



Clinical Laboratory Personnel Initial & Upgrade Licensure - Supervisor

Board of Clinical Laboratory Personnel

P.O. Box 6330

Tallahassee, FL 32314-6330

Website: FloridasClinicalLabs.gov

Email: MQA.ClinicalLab@FLHealth.gov ~~info@floridasclinicallabs.gov~~

Phone: [850-245-4355](tel:850-245-4355) ~~(850)-245-4355~~

Fax: [850-922-8876](tel:850-922-8876) ~~(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](http://www.FLHealthSource.gov/valor).~~http://www.~~



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Do Not Write in this Space
For Revenue Receipting Only

Select one **Only ONE** Supervisor application type:

Initial (1054) - \$130.00

Upgrade Technologist (1043) - \$130.00

Upgrade Technician (1045) - \$130.00

Total fee of \$130.00 includes the following:

Application Fee (non-refundable)	\$70.00
Licensure Fee (refundable)	\$55.00
Unlicensed Activity Fee (refundable)	\$5.00

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 \$60.00 (Licensure Fee and Unlicensed Activity Fee) refund. 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

Name: _____ Date of Birth: _____
Last/Surname First Middle MM/DD/YYYY

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 (Input without dashes)

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 Country Work/Cell Telephone (Input without dashes)

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 (~~F.S.~~), 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: _____
_____ (Input without dashes)

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 F.S. 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 www.ssa.gov or by calling 1-800-772-1213.

3. QUALIFICATIONS FOR LICENSURE-SPECIALITY SELECTION

A. Select specialty area(s):

<u>Andrology</u>	<u>Blood Donor Processing</u>	<u>Clinical Chemistry</u>
<u>Cytogenetics</u>	<u>Cytology</u>	<u>Embryology</u>
<u>*Generalist</u>	<u>Hematology</u>	<u>Histocompatibility</u>
<u>Histology</u>	<u>Immunohematology</u>	<u>Microbiology</u>
<u>Molecular Pathology</u>	<u>Serology/Immunology</u>	
—Andrology	—Blood Banking/Donor Processing	—Clinical Chemistry
—Cytogenetics	—Cytology	—Embryology
—Histocompatibility	—Histology	—Microbiology
—Molecular Pathology	—Serology/Immunology	—Immunohematology
—Hematology	—Generalist*	

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

4. QUALIFICATIONS FOR LICENSURE

The licensure qualifications and requirements are listed in Rule 64B3-5.002, Florida Administrative Code (F.A.C.). Find this rule at: <https://www.flrules.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.

Option Number: _____

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. **Submit a License Verification form to ALL your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license.**

D. List in chronological order all clinical laboratory employment, as defined in Rule 64B3-2.003(7) ~~rule 64B3-2.003(8)~~, 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** **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.

Name: _____

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.

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		
		to		
		to		
		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: <https://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 ~~Did you successfully pass a national certification examination~~ in the area for which you are applying ~~for~~? Yes No

If you responded "Yes," provide the following:

Name of National Certification Exam	<u>Expiration-Exam</u> Date (MM/DD/YYYY)

Contact the appropriate ~~Below are the~~ national certification body listed below ~~bodies that you must~~ ~~contact~~ 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](tel:314-241-1445) ~~(314)-241-1445~~

American Board of Histocompatibility & Immunogenetics
[856-380-6814](tel:856-380-6814) ~~(856)-380-6814~~

American Medical Technologists
[847-823-5169](tel:847-823-5169) ~~(847)-823-5169~~

American Society for Clinical Pathology
[800-267-2727](tel:800-267-2727) ~~(800)-267-2727~~

National Registry of Certified Chemists
(Clinical Chemistry and Toxicology)
[610-322-0657](tel:610-322-0657) ~~(610)-322-0657~~

- 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 www.cebroker.com. Applicants who have not completed the course may submit the "HIV/AIDS Affidavit" (found at the back of application) ~~an affidavit~~, 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? ~~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.~~ Yes No

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

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				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 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, ~~end date and that~~ 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 F.S.](#)

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 F.S.](#) (relating to social and economic assistance), ch. 817, [Florida Statutes F.S.](#) (relating to fraudulent practices), ch. 893, [Florida Statutes 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" 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~~ **ten** 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 F.S.](#))? Yes No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), [Florida Statutes F.S.](#), 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? ~~(If "Yes," provide supporting documentation).~~ Yes No

2. 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

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 F.S.](#)? 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, 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.

~~Documents in sections 8, 9, 10, and 11 must be mailed to:~~

~~Board of Clinical Laboratory Personnel~~

~~4052 Bald Cypress Way, Bin C 07~~

~~Tallahassee, FL 32399-3258~~

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. LIVESCAN PRIVACY STATEMENT

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 (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at FLHealthSource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH4530Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: _____

12. 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, ~~775.082, 775.083, and 775.084~~, Florida Statutes F.S.

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 F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
MM/DD/YYYY

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 _____

~~These fields cannot be typed. You may must print out the application and sign it or sign digitally before a notary public.~~

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

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

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 to be employed, licensed, work under contract, or 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 Person 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 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 your 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, Florida Statutes, and Rule 11C-8.001, 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.

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 may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure 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 additional information 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.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at FLHealthSource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Board of Clinical Laboratory Personnel is **EDOH4530Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- 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.

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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#: _____

Input without dashes

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

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 Approx. 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)
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]