Temporary Certificate for Visiting Physicians to Obtain Medical Privileges for Instruction Purposes in Conjunction with Certain Plastic Surgery, Medical or Surgical Training Programs and Educational Symposiums

Board of Medicine
4052 Bald Cypress Way, Bin C-03
Tallahassee, FL 32399-3253
Website: https://flboardofmedicine.gov/
Email: BOM_InitialApps@flhealth.gov
Phone: (850) 245-4131
Fax: (850) 488-0596

DH-MQA 1079, Revised 10/2022, Rule 64B8-4.009, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor .

DH-MQA 1079, Revised 10/2022, Rule 64B8-4.009, F.A.C.

Florida HEALTH
Medical Quality Assurance

Temporary Certificate for Visiting Physicians to Obtain Medial Privileges for Instruction Purposes in Conjunction with Certain Plastic Surgery, Medical or Surgical Training Programs and Educational Symposiums

Board of Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: 850-488-0596
Email: BOM_InitialApps@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

Temporary Certificate for Visiting Physician (1509)**: $500.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

Total fee of $500.00 includes the following:

Application Fee (non-refundable)	$300.00
Licensure Fee	$200.00

Choose from the following affiliations:

☐ Type of training program: _____

☐ Affiliated medical school, osteopathic school, or teaching hospital in this state: _____

_____

☐ Educational symposium cosponsor: _____

☐ Recognized expert in specific area of: _____

1. PERSONAL INFORMATION

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

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

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

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 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.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, § 653 and 654; and s. 456.013(1), 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 ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. Do you hold, or have you ever held a license to practice medicine or any other regulated professional license(s)? ☐ Yes ☐ No

B. List all regulated professional licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

License Type	License #	State/Jurisdiction or Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority or www.veridoc.org regardless of the status of the license. Check www.veridoc.org for states that use the online verification service.

4. EDUCATION / TRAINING HISTORY

List the medical school where you obtained your medical degree. The medical school must be accredited by the Liaison Committee on Medical Education (LCME) or if you are an international medical graduate, the medical school must be listed with the World Health Organization.

Program Name/Location	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)
	to	

☐ **Complete the "Medical Degree Verification" form** and submit it to your medical school or medical college. The form must be submitted directly to the board office from the medical school or medical college.

This information is exempt from public records disclosure

5. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, Florida Statutes, and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

6. DISCIPLINE HISTORY

A. Have you ever had a license to practice medicine or other license to practice any regulated profession revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory, or 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 the medical practice act, unprofessional, or unethical conduct? ☐ Yes ☐ No

C. Have you ever had any application for professional license denied by any state board or other governmental agency of any state or country? ☐ Yes ☐ No

D. Are you currently under investigation or prosecution in any jurisdiction for an act that would constitute a violation under s. 456.072 or s. 458.331(2)(b), Florida Statutes? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

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

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

E. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? ☐ Yes ☐ No

F. Have you ever been denied or surrendered a DEA registration? ☐ Yes ☐ No

7. CRIMINAL HISTORY

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? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" in this section, complete the following:

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

If you responded "Yes," you must provide the following:

☐ **Self-Explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   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 subsequent probation? (This question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes). ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five 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," provide supporting documentation). ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   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 s. 409.913, Florida Statutes? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   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? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

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

   b. Did 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 the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **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.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for sections 5 and 6 must be sent to the board office at BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Documentation for sections 7 and 8 must be sent to MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

9. MALPRACTICE / LIABILITY CLAIM HISTORY

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

B. 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? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** listing your involvement in each case

☐ **Completed Exhibit 1 form** for each case (found following the application)

☐ **A copy of the complaint and disposition for each case**

☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

Documentation for this section must be sent to the board office at BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Name: _____

10. STATEMENT OF PURPOSE

☐ I state that I have been invited by a plastic surgery or other medical surgical training program that is affiliated with a medical school in this state which is accredited by the ACGME, AOA, or a teaching hospital as defined in s. 408.07, Florida Statutes, or an educational symposium cosponsored by the American Society of Plastic Surgeons, the Plastic Surgery Education Foundation, the American Society for Aesthetic Plastic Surgery, or any other medical or surgical society in conjunction with a medical school or teaching hospital as defined in s. 408.07, Florida Statutes, and am a recognized expert in a specific area of plastic surgery, or another field of medicine or surgery as demonstrated by peer-review publications, invited lectureships, and academic affiliations.

The board will not be able to process your application if you do not confirm the above statement by checking the box.

11. APPLICANT SIGNATURE

I have carefully read the questions in the application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

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 Medicine information which is material to my application for licensure.

I understand that my records are protected under 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 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 upon it.

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

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

Complete verifications must be sent directly from the medical education institution to the board office by fax to (850) 412-1268 or by mail to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257

Board *of* Medicine
Medical Degree Verification

Name: _____ Date of Birth: _____
MM/DD/YYYY

Part I: To be completed by applicant

Name of Medical School: _____

Address: _____

City: _____ State: _____ ZIP: _____

Part II: To be completed by Medical Education Institution

The above-named doctor has applied for licensure in the state of Florida. Please complete this section and submit to the above address.

Type of degree awarded: _____

Date degree received: _____
MM/DD/YYYY

Verifier Name _____ Title _____

Signature _____ Date _____
MM/DD/YYYY

Affix school seal

This form is required for ALL applicants.

Board *of* Medicine
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 6** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I **do not** have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

☐ 2. I **have** hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with ch. 675, Florida Statutes, for a letter of credit and s. 625.52, Florida Statutes, for an escrow account.

☐ 3. 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, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

☐ 4. I **have** hospital staff privileges and I have 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, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self- insurance as provided in s. 627.357, Florida Statutes.

☐ 5. I have elected not to carry medical malpractice insurance; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, Florida Statutes. I understand 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. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), Florida Statutes.

☐ 6. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category on the following page.)***

Name: _____

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I hold a limited license issued pursuant to s. 458.317, Florida Statutes, and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals (interns and residents do not qualify for this exemption).

☐ 4. I do not practice medicine in the state of Florida.

☐ 5. I am exempt from demonstrating financial responsibility due to meeting **all** the following criteria (If you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):

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 a part-time practice of no more than 1,000 patient contact hours per year.
c. I have 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 ch. 458, Florida Statutes or the medical practice act in any other state.
e. I have not been subject, within the past 10 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 ch. 458, Florida Statutes, 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 s. 458.320(5)(f), Florida Statutes, for specific notice requirements.

Section 456.067, Florida Statutes, Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Applicant Signature _____ Date _____
MM/DD/YYYY

Board *of* Medicine
Financial Responsibility Affidavit of Exemption

This affidavit is <u>only</u> required if you are claiming exemption based on #5 on the preceding page.

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

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 a part-time practice of no more than 1,000 patient contact hours per year.
c. I have 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 ch. 458, Florida Statutes, or the medical practice act in any other state.
e. I have not been subject, within the past 10 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 ch. 458, Florida Statutes, 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 s. 458.320(5)(f), Florida Statutes, for specific notice requirements.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

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

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the form and sign it before a notary public.

[NOTARY SEAL]

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____ Date of Birth: _____
MM/DD/YYYY

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Medicine.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Was a temporary certificate issued prior to full licensure?
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.