INFORMATION/INSTRUCTION SHEET
CERTIFIED PODIATRIC X-RAY ASSISTANT

Chapter 461, Florida Statutes
Rule Chapter 64B18-24, Florida Administrative Code

Any Certified Podiatric X-ray Assistant may perform services only:

(a) In the office(s) of the podiatric physician(s) to whom the Certified Podiatric X-ray Assistant has been assigned, in which office(s) such physician maintains his or her practice;
(b) When the podiatric physician(s) to whom he or she is assigned is present;
(c) Each podiatric physician or group of podiatric physicians utilizing Certified Podiatric X-ray Assistants shall be liable for any act or omission of any Certified Podiatric X-ray Assistant acting under supervision and control.

Section 461.003(2), Florida Statutes, Definitions. "Certified podiatric x-ray assistant," means a person who is employed by and under the direct supervision of a licensed podiatric physician to perform only those radiographic functions that are within the scope of practice of a podiatric physician licensed under this chapter. For purposes of this subsection, the term "direct supervision" means supervision whereby a podiatric physician orders the X ray, remains on the premises while the X ray is being performed and exposed, and approves the work performed before dismissal of the patient.

Section 461.0135, Florida Statutes, Operation of X-ray machines by podiatric X-ray assistants. -- A licensed podiatric physician may utilize an X-ray machine, expose X-rays films, and interpret or read such films. The provision of part IV of chapter 461 to the contrary notwithstanding, a licensed podiatric physician may authorize or direct a certified podiatric X-ray assistant to operate such equipment and expose such films under the licensed podiatric physician's direction and supervision, pursuant to rules adopted by the board in accordance with s. 461.004, which ensures that such certified podiatric X-ray assistant is competent to operate such equipment in a safe and efficient manner by reason of training, experience, and passage of a board- approved course which includes an examination. The board shall issue a certificate to an individual who successfully completes the board-approved course and passes the examination to be administered by the training authority upon completion of such course.

Initial Application must be accompanied by a total fee of $80 (Certified Check or Money Order)
Licensure Certification fee: $75 (non-refundable fee)
Unlicensed Activity fee: $5

Certification Update fee: $25 (Duplicate License)

NOTE: Please make certified check or money order payable to the **Department of Health**. Return

application and fees to:
Department of Health
Board of Podiatric Medicine
Post Office Box 6330
Tallahassee, Florida 32314-6330

Mail all supporting documents to:
Department of Health
Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

APPLICATION INSTRUCTIONS:
The application must be completed in its entirety. If you do not have enough room to provide the answer to a question, please attach an additional page(s). Answers written on additional pages should be numbered to correspond with the question being answered. All parts of the application should be legibly written or typed.

Florida HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Podiatric Medicine

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

Department of Health
Board of Podiatric Medicine
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257

FLORIDA BOARD OF PODIATRIC MEDICINE
INITIAL APPLICATION / UPDATE APPLICATION
FOR CERTIFIED PODIATRIC X-RAY ASSISTANT

Initial Application must be accompanied by a total fee of $80 (Certified Check or Money Order) - Client 2105

Licensure Certification fee: $75 (non-refundable fee)
Unlicensed Activity fee: $5
Certification Update: $25.00 (Duplicate licensure fee)

(To be completed by applicant and licensee)

1. APPLICATION PROFILE DATA: Please print or type

(Name) Last First Middle

(Address) Street Number Apt/Suite Number

City State Zip Code

Home Telephone Number Business Telephone Number

Date of Birth

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.

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
_____yes _____ no

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

2. EQUAL OPPORTUNITY DATA:

Your furnishing of the information below is voluntary. We are required to ask that you furnish this information as part of your voluntary compliance with Section 2-Uniform Guidelines on Employee Selection Procedure 43FR38295 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for certification.
Race: ____ White ____ Black ____ Hispanic ____ Asian/Pacific Islander ____ Native American
_____ Other (Specify race)
Sex: ____ Male ____ Female

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

NAME: _____

3. **TRAINING COMPLETED:**

Name of Certification Course Completed: _____

Date Completed: _____

4. **GENERAL-HISTORY:** [Attach additional sheet(s) if necessary]

a. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations. Yes _____ No _____

If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information: _____

_____

_____

b. Have you ever been the subject of any disciplinary action by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? Yes _____ No _____

If yes, provide details: _____

_____

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.

5. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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? Yes _____No _____ ? **(If you responded NO, skip to 6)**

a. If "yes" to 5, for 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 5, for 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 5, 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 5, 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 _____
(If "yes", please provide supporting documentation)

6. 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 6, 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 _____

7. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? Yes _____ No _____ **(If "No", do not answer 7a.)**

NAME: _____

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 _____

8. 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 "No", do not answer 8a or 8b.)**

   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 _____

9. 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 _____

TO BE COMPLETED BY SUPERVISING PHYSICIAN:
This section to be completed by each podiatric physician who will supervise assistant. Please make copies if necessary.

[ ] Individual Application
[ ] Group Application

DATA ON PODIATRIC PHYSICIAN WHOM YOU PLAN TO WORK UNDER. [IF GROUP PRACTICE USE NAME OF THE PRESIDENT OR MANAGING PARTNER]:

Name of Group

(Name) Last First Middle (Podiatric Physician License Number)

(Address Where Assistant is Employed) Street Number Apt/Suite Number

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.

City State Zip Code

E-mail: Business Telephone Number Date of Birth

Both Applicant and Supervising Podiatric Physician shall sign the following:

APPLICANT SIGNATURE

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

I state 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, 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 instruments (local, state, federal or foreign) to release to the Department of Health, any information, files and/or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organization, individuals, and groups listed above, any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board of Podiatric Medicine's decision concerning my eligibility for licensure. (Section 456.013, Florida Statutes) Failure to do so may result in action by the Board including denial of licensure.

I further state that 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 understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida in the profession for which I am applying.

NAME: _____

I also state that I will comply with all requirements for licensure renewal in effect at the time of license renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the Department.

_____

Podiatric X-Ray Assistant Signature (required) Date Signed

_____

Supervising Physician Signature (required) Date Signed