

This form is required  
for ALL applicants.

## Board of Medicine Financial Responsibility

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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, I **do not** perform surgery at an ambulatory surgical center, 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, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
2. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, 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, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
3. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, 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, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
4. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, 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, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
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, F.S. 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), F.S.
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.***)

**Board of Medicine**  
**Financial Responsibility**  
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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, F.S., 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 have no malpractice exposure because I do not practice in the state of Florida. I will notify the department immediately before commencing practice in the state.
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, F.S., or the medical practice act in any other state.
  - 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 ch. 458, 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 s. 458.320(5)(f), F.S., for specific notice requirements.

Section 456.067, F.S., Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., 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, F.S., s. 775.083, F.S., or s. 775.084, F.S.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY

**Board of Medicine**  
**Financial Responsibility Affidavit of Exemption**



**This affidavit is only required if you are claiming exemption based on #5 on the preceding page.**

I, \_\_\_\_\_, do 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, F.S., or the medical practice act in any other state.
- 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 ch. 458, 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 s. 458.320(5)(f), F.S., 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]