

**State of Florida
Department of Health**

Board of Osteopathic Medicine

**Application for
Limited License**



Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 488-0595
February 2010 Edition

SECTION I: **APPLICATION INSTRUCTIONS**

Please read the following **IN ITS ENTIRETY** before attempting to complete the application, as this information is provided to assist you in expediting the application process.

The Board of Osteopathic Medicine may be required to review your application at one of its quarterly meetings before a license can be issued. The Board's meeting schedule and agenda deadlines can be found on their website at: <http://www.doh.state.fl.us/mqa/index.html>. Please be advised that dates and locations are subject to change.

It is recommended that you submit your application several months in advance of the meeting for which you wish to appear, as many of the documents necessary to complete your file can take several weeks to be received by the Board office and incorporated into your file.

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.

FEE SCHEDULE

All fees must be made payable to the Department of Health and must be by cashiers check or money order. All fees must be encompassed in one check. Please do not send separate checks. The fees required for initial licensure are listed below. Please be advised that the fees listed below are subject to change.

Application processing fee (if compensated): (Application fee is waived if not compensated)	\$100.00 (NON-REFUNDABLE)
Fingerprint card processing fee:	\$48.00 (NON-REFUNDABLE)

Where to send the APPLICATION: The original application and any documentation sent with it (in the same envelope) should be mailed to:

Department of Health
Board of Osteopathic Medicine
PO Box 6330
Tallahassee, FL 32314-6330

The initial process of receiving the application and logging in your check usually takes about 5 to 7 days. Once your application is logged in it is then forwarded to the Board Office.

Where to send all SUPPORTING DOCUMENTATION: Any additional documents submitted (including all supplemental forms) that are mailed separately from the application should be mailed to:

Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

List your name on all correspondence. When you receive any correspondence from the Board Office, please make sure that all information regarding your name and address is correct. If you find that it is not, please notify the Board Office in writing of any changes that need to be made.

APPEARANCES: Appearances before the Board may be required for a variety of reasons, such as length of time since practice, malpractice, unfavorable evaluations, criminal history or disciplinary action against you in another state. You will be notified via mail of the date, time and location if your appearance before the Board is necessary. The Chairman of the Board, not Board Office staff, determines the necessity of an appearance.

ELIGIBILITY REQUIREMENTS: If you are unsure as to your eligibility for limited licensure in Florida, please refer to sections 459.0055 and 459.0075, Florida Statutes.

FINGERPRINT CARD/BACKGROUND CHECK: A properly executed fingerprint card must be submitted with your application. The fingerprint card will be used by the Florida Department of Law Enforcement and Federal Bureau of Investigation to conduct a background check as required by law. See the instructions below for the proper procedures for completing/ executing the fingerprint card. Failure to accurately follow these instructions may result in additional costs, which must be borne by you, the applicant, and will result in a significant processing delay. The procedure for proper submission of a fingerprint card is below.

- Log on to **www.fldoh.sofn.net**.
- To Register:
ENTER personal demographic data required to submit fingerprints.
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.
- **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.

REQUIRED SUPPORTING DOCUMENTATION

The following is a list of supporting documentation that is REQUIRED in order to complete your application for limited licensure in Florida. Many of these documents take several weeks to arrive in the Board Office, so please do not panic should we inform you initially that they have not arrived.

A LETTER OF INTENT TO EMPLOY: This letter must be from the agency/institution that intends to employ you and must be addressed to the Board of Osteopathic Medicine. It must also indicate whether or not you will receive compensation for the medical services provided. If the applicant submits a notarized statement from the employing agency or institution stating that he or she will not receive monetary compensation for any service involving the practice of osteopathic medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of osteopathic medicine. (See section 459.0075(1)(a), F.S.)

POSTGRADUATE TRAINING CERTIFICATES (internship, residency & fellowship): Please provide a copy of ALL postgraduate training certificates.

AOA PROFILE: Contact the American Osteopathic Association – (800) 621-1773 or Profile Services, 142 East Ontario Street, Chicago, IL 60611.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) DATA CHECK: Please visit the FSMB website at http://www.fsmb.org/fpdc_data_inquiry.html to obtain the Board Action Data Search Form.

NATIONAL PRACTITIONERS DATA BANK INQUIRY: This is a “self query”. Please contact the National Practitioners Data Bank (NPDB) at (800) 767-6732. They will send a “Request for Information Disclosure” form to you. You must then send that from back to the NPDB. They will in return, send you a “Response”. **You must then send the “Response” to the Board Office.**

MEDICAL SCHOOL TRANSCRIPT: Have your medical school forward your OFFICIAL transcript directly to the Board office.

TWO (2) RECOMMENDATION LETTERS: These must be from physicians (DO's or MD's) who have knowledge of your ability to practice osteopathic medicine. These must be addressed to the Board of Osteopathic Medicine.

VERIFICATION OF OTHER STATE LICENSES: You must request that verification of any state license that you now hold or have ever held be mailed directly from the other state licensing entity to the Board Office. A copy of your license is not considered verification. Some states are using www.Veridoc.org for verification. Please check to see if the state you are licensed in utilizes Veridoc.

PROOF OF CONTINUING EDUCATION: You must provide copies of certificates verifying that you completed the following continuing education within the preceding two year period:
40 TOTAL hours, 20 hours of which must be AOA category I approved and of the 40 hours, two (2) hours must be in the prevention of medical errors and one (1) hour must be in each of the following subjects: risk management, use and abuses of control substances and Florida Laws and Rules.

FINANCIAL RESPONSIBILITY FORM: (Attached)

COMPLETED FINGERPRINT CARD: Go to www.fldoh.sofn.net

DOCUMENTATION CONFIRMING RETIREMENT: (If applicable)

MILITARY DISCHARGE FORM OR PROOF OF CURRENT ENLISTMENT: (If applicable) A copy of your DD214

NAME CHANGE DOCUMENTATION: (If applicable) A copy of your marriage certificate, divorce decree or other court documentation)

COMPLETING THE APPLICATION

The following instructions are numbered so that they correspond with the numbered sections of the application. Each instruction will give specific information regarding the corresponding section of the application. We request that you keep the instructions and a copy of the completed application, as you may need to refer to them during the processing of your application. A response must be given in each section. If a question does not pertain to you, indicate "N/A" in that section. All questions with "YES/NO" answers must have either "YES" or "NO" marked. No other response is acceptable.

ADDITIONAL SPACE NOTE: If any of the sections in the application do not contain sufficient space for the requested information, use an additional page. Always number the additional information with the corresponding number of the question in the application.

1. Check your method of application. Processing WILL BE DELAYED if you fail to list your method of application. You must also sign the statement regarding licensure in another jurisdiction if applicable. (See 459.0075, F.S.)
2. Pursuant to section 456.38 and 381.0303, Florida Statutes, we are required to ask all applicants if they would be willing to assist in the event of a disaster. Please answer yes or no.
3. List your FULL name.
 - a) Name changes: If you have ever had your name changed due to marriage, divorce or any other court action, this constitutes a name change and you must submit legal documentation of the change.
4. Mailing address: This is the address where you receive mail.
5. Facility Information: This should be the name, address, director's name, etc. where you plan to practice. No PO boxes.
6. Telephone numbers: Please list both your home and work numbers.
7. List your fax number.
8. List your e-mail address. Staff may utilize e-mail to contact you about your application.
 - a. Please answer yes or no. If you want to receive notices regarding your application deficiencies by e-mail only, please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through e-mail only. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board. Note- Additional notices regarding any required Board appearances or licensure decisions will be provided through the regular USPS mail system.
9. Response to this section is voluntary and self-explanatory.
10. Citizenship – Answer Yes or no. Provide additional information, if applicable.
11. You must answer yes or no and provide documentation (listed on page 4) if applicable.
 - a) You must answer Yes or No. If yes, please attach a letter of explanation as well as all documentation pertaining to the charge.
12. **OTHER STATE LICENSES:** You must answer yes or no. If yes, please list any license you hold or have EVER held (regardless of current status). Be sure to include the state, territory or foreign country, dates, type, license number and current status. You must request that every state, territory or foreign country where you have ever held a license send the Board an OFFICIAL LICENSE VERIFICATION. Some states may require a fee for this service.
13. List where and when you legally began to practice.
14. **EXAM:** Please indicate if you have passed all 3 parts of the NBOME. If you have taken any other licensure exams, please list those as well.

15. List the college where you obtained your Doctor of Osteopathy degree, as well as the address and the date your degree was awarded. Request that your osteopathic school send an OFFICIAL TRANSCRIPT to the Board Office.
16. List ALL undergraduate and graduate schools, colleges and universities you attended (even if a degree was not awarded), in chronological order. Attach additional sheets if necessary.
17. **TRAINING** - Please list your entire postgraduate training sequence (internship, residency and fellowship). You must indicate whether that program was approved by the **AOA** or the **AMA**. Please list ALL programs, regardless of completion.
18. Answer yes or no. If yes, please provide a letter of explanation in your own words regarding the incident. You must also direct the school to send a letter of explanation.
19. Answer yes or no. If yes, please provide an explanation in your own words.
20. Answer yes or no. If yes, please provide an explanation in your own words.
21. **PRACTICE EMPLOYMENT** – List in chronological order from the date of graduation to the present, all practice employment, non-employment and/or unaccounted period of time. Attach additional sheets if necessary.
22. Answer yes or no.
23. Answer yes or no. If yes, list. Attach additional sheets if necessary.
24. **STAFF PRIVILEGES** – You must answer yes or no. If yes, list your privileges in the space provided.
25. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.
26. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.
27. Answer yes or no. If yes, list the action in the space provided on the application AS WELL AS attach additional sheets, if necessary, to describe the action. Please direct the hospital to send a letter of explanation regarding the incident.
28. **BOARD CERTIFICATION:** Answer yes or no. If yes, list in the space provided.
29. Answer yes or no. If yes, explain on a separate sheet.
30. Answer yes or no. If yes, list in the space provided and direct the organization to submit a letter of explanation.
31. If none, list “N/A” in the space provided.
32. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.
33. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.
34. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.
35. **** MEDICAL MALPRACTICE JUDGMENTS OCCURRING AFTER NOVEMBER 2, 2004:** Answer yes or no. If yes, you must provide the following documentation for **each** case:
- A detailed explanation in your own words listing your involvement in the case.
 - The entire case record must be submitted in **electronic format** (either PDF or TIFF), preferably on a CD mailed to our office. The record must include:
 - Initial and/or amended complaint
 - Trial transcripts
 - Evidentiary exhibits
 - Final judgment

- 36. MALPRACTICE / LIABILITY CLAIMS:** Answer yes or no. If yes, provide the following:
- A statement indicating how many malpractice case(s) you have been named in.
 - A detailed explanation, in your own words, listing your involvement in each case.
 - A copy of the complaint for each case.
 - A copy of the disposition for each case.
 - Complete the Exhibit 1 form located under Section II, Supplemental Forms.
- 37.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Additional documentation MAY be required.
- 38.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.
- 39.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Also direct the licensing agency to submit (directly to the Board office) copies of all pertinent information, including final orders, complaints, current disposition, etc.
- 40.** Answer yes or no. Provide an explanation on a separate sheet.
- 41.** Answer yes or no. Provide an explanation on a separate sheet.
- 42.** Answer yes or no. If yes, please provide an explanation regarding the charges on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges and current disposition.
- 43.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Additional documentation MAY be required.
- 44.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Additional documentation MAY be required.
- 45.** Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. You must also direct the DEA to submit (directly to the Board office) all pertinent documentation.
- 46.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your recovery program/impaired practitioners program to submit a report, to include your initial condition and current prognosis.
- 47.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report, to include your initial condition and current prognosis.
- 48.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report, to include your initial condition and current prognosis.
- 49.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report, to include your initial condition and current prognosis.
- 50.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.
- 51.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.
- 52.** Answer yes or no. If yes, provide an explanation on a separate sheet. You must also submit all pertinent documentation directly to the Board office.
- 53.** Answer yes or no. If yes, please provide an explanation on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges, restoration of civil rights (if applicable) and current disposition.

54. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.
55. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.
56. **OPTIONAL INFORMATION:** Self explanatory.
57. **STATEMENT OF APPLICANT:** Please read this section CAREFULLY then sign and date the application. If you fail to sign and/or date your application, it will be returned to you as incomplete.
- a. ATTACH a 2 x 2 inch head and shoulder photograph at the bottom of the last page, where indicated.

PLEASE KEEP A COPY OF THE APPLICATION AND ALL SUPPORTING DOCUMENTS SENT TO THIS OFFICE AS YOU MAY BE REQUIRED TO REFERENCE YOUR APPLICATION IN THE FUTURE. ALSO KEEP ON FILE ANY FORMS NOT SUBMITTED TO THE BOARD OFFICE, AS APPLICATIONS ARE FREQUENTLY INCOMPLETE DUE TO REQUIRED FORMS BEING OVERLOOKED IN THE INITIAL APPLICATION PROCESS.

APPLICATION FOR LIMITED LICENSE

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256**

1. APPLICATION CATEGORY: CLIENT 1903

- I am NOT fully retired in all jurisdictions and will use this for NON-COMPENSATED practice.
- I am fully retired in all jurisdictions and will use this for compensated practice.
- I am fully retired in all jurisdictions and will use this for NON-COMPENSATED practice.

Under penalties of perjury, I declare that I have been licensed to practice osteopathic medicine in any jurisdiction in the United States for at least 10 years and intend to practice only pursuant to the restrictions of a limited license granted pursuant to Section 459.0075, Florida Statutes. A person who knowingly makes a false declaration under Section 92.525(2), F.S. is guilty of the crime of perjury by false written declaration, a felony of the third degree, punishable as provided in s.775.082, s.755.083, or s. 775.084.

Signature _____ Date _____

2. Would you be able to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? YES NO

3. NAME: _____
(last) (first) (middle)

- a. Have you ever changed your name through marriage or through action of a court? YES NO

If "yes", list: Name(s) and date(s) of change(s) above _____

4. MAILING ADDRESS (where you receive mail): _____
(Street and number or PO Box)

(City, State/Province, Zip/Postal Code, Country)

5. APPROVED FACILITY NAME/ ADDRESS: _____
(Facility Name)

(Street and number) **NO PO BOX**

(City, State/Province, Zip/Postal Code, Country)

Facility Director's Name

Anticipated Start Date / Facility Phone Number

6. TELEPHONE: (_____) (_____)
Home Work

7. FAX NUMBER: _____ 8. E-MAIL ADDRESS: _____

8a. **E-Mail Notification:** If you want to receive notices regarding your application deficiencies by **e-mail only**, please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through **e-mail only**. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board. YES NO

9. PERSONAL DATA:

HEIGHT: _____ WEIGHT: _____ EYES: _____ HAIR: _____

BIRTH DATE: _____ BIRTH PLACE: _____
(Month/Day/Year) (City) (State/Province) (Country)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian [] Black [] Hispanic [] Asian [] Native American [] Other []
SEX: Male [] Female []

10. CITIZENSHIP:

Are you a citizen of the United States? [] YES [] NO

If you were not born in the U.S. but are a Naturalized citizen, please provide date and place of Naturalization:

(Month/Day/Year) & (City/State/Province/Country)

If you are not a U.S. citizen, please provide alien number: _____

11. Have you ever been in the United States Military or Public Health Service? [] YES [] NO

If "yes", list branch of service, rank and dates of service.

a. Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States? [] YES [] NO
If "yes" see instructions for required documentation.

12. OTHER STATE LICENSES:

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

<u>STATE</u>	<u>LICENSE NUMBER</u>	<u>ISSUE DATE</u>	<u>CURRENT STATUS</u>	<u>METHOD</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. List the year and state/province/country where you legally began to practice: _____

14. Have you passed all three parts of the National Board of Osteopathic Medical Examination? [] YES [] NO

If "no", list the dates and exams you HAVE taken: _____

15. POSTGRADUATE EDUCATION: Doctor of Osteopathic Medicine Degree was obtained from:

(Name of School/College) (Dates of Attendance) (Degree Title)

16. UNDERGRADUATE/GRADUATE EDUCATION:

Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order:

(College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

(College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

(College Name/Address) (Major/Minor Course of Study) (Dates of Attendance) (Degree)

17. POSTGRADUATE TRAINING: List in chronological order from date of graduation from Osteopathic School all professional/postgraduate training (Internship/Residency/Fellowship).

Name of Training Program	Full Mailing Address	Specialty Area	AOA/AMA Approved	Dates of Attendance		Credit Received
				Began	Ended	

18. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign from, or otherwise acted against by any school, college, university, internship, residency or other training program? [] YES [] NO
 (If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

19. Was your attendance in Osteopathic Medical school or any postgraduate training program for a period of time other than the normal curriculum or established timeframe? [] YES [] NO
 (If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

20. Were you required to repeat any part of your Osteopathic Medical education, internship, residency or other training program? [] YES [] NO
 (If "yes" explain on a separate sheet, providing accurate details. See instructions for required documentation)

21. PRACTICE / EMPLOYMENT: List in chronological order from date of graduation to present, all practice employment, non-employment and/or any unaccounted for period of time. (Attach additional sheets if necessary.)

 (Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

 (Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

 (Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

 (Name and mailing address of employment) (Type of Employment) From: MM/YY To: MM/YY

22. Have you had responsibility for graduate medical education within the last 10 years? [] YES [] NO

23. Do you currently hold a faculty appointment at an Osteopathic/health related institution of higher learning? [] YES [] NO
 (If "yes", list below.)

 (Name and mailing address of institution) (Title of Appointment)

 (Name and mailing address of institution) (Title of Appointment)

24. STAFF PRIVILEGES: Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If "yes" list below.) DO NOT LIST TRAINING PRIVILEGES. YES NO
 Attach additional sheets if necessary.

Name of Institution	Full Mailing Address	Type of Privileges	Chief of Staff	Dates of Service

25. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign, or take a temporary leave of absence or otherwise acted against by any facility? (If "yes", list below and see instructions for required documentation.) YES NO

 (Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

 (Name of Institution) (Date: MM/DD/YY) (Violation) (Final Action) (Under Appeal? Y/N)

26. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? (If "yes", list below and see instructions for required documentation.) YES NO

 (Name/Address of Facility) (Date: MM/DD/YY) (Circumstances) (Final Action)

27. Have you ever been asked, or allowed to resign, from any facility in lieu of disciplinary action or during any pending investigations into your practice? (If "yes", list below and see instructions for required documentation.) YES NO

 (Name/Address of Facility) (Date: MM/DD/YY) (Violation/Investigation) (Reason for Resignation)

28. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Osteopathic Association or other similar national organization? (If "yes", list below and enclose a copy of each certification or letter of verification.) YES NO

 (Board Name) (Certification/Specialty/Subspecialty) (Date of Certification)

 (Board Name) (Certification/Specialty/Subspecialty) (Date of Certification)

 (Board Name) (Certification/Specialty/Subspecialty) (Date of Certification)

29. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? YES NO
(If "yes", explain on a separate sheet, providing accurate details.)

30. Have you ever had any sanctions taken against you by a specialty board recognized by the AOA or other similar national organization? YES NO
(If "yes", list below and see instructions for required documentation.)

(Name of Specialty Board) (Date: MM/DD/YY) (Circumstances) (Final Action) (Under Appeal?)

31. List all Osteopathic/Professional Society or Association Memberships:

(Name / Address) (Dates of Affiliation: From/To)

(Name / Address) (Dates of Affiliation: From/To)

(Name / Address) (Dates of Affiliation: From/To)

(Name / Address) (Dates of Affiliation: From/To)

32. Have you ever had an application for membership denied by an Osteopathic/Professional Society or Organization? YES NO

33. Have you ever had an Osteopathic/Professional Society or Association membership suspended? YES NO

34. Have you ever been notified to appear before an Osteopathic/Professional Society or Association in regard to charges/complaints filed against you? YES NO

(If "yes" to 33, 34 or 35, list below.)

(Name of Society/Association) (Address) (Date of Action: MM/DD/YY)

LIABILITY / MALPRACTICE CLAIMS:

35. Have you had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after **November 2, 2004**? YES NO
(If yes, complete Exhibit 1 sheet located in Section II, Supplemental Forms and see instructions for additional information required.)

36. Within the previous 10 years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000? YES NO
(If yes, complete Exhibit 1 sheet located in Section II, Supplemental Forms and see instructions for additional information required.)

37. Have any actions in bankruptcy court or any civil judgments ever been entered against you arising from your professional activity? YES NO
(If "yes", list below and see instructions for required documentation)

(Date of Occurrence) (Location) (Claimant) (Amount) (Date of Final Disposition)

(Date of Occurrence) (Location) (Claimant) (Amount) (Date of Final Disposition)

**ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET.
DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.**

- 38.** Have you had any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or the licensing authority of any state territory or country? [] YES [] NO
- 39.** Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Osteopathic Medicine practice act, unprofessional or unethical conduct? [] YES [] NO
- 40.** Have you ever had any professional license or license to practice Osteopathic Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [] YES [] NO
- 41.** Have you ever had employment terminated for cause? [] YES [] NO
- 42.** Have you ever been convicted of, or entered a plea of guilty, nolo contendere, 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 s not considered a minor traffic offense for purposes of this question. [] YES [] NO
- 43.** Have you ever received a letter of admonition or notice of administrative hearing from the Drug Enforcement Agency (DEA)? [] YES [] NO
- 44.** Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [] YES [] NO
- 45.** Have you ever been denied, or surrendered a DEA Registration? [] YES [] NO
- 46.** In the last 5 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
- 47. a)** 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
- b)** 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 as an osteopathic physician within the last five years. [] YES [] NO
- 48.** During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice as an osteopathic physician? [] YES [] NO
- 49. a)** 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

b) 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 as an osteopathic physician within the last five years?

[] YES [] NO

50. Have you ever been terminated for cause from participating in the Florida Medicaid Program?

[] YES [] NO

51. Have you ever been sanctioned by any state Medicaid program?

[] YES [] NO

52. Have you ever defaulted on any health education loan or scholarship obligation?

[] YES [] NO

Pursuant to Section 456.0635(2), Florida Statutes, the following questions (53 – 55) are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of all supporting documentation. Please see instructions for required documentation

53a. 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 53b.)

[] YES [] NO

b. 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

54a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?
(If no, do not answer 54b.)

[] YES [] NO

b. 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

55a. 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 55b and 55c.)

[] YES [] NO

b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?

[] YES [] NO

c. Did the termination occur at least 20 years prior to the date of this application?

[] YES [] NO

56. OPTIONAL INFORMATION:

- a. **PUBLICATIONS:** List any publications you have authored in peer-reviewed medical literature within the previous 10 years.

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

- b. **Do you participate in the Medicaid program?** YES NO
If "yes", list:

(Type of Provider)

(Type of Provider)

- c. **PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS OR AWARDS:**

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

- d. **LANGUAGES OTHER THAN ENGLISH:** Please indicate any languages used by you to communicate with patients and any translation service available for at your primary place of practice.

- e. **COMMITTEES/MEMBERSHIPS:** Please indicate any committees on which you serve for any health entity with which you are affiliated.

(Name of Organization)

(Name of Organization)

57. STATEMENT OF APPLICANT:

These statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

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 Osteopathic Medicine any 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, and I declare 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 shall constitute cause for denial, suspension or revocation of my license to practice Osteopathic Medicine in the State of Florida.

I understand that 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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of date, event or condition upon which this consent expires.)

(Signature of Applicant)

(Date)

a.
Attach
2 x 2 inch
photograph
here

FINANCIAL RESPONSIBILITY FILING FORM

COMPLETE THE FORM BASED ON WHAT YOUR STATUS **WILL BE** UPON BEGINNING PRACTICE IN FLORIDA. IF THIS INFORMATION IS UNAVAILABLE, SEE SECTION 6D OF THIS FORM. PLEASE RETAIN A BLANK COPY OF THIS FORM SO THAT YOU MAY UPDATE YOUR STATUS IF NECESSARY AFTER YOU ARE APPROVED BY THE BOARD.

Check only one option.

1. 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.
2. I have hospital staff privileges and I have obtained and maintain 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.
3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than \$100,000 per claim with a minimum aggregate availability of credit of not less than \$300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.
4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than \$250,000 per claim, with a minimum aggregate availability of credit of not less than \$750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.
5. I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

6. I am exempt from demonstrating financial responsibility because:

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

6B [] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.

6C [] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)

6D [] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.

6E [] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:

1) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.

2) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.

3) I have had no more than 2 claims resulting in an indemnity exceeding \$25,000 within the previous 5 year period.

4) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.

5) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of \$500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. **YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This notice is provided pursuant to Florida law.

APPLICANT STATEMENT:

Under penalties of perjury, I declare that I have read the foregoing response in question 6, and the facts stated in it are true. A person who knowingly makes a false declaration under subsection (2) is guilty of the crime of perjury by false written declaration, a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084." followed immediately by the signature line and date.

Signature

Printed Name

Date