Application for Temporary Certificate for Active Duty Military and Veterans Practicing in Areas of Critical Need

Chapter 459.00761, Florida Statutes

This temporary and restricted licensure avenue is for osteopathic physicians who are on active duty in the US Armed Forces or served in the US Armed Forces for at least 10 years and received an honorable discharge, and hold a current and valid license to practice in any jurisdiction of the US. This license is restricted to practice in one of the following:

- an area of critical need;
- a county health department;
- a correctional facility;
- a Department of Veterans' Affairs clinic;
- a community health center funded by s. 329, s. 330 or s. 340 of the United States Public Service Act;
- another agency or institution approved by the State Surgeon General that provides health care to meet the needs of underserved populations in this state; or
- an area for a limited time to address critical physician-specialty, demographic or geographic needs for Florida's physician workforce as determined by the State Surgeon General.

GENERAL INFORMATION

For a detailed list of licensure requirements please visit www.floridasosteopathicmedicine.gov

Mailing Information: Submit your application, fees, and any supplemental documentation you are sending with your application to the following address: Department of Health, PO Box 6330, Tallahassee, FL 32314-6330.

Mail additional information, not included with your application, to the following address: Board of Osteopathic Medicine, 4052 Bald Cypress Way, Bin #C-06, Tallahassee, FL 32399-3256.

Fees: All fees must be made payable to the Department of Health and must be by cashiers check or money order.

If compensation will be received:	If compensation will **not** be received:
$429.00 - Licensure fee * Additional background check fee will be paid directly to the LiveScan provider	* Background check fee will be paid directly to the LiveScan provider

ADDITIONAL DOCUMENTATION REQUIRED

- ❑ **Letter Authorizing Practice:** If on active duty, a letter from your military command authorizing you to practice medicine at an approved entity in an area of critical need.
- ❑ **Military Documentation:** Documentation demonstrating that you are currently on active duty as a commissioned medical officer or that you previously served as a commissioned medical officer in the US Armed Forces for at least 10 years and received an honorable discharge (**DD-214 or NGB-22).**
- ❑ **Affidavit regarding compensation:** If you will not receive compensation for any medical service, the agency/institution must submit an affidavit to that effect so that the licensure fees, including the NICA fee, can be waived. (See section 459.00761(5), F.S.)
- ❑ **National Practitioners Data Bank Self-Query (NPDB):** Contact the NPDB at www.npdb-hipdb.gov. Upon receipt of the self-query please send directly to the Board office. NPDB charges a fee for this service
- ❑ **Verification of Other State Licenses:** Direct the licensing entity to send official licensure verification directly to the Board office (check www.veridoc.org for states that use the online verification service).
- ❑ **Prevention of Medical Errors Course:** Section 456.013(7), F.S. requires completion of a 2-hour course in the prevention of medical errors for initial licensure.
- ❑ **Background Check:** You must undergo a state/national criminal history background check. All fingerprinting is done through a LiveScan provider and all fingerprints are retained by the Florida Department of Law Enforcement. Complete instructions regarding fingerprinting are attached to this application.
- ❑ **NICA Fee (if you use this temporary certificate for NON-COMPENSATED practice, the NICA fee is waived):** All physicians licensed in Florida are required to pay into the Florida Birth Related Neurological Injury Compensation Association (NICA) fund unless you qualify for an exemption. Visit www.nica.com for exemption and participation information. Note- if you claim an exemption you must submit proof of exemption qualification to the Board office and NICA.
- ❑ **Additional Documents:** May be required based on answers to application questions and your particular situation. Those items are listed on the application form with the corresponding questions.

Board of Osteopathic Medicine
Application for Temporary Certificate for Active Duty
Military and Veterans Practicing in Areas of Critical Need
Apply for your license online at www.floridasosteopathicmedicine.gov

Application Method (Check only one)- Client 1905:

☐ I will use this temporary certificate for COMPENSATED practice
NICA Fee: [ ] Exempt [ ] $250.00 (non-participating) [ ] $5,000.00 (participating)

☐ I will use this temporary certificate for NON-COMPENSATED practice

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PERSONAL INFORMATION:

Name: _____ **Birth Date**: _____
(last) (first) (middle) (mm/dd/yyyy)

List any other names you have been known by: _____

Mailing Address: (the address where mail and your license should be sent)

_____
Street and number or PO Box Suite/Apt #

_____
City State/Province Zip/Postal Code Country

Telephone: _____ _____ _____
Primary Alternate Cell

Email Address: _____
Under Florida law, email addresses are public records. If you do not want your e-mail 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.

Name of Approved Facility: _____

Facility Address: _____
(No & Street) (City) (State) (Zip)

Facility Director's Name: _____ **Facility Phone Number:** _____
(area code/number)

Anticipated Employment Start Date: _____

Type of Facility (check one): ___ County Health Department ___ Correctional Facility ___ VA Clinic
___ Community Health Center ___ Other: _____

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43C FR 38295 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: White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other [ ]
Sex: Male [ ] Female [ ]

☐ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

Prevention of Medical Errors Course: Visit www.CEBroker.com for a list of providers offering this course.

☐ I hereby state that I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing education in accordance with s. 456.013(7), Florida Statutes.

EDUCATION / TRAINING:

Osteopathic Medical Education: List your osteopathic medical school and dates of attendance below.

College/University Name	Address	Attendance Dates (Month/Year)

Postgraduate Training: List in chronological order from date of graduation from osteopathic medical school to the present all postgraduate training (Internship/Residency/Fellowship).

Program Name	City/State	Dates (Month/Year)	Specialty Area
Program Name	City/State	Dates (Month/Year)	Specialty Area
Program Name	City/State	Dates (Month/Year)	Specialty Area

Loan History:

☐ Yes ☐ No Are you currently in default on any health education loan or scholarship obligation?

o A "yes" answer to the question above requires the following:
- A self-explanation on a separate sheet providing accurate details and
- Documentation from the lender regarding your current repayment/default status

LICENSURE HISTORY:

☐ Yes ☐ No Do you hold or have you ever held a license to practice osteopathic medicine in any US State or territory, or foreign country? If yes, list below.

State or Country	License Number	Original Issue Date	Expiration Date	License Type

o Provide the following documentation to support your licensure history**:** request **verification of licensure** status be sent directly to the Board office from the licensing entity or www.veridoc.org.

☐ Yes ☐ No Have you had <u>any</u> application for a license to practice any profession, including osteopathic medicine, denied by any state board or the licensing authority of any state territory or country?

☐ Yes ☐ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 459.015, Florida Statutes?

☐ Yes ☐ No Have you ever had any license to practice osteopathic medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

o A "yes" answer to any of the three questions above requires the following:
- o A self-explanation on a separate sheet providing accurate details and
- o A copy of the administrative complaint/charging document, final order/document outlining sanctions, and proof of compliance with sanctions (if applicable)

PRACTICE / EMPLOYMENT HISTORY:

List the year you legally began to practice medicine: _____ (may be the date you began postgraduate training)

☐ Yes ☐ No Has it been more than three years since you practiced osteopathic medicine in any jurisdiction? If yes, list the year you last practiced osteopathic medicine: _____

☐ Yes ☐ No Do you currently hold a **faculty appointment** at a medical school, or have you had responsibility for **graduate medical education** (GME) within the last 10 years? If yes, list below:

Name of School / Institution	Check Applicable Box(s):
	[ ] Is this a faculty appointment? [ ] Is this GME?
	[ ] Is this a faculty appointment? [ ] Is this GME?

☐ Yes ☐ No Do you currently hold **staff privileges** in any hospital, health institution, clinic or medical facility? Do not include postgraduate training privileges. If yes, list below:

Name of Facility

For the three questions below, a "facility" is defined as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

☐ Yes ☐ No Have you ever had any **staff privileges** denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

☐ Yes ☐ No Have you ever had any **staff privileges** restricted or not renewed by any facility instead of disciplinary action? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

☐ Yes ☐ No Have you ever been asked, or allowed to resign, from any facility instead of disciplinary action or during any pending investigations into your practice? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

- A "yes" answer to any of the above three questions requires the following:
  - A self-explanation on a separate sheet providing accurate details and
  - Supporting documents from the facility(s)

☐ Yes ☐ No Are you certified by any **specialty board** recognized by the AOA, ABMS, ABIPP, or AAPS? If yes, list below and provide verification of each certification.

Board Name	Certification / Specialty / Sub-Specialty	Certification Date

☐ Yes ☐ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☐ No Have you ever been sanctioned by any state Medicaid program?

- A "yes" answer to any of the above questions requires the following:
  - A self-explanation on a separate sheet providing accurate details and
  - Supporting documents from the applicable entity

MALPRACTICE / LIABILITY CLAIM HISTORY:

☐ Yes ☐ No Have you had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after **November 2, 2004**?

☐ Yes ☐ No Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000?

- A "yes" answer to either of the above two questions requires the following:
  - A self-explanation listing your involvement in each case
  - Completed Exhibit 1 Form for each case (follows application)
  - A copy of the complaint and disposition for each case
  - **In addition to the above, for judgments occurring after November 2,** 2004 the entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a DVD (don not send originals). The record must include:
    - Initial and/or amended complaint
    - Trial transcripts
    - Evidentiary exhibits
    - Final judgment

CRIMINAL HISTORY:

☐ Yes ☐ No Have you ever been convicted of, or entered a plea of guilty, nolo contendre, or no contest to a 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 <u>not</u> considered a minor traffic offense for purposes of this question.*

- A "yes" answer to the above question requires the following:
  - A self-explanation listing accurate details (including dates, city/state, charges and final results)
  - Final disposition and arrest records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
  - Completion of sentence documents. If unavailable with the Clerk of Courts, obtain from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

ADDITIONAL CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS:
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.

1. ☐ Yes ☐ No 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 question 2.)**

a. ☐ Yes ☐ No 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?

b. ☐ Yes ☐ No 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).

c. ☐ Yes ☐ No 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?

d. ☐ Yes ☐ No 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).

2. ☐ Yes ☐ No 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)? **(If you responded "no", skip to question 3.)**

a. ☐ Yes ☐ No 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?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If you responded "no", skip to question 4.)**

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no", skip to question 5.)**

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No 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?

6. ☐ Yes ☐ No **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.)

- A "yes" answer to any of the above questions requires the following:
  - A self-explanation for each providing accurate details (including the county and state of each termination or conviction, date of each termination or conviction)
  - Copies of supporting documentation (including court dispositions or agency orders where applicable)

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Name: _____
Last **First** **Middle**

Social Security Number: _____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

HEALTH HISTORY:

☐ Yes ☐ No In the last five 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 five years?

☐ Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

☐ Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?

- A “yes” answer to any of the above questions requires the following:
  - A self-explanation providing accurate details (including, but not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved).
  - If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

FINANCIAL RESPONSIBILITY FILING FORM:

The Financial Responsibility options are divided into two categories: coverage and exemptions. Check only **one** of the ten options provided as required by s. 459.0085, Florida Statutes.

CATEGORY I: Financial Responsibility Coverage for Florida Practice Only

1. [ ] I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.

2. [ ] I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

5. [ ] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

CATEGORY II: Financial Responsibility Exemptions

6. [ ] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
7. [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
8. [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)
9. [ ] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
10. [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria**** See note below**:
    (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
    (b) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.
    (c) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period.
    (d) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.
    (e) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

**** If you select an exemption based on based on #10, you must also complete the affidavit on the following page.**

_____ _____

Signature Printed Name

DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an exemption based on #10 on the preceding page.

I, _____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 459, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 459, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 459.0085(5) (f), F.S., for specific notice requirements.

Dated:_____ Signature:_____

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of_____, by

_____

_____
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced_____

CONFIRMATION OF RECEIPT OF THE FOLLOIWNG DOCUMENTS (attached to application**):**

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

Name: _____

Profession: _____ Date of Birth: _____
(MM/DD/YYYY)

Other last names: _____

☐ Yes ☐ No 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.

STATEMENT OF APPLICANT

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Osteopathic Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature: _____ Date: _____
(MM/DD/YYYY)

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please 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 to a fingerprint scan using the livescan method;
- You can find a Livescan service provider at: **www.floridahealth.gov/licensing-and-regulation/background-screening/index.html**;
- 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;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Osteopathic Medicine is **EDOH2015Z**;
- 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:_____ Social Security Number: _____

Aliases:_____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Race: _____ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ Weight: _____ Height: _____
(M=Male; F=Female)

Eye Color:_____ Hair Color: _____

Address: _____ Apt. Number: _____

City:_____ State: _____ Zip Code: _____

Transaction Control Number (TCN#):_____
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD 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 that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to 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 Persons 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 as 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 the 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, F.S., 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 my 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, disclosures 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 you additional information pertinent 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.

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Practitioner's Name _____

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b), F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.049, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ___/___/___ Date reported to licensee: ____/____/____ Date claim reported to insurer or self-insurer ___/___/___

Injured person's name: (last, first, middle initial)_____
Street Address:_____
City: _____ State: _____Zip Code: _____
Age: _____ Sex: _____

Date of suit, if filed: _____/_____/_____

List all defendants with their healthcare provider license number involved in this claim:
1. _____ 2._____
3. _____ 4._____

Date of final claim disposition: _____/_____/_____

Date and amount of judgment or settlement, if any:_____

Was there an itemized verdict? ☐Yes ☐No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

Date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred:_____
Location of injury occurrence:

____Patient's Room	____Physical Therapy Dept.	____Radiology	____Labor & Delivery Room
____Operating Suite	____Nursery	____Emergency Room	____Special Procedure Room
____Recovery Room	____Critical Care Unit	____Other _____	

Final diagnosis for which treatment was sought or rendered._____
_____

Describe misdiagnosis made, if any, of the patient's actual condition._____
_____

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.
_____
_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable._____
_____

Safety management steps taken by the licensee to make similar occurrences less likely._____
_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty is a misdemeanor of the second degree, punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of Physician: Date:
_____