DEPARTMENT OF HEALTH
MEDICAL PHYSICIST
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257
850/245-4355

APPLICATION INSTRUCTIONS

MEDICAL PHYSICIST

*** If you are applying for a license in more than one specialty, you must submit a separate application and fees for each specialty for which a license is desired. You may photocopy the application form.**

1. **FLORIDA LAWS & RULES:**
   You may download a copy of Section 483, Part IV, Florida Statutes and Rule Chapter 64B23, Florida Administrative Code at **http://www.floridahealth.gov/licensing-and-regulation/medical-physicist/resources/index.html.** It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. **APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:**
   Within thirty (30) days after the office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application expires one year after initial filing with the department.

3. **YES/NO QUESTIONS:**
   All questions with "Yes or No" answer must be marked with either a "Yes or No", unless otherwise indicated. No other response is acceptable. For questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). HOWEVER, IF A QUESTION CONTAINED IS NOT APPLICABLE ANSWER "N/A" IN THE NO COLUMN. **Documentation of final disposition to "Yes" answers is required.**

4. **APPLICATION AND LICENSURE FEES:**
   A certified check, or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. The application fee is non-refundable. These fees are required by law and include the following:

Application Fee -	$500.00 per specialty*
Licensure Fee -	$100.00 per specialty*
Unlicensed Activity Fee -	$ 5.00 per specialty*
	$605.00 per specialty*

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5. **COMPLETING THE APPLICATION FORM** – Complete the application form by printing or typing the information on the form. Questions must be answered fully and truthfully. Obtaining a license by fraudulent misrepresentation is grounds for denial of your application or revocation of your license. Original documentation must be submitted; photocopies of signature(s) are not acceptable. It is your responsibility to notify this office in writing if the answers to any of the questions change, even if the application is already approved.

a. **License Specialty:** Mark the appropriate box for the type of license for which you are applying. If you are applying for more than one specialty, a separate application must be submitted.

b. **Applicant Profile Data:** Complete this section.

Mailing Address: List the address where correspondence regarding this application may be received.

c. **Board Certification:** Complete this section by checking the box indicating the appropriate Board, for which you hold certification, also indicate the specialty in which you hold certification. The appropriate board that granted certification must submit verification directly to the board office.

American Board of Radiology
American Board of Medical Physics
Canadian College of Physicists in Medicine
American Board of Health Physics
American Board of Science in Nuclear Medicine

d. **Applicant Licensure/Certification Status:** Complete this section indicating license/certification number and any pertinent information regarding any health profession license/certification you now hold or have ever held, whether or not the license/certification is current. The Agency that granted the license/certification must submit a licensure/certification verification directly to this office.

e. **Applicant Medicare/Medicaid/Criminal History:** If you answer "yes" to any question, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

g. **Statement of Applicant:** Please read the statement, sign and date and return as a part of the application.

SUBMISSION OF DOCUMENTS:

All applications and fees should be mailed to:

Department of Health
Division of Medical Quality Assurance
Medical Physicists
Post Office Box 6330
Tallahassee, Florida 32314-6330

All supporting documents should be mailed to:

Department of Health
Division of Medical Quality Assurance
Medical Physicists
4052 Bald Cypress Way, Bin #C-07
Tallahassee, Florida 32399-3257

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Medical Physicists

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.

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

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO

2. 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

3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO

4. 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? [ ] YES [ ] NO

5. 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

6. 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 within the last five years? [ ] YES [ ] NO

APPLICATION for
LICENSURE AS A MEDICAL PHYSICIST
(1010 Revenue Receipt Validation Transaction – all clients)

LICENSE SPECIALTY FEES: $605.00

Please check the appropriate box for the type of license for which you are applying. If you are applying for a license in more than one specialty, you must submit a separate application for each specialty in which you are seeking licensure.

[ ] Diagnostic Radiological Physicist (Client 6001)
[ ] Therapeutic Radiological Physicist (Client 6002)
[ ] Medical Nuclear Radiological Physicist (Client 6003)
[ ] Medical Health Physicist (Client 6004)

(PLEASE PRINT or TYPE)

1. APPLICANT PROFILE DATA:

NAME: _____
(Last) (First) (Middle)

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

If YES, list provide: _____
(Last) (First) (Middle)

2. ADDRESS:

a. **MAILING ADDRESS:** _____
(Street and Number) (Apt. #) (City) (State) (Zip)

b. **PRIMARY PRACTICE LOCATION:** _____
(Street and Number) (Apt. #) (City) (State) (Zip)

c. **TELEPHONE:** (____)_____ (____)_____
Primary: Area Code/Phone Number Business: Area Code/Phone Number

d. **EMAIL ADDRESS:** _____
Optional: Florida law provides that email addresses are public record. Do not provide an email address if you do not want it released pursuant to a public records request.

3. PERSONAL DATA

a. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 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 [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other
SEX: [ ] Male [ ] Female

b. 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 disasters? [ ] YES [ ] NO

APPLICANTNAME: _____

4. EDUCATION INFORMATION:

Please provide college/university education information as indicated below:

(School Name)	(City/State or Country)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)

5. BOARD CERTIFICATION

Please check the appropriate box for the Certification Board and indicate the specialty. The enclosed verification form must be completed and submitted by the appropriate Board.

[ ] American Board of Radiology: Specialty: _____

[ ] American Board of Medical Physics: Specialty: _____

[ ] American Board of Health Physics: Specialty: _____

[ ] Canadian College of Physicists in Medicine: Specialty: _____

[ ] Other Certifying Body: _____

Specialty: _____

[ ] American Board of Science in Nuclear Medicine: Specialty: _____

6. LICENSURE INFORMATION:

Do you hold or have you ever held a **STATE** license to practice Medical Physicist in this or any other state? [ ] YES [ ] NO

License Number	State/Country	Original Date Issued	Expiration Date
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

PROCEEDINGS and/or ACTIONS

APPLICANTNAME: _____

7. LICENSURE ACTIONS:

a. Have you had any application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state or country? [ ] 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 been refused a license to practice, or the renewal thereof in any state or other jurisdiction? [ ] YES [ ] NO

If **YES**, please complete the following:

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

8. CRIMINAL INFORMATION:

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 **YES**, 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.

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

APPLICANT MEDICARE/MEDICAID/CRIMINAL HISTORY:

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.

9. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, 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 10)** [ ] YES [ ] NO

a. If "yes" to 9, for felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation? [ ] YES [ ] NO

b. If "yes" to 9, for felonies of the third degree, has it been more than 10 years before 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

APPLICANTNAME: _____

c. If "yes" to 9, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

d. If "yes" to 9, 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

10. Have you been convicted of, or entered a plea of guilty or nolo contendere to, 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

a. If "yes" to 10, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

11. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If " No", do not answer 11a.)** [ ] 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

12. 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 12a or 12b.)** [ ] 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 to the date of this application? [ ] YES [ ] NO

13. 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

[ ] YES [ ] NO

14. APPLICANT SIGNATURE:

I understand that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 483.901(6)(g), and (9), 775.082, 775.083 and 775.084, Florida Statutes.

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare 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 to practice Medical Physicist in the State of Florida.

I understand that 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, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

_____ _____

APPLICANT SIGNATURE **DATE**