Mobile Opportunity by Interstate Licensure Endorsement (MOBILE)

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: http://www.flhealthsource.gov
Phone: (850) 488-0595

Qualifications for Licensure

Expedite your application by applying online at www.flhealthsource.gov.

1. Must hold an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, determined by the board or the department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

2. Must have obtained a passing score on a national licensure examination or hold a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state;

   OR

   An applicant for a profession that does not require a national examination or national certification is eligible for licensure if the applicable board, or the department if there is no board, determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in this state.

3. Must have actively practiced the profession for which the applicant is applying for at least three years during the four-year period immediately preceding the date of submission of this application.

4. Must not be, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reason related to the practice of the profession for which the applicant is applying.

5. Must not have had disciplinary action taken against you in the five years immediately preceding the date of submission of the application.

6. Must meet the financial responsibility requirements of s. 456.048, Florida Statutes, or the applicable practice act, if required for the profession for which you are applying. The following professions must demonstrate compliance with financial responsibility as part of licensure.

Acupuncturist (ch. 457)	Chiropractic Physician (ch. 460)	Dentist (ch. 466)
Medical Doctor (ch. 458)	Podiatric Physician (ch. 461)	Licensed Midwife (ch. 467)
Osteopathic Physician (ch. 459)	Advanced Practice Registered Nurse (ch. 464)	Anesthesiologist Assistant (ch. 458, 459)

7. Refer to s. 456.0145(2)(c), Florida Statutes, for licensure ineligibility criteria.

8. Certain professions require Livescan screening, listed below.

Medical Doctor (ch. 458)	Nurse- LPN, RN, APRN (ch. 464)	Anesthesiologist Assistant (ch. 458, 459)
Osteopathic Physician (ch. 459)	Athletic Trainer (ch. 468, Part XIII)	Certified Nursing Assistant (ch. 464)
Chiropractic Physician (ch. 460)	Massage Therapist (ch. 480)	Orthotist, Prosthetist, and Pedorthist (ch. 468)
Podiatric Physician (ch. 461)	Physician Assistant (ch. 458, 459)	

9. Apply online at www.flhealthsource.gov or submit your application, any applicable fees, and any supplemental documentation to the Department of Health at the address listed on the application below.

10. **Practitioner Profiling:** Sections 456.039 and 456.0391, Florida Statutes, requires practitioners to furnish specific information for publication on the Department of Health's website.

Medical Doctor (ch. 458)	Chiropractic Physician (ch. 460)	Advanced Practice Registered Nurse (ch. 464)
Osteopathic Physician (ch. 459)	Podiatric Physician (ch. 461)	

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P.O. Box 6330
Tallahassee, FL 32314-6330

Do Not Write in this Space
For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Certain fees are refundable for up to three years from the date of receipt. Requests for a refund must be made in writing. Refer to pages 12 and 13 to determine the appropriate fee to submit with your application.

List the profession you are applying for:

_____
(Examples: Dentist, Medical Doctor, Osteopathic Physician, Registered Nurse, Licensed Practical Nurse, etc.)

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

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

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country 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 Female

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

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 of Health 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 www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. Do you hold an active, unencumbered license in a U.S. jurisdiction or territory to practice the profession for which you are applying? Yes No

B. 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.

C. Have you actively practiced the profession for which you are applying for at least three years during the four-year period immediately preceding the submission of this application? Yes No

D. Have you obtained a passing score on a national licensure examination or do you hold a national certification recognized by the board for the profession for which you are applying? Yes No

If "Yes," complete one of the following:

Licensure Examination	Date of Examination (MM/DD/YYYY)

OR

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

Board staff will obtain national scores from the examination vendor, if available. Applicants must submit proof of national certification.

4. 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: _____

This information is exempt from public records disclosure.

5. 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: _____

6. DISCIPLINE HISTORY

A. Are you currently the subject of a disciplinary proceeding in a jurisdiction in which you hold a license or by the United States Department of Defense for reasons related to the practice of the profession for which you are applying? Yes No

B. Have you ever had any disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country? Yes No

C. **If you responded "Yes" to question B,** have you had disciplinary action taken against any license by the licensing authority in any state, jurisdiction, or country within the last five years? Yes No N/A

D. Do you have a complaint, an allegation, or investigation pending before a licensing entity in any U.S. jurisdiction or territory? Yes No

E. Have you ever had a license to practice a health care profession revoked or suspended by any U.S. jurisdiction or territory or voluntarily surrendered any such license in lieu of having disciplinary action taken against the license? 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, Final Order, and proof of compliance of any obligations, if applicable**.

F. Have you been reported to the National Practitioner Data Bank (NPDB)? Yes No

G. **If you responded "Yes" to question F,** have you successfully appealed to have your name removed from the data bank? Yes No N/A

Staff will complete a NPDB query. For more information, visit the National Practitioner Data Bank at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp.

Name: _____

7. CRIMINAL HISTORY

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? 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. You must include all misdemeanors and felonies, even if adjudication was withheld. 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.

Yes No

If you responded "Yes" 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" 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.

8. 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 time frames 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 (if "Yes" provide supporting documentation)?
Yes No

Name: _____

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. If "Yes" to 4, 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

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 that includes court dispositions, agency orders, and completion of sentence documents, if applicable.

Name: _____

9. LIVESCAN PRIVACY STATEMENT (for professions requiring background screening only)

Medical Doctor (ch. 458)	Podiatric Physician (ch. 461)	Orthotist, Prosthetist, and Pedorthist (ch. 468)
Osteopathic Physician (ch. 459)	Nurse- LPN/RN/APRN (ch. 464)	Massage Therapist (ch. 480)
Chiropractic Physician (ch. 460)	Athletic Trainer (ch. 468, Part XIII)	Certified Nursing Assistants (ch. 464)
Anesthesiologist Assistant (ch. 458, 459)	Physician Assistant (ch. 458, 459)	

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.

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: http://www.flhealthsource.gov/background-screening/.

Typically, background results submitted by Livescan are received by the board within 24-72 hours of being processed. 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.

IMPORTANT NOTICE: Beginning July 1, 2025, applicants seeking initial licensure in health care professions must comply with background screening requirements of s. 456.0135, Florida Statutes. To ensure that all health care practitioners practicing in the health care professions subject to the background screening requirements for initial licensure under s. 456.0135, Florida Statutes, are screened, health care practitioners who were already licensed in such health care professions before July 1, 2025, must submit to background screening in accordance with s. 456.0135, Florida Statutes, by their next licensure renewal that takes place on or after July 1, 2025, notwithstanding the fact that s. 456.0135, Florida Statutes, applies to initial licensure only. The Department of Health may not renew the license of such a health care practitioner after July 1, 2025, until they comply with these background screening requirements. **Practitioners not listed in the chart above should not submit Livescan screenings prior July 1, 2025.**

Name: _____

10. APPLICANT SIGNATURE

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

I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in denial of certification/licensure, disciplinary action against my certification/license, or criminal penalties pursuant to s. 456.067, Florida Statutes. I have read ch. 456, Florida Statutes, the practice act governing the profession for which I am applying, and the Florida Administrative Code chapter governing the profession for which I am applying.

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.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my certification/license to practice the profession for which I am applying in the state of Florida. 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 of Health.

Applicant Signature _____ Date _____

You may print out this application and sign it or sign digitally. MM/DD/YYYY

Total Fees by Profession - The following chart shows the total fee breakdown for each profession. Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Licensure Fees, Unlicensed Activity Fees, and Additional Fees are refundable for up to three years from the date of receipt. The Application Fees are non-refundable. Requests for a refund must be made in writing.

Profession	Application Fee	Licensure Fee	Unlicensed Activity Fee	Additional Fees	Total Fee
Acupuncture - Acupuncturist	$200.00	$200.00	$5.00	-	$405.00
Athletic Training - Athletic Trainer	$100.00	$100.00	$5.00	-	$205.00
Chiropractic Medicine					
Chiropractic Physician		-	$5.00	-	$5.00
Chiropractic Physician's Assistant	$100.00	$100.00	$5.00	SPF* - $100.00	$305.00
Clinical Laboratory Personnel					
Director	$90.00	$65.00	$5.00	-	$160.00
Supervisor	$70.00	$55.00	$5.00	-	$130.00
Technologist	$50.00	$45.00	$5.00	-	$100.00
Technician	$25.00	$25.00	$5.00	-	$55.00
Dentistry					
Dentist	-	$300.00	$5.00	-	$305.00
Dental Hygienist**	-	$37.50 **or** $75.00	$5.00	-	$42.50 **or** $80.00
Dental Radiographer	-	$35.00	-	-	$35.00
Dietetics and Nutrition - Dietitian/Nutritionist	$85.00	$80.00	$5.00	-	$170.00
Electrolysis - Electrologist	$100.00	$100.00	$5.00	-	$205.00
Emergency Medical Services					
Emergency Medical Technician	-	$35.00	-	-	$35.00
Paramedic	-	$45.00	-	-	$45.00
Genetic Counseling - Genetic Counselor	-	-	$5.00	-	$5.00
Hearing Aid Specialists - Hearing Aid Specialist	-	$320.00	$5.00	-	$325.00
Massage Therapy - Massage Therapist	$50.00	$100.00	$5.00	-	$155.00
Medical Physicists - Medical Physicist	$500.00	$100.00	$5.00	-	$605.00
Medicine					
Medical Doctor	$350.00	$350.00	$5.00	NICA***	$705.00
Resident, Intern, and Fellow	$200.00	-	-	-	$200.00
House Physician	$300.00	-	-	-	$300.00
Physician Assistant	$100.00	$200.00	$5.00	-	$305.00
Anesthesiologist Assistant	$150.00	$100.00	$5.00	-	$255.00
Mental Health Professions					
Clinical Social Worker	$100.00	$75.00	$5.00	-	$180.00
Marriage and Family Therapist	$100.00	$75.00	$5.00	-	$180.00
Mental Health Counselor	$100.00	$75.00	$5.00	-	$180.00
Midwifery - Licensed Midwife	$200.00	$500.00	$5.00	$250.00	$955.00
Nursing				**Student Loan Forgiveness**	
Certified Nursing Assistant	-	-	-	-	$0.00
Licensed Practical Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Registered Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Advanced Practice Registered Nurse	$50.00	$50.00	$5.00	$5.00	$110.00
Nursing Home Administrators - Nursing Home Administrator	-	$500.00	$5.00	-	$505.00
Occupational Therapy					
Occupational Therapist	$100.00	$75.00	$5.00	-	$180.00
Occupational Therapist Assistant	$100.00	$75.00	$5.00	-	$180.00

Profession	Application Fee	Licensure Fee	Unlicensed Activity Fee	Additional Fees	Total Fee
Opticianry - Optician**	-	$62.50 **or** $125.00	$5.00	-	$67.50 **or** $130.00
Optometry - Optometrist	-	$300.00	$5.00	-	$305.00
Orthotists and Prosthetists					
Prosthetist-Orthotist	$400.00	$400.00	$5.00	-	$805.00
Orthotist	$400.00	$400.00	$5.00	-	$805.00
Prosthetist	$400.00	$400.00	$5.00	-	$805.00
Orthotic Fitter	$400.00	$400.00	$5.00	-	$805.00
Orthotic Fitter Assistant	$400.00	$400.00	$5.00	-	$805.00
Pedorthist	$400.00	$400.00	$5.00	-	$805.00
Osteopathic Medicine					
Osteopathic Physician	-	$300.00	$5.00	NICA***	$305.00
Intern, Resident, and Fellow	-	$100.00	-	-	$100.00
Pharmacy					
Pharmacist	$100.00	$190.00	$5.00	-	$295.00
Registered Pharmacy Technician	$50.00	$50.00	$5.00	-	$105.00
Physical Therapy					
Physical Therapist	$100.00	$75.00	$5.00	-	$180.00
Physical Therapist Assistant	$100.00	$75.00	$5.00	-	$180.00
Podiatric Medicine					
Podiatric Physician	-	$350.00	$5.00		$355.00
Certified Podiatric X-Ray Assistant	-	-	$5.00	$75.00 Certification Fee	$80.00
Psychology - Psychologist	$200.00	$100.00	$5.00	-	$305.00
School Psychologists - School Psychologist	$175.00	$175.00	$5.00	-	$355.00
Speech-Language Pathology and Audiology					
Audiologist**	$75.00	$100.00 **or** $200.00	$5.00	-	$180.00 **or** $280.00
Audiologist Assistant	$75.00	$50.00	$5.00	-	$130.00
Speech-Language Pathologist**	$75.00	$100.00 **or** $200.00	$5.00	-	$180.00 **or** $280.00
Speech-Language Pathologist Assistant	$75.00	$50.00	$5.00	-	$130.00

***SPF** - Supervising Physician Fee

****This profession's Licensure Fee is based on the length of time the initial license will be valid. Depending on what point during the licensure biennium you apply, your Licensure Fee may be different. Visit www.flhealthsource.gov and refer to the appropriate board's website to determine the appropriate fees.

*****Florida Birth-Related Neurological Injury Compensation Association (NICA) Fund** - All allopathic and osteopathic physicians licensed in Florida are required to pay into the NICA fund unless qualified for exemption. Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

"Participating," is for Florida licensed physicians who practice obstetrics or perform obstetrical services on a full or part-time basis and do not meet any of the exemption criteria. **NICA Participating: $5,000.00** in addition to the total fee listed above.

"Non-participating," is for Florida licensed physicians who do not practice obstetrics or perform obstetrical services and do not meet any of the exemption criteria. **NICA Non-Participating: $250.00** in addition to the total fee listed above.

To determine if you qualify for exemption review the exemptions at the NICA website listed above. Applicants who qualify for NICA exemption are not required to submit a NICA fee in addition to the total fee listed above. Exempt applicants must submit proof of exemption. Refer to and complete the appropriate "Florida Birth-Related Neurological Injury Compensation Association (NICA) Form" on page 17 or 18 for your profession.

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.

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

PRIVACY STATEMENT

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

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

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as 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.

Department of Health
Electronic Fingerprinting

This form is only for the professions that require Livescan. See the list at the bottom of this form.

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening.
- Livescan screenings done by Florida Police or Sheriff's Departments require that you login into the FDLE Civil Applicant Payment System (CAPS) at https://caps.fdle.state.fl.us and pay a fee before results will be released to our office.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the Department of Health.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider applicable board offices will not receive your background screening results; ORI #s are listed by profession below.
- You must provide 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.

Name: _____ SSN#: _____

Aliases: _____ Date of Birth: _____
MM/DD/YYYY

Citizenship: _____ Place of Birth: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Profession	ORI Number	Profession	ORI Number
Medical Doctor	EDOH2014Z	Orthotist, Prosthetist, and Pedorthist	EDOH3451Z
Osteopathic Physician	EDOH2015Z	Massage Therapist	EDOH4600Z
Chiropractic Physician	EDOH2016Z	Athletic Trainer	EDOH4520Z
Podiatric Physician	EDOH2017Z	Anesthesiologist Assistant	EDOH4510Z
Nurse (LPN/RN/APRN)	EDOH4420Z	Physician Assistant	EDOH4700Z
Certified Nursing Assistant	EDOH0380Z		

Keep this form for your records.

Acupuncture ONLY

Board *of* Acupuncture
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 4** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

1. I hereby certify that I have professional liability coverage in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

2. I hereby certify that I have an irrevocable letter of credit, established pursuant to ch. 675, Florida Statutes, in an amount not less than $10,000 per claim, with a minimum aggregate availability of credit no less than $30,000.

3. I hereby certify that I have obtained a surety bond in an amount not less than $10,000 per claim, with a minimum annual aggregate of not less than $30,000.

4. I am exempt from financial responsibility coverage ***(if you choose this option you must choose one option from the exemption category below).***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

2. I practice only in conjunction with my teaching duties at an accredited acupuncture school.

3. I do not practice in the state of Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in s. 456.067, 456.072, 775.082, 775.083, and 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Board *of* Acupuncture
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

64B1-3.010 Licensure by Endorsement Through Another State License.

Pursuant to Section 457.105(2)(c), F.S., the Board of Acupuncture will certify for licensure those applicants who:

(1) Submit proof of being actively licensed in a state which has examination requirements that are substantially equivalent to or more stringent than those of this state at the time applicant was orginally licensed. Applicants must establish their other state licensure by requesting the licensing authority of the other state provide to the Board a statement which indicates the current status of the applicant's license as of the date of statement, the expiration date of the other state license, and the other examination requirements at the time the license was issued; and

(2) Meet the requirements of Sections 457.105(2)(a) and (d), F.S.; and

(3) Meet the minimal requirements set forth in 64B1-4.001, F.A.C.

Rulemaking Authority 457.104, 457.105 FS. Law Implemented 457.105 FS. History–New 10-1-89, Amended 2-27-92, Formerly 21AA-3.010, 61F1-3.010, Amended 2-20-96, Formerly 59M-3.010, Amended 4-7-98, 2-22-01, 2-7-17, 8-9-18, 9-22-21, 8-20-23.