DEPARTMENT OF HEALTH

BOARD OF MEDICINE

APPLICATION MATERIALS FOR INITIAL REGISTRATION & RENEWAL OF INTERN/RESIDENT/FELLOW & HOUSE PHYSICIAN

PURSUANT TO
458.345, F.S.

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******NOTICE TO ALL APPLICANTS******

When returning your application to the Department, mail only the application form and any supplemental documentation forms as required.

SECTION I:

APPLICATION INSTRUCTIONS

- **Read all instructions thoroughly before completing the application.**

- **Keep these instructions for your records.**

No person under this section may be employed or utilized as
- a house physician
- an intern
- a resident physician
- an assistant resident physician, or
- fellow in fellowship training in a teaching hospital in this state as defined by s. 408.07(45) or s. 395.805(2), F.S. for more than 2 years without a valid, active license or renewal of registration under this section.

Registration shall automatically expire after 2 years without further action by the board or the department unless an application for renewal is approved by the Board of Medicine. It is your responsibility to apply for renewal. You will not be sent a notice. If you do not apply for renewal the registration will become null and void at the time of expiration. If you discontinue practice at your registered location, it is your responsibility to notify the Board of Medicine. Upon termination of your employment the registration becomes null and void.

- Application forms and documents returned to the Board office, will be clocked in and processed in the order in which they are received.
- All registration applications and applicable fees must be submitted to the Board office at least 60 days prior to the date in which the physician is scheduled to begin training/employment.
- The physician is ultimately responsible for ensuring they obtain a registration number prior to commencing training.
- When the registration number is issued, a letter of notification will be mailed to the physicians mailing address listed on the application.

PITFALLS: The following items may cause serious delays in the registration process; therefore we strongly recommend the following:

1. That the applicant takes personal responsibility for preparing the application; read the applicable laws and rules, and follows all instructions.

2. Refrain from beginning employment as a resident physician, assistant resident physician, intern, fellow, or house physician, until you have been issued a registration number.

3. Questions (9 and 11-25) answered with a "yes"; require that the applicant provide the Board office with the requisite documentation and also may require an appearance before the Credentials Committee of the Board of Medicine for consideration of registration.

4. All registrations must be accompanied by the appropriate fee:
   - $200.00 – Initial registration for resident physician, assistant resident physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s.408.07(44) or s.395.805(2).
   - $300.00 – Initial registration for House physician.
   - $200.00 – House physician renewal registration fee.
   - No fee is required for renewal of resident physician, assistant resident physician, intern or fellow.

Send the **original application and fee**, payable to the Board of Medicine to the following address:

Department of Health HMQAM
P.O. Box 6330
Tallahassee, FL 32399-6330

All other **additional documentation sent either by the applicant or any other source**, should be mailed to:

Department of Health
MQA/BOM
4052 Bald Cypress Way,
Bin #C03 Tallahassee, FL 32399-3253

The validation (deposit) process may take 7 to 10 working days before the application is received in the Board office. If the appropriate fee(s) is not received with the registration application, the fee will be returned to the originating entity and the registration request will not be processed until the appropriate fee is received.

PLEASE NOTE: All sections of the application must be complete and accurate. The last page of the application must be signed and dated by the applicant.

MEDICAL DEGREE Registrants are required to furnish a copy of their original medical school diploma, and a translation if in a language other than English. Translations must meet the following Board of Medicine's criteria:

- The translations must be verbatim, meaning all information appearing on the document must appear on the translation.
- Pre-printed information, e.g. the Letterhead of the University, Title, Etc.
- Stamps, Seals, half Seals, if legible, if not, they must be indicated as seals, not legible.
- All signatures, if legible, if not, indicate not legible.
- All Text on the document.
- Translations prepared in foreign countries often have certifications located on the translation. If these certifications appear, they must be translated.

"YES/NO" QUESTIONS: If questions 9 and 11-25 are answered "Yes", you must provide a statement explaining the basis for such answer in the space provided. If the application fails to provide sufficient space for the requested information, use an additional page. Always number the additional information to be provided with the corresponding number in the application.

Documentation to be provided, but not limited to:

- If ever held any professional/medical license in any State in the U.S., Guam, Puerto Rico, U.S. Virgin Islands or Canada, provide licensure verification directly from the applicable Medical Board.
- 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). Submit copies of any litigation or any other proceedings in any court of law or equity, any criminal court, any arbitration Board or before any governmental Board or Agency, to which you have been a party, either as a plaintiff, defendant, co-defendant, or otherwise.
- Conviction(s): misdemeanor and/or felony; submit copies of charges, indictment and judgment.

Upon receipt of the explanation(s) provided and supporting documentation, you will be notified of any evaluation and/or any additional documentation needed.

SECTION II:

APPLICATION FORM

- Please make sure the application is completely filled out. **OMISSIONS WILL CAUSE A DELAY IN THE APPLICATION PROCESS.**

- **Social Security number:**
  Provide. 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, Sections 653 and 654; and Sections 456.004(9), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by Title IV-D child support agency 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 pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

- **Medical School:**
  Provide the name of school, address, city, state, country and the month/day/year of graduation. Submit a copy of your medical school diploma. (Diplomas in a language other than English must be translated).

  If the medical school diploma has not been issued, please submit an original letter addressed to the Florida Board of Medicine from your medical school listing your date of graduation.

- **Postgraduate Training/Employment/Non-Employment:**
  Must be listed on registration application. List in chronological order from the date of graduation from medical school to the present all employment and non-employment activities. All activities of 30 days or longer must be accounted for.

- **"Yes/No" Questions:**
  Should any questions numbered 9 and 11-25, be answered "yes", you must provide a statement on a separate sheet of paper explaining the basis for such answer and include supporting documentation. Number any additional information provided with the corresponding number in the application.

  REGISTRATIONS ARE VALID FOR TWO YEARS OR UNTIL RENEWED OR FULL LICENSE IS ACQUIRED.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine Application

Name: _____
First **Middle** **Last**

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.

4052 Bald Cypress Way, Bin # C03 Tallahassee,
Florida 32399-3257
Phone: (850) 245-4355
Website: www.flboardofmedicine.gov

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.flhealthsource.gov/background-screening/ (Select Locate a Provider)
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- The ORI number for the **Board of Medicine is EDOH2014Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, including your Social Security number (SSN);
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ Social Security Number: _____

Aliases: _____ Date of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Place of Birth: _____

Race: _____ Sex: _____

(**W**-White/Latino(a); **B**-Black; **A**-Asian; **NA**-Native American; **U**-Unknown) (**M**=Male; **F**=Female)

Weight: _____ Height: _____

Eye Color:_____ Hair Color: _____

Address:_____Apt. Number: _____

City:_____State:_____Zip Code: _____

Transaction Control Number (TCN#):_____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people **may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.**

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI (may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

REGISTRATION APPLICATION FOR INTERN/RESIDENT/FELLOW OR HOUSE PHYSICIAN

(Client 1510)

Registration Method (Check only one)

[ ] I am applying for registration to participate in a training program (Intern/Resident/Fellowship) $200.00 FEE
[ ] I am applying for registration renewal. TRN#_____Expiration Date_____NO FEE
[ ] I am applying for House Physician Registration. $300.00 FEE
[ ] I am applying for House Physician Renewal HSE#_____Expiration Date_____$200.00 FEE

Registration fees are non-refundable

APPLICATION SHOULD BE TYPED

1. Employment Date:_____University/Hospital: _____
   Program Specialty:_____Director of Medical Education: _____
   Program Address:_____Clinical Sites: _____
   Name/Telephone# of Administrator:_____

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

3. Mailing Address:_____
   (No & Street) (City) (State) (Zip)

4. Date of Birth_____
   (Month/Day/Year)

5. Telephone Number:_____ _____
   (Residence-area code/number) (Office-area code/number)
   Email: (optional)_____

6. Medical Degree was obtained from:_____
   (Medical School) (City, State & Country) (Month/Day/Year)

7. List in chronological order **from date of graduation from medical school to the present** all postgraduate training/employment/non-employment. If additional space is needed please attach to application: _____

   _____

   _____

8. Are you or have you ever held a medical license in any state in the United States, Guam, Puerto Rico, U.S. Virgin Islands or Canada? Yes_____No____

   _____
   (If yes, list profession(s), state(s), license number(s) and date(s) of issuance)

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 9 and 11-25 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

9. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S.(relating to fraudulent practices), Chapter 893, F.S.(relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes____No____
(If you responded "no", skip to #10.)

9a. If "yes" to 9, 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____

9b. If "yes" to 9, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes) Yes____No____

9c. If "yes" to 9, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Yes____No____

9d. If "yes" to 9, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed? (If "yes", please provide supporting documentation). Yes____No____

10. I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. Yes___No ____

11. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes____No____

11a. If "yes" to 11, 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____

12. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 12a.) Yes___ No____

12a. 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____

13. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 13a or 13b) Yes____No ____

13a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes____No____

13b. Did the termination occur at least 20 years before the date of this application? Yes____No____

14. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes___No____

14a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes____No____

14b. If you responded "Yes" to the question 14.a., is the student loan defaulted or delinquency the only reason you are listed on the LEIE? Yes____No____

15. Have you ever had any application for professional license, registration or any application to practice medicine/surgery denied by any state, territory or country? Yes____ No___

16. Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country? Yes____No____

17. 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___

18. 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___

19. 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___

20. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? Yes___No___

21. 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____

22. 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____

23. Have you ever been convicted of, or entered a plea of guilty, nolo contender or no contest to, a 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____

24. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s. 458.331(2)(b), F.S.? Yes____ No____

25. Have you ever had employment terminated for cause? Yes____ No____

26. 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

27. STATEMENT OF APPLICANT:

I,_____, state that I am the person referred to in the foregoing registration application and supporting documentation.

I hereby authorized all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all government agencies and instrumentality's (local, state, federal or foreign) to release to the Florida Board of Medicine any information which is material to my registration application pursuant to 458.345, F.S.

I have carefully read the questions in the foregoing registration application and have answered them completely, without reservations of any kind, and I state that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this registration application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my registration as a physician in the State of Florida.

I understand my records are protected under the 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 the 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.

_____

(Signature of Applicant) *(Date)*