



RECERTIFICATION NOTICE AND APPLICATION

Bureau of Emergency Medical Oversight– Paramedic and EMT

Expiration: 12/01/_____

License Type: Status:

The fee of \$45.00 for a paramedic, \$20 for an EMT and the recertification notice must be postmarked on or before December 01, 20____. A renewal notice postmarked on or after December 02, _____ requires the renewal fee in addition to a late renewal fee of \$25.00.

Name:	
Mailing Address:	Practice Location:
Attention:	Attention:

My mailing address has changed, please see update on Information Sheet.

My practice location address has changed, please see update on Information Sheet.

License/Certificate Status

Change of License/Certificate Status

I wish to change my license/certificate status from Active to Voluntary Inactive. The fee for a Voluntary Inactive status receipt on or before December 01, 20 ____, is \$50.00. You may not practice in this status according to Florida Administrative Code Rule 64J-1.010.

Change of Military Status

I am requesting Military Active status (You must submit proof of active military duty. Please attach a copy of current active duty orders or a letter from your Commanding Officer). There is no fee for Military Active status.

Name Change

Name changes require legal documentation showing the name change. Please ensure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the Department has a question about the authenticity of the document. A driver license or Social Security card is not considered legal documentation. If the name change cannot be completed, your license will be renewed using your current name.

Last	First	Middle	Title

Emergency Registration

Please check if you are renewing in active status and would 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.

Required Criminal Conviction Question

Yes No Have you ever been convicted, pled guilty or pled nolo contendere, regardless of adjudication, to a felony charge since your last certification?

If you have ever been convicted, pled guilty or pled nolo contendere, regardless of adjudication, to a felony charge within the last two years you must:

1. Submit documentation of the date, location, facts and disposition of the charge and, as applicable, documentation of the status of your civil rights after the felony conviction;
2. Submit a copy of the judgment and sentence of each felony, all probation documents, any documents that are relevant to the

felony, which must be certified by a court of competent jurisdiction. You may also submit any current letters of recommendation from your employer, probation officer, or other community leaders that you would like to have considered in this review;

3. Provide the jurisdiction where the plea or conviction occurred and the date of the judgement and sentence;
4. Provide a citation to every law you were charged with violating for which you entered a plea of guilty or nolo contendere, or for which you were convicted.

Criminal History and Background; Section 456.0635 Florida Statutes.

As required by section 456.0635(3), F.S., please answer Yes or No to the questions below. If you answer 'Yes' to any of the following questions, please send a written explanation for each such question, including the county and state of each termination, plea, or conviction, the date of each termination, plea, or conviction, and copies of supporting documentation, to the address below. Supporting documentation may include court dispositions or agency orders.

**Department of Health
Division of Medical Quality Assurance
Bureau of Operations
4052 Bald Cypress Way, Bin #C-10
Tallahassee, FL 32399-3260**

- Yes No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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.)**
 - Yes No If "Yes" to 1, did the arrest or felony charge resulting in the conviction or plea occur before July 1, 2009? **(If you responded "Yes," skip to question 2.)**
 - 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 or conviction, and completion of any sentence or subsequent period of probation?
 - 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 or conviction, and completion of any sentence or subsequent period of probation? (This question does not apply to felonies of the third degree under section 893.13(6)(a), F.S.)
 - Yes No If "Yes" to 1, for the felonies of the third degree under section 893.13(6)(a), F.S., has it been more than five (5) years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?
 - Yes No If "Yes" to 1, is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently enrolled in a pretrial diversion or drug court program that allows for the withdrawal of the plea or dismissal of the charges for the felony offense upon successful completion of that program? (If "Yes", please provide supporting documentation).
- Yes No Since July 1, 2009, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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.)**
 - Yes No If "Yes" to 2, did the sentence and any subsequent period of probation for such conviction or plea end more than fifteen (15) years before the date of this application?
- Yes No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, F.S.? **(If you responded "No," skip to question 4.)**
 - Yes No If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has that person been in good standing with the Florida Medicaid Program for the most recent five (5) years?

4. Yes No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedure established by the state, from any other state Medicaid program? **(If you responded "No," skip to question 5.)**
- a. Yes No If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has that person been in good standing with a state Medicaid program for the most recent five (5) years?
- b. Yes No Did the termination occur at least twenty (20) years before the date of this application?
5. Yes No Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities?

Certifications: (Check the correct box).

I hereby certify that I am not addicted to alcohol or any controlled substance. Yes No

I hereby certify that I am free from any physical or mental defect or disease that might impair my ability to perform my duties. Yes No

I hereby certify that I am the applicant for renewal of this certification whose signature appears below. Yes No

Oath:

Under penalties of perjury, I declare that I have read the foregoing application and that the facts stated in it are true.

Applicant

Date

If mailing your recertification notice/application form use the checklist below as a guide to ensure your application is complete. Please allow 2-4 weeks processing time.

Required items:

- Recertification Notice/Application Form
- Cashier's Check or Money Order made payable to "Florida Department of Health"
- Mail to: Florida Department of Health
P.O. Box 6320
Tallahassee, Florida 32314-6320

INFORMATION SHEET

Address Updates

If your address has changed, complete the information below and mail this page with your renewal form.

- Change of Mailing Address

Certificate Number

Last Name First Name Middle Initial

Street and Number

City State ZIP Country

Telephone: Primary Alternate Cell/Mobile

- Change of Practice Location **(Please note: Practice location must be a street address, not a post office box.)**

Street and Number

City State ZIP Country

- I am not practicing in the state of Florida and wish to change my Practice Location to "Not Practicing in Florida." By checking the box, you are indicating that you do not practice in Florida. The Department website will reflect "Not Practicing in Florida," and your mailing address will be printed on your license.