

## FINANCIAL RESPONSIBILITY

NAME: \_\_\_\_\_ LICENSE NUMBER: DO \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Note: Mailing Addresses are not published on the internet**

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only one option of the ten provided pursuant to s.459.0085, Florida Statutes.**

### **CATEGORY I: Financial Responsibility Coverage for Florida Practice Only**

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.

**CATEGORY II: Financial Responsibility Exemptions**

6. [ ] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
7. [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
8. [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)
9. [ ] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
10. [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria\*\* **See note below:**
- (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
  - (b) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.
  - (c) I have had no more than 2 claims resulting in an indemnity exceeding \$25,000 within the previous 5 year period.
  - (d) 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.
  - (e) 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.

**\*\* If you select an exemption based on based on #10, you must also complete the affidavit on the following page.**

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Physician Signature

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Date

**DEPARTMENT OF HEALTH  
BOARD OF OSTEOPATHIC MEDICINE  
Financial Responsibility Affidavit of Exemption**

**This affidavit is only required if you are claiming an exemption based on #10 on the preceding page.**

I, \_\_\_\_\_, do hereby certify and attest that I meet all of the following criteria:

- (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
- (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
- (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period;
- (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 459, F. S. or the medical practice act in any other state; and
- (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 459, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 459.0085(5) (f), F.S., for specific notice requirements.

Dated: \_\_\_\_\_

Signature: \_\_\_\_\_

STATE OF FLORIDA  
COUNTY OF \_\_\_\_\_

Sworn to (or affirmed) and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, by

\_\_\_\_\_

\_\_\_\_\_  
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known \_\_\_\_\_ OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_