FLORIDA DEPARTMENT OF HEALTH
BOARD OF MEDICINE
MEDICAL DOCTOR
APPLICATION
FOR LICENSURE

DEPARTMENT OF HEALTH-MEDICINE
4052 BALD CYPRESS WAY, BIN #C03
TALLAHASSEE, FL 32399
(850)488-0595

64B8-1.007 & 64B8-4.009, F.A.C. DH-MQA 1000 Revised 04/2011

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******ATTENTION******

- Please keep these application instructions for your records. Do not return them to the board office with your application. You may be referred back to the instructions during your application process.

- Make a copy of everything you send to the board office. You may need to refer to previously submitted documents during your application process.

IMPORTANT NOTICE:

Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

SECTION I
GENERAL INFORMATION

Section 456.013(1)(a), Florida Statutes, and Chapter 64B8-4.016, Florida Administrative Code, provides that a licensure application and application fee are valid for one year. Application fees are non-refundable.

- The State of Florida operates under Chapter 286, Florida Statutes, commonly referred to as the "Sunshine Law." This law requires that board meetings are public. All information that you provide to the Department is public record and shall be open to public inspection as required by 119.07 F. S., except financial information, examination records, and patient records.

- The Florida Board of Medicine general statutes require that you must have a valid Florida medical license to practice medicine in Florida. **We recommend that you do not make any commitments based upon expectation of licensure until you are actually licensed**. Some applicants suffer significant costs by signing mortgages and committing to a start date prematurely. One application is not accelerated at the expense of another, particularly if there is a premature commitment to start practicing medicine. All applicants are handled equally and fairly. The application process may take between two to six months to complete depending on your credentials. You will not be able to start work until you have been granted a full medical license. Applicants can help expedite the application process by including all relevant materials with their application packets (medical school transcripts, residency certificates, etc). We will mail you a deficiency letter approximately 30 days after receiving your application. Please refrain from contacting our office until after you have received your initial deficiency letter. E-mail contact is more efficient. Time spent on the telephone impacts time available for staff to process applications. Please direct questions or comments to MQA_Medicine@doh.state.fl.us. We process applications, mail, e-mails, and telephone calls in date order.

- **Read instructions before and while you complete the application. Failure to do so may result in delays in processing your application**.

- Licenses will not be issued without the background check results and will be issued in date order. When issuing licenses, we have a strict policy of fairness. One application will not be accelerated at the expense of another. All applications will be handled equally and fairly. Also, the less time reviewers spend responding to duplicate e-mails and telephone calls, the faster applications can be reviewed. The standard procedures for the reviewer is:

  Return phone calls within 24 hours.
  Check mail within one week from receipt date.
  Respond to e-mails within one week.

- It could take up to 14 days to issue your license after completion of your application. It will take approximately 10 business days to receive your license in the mail after issuance. To view your license, you may access our license look-up screen at www.FLHealthSource.com. Your license number will appear on the web site 24 to 48 hours after it is issued.

- Federal Credentials Verification Services (FCVS): The Florida Board of Medicine encourages all applicants to use FCVS to assist with the licensure process. However, it is not a requirement for licensure. For more information about FCVS, visit their web-site at www.fcvs.org/. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, and ECFMG verification.
  Note: If you have not completed the FCVS certification process prior to applying for license in Florida it could take longer to receive your Florida license.

- Before practicing medicine in Florida, read Chapter 456, 458, and 766.301-.316 Florida Statutes (F. S.), and Rule Chapter 64B8, Florida Administrative Code (F.A.C). You must know and comply with the laws and rules as they pertain to your professional practice. Laws and rules are subject to change at any time. For updated information refer to the following web-sites www.leg.state.fl.us/ (statutes) and www.fac.dos.state.fl.us (Florida Administrative Code).

- Personal Appearances before the Credentials Committee or the Board of Medicine may be required for a variety of reasons: e.g., malpractice, medical education, postgraduate training, disciplinary actions, etc. If an appearance is required, we will notify you by mail including the date, time, location, and reason(s) for the appearance. The Credentials Committee meets in conjunction with the full Board of Medicine meetings. In order for the Committee members to review all the information that is provided for this committee, other committee meetings at the same time, and for the full board meeting, a deadline for applications must be established and respected. The cut off for a complete application to be considered is six (6) weeks prior to the committee meeting. All Board and Committee meetings dates are posted on our web site at: http://www.doh.state.fl.us/mqa/medical/

- Any document submitted in a language other than English must be accompanied by a literal translation. Acceptable translators are: An employee of a professional translating company, a member of a professional translation company, a member of the American Translators Association, a faculty member of the modern languages or linguistics department of a United States college or university. Translations must be prepared on letterhead paper or bear the translator's certification seal. All information appearing on the original document must also appear on the translation each time it appears on the original document. This includes pre-printed information. For example, the letterhead of the university, titles, etc.

  All stamps and seals must be translated if legible. If not legible, state that it is not legible and cannot be translated.
  All signatures and photos must be identified.
  All numbers must be translated unless they appear as follows: 1 2 3 4 5 6 7 8 9 0. If they do not appear on the document as they do above, they must be accurately transcribed.
  Any other information on the document must be translated.

Note: Translations prepared in international countries often have certifications on the translation. If a certification is in a language other than English, it must also be translated. Omissions or errors will cause a delay in the application process.

- Submit your application, supporting documentation, and fees, to the following address:

  Department of Health/ HMQAM
  P.O. Box 6330
  Tallahassee, Florida 32314-6330

Receiving your application and logging in your check usually takes about 7-10 days. Once the application is logged in, it is then forwarded to the board office. NOTE: The reason you are using this address is because it has fees enclosed.

- Mail additional documentation or anything without a fee to the following address:

  Department of Health
  Medical Quality Assurance/Board of Medicine
  HMQAM
  4052 Bald Cypress Way, BIN #CO3
  Tallahassee, Florida 32399-3253

All documents must have your name as listed on your application to ensure materials reach your application in a timely manner**.**

Guidelines for requesting the Finger print Card:

To request a fingerprint card please visit http://www.fldoh.sofn.net/

This website is designed to allow Florida Department of Health-MQA Candidates a means to register their demographic information and the option to purchase FD258 fingerprint cards to process their fingerprint-based criminal history background screening checks in accordance with the Florida law.

To Register:

1. ENTER personal demographic data required to submit fingerprints.
2. OPTION to purchase FD 258 fingerprint cards.
    - If you chose not to purchase a fingerprint card you must make sure the police department or agency you choose to roll your fingerprints uses an FD 258. If the FD 258 is not used the fingerprints will not be accepted, you will be required to have another set rolled and your application will be delayed.
3. PAY: If fingerprint cards are purchased.
    - $4.00 for regular USPS mail
    - $10 for priority mail

OBTAIN RECEIPT generated online. Print the Bar Code Receipt and mail it to the address listed on the receipt with the completed fingerprint cards.

SECTION II

Completing the Application

Read instructions before and while you complete your application. Failure to do so may result in delays in processing your application.

Type or legibly write your application. As we receive supporting documentation, we may need to ask you additional questions and require additional documentation.

Item-by Item Instructions

1. **Social Security Number:** List your social security number as in this example: 333-33-3333. 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 as required by Title 42 United States Code, Sections 653 and 654; and Sections 456.004(9), 456.013(1)(a), 409.2577, and 409.2598, Florida Statutes. Social security numbers are used to efficiently screen applicants and licensees by Title IV-D to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

2. **Application category/applicable fees:** Check either Endorsement or Examination. To determine which to check, read the following explanations for endorsement and examination.

458.313 Licensure by endorsement- Applicants who have been issued licensure in another jurisdiction and who have passed a national examination.

- Any applicant who has actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years
- Any applicant who has successfully completed a board approved postgraduate training program within two years preceding filing of the application (ACGME, CFPC or RCPSC approved residency or fellowship in a teaching hospital)
- Any applicant who has passed a board-approved clinical competency examination
- within the year preceding filing of the application (USMLE, SPEX or ABMS specialty examination)

458.311 Licensure by examination- Applicants who do not hold a state license or who have not passed a national examination.

- Any applicant who has passed all parts of a national examination (NBME, FLEX, or USMLE) and does not hold a valid medical license in the U.S.
- Any applicant who is currently licensed in the U.S. or Canada, who has actively practiced pursuant to such licensure for at least 10 years, has passed a state board or LMCC examination, and passed the SPEX examination
- Any applicant who was licensed on the basis of a state board exam prior to 1974, and is currently licensed in at least three other jurisdictions in the U.S. or Canada, and practiced pursuant to such licensure for at least 20 years
- Any applicant who has completed the formal requirements of an international medical school except the internship or social service requirement, passed parts I and II of the NBME or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5^{th} pathway)

Fees for an unrestricted Florida medical license:

Application fee:	$500.00 (non-refundable)
Background check fee:	$48.00 (non-refundable)
Initial license fee:	$429.00
NICA fee:	$250.00 or $5,000.00 (please read information at www.nica.com)
Dispensing Practitioner fee:	$100.00 (optional, this fee is for selling pharmaceuticals in your office)

If you are in a residency or fellowship at the time of certification (approval), you may pay a reduced license fee. As a result, your license will reflect an "in-training" status. Reduced Fees:

Application fee:	$500.00 (non-refundable)
Background check fee:	$48.00 (non-refundable)
Initial license fee:	$205.00
NICA fee:	Exempt (please read information at www.nica.com)

To receive the fee reduction your training director must send a letter addressed to the Florida Board of Medicine verifying dates of your training. NOTE: "in-training" status will not limit your practice to training; license issued will be an unrestricted medical license.

Make one cashier's check or money order for the total amount payable to the Department of Health-Board of Medicine. Cash and credit card payments are not acceptable. Mail complete fee with your application to: Department of Health/ HMQAM,P.O. Box 6330,Tallahassee, Florida 32314-6330

3. **Name:** List your name as it appears on your birth certificate and/or a legal name-change document. Nicknames or shortened versions are unacceptable. If you have a hyphenated last name, enter both names in the last name space. It will be recognized by the first letter of the first name; e.g., Diaz-Jones.
   a. List name(s). Name changes include marriage, naturalization, divorce, or by any other means. Please provide a copy of the legal name-change document.
   b. List your aliases or any of your other names that may appear on supporting documentation.

4. **Mailing address:** List your current mailing address. We will mail correspondence to you at this address unless you notify the board in writing of an address change. NOTE: If your address changes prior to the issuance of the license, it is your responsibility to notify your reviewer of your address change in writing.

5. **Physical location or address of employment:** List your physical location or address of employment. This address will be available to the public on the MQA License Verification web site. Post Office Box is not acceptable.

6. **Telephone:** List your **primary and alternate** telephone numbers.

7. **E-mail address:** List your e-mail address. We will e-mail correspondence to you at this address instead of the mailing address when possible.

8. **Citizenship**: List the country where you are a citizen. Provide your date and place of birth.

9. **Demographics:** Check your race and sex.

10. **Disaster Registry:** Check Yes or No. The Department of Health must maintain a healthcare practitioner registry for disasters and emergencies. Your response to this question will not affect processing your licensure application.

11. **Federation of Credentials Verification Services (FCVS):** Check Yes or No

12. United States military and/or Public Health: Check Yes or No. If yes, list the branch of service, rank, and dates of service. Provide a copy of your discharge documents indicating type of discharge.

12a. United States military charges: Check Yes or No. If yes, explain the circumstances and provide supporting documentation.

13. Education: List **all** undergraduate, graduate, medical and professional education. List each institution attended even if you did not receive a degree. For items 13a-d, if yes, explain on a separate sheet providing accurate details. In addition, request that the medical school submit supporting documentation directly to the Board of Medicine. For item 13e, if "yes" list on a separate sheet core clerkship performed in the United States.

If you fail to disclose accurate information, you may have to personally appear before the Credentials Committee. If you are unsure as to whether you had any type of break or leave, extended medical education, or any type of probation, etc., contact your medical school or review your transcripts prior to completing these questions. In the event the transcript is lost or destroyed, see Rule 64B8-4.009(4), Florida Administrative Code, for procedure to be followed.

Provide the following documentation to support your education:

1) A copy of your medical school transcripts from all schools attended and a copy of your medical school diploma**. ***
2) Undergraduate transcripts, if you graduated from medical school after October 1, 1992.
3) Complete the medical school verification request form and remit to the medical school. This form must be received directly from the medical school to the Board office with the school seal. ***
4) ECFMG certificate, if you are an international medical graduate***
5) Verification of ECFMG status report sent directly from the ECFMG. ***
6) Your undergraduate degree and 5th pathway certificate, if applicable. ***
7) Verification of your 5th pathway program direct from the program to the Board office. ***
8) Verification of NBME I & II examination, USMLE or ECFMG examination equivalent score reports sent directly from the NBME, USMLE or ECFMG, if you completed a 5th pathway program. ***

*** If you are using FCVS do not submit the items identified with an *, as FCVS will submit these items for you.**

14. Postgraduate Training: List chronologically each program that you attended after graduation from medical school. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training. For items 14a-c, if yes, explain on a separate sheet providing accurate details. In addition, request that your training program(s) submit supporting documentation directly to the Board of Medicine.

If you fail to disclose accurate information, you may have to personally appear before the Credentials Committee. If you are unsure as to whether you had any type of break or leave, extended medical education, or any type of probation, etc., contact your training program prior to completing these questions.

Domestic Medical Graduates: Must have completed at least one full year of accredited training within the U.S., Canada or Puerto Rico. Submit a copy of the internship/residency training certificate(s) for each year of training. If you have not been issued a certificate, submit a current original letter from the Program Director of the training program, addressed to the Florida Board of Medicine, stating the PGY levels completed, dates of attendance for each level. Letters must verify completion of at least one year of training.

International Medical Graduates: Must have completed at least two full progressive years of accredited training in the U.S., Canada or Puerto Rico. Submit a copy of the internship/residency training or fellowship certificate(s) for each year of training. If you have not been issued a certificate, submit a current original letter from the Program Director of the training program, addressed to the Florida Board of Medicine, stating the PGY levels completed, dates of attendance for each level. Letters must verify completion of at least of two years of training.

Provide the following documentation to support your postgraduate training:

1) A copy of all of your internship, residency, and fellowship training certificate(s). If you have not been issued a certificate, provide a current original letter from the training program director addressed to the Florida Board of Medicine that states the PGY levels completed and dates you attended each level.
2) A completed postgraduate evaluation form and remit it to **all** postgraduate training programs you began whether you completed or received credit for the training. We must receive this form directly from the training program with an original signature of the current program chairman or director.

15. Licensing Examination: List examination(s) taken and date(s) passed. Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states you must also request your SPEX score be sent.

16. List the year that you legally first began to practice medicine. This would be the year you began practicing medicine and could be the date you began your postgraduate training.

17. Licensure: List all state(s) license number(s) where you **hold** or **ever held** a **medical or any other professional license** regardless of the current status in any state in the United States, Canada, Guam, Puerto Rico, or the U.S. Virgin Islands.

For items 17a-e, if yes, explain on a separate sheet providing accurate details. Request verification of the following:

- Licensure status directly from the licensing entity or www.veridoc.org
- International license verification(s) if you have practiced outside of the US for at least 2 of the previous 4 years
- Documentation directly from the licensing entity supporting your yes answers for items 17a-e

18. PRACTICE/EMPLOYMENT: List in chronological order all periods of time starting from the date you graduated from medical school to the present. Be specific, and give type of practice or non employment and address. Account for all activities more than 30 days. Include vacation, moonlighting and locum tenens. Unaccounted periods of time may cause a delay in the processing of your application. If sufficient space is not provided, submit on a separate sheet.

For items 18a-b, if yes, explain on a separate sheet providing accurate details and request supporting documentation be sent directly from the applicable entity.

19. Staff Privileges: Check Yes or No and list all hospital(s), health institution(s), clinics(s), or medical facilities where you currently hold staff privileges. Do not list training privileges. Request that verification of staff privileges be sent from the applicable entity.

For items 19a-b, if yes, explain on a separate sheet providing accurate details and request supporting documentation be sent directly from the applicable entity.

20. **Graduate Medical Education:** Check Yes or No. If yes, list all institutions where you have had responsibility for graduate medical education.

21. **Faculty appointment**: Check Yes or No. If yes, list any facility appointment(s) you currently have at any medical school(s).

22. **American Board of Medical Specialties:** Check Yes or No.

If yes, list specialty board name, specialty/sub-specialty, and date of certification. For items 22a-b, if yes explain on a separate sheet providing accurate details. Request that the specialty board send supporting documentation directly to the Board of Medicine.

23-31. DEA/Medicare/State Healthcare Programs/Medical Societies and Associations: Check Yes or no.

If yes, explain on a separate sheet providing accurate details. Request that the entity send supporting documentation directly to the Board of Medicine.

32-33. MALPRACTICE: Check Yes or No.

If yes, provide the following:

- A statement indicating date of each incident and the number for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- An explanation of details for each case and your involvement for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 33, in addition to the documents listed above, submit the enclosed Exhibit 1 form.
- A copy of complaint, judgments and/or settlements for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 32, in addition to submitting the above documents, submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format (CD or DVD).

34-35. Criminal Convictions and/or Criminal and/or Civil Charges: Check Yes or No.

If yes, explain on a separate sheet providing the date, accurate details and submit copies of charge(s), indictment(s), judgment(s).

36-41. Disorder/Impairment: Check Yes or No.

If yes, submit the following:

- A statement providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

You may be asked to submit to a current evaluation by a board-approved physician independent of your current treating physician and appear before the Credentials Committee.

42. Continuing Medical Education:

Prevention of Medical Errors: Check the box to certify that you have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education since June 1, 2002. The education must meet requirements defined in § 456.013(7), Florida Statutes, and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

Please note: You will be required by Chapter 456, F.S., to take an HIV/AIDS course approved by the board for your first renewal and a two (2) hour Domestic Violence Course approved by the board prior to your third renewal.

43. Dispensing Practitioner Registration: Check the box to register for dispensing medical drugs for profit from your private office. Checking the box shows that you understand that the dispensing fee is $100.00 **over and above** your initial license fee, and you will submit it along with your license fee.

Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medical drugs pay a fee of $100.00 when they register to dispense or when they renew their practitioner's license. It is unlawful to sell samples or complimentary packages of drug products. Physicians who dispense only complimentary packages of medicinal drugs to patients in the regular course of practice are **not** required to register. Do not check the box if you plan to dispense only samples or complimentary medical drugs.

The State of Florida does not have a separate prescribing number. However, if you are going to prescribe controlled substances you are required to obtain a number through the Drug Enforcement Agency. You may contact the DEA at www.dea.gov or (305) 994-4870.

44. Financial Responsibility: Check only **one** of the ten Financial Responsibility options to comply with §458.320, Florida Statutes. The options are divided into two categories: coverage and exemptions. If you are not licensed in Florida through another licensure provision, you may choose the exemption provision until you are licensed and began practicing in Florida.

45. Neurological Injury Compensation Association: If you are a participating or non-participating physician, or a physician claiming exemption, complete the Florida Birth Related Neurological Compensation Association (Item 45) form, sign and date it, and return it with your application.

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated compensation form (Item 45) with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

To complete the form, check one of the three boxes to choose your compensation option for Florida birth-related neurological compensation. Check only one. If you will submit payment, list the amount on the "Amount Enclosed" line and submit fee with your licensure application.

If you check "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

Sign your name on the Signature line to show that you have read the explanatory information provided by NICA at WWW.NICA.COM and have chosen a compensation option. List the date that you signed in mm/dd/yy. Print or type your name, street address, city, state, and zip on the lines provided.

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

46. Statement of Applicant: Read the Statement of Applicant. If you agree with the content print or type your name, sign your name, and list the date that you signed as mm/dd/yy on the lines provided to show that you consent to the statement. You must sign and date the statement. If you have used any outside resources to assist you in completing this application, please remember only you are responsible for the contents of this application.

Important Addresses

National Board, FLEX, SPEX, USMLE or State Board (prior to 1974) Score Reports: The applicant is responsible for requesting examination results be sent to the Florida Board of Medicine directly from the score reporting entity. A fee is charged to furnish this information.

National Board score report
National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3190
(215)590-9500
www.nbme.org

SPEX, FLEX or USMLE score report
Federation of State Medical Boards, Inc.
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855
(817)868-4000
www.fsmb.org

National Practitioner Data Bank Self-Query: Applicants are required to complete a self query to the National Practitioner Data Bank (NPDB) and upon receipt of the query, provide the Board office with a copy. A fee is charged to furnish this information. www.npdb-hipdb.hrsa.gov

NPDB
P.O. Box 10832
Chantilly, VA 22021
(800)767-6732

AMA Physician Profile Sheet: Applicants are responsible for requesting an AMA Physician Profile be sent to the Board office directly from the American Medical Association. www.ama-assn.org/amaprofiles

American Medical Association
515 North State Street
Chicago, IL 60610
(800)621-8335

Contact Applicant Information Services at:

ECFMG www.ecfmg.org
3624 Market Street
Philadelphia, PA 19104-2685 USA
TEL: (215) 386-5900 FAX: (215) 386-9196
(Telephone assistance is available between 9:00 a.m. and 5:00 p.m., Eastern Time, Monday through Friday.)

Always include your USMLE/ECFMG Identification Number, if one has been assigned, when communicating with ECFMG.

Licensure Verifications received from www.veridoc.org are acceptable.

SECTION III

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine

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.

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

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2. Application category/applicable fees: Client 1501
☐ Endorsement (1021) ☐ Examination (1024)

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

3a. Have you ever changed your name through marriage, naturalization or action of a **court or have you been known by any other names?** If yes; list original name(s)

☐ YES ☐ NO

_____
Last First Middle

3b. List any other names by which you have been known.

_____
If 'yes', list name(s) (Last, First, Middle, and Suffix).

4. Mailing address:

_____
(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

5. Physical location or address of employment – This address will be available to the public on the MQA License Verification website. Post Office Box is not acceptable.

_____
(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

6. Telephone **(_____)_____** **(_____)_____**
(Primary: Area Code/Phone Number) (Alternate: Area Code/Phone Number)

7. E-mail address: _____

8. List the country where you are citizen_____

Birth Date: _____ Birth Place: _____

9. Demographics: **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) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and will not affect your candidacy for licensure.**

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Sex: ☐ Male ☐ Female

10. Disaster Registry: As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? ☐ YES ☐ NO

11. Are you using the Federation Credentials Verification Service to verify your core credentials? ☐ YES ☐ NO

12. Have you ever been in the United States Military and/or Public Health Service? ☐ YES ☐ NO

12a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? If yes, explain the circumstances on a separate sheet. ☐ YES ☐ NO

13. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received

For items 13a-d, if yes explain on a separate sheet providing accurate details.

13a. Have you ever been dropped, suspended, placed on probation, asked to resign, or expelled from **any** school, college or university? ☐ YES ☐ NO

13b. Did you attend medical school for a period other than the normal curriculum, or were you required to repeat **any** of your medical education including classes, test/exams, lectures or any other part of the curriculum? ☐ YES ☐ NO

13c. Did you take **any** type of break or leave of absence for any reason during medical school? (Including maternity/paternity, medical leave or any other type of break or leave.) ☐ YES ☐ NO

13d. Have you ever defaulted on any health education loan or scholarship obligation? ☐ YES ☐ NO

13e. If you are an international medical graduate, did you perform your core clerkships in the United States? ☐ YES ☐ NO
If 'yes', list on a separate sheet core clerkship, institution, address, and date of each rotation completed in the U.S.

14. Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No

For items 14a-c, if yes, explain on a separate sheet providing accurate details.

14a. Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from **any** postgraduate training program? ☐ YES ☐ NO

14b. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat **any** of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum? ☐ YES ☐ NO

14c. Did you take **any** type of break or leave of absence for any reason during your postgraduate training? (Including maternity/paternity, medical leave or any other type of break or leave.) ☐ YES ☐ NO

15. Licensing Examination: State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Exam taken _____ Date passed _____
mm/dd/yy

16. List the year you legally first began to practice medicine, ____(yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

17. Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **If "yes" list below (attach additional sheets if necessary).** ☐ YES ☐ NO

State or Country	License number	Original date issued	Expiration date

For items 17a-e, if yes, explain on a separate sheet providing accurate details.

17a. Have you had **any** application for a medical license or professional license denied by **any** state board or other governmental agency of **any** state, territory, or country? ☐ YES ☐ NO

17b. Have you ever been allowed to withdraw an application for medical licensure or professional license for **any** reason or during a pending investigation in any jurisdiction in lieu of your license being denied? ☐ YES ☐ NO

17c. Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? ☐ YES ☐ NO

17d. Have you ever been notified, invited or required to appear before **any** licensing agency for a hearing on a complaint of **any** nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct? ☐ YES ☐ NO

17e. Have you ever had **any** professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in **any** state, territory or country? ☐ YES ☐ NO

18. Practice/Employment: In the table below, list in chronological order **all** employment, non-employment, and/or **any unaccounted period of time** from date you graduated medical school to present.
If needed, continue on a separate sheet of paper.

Name and full mailing address of employment or activity	Type of employment or activity	From: mm/yy	To: mm/yy

For items 18a-b, if yes, explain on a separate sheet providing accurate details.

18a. Have you ever had employment terminated for cause? ☐ YES ☐ NO

18b. Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? ☐ YES ☐ NO

19. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? ☐ YES ☐ NO

Name of facility	Mailing address	Type of privileges	From: mm/yy	To: mm/yy

For items 19a-b, if yes, explain on a separate sheet providing accurate details.

19a. 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? ☐ YES ☐ NO

19b. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? ☐ YES ☐ NO

20. Have you had responsibility for graduate medical education within the last 10 years? If yes, list in the table below. ☐ YES ☐ NO

21. Do you currently hold a faculty appointment at a medical school? If yes, list in the table below. ☐ YES ☐ NO

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution	Full mailing address	Title of appointment

22. American Board of Medical Specialties: Are you certified by any specialty board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? ☐ YES ☐ NO
If yes, list in the table below.

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification mm/yy

For items 22a. - 41, if yes, explain on a separate sheet providing accurate details.

22a. Have you ever failed to receive specialty board certification or re-certification for any reason? ☐ YES ☐ NO

22b. Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? ☐ YES ☐ NO

23. Have you ever been warned or called before the United States Drug Enforcement Administration (DEA)? ☐ YES ☐ NO

24. Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA? ☐ YES ☐ NO

25. Have you ever been denied or surrendered a DEA registration? ☐ YES ☐ NO

26. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 26a.) ☐ YES ☐ NO

26a. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? ☐ YES ☐ NO

27 Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 27a.) ☐ YES ☐ NO

27a. 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

28. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 28a and 28b.) ☐ YES ☐ NO

28a. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? ☐ YES ☐ NO

28b. Did the termination occur at least 20 years prior to the date of this application? ☐ YES ☐ NO

29. Have you ever been denied or been excluded from Medicare and/or state health care programs? ☐ YES ☐ NO

30. Have you ever had an application for membership denied by a medical society or association or had a medical society or association membership revoked, suspended, placed on probation, or other disciplinary action taken? ☐ YES ☐ NO

31. Have you ever been notified to appear before a medical society or association about charges or complaints filed against you? ☐ YES ☐ NO

32. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? ☐ YES ☐ NO

33. Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00? ☐ YES ☐ NO
If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.

34. 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 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

35. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? ☐ YES ☐ NO

36. 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

37. 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

38. 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

39. In 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

40. 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

41. 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? ☐ YES ☐ NO

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

42. Prevention of Medical Errors:

☐ I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.flmedical.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

43. Dispensing Practitioner Registration:

This is optional and for physicians whose primary practice is in the State of Florida. Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit. Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice is **not** required to register.

Check if applicable to you.

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 **over and above** the required initial license fee and will submit it along with the license fee.

44. Financial Responsibility

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only **one** option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

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

Category II: Financial Responsibility Exemptions

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

☐**7.** I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐**8.** **I do not practice medicine in the State of Florida**.

☐**9.** 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 458, 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 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 Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐**10.** 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).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Financial Responsibility Form:

DEPARTMENT OF HEALTH
BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an exemption based on number 9 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 458, 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 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 Section 458.320(5)(f), F.S., for specific notice requirements.

Dated:_____ Signature:_____

STATE OF _____
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_____

45. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating

☐ $250 Non-participating

☐ $0 Exempt

_____ Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

_____ Name

_____ _____
Signature Date

_____ Street Address

_____ City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191 .

46. Statement of Applicant

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

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 Medicine 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. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days. 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, 42CFR 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.

_____

(Please print your name.)

_____

(Signature of applicant required.) (Date signed required.)

Medical Degree Verification Form

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253
FAX (850) 412-1268

The physician listed below submitted an application for Florida licensure and is under investigation by this authority. Verify number 2 through 4, complete number 5 through 7, and return directly to the Board of Medicine. Thank you.

Applicant completes number 1 through 3.

1. TO: _____

_____
Address of medical school

_____
City - State - Zip - Country

2. Name: _____

3. Date of Birth:_____

4. Type of Degree: _____ _____ Date Degree Received: _____

5. Was the above referenced physician ever dropped, suspended, placed on probation, or asked to resign? (**If yes please explain**) ☐ YES ☐ NO

6. Did the above referenced physician attend medical school for a period other than the normal curriculum, or was he/she required to repeat any of his/her medical education? (**If yes please explain**) ☐ YES ☐ NO

7. Did the above referenced physician take any type of break or leave of absence for any reason during medical school? (**If yes please explain**) ☐ YES ☐ NO

8. EXPLANATIONS OR COMMENTS:

_____

_____

Authenticate by signature and school seal.

_____
Verified by

SEAL

_____
Name

_____
Title

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 412-1268 -Fax

Post-Graduate Training Evaluation Form

The physician listed in number 1 submitted an application for licensure and is under investigation by this authority. Please complete number 3 through 7 of this form and return directly to the Board of Medicine. Thank You!

To: _____
School

_____
Department

_____
Address

_____
City, State, Zip

1. Name:_____
2. Internship/Residency/Fellowship_____From:_____

3. Please verify: **If yes, explain on a separate sheet providing accurate details**.
   a. Matriculation Date _____Completion Date _____ Specialty _____
   b. Levels completed: PGY I ☐ PGY II ☐ PGY III ☐ PGY IV ☐ PGY V ☐
   c. Did this individual take any type of break or leave of absence for any reason? Yes ☐ No ☐
   d. Was this individual ever dropped, suspended, placed on probation, asked to resign or expelled? Yes ☐ No ☐
   e. Was attendance for a period other than the established timeframe or was he/she required to repeat any training? Yes ☐ No ☐
   f. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes ☐ No ☐

4. Professional Character: Evaluate compared to a physician or similar experience.

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge					
b. Diagnostic/Clinical Ability					
c. Teaching Ability					
d. Research Potential					
e. Fitness for Clinical Practice					
5. Personal Character:					
a. Motivation					
b. Initiative					
c. Responsibility					
d. Integrity					
e. Appearance					
f. Knowledge of English					
6. Professional Relationship With:					
a. Teaching Staff					
b. Colleagues					
c. Nursing Staff					
d. Patients					

7. Overall Evaluation: **If item C or D is checked, provide a written explanation on a separate sheet.**
   a._____ Recommended as an outstanding applicant
   b._____ Recommended as qualified and competent
   c._____ Recommended with some reservation
   d._____ Cannot Recommend Signed: _____

Chairman or Program Director Only No **stamped** signatures please.

Licensure Verification Form

1. To: _____
State Board

_____
Street Address

_____
City/State/Zip

I, the physician listed below, has made application for licensure in the State of Florida. Please forward verification of licensure directly to the Florida Board of Medicine.

This form may be duplicated.
Physician: Complete number 1 through 8 and mail to applicable state board.

2. Date: _____

3. Name:_____
First Middle Last

4. Address: _____
City State Zip

5. Place of Birth: _____
City State Country

6. Date of Birth: _____
Month Day Year

7. Medical Education: _____
City State Country

8. Year of Graduation: _____
Month Day Year

State Board, please return your completed form to:

The Department of Health
Medical Quality Assurance/Board of Medicine
HMQAM
4052 Bald Cypress Way BIN #CO3
Tallahassee, Florida 32399-3253
Fax (850)412-1268 (850)245-4131

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, BIN #C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 488-0596-Fax

Staff Privilege Verification Form

The physician listed below submitted an application for Florida licensure and is under investigation by this authority. Please complete number 1 through 4 of this form, and return directly to the Board of Medicine. Thank you.

To: Medical Staff Office
Attn: Chief of Staff

_____
Facility

_____
Address

_____
City, State, Zip

From: Florida Board of Medicine -- Medical Endorsement/Examination Section

Name:_____

1. Does (s)he have full staff privileges in his/her specialty? Yes☐ No☐

   If no, explain _____

2. Does (s)he perform competently? Yes☐ No☐

   If no, explain_____

3. Has (s)he been regularly reappointed? Yes☐ No☐

   If no, explain_____

4. Have any restrictions ever been placed on this individual beyond the original period of probation? Yes☐ No☐

   If yes, explain_____

Remarks:_____

Date:_____

Signature of
Chief of Staff: _____
No **stamped** signatures please

Practitioner's Name _____

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

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. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

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 health care 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: $_____

The 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 providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

Application Checklist

Please ensure that you have submitted the following supporting documentation:

- ☐ Your completed fingerprint card
- ☐ Applicable fees
- ☐ Copy of your military discharge document, (if applicable)
- ☐ Copy of your undergraduate transcripts
- ☐ *Copy of your medical school transcripts
- ☐ *Copy of your medical school diploma
- ☐ *Copy of your valid ECFMG certificate, (if applicable)
- ☐ Copy of your post graduate training certificate(s) or letter(s) from your program director
- ☐ Copy of your National Practitioners Data Bank and Healthcare Integrity and Protection Data Bank reports
- ☐ Statements for all yes answers and supporting documentation, (if applicable)

Please be sure you have requested the following be sent directly to the Florida Board of Medicine:

- ☐ ***Medical Degree Verification Form
- ☐ *Examination Score report
- ☐ *ECFMG Verification, (if applicable)
- ☐ State License Verification(s)
- ☐ *Training Evaluation Form(s)
- ☐ Staff Privilege Verification Form(s)
- ☐ Two current letters or recommendation (Each letter must be addressed to the Florida Board of Medicine and must be from a colleague who has factual knowledge of your personal and professional qualifications. Letters from relatives are not acceptable)
- ☐ AMA Profile

*** If you are using FCVS do not submit the items identified with an *, as FCVS will submit these items for you.**