Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257
(850) 245-4355

GENERAL INFORMATION

Application for Clinical Laboratory Personnel

TECHNICIAN

Initial Licensure Level

PLEASE NOTE: REVIEW THE RELEVANT BOARD RULE TO DETERMINE YOUR ELIGIBILITY FOR LICENSURE

1. **FLORIDA LAWS & RULES:**
You may download a copy of Chapter 483, Part II, Florida Statutes at http://floridasclinicallabs.gov/resources/. It is important to read this to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. **APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:**
Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact the board office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application expires one (1) year after the initial filing date with the department.

3. **YES/NO QUESTIONS:**
All questions with a "Yes or No" answer must be marked with either a "Yes" or "No" unless otherwise indicated. No other response is acceptable. For questions that require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations), the institution/organization that took the disciplinary or other action (e.g., probation, limitation, suspension, revocation, denial, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). HOWEVER, IF A QUESTION IS NOT APPLICABLE, ANSWER "N/A" IN THE "NO" COLUMN.

4. **FEE SCHEDULE:**
A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. The fees are required by law and include the following:

Initial & upgrade licensure level:

Application Fee: (non-refundable)	$ 25.00	
Licensure Fee:	$ 25.00	
Unlicensed Activity Fee:	$ 5.00	(Section 456.065(3), Florida Statutes, requires the Department of Health to a fee of $5 per licensee or applicant to fund efforts to combat unlicensed activity)
Total Fee:	**$ 55.00**	

5. REQUIRED NATIONAL EXAMS:

Below are the national certification bodies that you must contact to request verification of your National Certification. **The verified certification must be mailed directly from the national certifying body to the Board of Clinical Laboratory Personnel.**

Technician:

American Association of Bioanalysts
(314) 241-1445

American Board of Histocompatability & Immunogenetics
(856) 380-6814

American Medical Technologists
(847) 823-5169

American Society for Clinical Pathology
(800) 267-2727

If you are certified by organizations other than those listed, you may not be eligible for licensure.

6. EMPLOYMENT HISTORY: (Please refer to Rule 64B3-2.003, F.A.C.)

Do not include testing done in research, physician office laboratories, or veterinary work. Observation in a laboratory setting when the applicant does not have a Florida license is not pertinent clinical laboratory experience.
Forward the verification of experience form to your employer for completion. A letter from the employer may be used to document experience but it must contain all the information requested on the verification of employment form. Have your employer verify the tests you performed. This form is used to determine whether you have performed tests in the full range of each area of the laboratory. **PLEASE NOTE**: If you an applicant from Cuba and are unable to obtain employment verification, you may submit written documentation from a Florida licensed Clinical Laboratory Personnel or Medical Doctor, describing your clinical laboratory experience.

7. HIV/AIDS:

Florida law requires that all initial licensure applicants have a Florida board approved course of one (1) hour in HIV/AIDS education prior to licensure. In lieu of the course completion, you may submit an affidavit that the one (1) hour course will be completed within six (6) months of licensure.

PLEASE NOTE: To obtain information about board approved HIV/AIDS courses, contact **CE Broker @ 1-877-434-6323 or** www.cebroker.com.

8. FINAL OFFICIAL TRANSCRIPT:

Official transcripts must be sent directly to the board office from your college or university. If you were educated at an institution outside of the United States, it is your responsibility to have your education evaluated to determine U.S. equivalency.

9. VOCATIONAL/TRAINING PROGRAMS:

If you attended an accredited program or an approved technical training program that is not part of your college degree, submit a copy of the training certificate you were issued or submit a copy of your diploma or certificate of graduation. If you have completed a Florida training program, include the training program approval number.

It is the responsibility of the applicant to know the requirements for licensure before an application is submitted. Determine what documentation is necessary according to your own qualifications. Official transcripts must be sent directly from the school; student copies are not acceptable (see additional sections concerning foreign transcripts and U.S. equivalency). A copy of a diploma or a DD-214 (military) may document training, but the employer must verify experience

10. NAME CHANGE:

Notify the board office in writing of any change in name or address. If you have changed your name (by marriage, divorce or court order) since your last application (including license renewal), you must submit a certified copy of the marriage, divorce, or court record to change your name for licensure purposes.

11. TEMPORARY PERMIT:

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

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

FOREIGN EDUCATION EQUIVALENCY REQUIREMENTS:

All foreign graduates who intend to utilize credit earned in college or universities outside of the United States to qualify for licensure will need to provide evidence of U.S. equivalency of such credit hours. The credentials evaluation must be performed by one of the board approved credential evaluation services and include a breakdown of all college level courses by subject. Credit hours must be listed in semester hours. The credentials evaluation should be sent directly to the board office from the evaluator. If transcripts cannot be ordered from the foreign institution, certified copies of the original documents used in the evaluation must be submitted to the agency. (Please review Rule 64B3-6.002, Florida Administrative Code).

NOTE: Bachelor's degrees from Puerto Rico and the Philippines do not need a credentials evaluation; however, official transcripts must be submitted from the institution.

FEDERAL PRIVACY ACT:

Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. **In this instance, disclosure of a social security number is mandatory pursuant to Title 42 United States Code, Sections 653 and 654, and Sections 456.013, 409.2577, and 409.2598, F.S.** Social security numbers are used for efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Barring any exemption under Florida law or federal law, social security numbers must be recorded on all professional and occupational licensure applications and will be used for license verification. **Note: If you do not fill in your social security number, your application may be delayed.**

Technician: General Qualifications

For a description of the licensure qualifications and requirements, please reference:

Rule 64B3-5.004, Florida Administrative Code, which can be reviewed by viewing this link:

https://www.flrules.org/gateway/RuleNo.asp?title=QUALIFICATIONS%20FOR%20LICENSURE&ID=64B3-5.004

Additional information:

Degrees or semester hours of academic credit required in this section shall be obtained at a regionally accredited college or university or by foreign education equated pursuant to Rule 64B3-6.002(6), F.A.C

All applicants for a Technician license must satisfy the requirements for Moderate Complexity Testing under CLIA Amendments, 42 CFR 493.1423, effective January 19, 1993, which is incorporated by reference herein and available at http://www.gpo.gov.fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec493-1489.pdf. Technicians performing high complexity testing as defined in 42 CFR 493.5 and 493.17, both effective April 24, 1995, which are incorporated by reference herein and available at http://www.gpo.gov.fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec493-1489.pdf, and who have been licensed after September 1, 1997, shall meet the minimum educational and training qualifications provided in 42 CFR 493.1489, effective April 24, 1995, which is incorporated by reference herein and available at http://www.gpo.gov.fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec493-1489.pdf, including a minimum of an associate degree in laboratory science, medical laboratory technology, or equivalent education and training.

BOARD OF CLINICAL LABORATORY PERSONNEL
INITIAL LICENSURE LEVEL

FOR

TECHNICIAN

APPLICATION CHECKLIST

_____**1. Application:**

- All questions answered on all pages and if question not applicable, mark with N/A
- All "Yes" answers must be accompanied by an explanation, as instructed
- Public Records Disclosure Form SSN

PLEASE NOTE: Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one (1) year after the initial filing date with the department.

_____**2. Fees:**

Please make cashier check or money order payable to the Department of Health-Clinical Laboratory Personnel.
Return application and fees to:
Department of Health
Revenue Services
P.O. Box 6330
Tallahassee, FL 32314-6330

_____**3. Board of Clinical Laboratory Personnel approved HIV/AIDS course** (Copy of Certificate of Completion) **or affidavit**

_____**4. Official College Transcript** (sent directly to the board office from the educational institute)

_____**5. Verification of National Certification** (sent directly to the board office from the national examiners)

Technician:

- American Association of Bioanalysts
- American Medical Technologists
- American Board of Histocompatibility & Immunogenetics
- American Society for Clinical Pathology

_____**6. Verification of Employment/Experience form** (must be signed by your Laboratory Supervisor/Director or Personnel Director)

If you have any additional documents to submit after your application has been mailed, please send to:
(supporting documents/correspondence with NO money)
Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Clinical Laboratory Personnel

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.

Name: _____

Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.

1. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO

2. 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

3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO

4. 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? [ ] YES [ ] NO

5. 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

6. 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 within the last five years? [ ] YES [ ] NO

CLINICAL LABORATORY LICENSURE
(Client: 6601)
INITIAL LICENSE – TECHNICIAN

INITIAL LICENSURE LEVEL FEES:
(Fees include: application (non-refundable), licensure, and unlicensed activity).

Technician $55.00 (1051)

PROFILE DATA: (PLEASE TYPE OR PRINT IN BLACK INK)

1. **NAME:** _____
(Last) (First) (Middle)

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

IF YES, provide: _____
(Last) (First) (Middle)

2. **ADDRESS:**
   a. **MAILING ADDRESS:** _____
   (Street and Number) (Apt. #) (City) (State) (Zip)

   b. **PRIMARY ADDRESS:** _____
   (Street and Number) (Apt.#) (City) (State) (Zip)

   c. **TELEPHONE:** (___) _____ (___) _____
   Primary: Area Code/Phone Number **Business: Area Code/Phone Number**

   d. **EMAIL ADDRESS:** _____
   Email Notification: If you want to be notified of the status of your application by email, please check the "YES" box and write your email address on the line provided above. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office info@floridaclinicallabs.gov. 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 the board office. Instead, contact the board office by telephone or in writing. [ ] YES [ ] NO

3. **PERSONAL DATA**
   a. Date of Birth **(optional)**: _____
   (Month/Day/Year)

   b. 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) 43FR 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.

   RACE: [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other
   SEX: [ ] Male [ ] Female

   c. 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 disasters? [ ] YES [ ] NO

4. **LICENSURE LEVEL (Director)**

Please review Rule 64B3-5.004, F.A.C., to determine the licensure pathway and OPTION. Once you have made the determination, please provide the OPTION number as requested below. Failure to provide an OPTION will result in delaying the process and you will be notified of the deficiency.

Technician: OPTION: _____

[ ] Histology [ ] Molecular Pathology [ ] Andrology [ ] Embryology

[ ] Generalist (Microbiology, Serology/Immunology, Clinical Chemistry, Hematology and Immunohematology)

NAME: _____

PLEASE USE ADDITIONAL PAGES, as necessary

5. EDUCATION INFORMATION:

Please provide college/university education information, whether completed or not, in chronological order:

(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State/Country)	(From: MM/DD/YYYY- To: MM/DD/YYYY	(Graduation Date)	(Degree Awarded)

6. VOCATIONAL/TRAINING PROGRAM:

Did you complete a training program in the area of applying for licensure: [ ] YES [ ] NO

(If **YES**, please provide the following):

(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)
(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)
(Program Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Completion Date)

7. NATIONAL CERTIFICATION EXAMINATION:

Did you successfully pass a National Certification Examination in the area applying for licensure: [ ] YES [ ] NO

If **YES**, please provide the following:

(Name of National Certification Examination)	(Examination Date)
(Name of National Certification Examination)	(Examination Date)

8. EMPLOYMENT HISTORY:

List in chronological order all clinical laboratory employment, as defined in Rule 64b3-2.003(8), F.A.C.

(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(From: MM/DD/YYYY to MM/DD/YYYY)

NAME: _____

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

PROCEEDINGS and/or ACTIONS

9. APPLICANT HISTORY:

a. Have you had <u>any</u> application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state or country? [ ] YES [ ] NO

b. Have you ever been notified to appear before <u>any</u> licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Clinical Laboratory Personnel practice act, unprofessional or unethical conduct? [ ] YES [ ] NO

If YES, please complete the following:

(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)

10. LICENSURE ACTIONS:

a. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? [ ] YES [ ] NO

b. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? [ ] YES [ ] NO

c. Have you been refused a license to practice, or the renewal thereof in any state? [ ] YES [ ] NO

11. CRIMINAL INFORMATION:

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? [ ] YES [ ] NO

If YES, 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

(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)
(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)

12. LICENSURE INFORMATION: Do you hold or have you ever held a **<u>STATE</u>** license to practice as a Clinical Laboratory Personnel in this state or any other state? [ ] YES [ ] NO

License Number	State/Country	Original Date Issued	Expiration Date
		____/____/____	____/____/____
		____/____/____	____/____/____
		____/____/____	____/____/____

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

NAME: _____

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.

13. Have you been convicted of, or entered a plea or guilty or nolo contendere, 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 13)** [ ] YES [ ] NO

a. If "yes" to 12, for 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 12, for 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 12, for 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 12, 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

14. 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 13, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

15. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 14a.)** [ ] 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

16. 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 15a or 15b.)** [ ] 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

17. 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

NAME: _____

18. APPLICANT SIGNATURE:

I acknowledge that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083 and 775.084, Florida Statutes.

I 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 Clinical Laboratory Personnel 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 under penalty of perjury 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 Clinical Laboratory Personnel in the State of Florida.

_____ _____

APPLICANT'S SIGNATURE **DATE**

STATE OF _____

COUNTY OF _____

Sworn to and/or subscribed before me this _____ day of _____, 20____

by _____ whose identity is known to me by _____.

_____

Notary Signature

_____

Name of Notary Printed

Stamp Commissioned Name of Notary Public

***As a reminder to all applicants Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one (1) year after the initial filing date with the department.**

Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

VERIFICATION OF CLINICAL LABORATORY EXPERIENCE

APPLICANT SECTION: (Complete only the APPLICANT SECTION. Do not fill out EMPLOYER SECTION).

APPLICANT NAME: _____
(Last) (First) (Middle)

EMPLOYER NAME: _____

MAILING ADDRESS: _____
(Street and Number) (Apt.#) (City) (State) (Zip)

TELEPHONE: (__)_____ **CLIA#** _____
Business: Area Code/Phone Number

Please forward to **your laboratory Supervisor/Director or Personnel Director** for completion. The form must be signed. Do not write over/white-out information, or fill in the list of tests or the form will be returned to you.

EMPLOYER SECTION: (Please complete the information below)

Do not include testing done in research, physician office laboratories or veterinary work. Observation in a laboratory setting when the Applicant does not have a Florida license is not pertinent clinical laboratory experience.

Employment period performing tests in the laboratory: From: _____ To: _____ Full Time: _____ Part Time: _____
MM/YYYY MM/YYYY (hrs. per wk) (hrs. per wk)

Please indicate an "X" in each SPECIALTY worked:

X	SPECIALTY AREA WORKED	TESTS PERFORMED	APPROX. DATES PERFORMED (MM/YYYY) to (MM/YYYY)
	Microbiology		/ to /
	Serology/Immunology		/ to /
	Clinical Chemistry		/ to /
	Hematology		/ to /
	Immunohematology		/ to /
	Cytogenetics		/ to /
	Molecular Pathology		/ to /
	Histocompatibility		/ to /
	Histology		/ to /
	Cytology		/ to /
	Andrology		/ to /
	Embryology		/ to /

The above information is correct to the best of my knowledge.

_____ _____
Print Name (Laboratory Supervisor/Director/Personnel Director) **Date**

_____ _____
Signature (Laboratory Supervisor/Director/Personnel Director) **Title**

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT;
1. Complete the information in Part I only.
2. This form must be returned by the state Board or agency that issued your license.

PART I: TO BE COMPLETED BY APPLICANT: (PRINT OR TYPE)

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

DOB: ____/____/_____ License No. _____ Title of License_____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE: (PRINT OR TYPE)

The individual listed above has applied for licensure in Florida as a Clinical Laboratory Personnel. Before further consideration is given to this application, we require the information requested on this form. The Board may submit your standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Clinical Laboratory Personnel, 4052 Bald Cypress Way, Bin C#07, Tallahassee, Florida 32399-3257.**

Licensee Name: _____
(Last) (First) (Middle)

State: _____ Title of License: _____ License No: _____ Original Issue Date ____/____/_____

THIS LICENSE IS CURRENTLY:
[ ] Active [ ] Inactive [ ] Temporary [ ] Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ] Examination [ ] Grandfathering [ ] Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ] No Disciplinary Action Taken [ ] Disciplinary Action Taken

_____ _____ **PLEASE AFFIX BOARD SEAL**
Print Name (Completing Form) Title

_____
Signature

If disciplinary action has been taken against this licensee; please provide certified copies of documentation regarding any disciplinary actions directly to the Florida Board of Clinical Laboratory Personnel.