Application for Out-of-State Telehealth Provider Registration

Telehealth
4052 Bald Cypress Way, Bin C-11
Tallahassee, FL 32399-1708
Email: MQA.Telehealth@flhealth.gov

1. PERSONAL INFORMATION

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

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

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

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Gender: ☐ Male ☐ Female

Email Notification: Provide your email address on the line below if you choose to be notified of the status of your application via email. You will be responsible for checking your email regularly and updating your email address with the Department of Health. 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. Contact the office by phone or in writing instead.

Email Address: _____

2. LICENSE REGISTRATION INFORMATION

To qualify as an out-of-state telehealth provider in Florida, you must have an out-of-state license or certification that is the same or substantially similar to those listed in section 456.47(1)(b), Florida Statutes (F.S.).

A. List the health care profession for which you are licensed.

Profession: _____

B. Provide the license or certification information for the profession listed in part A. The license must be active and unencumbered from another state, District of Columbia, or U.S. territory. If the license is not the same as one listed in section 456.47(1)(b), F.S., you must include documentary evidence with this application that your license is substantially similar to one listed.

License/Certification Number	State/Territory	Original Date Issued MM/DD/YYYY	Expiration Date MM/DD/YYYY

☐ You must submit a **License Verification Request** (DH5041-MQA-07/2019) to your state of licensure. 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.

3. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to 42 U.S.C. § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

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, Section 653 and 654; and sections 456.013(1), 409.2577, and 409.2598, 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.

4. EDUCATION HISTORY

Section 456.47(4)(h), F.S., requires the Department of Health to publish completed health care training and education of all out-of-state telehealth registrants on its website, including completion dates, any certificates or degrees obtained, specialties, and board certifications.

A. List any training and education related to the license or certification you are registering in chronological order, whether completed or not (if incomplete, list N/A for completion date):

School Name	Degree / Certificate	Completion Date MM/YYYY

B. List any postgraduate training related to the license or certification you are registering in chronological order, whether completed or not (if incomplete, list N/A for completion date):

Program Name	Specialty Area	Completion Date MM/YYYY

C. List any board certifications or specialties if applicable:

Board Name	Certification / Specialty	Certification Date MM/YYYY

5. DISCIPLINARY HISTORY

Section 456.47(4)(b), F.S., provides that out-of-state telehealth registrants cannot have been the subject of disciplinary action relating to their license or certification within the last five years of applying for registration.

A. Have you had disciplinary action taken against your license to practice any health care related profession, up to and including revocation, by the licensing authority in any state, jurisdiction, or country?

☐ Yes ☐ No

B. Have you surrendered a license to practice any health care related profession in any state, jurisdiction, or country while any such disciplinary charges were pending against you?

☐ Yes ☐ No

C. Do you have any disciplinary investigation or action pending against any license?

☐ Yes ☐ No

If you answered "Yes" to parts A, B, or C, complete the following:

Profession	License Number	State	Action Date MM/DD/YYYY	Final Action

☐ You are required to send a copy of the **Administrative Complaint** and **Final Order** for each disciplinary action you have listed in the table above.

6. FINANCIAL RESPONSIBILITY

Section 456.47(4)(e), F.S, requires **all** out-of-state telehealth providers to maintain professional liability coverage or financial responsibility that includes coverage for telehealth services provided to patients in Florida. The coverage amount must be equal to or greater than the requirements in sections 456.048, 458.320 (for the practice of medicine), or 459.0085 (for the practice of osteopathic medicine), F.S.

Choose only ONE option that best describes your situation. Your choice should be consistent with financial responsibility information provided to a hospital or other entity. Failing to choose an option or choosing more than one will invalidate this section and delay your registration. Department staff cannot advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company, or financial institution.

☐ **A.** I have obtained and will maintain professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under section 624.09, F.S., a surplus lines insurer under section 626.914(2), F.S., the Joint Underwriting Association under section 627.351(4), F.S., a self-insurance plan under section 627.357, F.S., or a risk retention group under section 627.942, F.S.

☐ **B.** I have obtained and will maintain an unexpired irrevocable letter of credit or escrow account as defined by Chapter 675, F.S. which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000.

7. MEDICAL MALPRACTICE INSURANCE

Section 456.47(4)(h), F.S, requires the Department of Health to publish the medical malpractice insurance provider and policy limits, including whether the policy covers claims in Florida, of all out-of-state telehealth providers on its website.

A. List your medical malpractice insurance provider:

Insurance Provider: _____

B. List the policy limits of liability:

Policy Limits: _____

C. Does your insurance policy cover claims that arise in Florida?

☐ Yes ☐ No

Applicant: _____

8. DESIGNATION OF REGISTERED AGENT

Section 456.47(4)(b), F.S., requires out-of-state telehealth registrants to designate a duly appointed registered agent for service of process in Florida.

Provide the name and street address of the agent and office you have registered with the **Florida Department of State, Division of Corporations**. The agent's name must be on the Registered Agent Name List maintained by the **Division of Corporations**. Changes to the registered agent and/or office after registration must be reported to the department on Form DH5038-MQA.

Name of Registered Agent: _____

Physical Address: _____ _____
Street (cannot be a P.O. Box) Apt. No.

_____ **Florida** _____
City State ZIP

9. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for out-of-state telehealth registration in the state of Florida.

I recognize that providing false information may result in disciplinary action against my registration or criminal penalties pursuant to sections 456.067, 775.083 and 775.084, F.S.

Florida law requires you to immediately inform the board, or the Department of Health if there is no 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 registration and to supplement the information on this application as needed.

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

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