BOARD OF ATHLETIC TRAINING

STATE OF FLORIDA

EXAMINATION APPLICATION FOR LICENSURE

You must read the laws and rules in order to determine your eligibility for licensure. Chapter 468, Part XIII, Florida Statutes (F.S.), and Rule Chapter 64B33, Florida Administrative Code (F.A.C.), can be found on our web site at www.doh.state.fl.us/mqa/athtrain.

Requirements for licensure as an athletic trainer:

- Submit a completed application with required fees;
- Be at least 21 years of age;
- Has obtained a baccalaureate degree from a college or university accredited by an accrediting agency recognized and approved by the U.S. Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification;
- If graduated after 2004, has completed an approved athletic training curriculum from a college or university accredited by a program recognized by the Board of Certification;
- Has passed the Board of Certification Entry Level Certification examination and is certified by the Board of Certification;
- Has current certification in cardiovascular pulmonary (CPR) resuscitation with an automated external defibrillator (AED) at the professional rescue level from the American Heart Association, American Red Cross, American Safety and Health Institute, National Safety Council, or an entity approved by the board as equivalent;
- Has completed a board approved 2 hour continuing education course relating to the prevention of medical errors. Approved providers can be found on www.cebroker.com.

APPLICATION INSTRUCTIONS

I. FEES

Attach a check or money order payable to the Department of Health. Do not submit cash with the application.

Full Biennium Fees	Second Half Biennium Fees
Application Fee -- $100.00 [Nonrefundable]	Application Fee -$100.00 [Nonrefundable]
License Fee -------- 125.00	Licensee Fee------- 75.00
Unlicensed Activity -- 5.00	Unlicensed Activity -5.00
TOTAL FEES ---- $230.00	TOTAL FEES ---$180.00

Please see the following schedule:

Date Application is Submitted	Fee to Submit with The Application
09/16/11 through 04/20/12	$180.00
04/21/12 through 09/15/13	$230.00
09/16/13 through 04/20/14	$180.00
04/21/14 through 09/15/15	$230.00
09/16/15 through 04/20/16	$180.00
04/21/16 through 09/15/17	$230.00

II. OFFICIAL TRANSCRIPTS

You must request an official transcript from the accredited institution(s) from which you received your degree or have taken coursework. These transcripts must be sent directly to the Board office from the registrar's office of the institution or they will not be considered official.

III. EXAMINATION AND CERTIFICATION INFORMATION

The Board of Certification Entry Level Certification examination has been approved by the Board, pursuant to Rule 64B33-2.001(1)(b), F.A.C. Applicants must submit a CERTIFIED copy of his or her Board of Certification, Inc. (BOC) certificate. For information on examination registration procedures, applicants may call (877) 262-3926 or write: BOC, 1415 Harney Street, Suite 200, Omaha NE 68102 or visit their web site at www.bocatc.org.

IV. CPR CERTIFICATION

You must submit a copy of your current certification in Cardiovascular Pulmonary Resuscitation (CPR) with an automated external defibrillator (AED) at the professional rescue level from the American Red Cross, the American Heart Association, American Safety and Health Institute, the National Safety Council, or an entity approved by the Board as equivalent.

V. CONTINUING EDUCATION REQUIREMENTS

Prior to licensure you must complete a board approved two hour course on the prevention of medical errors. A copy of your certificate of completion should be forwarded to the Board office.

VI. COMPLETING THE FORMS

All sections of the application must be completed. Print neatly in blue or black ink or type the information. All completed forms must be original, including signatures. If sufficient space is not included on the application, please attach additional sheets identifying the specific section of the application for which additional information is being provided. Please call (850) 245-4474 if you have questions.

1. Applicant Profile Data

Your "practice location address" will show on the Internet license verification screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, renewals, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address.

2. Applicant Licensure Status

List the names of all the states, U.S. territories, or foreign countries in which you hold or have ever held a license, certificate, or registration to practice athletic training.

3. Photo

Attach one passport-style head and shoulder photograph (less than 6 months old) to the form. Your name must be printed on the back of the photograph.

4. Education

List the name and location of the institution(s), the dates of attendance and the type of degree and date received.

5. Applicant History - Professional

If you answer "YES" to any questions in this section, please provide a complete and detailed statement of the circumstances which are the basis for such answer, as well as the names and addresses of all physicians, counselors, hospitals, facilities, treatment programs providing treatment and the dates of treatment. In addition, you must have each of the treatment providers submit a complete record of such treatment to include diagnosis, prognosis, admission and discharge summaries, etc. directly to: Department of Health, Board of Athletic Training, 4052 Bald Cypress Way, BIN C08, Tallahassee, FL 32399-3258.

6. Applicant History - General

If you answer "YES" to any question in this section, please provide a complete and detailed statement of the circumstances surrounding each event that is the basis for such answer. In addition, you must provide certified copies of any and all Complaints, Orders, Indictments, Judgments or other documents of disposition.

7. Applicant History – Pursuant to Section 456.0635, Florida Statutes: **IMPORTANT NOTICE**:

Effective July 1, 2012, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and **shall refuse** to admit a candidate for examination if the applicant:

1. Has been convicted of, or entered a plea of guilty or nolo contendere to, 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 unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed.

   Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:

   - For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;

   - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;

- For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;

2. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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), unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;

3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;

4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;

5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

NOTE: This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

8. Certification

Read this section carefully. Your signature is required. By signing this statement you are attesting you have provided true and correct information on the application and supporting documents.

9. Social Security Number: Your social security number is required.

10. Applicant History – Health

The board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. Please read these questions very carefully. If you answer "yes" to any question(s) in this section, you must provide the Board complete details.

LICENSE/CERTIFICATION VERIFICATION FORM

This form is only to be completed if you hold or have held a license in another state, U.S. territory, or foreign country. You must mail this form to the office that issued the license or certification. That office must complete and mail the form directly to the Board office.

It will not be considered official if received from the applicant.

STATE OF FLORIDA
Examination Application For Licensure Athletic Training (1001)

1. APPLICANT PROFILE DATA (PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
*Practice Location Address	Street and No.		Apt. No.
	City	State	Zip

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Date of birth: ________/________/________

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 names and dates of changes below:

Home Telephone: area code ( )

Business Telephone: area code ( )

E-Mail Address: (Optional)

Place of Birth: (City, State)

Eye Color: ____________

Hair Color: ____________

Height: ____________

Weight : ____________

Sex: ❑ Male ❑ Female

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑ Other ____________

* Your Practice Location Address Will Show On The Internet License Verification Screen

Our Internet license lookup provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

2. APPLICANT LICENSURE STATUS

Do you hold or have you ever held a license to practice athletic training in any state, U.S. territory, or foreign country? ❑ YES ❑ NO

If YES, list all licenses and the issuing state, territory, or foreign country:

3. PLEASE TAPE ONE PHOTO HERE

APPLICANT NAME ____________________

4. EDUCATION

Name and Location of Institution	Dates of Attendance	Degree Earned	Graduation Date

5. APPLICANT HISTORY – PROFESSIONAL

A.	Have you ever been denied a license to practice as an athletic trainer or other health care practitioner or the renewal thereof by any state, U.S. territory or foreign country?	❑ YES ❑ NO
B.	Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?	❑ YES ❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES ❑ NO
D.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	❑ YES ❑ NO
E.	Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?	❑ YES ❑ NO

If you answered "YES" to any question in Section 5, you must provide the Board complete details. A "yes" answer does not mean the application will be denied; however, failure to provide the correct information may result in licensure denial.

6. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (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 by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.

7. Initial Licensure – Individual

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.

	Question	Answer
1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, 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? (If you responded "no", skip to #2.)	❑ YES ❑ NO
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 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 1, for the 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 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", please provide supporting documentation).	❑ YES ❑ NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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 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 Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑ YES ❑ NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑ YES ❑ NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑ YES ❑ NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑ YES ❑ NO
b.	Did the termination occur at least 20 years before the date of this application?	❑ YES ❑ NO
5.	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
6.	If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	❑ YES ❑ NO

APPLICANT NAME ______________________________

8. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility 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's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them truthfully and completely without reservations of any kind. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further 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 continuing education credits.

I hereby acknowledge that I have read the regulations in Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

____

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health

Board of Athletic Training

This page must be returned, but 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), and 456.013(12) Florida Statutes.

Name: ____
Last First Middle

9. Social Security Number: __________ - __________ - __________

10. APPLICANT HISTORY – HEALTH
If you answer "YES" to any of the following questions, please provide detailed information.

	Question	Answer
A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 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
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 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 5 years?	❑ YES ❑ NO
E.	During the last 5 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 your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

LICENSE/CERTIFICATION VERIFICATION

(MAIL A COPY OF THIS FORM TO EACH STATE THAT YOU HOLD OR EVER HELD A LICENSE)

APPLICANT NAME ____

Print clearly in black ink or type the information.

Applicant's Address:	
Title of License:	License Number:

THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:

BOARD OF ATHLETIC TRAINING
4052 Bald Cypress Way, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.

Title of License:	License Number:
Original Issue Date:	Expiration Date:

License Status: ❑Active ❑Inactive ❑Temporary ❑Delinquent ❑Other (Explain)

Licensure Method: ❑ Grandfathering ❑ Reciprocity/Endorsement ❑Examination

If licensed by examination, please complete the following:

Name of Exam:	Date of Exam:
Level of Exam:	Score Achieved:

Has any disciplinary action been taken against this license? ❑ YES ❑ NO

If "YES", please provide our office with any documentation regarding the disciplinary action.

Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of:

Rule 64B33-2.001
DOH-AT 001, Revised 5/12

MAKE COPIES OF ALL DOCUMENTS

(For your records) prior to mailing the originals to the board office.

MAIL APPLICATION PACKET AND FEE TO:

BOARD OF ATHLETIC TRAINING
PO BOX 6330
TALLAHASSEE, FL 32314-6330

MAIL ANY OTHER CORRESPONDENCE TO:

BOARD OF ATHLETIC TRAINING
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FL 32399-3258

If information is mailed from a source other than the applicant, the applicant's full name must appear on the correspondence or documentation.

If you have further questions you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

PLEASE NOTE:

YOUR PRACTICE LOCATION ADDRESS WILL SHOW ON THE INTERNET LICENSE VERIFICATION SCREEN. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, newsletters, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address.

DISCLOSURE OF SOCIAL SECURITY NUMBER

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, Sections 653 and 654; and Sections 456.013(12), 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 assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.