

State of Florida Department of Health

Board of Osteopathic Medicine Application for Licensure



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

May 2010 Edition

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

- You must retain the application instructions for your records. Do not send them to the Board Office with your application. You may be referred back to the instructions during the application process.
- Make a copy of everything you send to the Board Office. You may need to refer to previously submitted documents during the 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.

Board Now Recognizes Federation's Credential Verification Service!

In an effort to assist applicants in the licensure process, the Board of Osteopathic Medicine voted to allow physicians applying for licensure in Florida to utilize the Federation Credentials Verification Service (FCVS) to obtain and report his or her "core" medical credentials.

The FCVS is a primary source verification service. Participation in the FCVS is not required for licensure, but recommended. For information on how to establish a permanent lifetime portfolio of primary source verified information, please call the FCVS at (888) 275-3287 or visit their web site at www.fsmb.org.

FCVS obtains primary source verification of medical education, postgraduate training, licensure examination history, board action history and identity. This repository of information allows an individual to establish a confidential, lifetime professional portfolio that can be forwarded at the individual's request to any interested party, including, but not limited to: state medical boards, hospitals, managed care plans and professional societies.

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.

APPEARANCES

Certain applicants may be required to appear before the Board to discuss his or her application before a determination of licensure can be made. An appearance may be required for a variety of reasons, such as:

- Malpractice
- Criminal Convictions
- Discipline
- Previous appearance before a licensing board or regulatory agency
- Non-Osteopathic Internship year (please see section entitled "Required AOA Approved Internship" for further information)
- Unfavorable training evaluations or staff privilege verifications
- Drug/alcohol addiction/impairment
- Discrepancies in application information/materials
- Participation in an impaired practitioner program
- Other reasons as deemed necessary by Board staff or the Board Chair

The scenarios listed above are not an automatic appearance before the Board. Appearances are determined on an individual basis. The Board Chair, not office staff, determines the necessity of an appearance. The Board Chair may also require an application be presented to the Board for review, but not require the appearance of the applicant. Should your appearance be required, you will be notified of the exact date, time and location of the meeting at which your appearance is necessary.

Please note- In the event that you believe you MAY be required to appear before the Board based on a scenario listed above, 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. You can view the Board's meeting dates and locations on its website at: www.doh.state.fl.us/mqa/osteopath/index.html.

The above recommendations along with the meeting dates and agenda deadlines are provided so that you may make licensure plans accordingly. Please refrain from making any commitments or accepting positions to practice osteopathic medicine in Florida prior to becoming licensed, as exceptions or special accommodations will not be made.

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.

Application processing fee:	\$200.00 (NON-REFUNDABLE)
Initial licensure fee:	*\$405.00 , if license is issued in the first year of the biennial period or *\$205.00 , if license is issued in the second year of the biennial period
Fingerprint card processing fee:	\$48.00 (NON-REFUNDABLE)
NICA assessment fee:	\$250.00 (some exemptions apply- see enclosed information)
Dispensing Practitioner fee:	\$100.00 , optional (this fee is to sell pharmaceuticals in the office)

* - All licenses expire March 31, every even numbered year. The above fees are contingent upon completion date of the application. Please note that it takes several months (on average) to complete the application process therefore, keep this in mind when calculating your fees.

Where to send the APPLICATION: The original application with fees attached 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 payment 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 without fees (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

Please be sure to list your name on all supporting documentation submitted to the Board office to ensure appropriate and timely processing.

ADDRESS CHANGES: 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.

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

REQUIRED AOA APPROVED INTERNSHIP: Florida Statutes require that you have completed an American Osteopathic Association (AOA) approved one-year internship. If you have **not** completed an internship approved by the AOA, you will fall into one of the 2 categories listed below and should plan accordingly:

1. **You have completed your ENTIRE residency program** - You are eligible to petition the Board for approval of your "good cause" for not completing an AOA approved internship year. A list of what the Board considers possible "good cause" reasons may be found in 64B15-16, F.A.C. You will need to include a written explanation with your application, documenting your good cause. You will be required to appear before the Board for a determination of licensure.
2. **You have not completed your entire residency program** - You must FIRST contact the AOA (**1-800-621-1773**) and request approval of your training. If the AOA approves your internship, including your "good cause explanation", then you have met the statutory requirement. However, if the AOA approves your educational equivalency but denies your "good cause" justification for not completing the AOA internship, then you must appear before the Board of Osteopathic Medicine (Board) to have your "good cause" justification considered for approval. You are not eligible to petition the Board for approval of your "good cause" reasons UNLESS the AOA has approved your educational equivalency.

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 EXAMINATION: Anyone applying for licensure must have passed all three parts of the examination conducted by the National Board of Osteopathic Medical Examiners (NBOME) or other substantially similar examination approved by the board.

If you have not taken and passed all three parts of the examination offered by the NBOME, you must demonstrate to the Board that the examination that you did take and pass is substantially similar to all three parts of the NBOME.

PLEASE NOTE THAT THE BOARD **DOES NOT CONSIDER THE FLEX EXAMINATION OR THE USMLE EXAMINATION** TO BE SUBSTANTIALLY SIMILAR TO THE NBOME EXAMINATION AS NEITHER OF THESE EXAMINATIONS HAS AN OSTEOPATHIC COMPONENT OR OSTEOPATHIC PHILOSOPHIES GENERALLY INCORPORATED INTO THE QUESTIONS.

If you were licensed in another state on the basis of that state's entire examination, you may request that the Board endorse those examination scores. It is the applicant's responsibility to demonstrate to the Board that the state licensing examination is substantially similar to all three parts of the NBOME examination.

You will need to request the state Board which administered the examination to send an official copy of your scores and a letter verifying that your license in that state was issued on the basis of the state examination. The more information you can provide regarding the examination, the better the chances the Board can determine the examination to be substantially similar to the NBOME examination. At the very least, the following information **MUST** be provided:

1. The number of questions the examination contained;
2. The subjects the examination tested;
3. Who or what entity created the examination;
4. Whether there was an osteopathic component and emphasis;
5. When was the examination administered and endorsed.

If you have not taken and passed all three parts of the NBOME, it may significantly affect your ability to obtain a Florida Osteopathic license. You should plan to appear before the Board when your application is considered in order to discuss the alternative examination and other options available if the Board deems it necessary to discuss your other state examination.

REQUIRED SUPPORTING DOCUMENTATION

The following is a list of supporting documentation that is REQUIRED in order to complete your application for 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.

***TRAINING EVALUATION (internship, residency & fellowship):** See Supplemental Forms
(Please fill out the top portion of the form and mail it to your training facility. The form needs to be returned to the Board Office DIRECTLY FROM THE FACILITY).

***STAFF PRIVILEGE VERIFICATION:** See Supplemental Forms
(Submitted to this office directly from the hospital)

***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 or <http://www.npdb-hipdb.com/npdb.html>. You must then send that notarized form to the NPDB. They will in return, send you a “Response to self query”. **You must then send the entire “Response to self query” to the Board Office.**

EXAMINATION SCORES: This must be an original transcript submitted directly from the NBOME or a certified copy of the scores directly from the state board (if applying by other state exam).

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 and need to state that they recommend you for licensure. These letters cannot be identical in content.

***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.

PREVENTION OF MEDICAL ERRORS CONTINUING MEDICAL EDUCATION: (See Supplemental Forms)
For initial licensure, a home study or online course is accepted.

***FINANCIAL RESPONSIBILITY FORM:** (See Supplemental Forms)

***NICA FORM:** (See Supplemental Forms)

***EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS:** (See Supplemental Forms)

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

BOARD CERTIFICATION: (If applicable) Submit a copy of your current board certification or a letter verifying board certification.

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

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

***NOTE - THE ABOVE DOCUMENTS MUST BE NO MORE THAN 6 MONTHS OLD IN ORDER TO BE ACCEPTED WITH YOUR APPLICATION. ANY DOCUMENTS RECEIVED MORE THAN 6 MONTHS PRIOR TO THE SUBMISSION OF YOUR APPLICATION WILL BE REJECTED.**

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. Do not leave any question blank.

1. Check your method of application. Processing WILL BE DELAYED if you fail to list your method of application.
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. **PRIMARY PRACTICE/PHYSICAL ADDRESS:** This should be the address where you are currently practicing. 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.
 - 8a. 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. **OTHER PRACTICE LOCATIONS:** Please list any other locations at which you may practice.
10. Please provide the information requested. Note - Response to this section regarding your race and sex is voluntary and self-explanatory.
11. **CITIZENSHIP:** – Answer Yes or no. Provide your date and place of birth. If you are naturalized, list your naturalization date.
12. 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.
13. **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 full or training license send the Board an OFFICIAL LICENSE VERIFICATION. Some states may require a fee for this service.
14. List where and when you legally began to practice.
15. **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.

16. 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.
17. 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.
18. **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. You must send a copy of the enclosed "Training Evaluation Form" to all training programs you have attended, regardless of completion; the form may be duplicated as needed. Please be aware that there are 3 separate forms: Internship, Residency and Fellowship. Make sure that you submit the correct form to your training program.

"Training Evaluation Form" Instructions - This form rates several areas of performance during training and is necessary to complete your file. If a training program no longer exists, you must locate a former official of the program to acquire the needed information. List the name of the Director of the program and the name of the institution in the spaces provided at the top of the form. List your name in the space provided immediately above the double line. Some programs require that you also submit a signed release for the information. If this is the case, it is YOUR responsibility to make sure that the program has permission to release your evaluation to the Board Office. **This form cannot be accepted without the hospital seal or notation that the hospital has no seal.** NOTE: Interns must submit a letter from their Program Director stating that they will be completing the program. Once your internship is completed, the Internship Training Evaluation Form MUST be completed.

19. 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.
20. Answer yes or no. If yes, please provide an explanation in your own words.
21. Answer yes or no. If yes, please provide an explanation in your own words.
22. **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.
23. Answer yes or no.
24. Answer yes or no. If yes, list. Attach additional sheets if necessary.
25. **STAFF PRIVILEGES:** – You must answer yes or no. If yes, list your privileges in the space provided. You must send a copy of the enclosed "Staff Privileges Verification Form" to verify your standing with each institution (hospital, clinic etc.) listed; the form may be duplicated as needed.

"Staff Privilege Verification Form" Instructions – A verification form must be submitted to any institution where you currently hold staff privileges. List the name of the Chief of Staff, etc. and the name of the institution in the spaces provided at the top of the form. List your name in the space provided immediately above the double line. It is preferred that the Chief of Staff or the Chief/Director of the department in which you hold specific privileges complete the form. Some hospitals will require that you also submit a signed release for the information. If this is the case, it is YOUR responsibility to make sure that the program has permission to release your evaluation to the Board Office. **This form cannot be accepted without the hospital seal or notation that the hospital has no seal.**

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. 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.
29. **BOARD CERTIFICATION:** Answer yes or no. If yes, list in the space provided and submit a copy of your board certification or letter verifying board certification.

30. Answer yes or no. If yes, explain on a separate sheet.
31. Answer yes or no. If yes, list in the space provided and direct the organization to submit a letter of explanation.
32. If none, list "N/A" in the space provided.
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. Answer yes or no. If yes, list in the space provided and explain in detail on a separate sheet.
36. ****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
37. **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.
38. Answer yes or no. If yes, list in the space provided and submit a copy of your "discharge to debtor" documentation.
39. Answer yes or no. If yes, please provide an explanation on a separate sheet, giving accurate details. Additional documentation MAY be required.
40. 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.
41. 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.
42. Answer yes or no. Provide an explanation on a separate sheet.
43. 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, restoration of civil rights (if applicable) and current disposition.
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. Additional documentation MAY be required.
46. 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.
47. 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 including 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 including 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 including your initial condition and current prognosis.
50. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report including your initial condition and current prognosis.
51. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report including your initial condition and current prognosis.
52. Answer yes or no. If yes, provide an explanation on a separate sheet. You must also direct your treating physician to submit a report including your initial condition and current prognosis.
53. 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.
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 submit all pertinent documentation directly to the Board office.
56. 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.
57. 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.
58. 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.
59. **OPTIONAL INFORMATION:** Self explanatory.
60. **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. This section gives the Florida Board of Osteopathic Medicine permission to obtain any information regarding licensure from reported entities.
 - a. **ATTACH** a 2 x 2 inch head and shoulder photograph at the bottom of the last page, where indicated. Computer generated and copied photographs will not be accepted.

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.

**** Special note regarding documents submitted which pertain to medical malpractice occurring after November 2, 2004 – These documents MUST be submitted to the Board in electronic format or they will not be accepted. Please be advised that the Board office will NOT maintain this documentation permanently, so it is your responsibility to maintain a copy of these records for any future use.**

SECTION II

SUPPLEMENTAL FORMS

- Read the instructions (section I) carefully for each form.
- Training Evaluation Forms, Staff Privilege Verification Form, and Exhibit 1 Report on Professional Liability Claims and Actions may need to be duplicated.

**Board of Osteopathic Medicine
Proof of Compliance with Mandatory
Continuing Medical Education Requirements**

Prevention of Medical Errors Form

_____ I hereby state that I have completed the required course entitled PREVENTION OF MEDICAL ERRORS in accordance with s. 456.013(7), Florida Statutes and that this course was a minimum of two (2) hours and included a study of root-cause analysis, error reduction and prevention and patient safety as well as information related to the 5 most misdiagnosed conditions of osteopathic physicians during the preceding biennium.

These statements are true and correct and I recognize that providing false information shall constitute cause for denial, suspension or revocation of my license to practice osteopathic medicine under Chapter 459, F.S., in the state of Florida or criminal penalties pursuant to sections 456.072, 459.013, 459.015, 775.082, 775.083, and 775.084, F.S.

Printed Name

Signature

Date

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

**FLORIDA BOARD OF OSTEOPATHIC MEDICINE
INTERNSHIP TRAINING EVALUATION**

TO: _____ INSTITUTION: _____

The doctor named below has applied for licensure in the State of Florida. Please complete the entire form and affix the hospital seal. If your hospital has no seal, please indicate such on this form.

NAME: _____

PROFESSIONAL COMPETENCY

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge	_____	_____	_____	_____	_____
b. Diagnostic/Clinical Ability	_____	_____	_____	_____	_____
c. Fitness for Clinical Practice	_____	_____	_____	_____	_____

PERSONAL CHARACTER

a. Motivation	_____	_____	_____	_____	_____
b. Initiative	_____	_____	_____	_____	_____
c. Responsibility	_____	_____	_____	_____	_____
d. Integrity	_____	_____	_____	_____	_____
e. Appearance	_____	_____	_____	_____	_____
f. Knowledge of English	_____	_____	_____	_____	_____
g. Emotional Stability/Attitude	_____	_____	_____	_____	_____

PROFESSIONAL RELATIONSHIPS

a. Teaching Staff	_____	_____	_____	_____	_____
b. Colleagues	_____	_____	_____	_____	_____
c. Nursing Staff	_____	_____	_____	_____	_____
d. Patients	_____	_____	_____	_____	_____

PLEASE VERIFY:

- Dates attended (start and end): _____
- The levels completed under your purview: INT/PGY I _____
- Has the physician named above completed an AOA approved, 12 month, Rotating Internship? YES ___ NO ___
- The specialty area of training was _____
- Did this individual ever take a leave of absence or break from training? YES ___ NO ___
- Was this individual ever placed on probation? YES ___ NO ___
- Was this individual ever disciplined or placed under investigation? YES ___ NO ___
- Did an instructor ever file any negative reports? YES ___ NO ___
- Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? YES ___ NO ___

(If "YES" is marked for 5 - 9 above, please provide details on a separate sheet.)

OVERALL EVALUATION: If 3 or 4 is checked, please explain on a separate sheet.

1. ___ Outstanding 2. ___ Qualified/Competent 3. ___ Less than Satisfactory (if 3 is checked, provide an explanation on a separate sheet).

Name of Evaluator

Signature

Position Title

Phone Number

Date

**AFFIX
HOSPITAL
SEAL**

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

**FLORIDA BOARD OF OSTEOPATHIC MEDICINE
RESIDENCY TRAINING EVALUATION**

TO: _____ INSTITUTION: _____

The doctor named below has applied for licensure in the State of Florida. Please complete the entire form and affix the hospital seal. If your hospital has no seal, please indicate such on this form.

NAME: _____

PROFESSIONAL COMPETENCY

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge	_____	_____	_____	_____	_____
b. Diagnostic/Clinical Ability	_____	_____	_____	_____	_____
c. Fitness for Clinical Practice	_____	_____	_____	_____	_____

PERSONAL CHARACTER

a. Motivation	_____	_____	_____	_____	_____
b. Initiative	_____	_____	_____	_____	_____
c. Responsibility	_____	_____	_____	_____	_____
d. Integrity	_____	_____	_____	_____	_____
e. Appearance	_____	_____	_____	_____	_____
f. Knowledge of English	_____	_____	_____	_____	_____
g. Emotional Stability/Attitude	_____	_____	_____	_____	_____

PROFESSIONAL RELATIONSHIPS

a. Teaching Staff	_____	_____	_____	_____	_____
b. Colleagues	_____	_____	_____	_____	_____
c. Nursing Staff	_____	_____	_____	_____	_____
d. Patients	_____	_____	_____	_____	_____

PLEASE VERIFY:

- Dates attended (start and end): _____
- The levels completed under your purview: PGY I _____ PGY II _____ PGY III _____ PGY IV _____ PGY V _____
- The specialty area of training was _____
- Did this individual ever take a leave of absence or break from training? YES ___ NO ___
- Was this individual ever placed on probation? YES ___ NO ___
- Was this individual ever disciplined or placed under investigation? YES ___ NO ___
- Did an instructor ever file any negative reports? YES ___ NO ___
- Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? YES ___ NO ___

(If "YES" is marked for 4 – 8 above, please provide details on a separate sheet.)

OVERALL EVALUATION: If 3 or 4 is checked, please explain on a separate sheet.

1. ___ Outstanding 2. ___ Qualified/Competent 3. ___ Less than Satisfactory (if 3 is checked, provide an explanation on a separate sheet).

Name of Evaluator

Signature

Position Title

Phone Number

Date

**AFFIX
HOSPITAL
SEAL**

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

**FLORIDA BOARD OF OSTEOPATHIC MEDICINE
FELLOWSHIP TRAINING EVALUATION**

TO: _____ INSTITUTION: _____

The doctor named below has applied for licensure in the State of Florida. Please complete the entire form and affix the hospital seal. If your hospital has no seal, please indicate such on this form.

NAME: _____

PROFESSIONAL COMPETENCY

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge	_____	_____	_____	_____	_____
b. Diagnostic/Clinical Ability	_____	_____	_____	_____	_____
c. Fitness for Clinical Practice	_____	_____	_____	_____	_____

PERSONAL CHARACTER

a. Motivation	_____	_____	_____	_____	_____
b. Initiative	_____	_____	_____	_____	_____
c. Responsibility	_____	_____	_____	_____	_____
d. Integrity	_____	_____	_____	_____	_____
e. Appearance	_____	_____	_____	_____	_____
f. Knowledge of English	_____	_____	_____	_____	_____
g. Emotional Stability/Attitude	_____	_____	_____	_____	_____

PROFESSIONAL RELATIONSHIPS

a. Teaching Staff	_____	_____	_____	_____	_____
b. Colleagues	_____	_____	_____	_____	_____
c. Nursing Staff	_____	_____	_____	_____	_____
d. Patients	_____	_____	_____	_____	_____

PLEASE VERIFY:

- Dates attended (start and end): _____
- The levels completed under your purview: PGY I _____ PGY II _____ PGY III _____ PGY IV _____ PGY V _____
- The specialty area of training was _____
- Did this individual ever take a leave of absence or break from training? **YES** ___ **NO** ___
- Was this individual ever placed on probation? **YES** ___ **NO** ___
- Was this individual ever disciplined or placed under investigation? **YES** ___ **NO** ___
- Did an instructor ever file any negative reports? **YES** ___ **NO** ___
- Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? **YES** ___ **NO** ___
(If "YES" is marked for 4 – 8 above, please provide details on a separate sheet.)

OVERALL EVALUATION: If 3 or 4 is checked, please explain on a separate sheet.

1. ___ Outstanding 2. ___ Qualified/Competent 3. ___ Less than Satisfactory (if 3 is checked, provide an explanation on a separate sheet).

Name of Evaluator

Signature

Position Title

Phone Number

Date

**AFFIX
HOSPITAL
SEAL**

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

**FLORIDA BOARD OF OSTEOPATHIC MEDICINE
STAFF PRIVILEGES VERIFICATION**

TO: _____

DATE: _____

INSTITUTION: _____

The doctor named below has applied for licensure in the State of Florida. Please complete this form and affix the hospital seal where indicated. If your hospital has no seal, please indicate that directly on the form.

NAME: _____

1. Does/did the doctor have full staff privileges in his/her specialty? YES __ NO __

If no, please explain: _____

2. What is/was the doctor's specialty? _____

3. Does/did he/she perform competently? YES __ NO __

If no, please explain: _____

4. How would you rate the doctors professional attitude: **Poor** ____ **Fair** ____ **Good** ____ **Superior** ____

5. Have any restrictions ever been placed on him/her beyond the original period of probation? YES __ NO __

If yes, please explain: _____

6. Please list the doctor's **dates of service**: _____

Name of Person Providing Information

Signature

Date Signed

Position/Title

Phone Number

**AFFIX
HOSPITAL
SEAL**

**Board of Osteopathic Medicine
4052 Bald Cypress Way # C06
Tallahassee, Florida 32399-3256**

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 or 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

FLORIDA BIRTH RELATED NEUROLOGICAL INJURY 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 Osteopathic Medicine and to NICA.

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

_____	_____	_____
Signature	Date	Name

		Street Address

		City, State, Zip

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

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

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

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

and 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 .

DISPENSING PRACTITIONER

This is optional and should be completed only if the \$100.00 fee is enclosed.

Section 465.0276, F.S., requires that licensees of the Board of Osteopathic Medicine who dispense medicinal drugs for a fee or remuneration of any kind, whether direct or indirect, shall be required to register with the Board and pay a fee of \$100.00 at the time of such registration and upon each renewal of the practitioner's license. Practitioners who limit their activities to the dispensing of complimentary packages of medicinal drugs to their own patients in the regular course of their practice shall not be required to register. Please note that upon registration, your practice will be inspected annually by the Department's Investigative Services for compliance with Florida law relevant to the dispensing of medicinal drugs.

YES, I plan to dispense medicinal drugs for a fee or other remuneration and hereby register pursuant to ss. 465.0276, F. S. I understand that the fee for registration is \$100.00 over and above the amount required for licensure.

YES []

Signature

NO [] No signature required

**Board of Osteopathic Medicine
4052 Bald Cypress Way # C06
Tallahassee, Florida 32399-3256**

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 456.0391 F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.0391, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ____/____/____ Date reported to licensee: ____/____/____

Injured person's name: (last, first, middle initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit: ____/____/____

List other defendants involved in this claim:

- 1. _____ 2. _____
- 3. _____ 4. _____

Date of final claim disposition: ____/____/____

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: \$ _____

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. 775.083 and 775.083, Florida Statutes.

Signature of Physician: _____

Date: _____

SECTION III

APPLICATION FORM

- Read ALL instructions thoroughly before completing the application.
- Mail the completed ORIGINAL application and fees to the Department at the address noted in the instructions.
- Keep a copy of the completed application (including all forms) for your records.
- Read the entire application package. Most questions can be answered by reading the enclosed instructions, application, and supplemental forms.

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

APPLICATION FOR LICENSURE
Please TYPE or print in black ink

1. APPLICATION CATEGORY: CLIENT 1901

- NBOME EXAMINATION
 OTHER STATE EXAMINATION (please see sheet entitled "Other State Exam")
 COMVEX (must complete separate application to register for exam)
 OTHER _____

2. Would you be able to provide healthcare 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. PRIMARY PRACTICE/PHYSICAL ADDRESS: _____
(Street and number) **NO PO BOX**

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

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. OTHER PRACTICE LOCATIONS: _____
(Practice Name) (Street and number) (City, State/Province, Zip/Postal Code, Country)

10. PERSONAL DATA:

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 FR38295 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

11. CITIZENSHIP:

Are you a citizen of the United States? YES NO

Birth Date: _____ Birth Place: _____ Naturalization Date: _____
(Month/Day/Year) (City/State/Province/Country) (Month/Day/Year)

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

12. 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.

13. 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>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

15. 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: _____

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

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

17. 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)

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

18. 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 Y/N
				Began	Ended	

19. 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)

20. 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)

21. 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)

22. 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

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

24. 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)

25. 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

26. 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)

27. 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)

28. 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)

29. CERTIFICATION: Are you certified by any Specialty Board recognized by the AOA, ABMS, ABPS, or AAPS? (If "yes", list below and enclose a copy of each certification or letter of verification. Do not list abbreviations) YES NO

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

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

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

31. 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?)

32. List all Osteopathic/Professional Society or Association Memberships: **Please do not abbreviate.** (Attach additional sheets if necessary.)

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

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

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

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

35. 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:

36. 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.)

37. 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.)

38. 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.**

39. 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
40. 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
41. 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
42. Have you ever had employment terminated for cause? [] YES [] NO
43. 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 is not considered a minor traffic offense for purposes of this question. [] YES [] NO
44. Have you ever received a letter of admonition or notice of administrative hearing from the Drug Enforcement Agency (DEA)? [] YES [] NO
45. 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
46. Have you ever been denied, or surrendered a DEA Registration? [] YES [] NO
47. 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
48. 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
49. 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 within the last five years? [] YES [] NO
50. 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? [] YES [] NO
51. 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
52. 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 within the last five years? [] YES [] NO
53. Have you ever been terminated for cause from participating in the Florida Medicaid program? [] YES [] NO

55. Have you ever been sanctioned by any state Medicaid program? YES NO

56. 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 (57 – 59) 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.

57a. 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? YES NO

(If no, do not answer 57b.)

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

58a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? YES NO

(If no, do not answer 58b.)

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

59a. 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? YES NO

(If no, do not answer 59b and 59c.)

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

60. 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)

(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)

61. STATEMENT OF APPLICANT:

These statements are true and correct and I 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 a 2 x 2 inch
Photo
Here