassee, FL 32399-3258



Board of Clinical Laboratory Personnel HIV/AIDS Affidavit

Pursuant to Rule chapter 64B3-5, Florida Administrative Code, all initial licensure applicants are required to complete an approved education course on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The course must provide a minimum of one hour of HIV/AIDS education acceptable to the board.

An applicant who has not taken the course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed six months to complete this requirement. If you have already completed this course, send proof with the application. If you have not yet completed the course, fill out this affidavit, have it notarized, and return it with your application.

Applications are incomplete without this affidavit or proof of completion of the HIV/AIDS course.

APPLICANT STATEMENT

I, _____, am of legal age and have personal knowledge of the matters stated in
(Applicant Full Name)
this affidavit. I will complete an approved course which provides a minimum of one hour of HIV/AIDS education within
the first six months of my licensure by the Department of Health.

Applicant Signature _____ Date _____
MM/DD/YYYY

NOTARY SIGNATURE

Before me, the undersigned authority, personally appeared _____ who
(Applicant Full Name)
deposes and affirms the above statement is true and correct.

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

By _____ whose identity is known to me by _____

Notary Signature _____ Printed Name of Notary _____

[NOTARY SEAL]