Osteopathic Physician Application for Temporary Certificate for Active Duty Military and Veterans Practicing in Areas of Critical Need

Board of Osteopathic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridasOsteopathicMedicine.gov
Email: MQA.Osteopath@FLHealth.gov
Phone: 850-245-4161
Fax: 850-412-2681

Florida HEALTH

DH-MQA 5002, Revised 5/2022, Rule 64B15-12.011, F.A.C.

Important Eligibility Information

This temporary and restricted licensure avenue is for osteopathic physicians who hold a **current and valid license** to practice in any state and who intend to practice in:

- an area of critical need as determined by the State Surgeon General;
- a county health department;
- a correctional facility;
- a Department of Veterans' Affairs clinic;
- a community health center funded by section (s.) 329, s. 330, or s. 340 of the United States Public Service Act;
- another agency or institution approved by the State Surgeon General that provides health care to meet the needs of underserved populations in this state; or
- an area for a limited time to address critical physician-specialty, demographic or geographic needs for Florida's physician workforce as determined by the State Surgeon General.

Florida Birth Related Neurological Injury Compensation Association (NICA) Fund

All physicians licensed in Florida are required to pay into the NICA fund unless qualified for exemption. Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

"Participating," is for Florida licensed physicians who practice obstetrics or perform obstetrical services on a full or part-time basis and do not meet any of the exemption criteria.

"Non-participating," is for Florida licensed physicians who do not practice obstetrics or perform obstetrical services and do not meet any of the exemption criteria.

"Exempt" - To determine if you qualify for exemption, review the exemptions listed below or visit the NICA website listed above.

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).

2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).

3. Physicians who hold a limited license, as defined by chapter (ch.) 458, Florida Statutes (F.S.), who do not receive any
compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).

4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).

5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).

6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

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Do Not Write in this Space
For Revenue Receipting Only

All physicians licensed in Florida are required to pay into the NICA fund unless qualified for exemption. See page 2 for information on NICA participating, non-participating, and exempt.

Osteopathic Physician Temporary Certificate (1905)

Select the option applicable to your proposed practice setting

Compensated Practice **$429.00 + NICA Fee**

- ☐ *NICA Exempt:* $0.00 - **Total $429.00** *(Submit proof of exemption)*
- ☐ *NICA Non-Participating:* $250.00 - **Total $679.00**
- ☐ *NICA Participating:* $5,000.00 - **Total $5,429.00**

☐ **Non-compensated Practice** **No Fee**
(Submit affidavit regarding compensation from agency/institution)

Fee includes the following:

Initial Licensure Fee (refundable)	$429.00
NICA Fee Varies Between	$0.00-$5,000.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Approved Facility: (This address will be posted on the Department of Health's website) **Anticipated Start Date:** _____
MM/DD/YYYY

_____ _____
Facility Name Facility Director Name

_____ _____ _____
Street (P.O. Box Addresses are not acceptable) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

Type of Facility: ☐ Community Health Center ☐ Correctional Facility ☐ County Health Dept ☐ VA Clinic

☐ Other:_____

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE - REQUIRED

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. List the year and state/territory/country you legally began to practice medicine. (This may be the date you began postgraduate training.)

Year: _____ (YYYY) Location: _____ (State/Territory/Country)

C. Has it been more than three years since you practiced osteopathic medicine in any jurisdiction?
☐ Yes ☐ No

If "Yes," list the year you last practiced osteopathic medicine: _____ (YYYY)

D. Do you hold, or have you ever held a license to practice osteopathic medicine or any other professional license(s)? ☐ Yes ☐ No

E. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Jurisdiction or Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a "License Verification Request" form** to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority or www.veridoc.org regardless of the status of the license. Check www.veridoc.org for states that use the online verification service.

F. Are you registered with the Drug Enforcement Agency (DEA) to prescribe controlled substances?
☐ Yes ☐ No

G. If you have ever served in the United States (U.S.) Military or Public Health Service (PHS), have you ever been disciplined by any branch of the U.S. Military or PHS? ☐ Yes ☐ No ☐ NA

If "Yes," provide the following:

☐ **A self-explanation** on a separate sheet providing accurate details (including, but not limited to, the date(s), location(s), and specific circumstances).

☐ **Documentation from the U.S. Military/PHS** regarding the disciplinary action and charge(s)/event(s).

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION / TRAINING HISTORY

A. List the osteopathic medical school you attended.

School Name	Address	Dates of Attendance: From-To (MM/DD/YYYY)
		to

☐ **All applicants must have an official transcript forwarded directly to the board office from their osteopathic medical school. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

B. List in chronological order from date of graduation from osteopathic medical school to the present all postgraduate training (internship/residency/fellowship). Attach additional sheets if necessary.

Program/Hospital/Employer Name	Address	Employment Dates: From-To (MM/DD/YYYY)	Position/Title
		to	
		to	
		to	
		to	

C. Are you certified by any specialty board recognized by the American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), American Board of Interventional Pain Physicians (ABIPP), or American Association of Pharmaceutical Scientists (AAPS)? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/DD/YYYY)

Name: _____

6. ACADEMIC FACULTY APPOINTMENTS / STAFF PRIVILEGES

A. Do you currently hold a faculty appointment at a medical school? ☐ Yes ☐ No

B. Have you had the responsibility for graduate medical education with the last 10 years? ☐ Yes ☐ No

If you responded "Yes" to A or B, complete the following:

Name of Institution	City/State	Title of Appointment

A **"facility"** is defined as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

C. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility (do not include postgraduate training privileges)? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

D. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility/ Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
			☐Y ☐N
			☐Y ☐N

E. 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? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility/ Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
			☐ Y ☐ N
			☐ Y ☐ N

F. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? ☐ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility/ Address	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
			☐Y ☐N
			☐Y ☐N

If you responded "Yes" in questions D-F, provide the following:

☐ **A self-explanation** on a separate sheet providing accurate details.

☐ **Supporting documents from the facility(ies).**

Name: _____

7. OTHER ITEMS REQUIRED

☐ **Affidavit Regarding Compensation-** Applicants who will **not** be receiving compensation for **any** medical service provided must direct the employing agency/institution to submit an affidavit to that effect so that the licensure fees, including the NICA fee, can be waived. (See section 459.00761(5), F.S.)

☐ **American Osteopathic Association (AOA) Profile- All applicants** are required to have their AOA profile made available to the board. Contact the AOA at www.aoaprofiles.org or by phone at 888-626-9262.

☐ **Federation of State Medical Boards (FSMB) Data Check- All applicants** are required to have an FSMB Data Check made available to the board. Contact FSMB at www.fsmb.org/PDC/query-services/.

☐ **Letter Authorizing Practice-** Applicants who are on **active duty** must provide a letter from their military command authorizing them to practice medicine at an approved entity in an area of critical need.

☐ **Military Documentation- All applicants** must provide documentation demonstrating active duty status as a commissioned medical officer **or** demonstrate previous service as a commissioned medical officer in the U.S. Armed Forces for at least 10 years and received an honorable discharge **(DD-214 or NGB-22).**

☐ **National Practitioner Data Bank (NPDB) Query- All applicants** are required to have a NPDB query. The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance. Federal regulations authorize eligible entities to report and/or query the NPDB. Board staff will complete this query when reviewing your application.

Name: _____

This information is exempt from public records disclosure.

8. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, F.S., and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

A. 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

B. Have you ever had any application for a license to practice a profession, including osteopathic medicine, denied by any state board or the licensing authority of any state, territory, or country? ☐ Yes ☐ No

C. Are you currently under investigation or prosecution in any jurisdiction for an act that would constitute a violation under s. 456.072, F.S., or s. 459.015, F.S.? ☐ Yes ☐ No

D. 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

If you responded "Yes" in questions A-D, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in questions A-D, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of all pertinent information including **Administrative Complaint(s), Final Order(s), and current disposition**.

E. Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? ☐ Yes ☐ No

F. Have you ever been sanctioned by any state Medicaid program? ☐ Yes ☐ No

G. Have you ever had employment terminated for cause? ☐ Yes ☐ No

If you responded "Yes" in questions E-G, you must provide the following:

☐ **A written self-explanation** on a separate sheet describing in detail the circumstances.

☐ **Supporting documents** from the applicable entity.

Name: _____

10. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes," you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?
   ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)?
   ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 4.

   a. 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

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for sections 8 and 9 must be sent to the board office at MQA.Osteopath@flhealth.gov or mailed to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Documentation for section 10 and 11 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Include your application file number, if known.

12. MALPRACTICE / LIABILITY CLAIM HISTORY

A. Have you had a judgement entered against you for medical malpractice where the incident(s) of malpractice occurred **after November 2, 2004**? ☐ Yes ☐ No

B. Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** listing your involvement in each case.

☐ **Completed Exhibit 1 form** for each case (found following the application).

☐ **A copy of the complaint and disposition for each case.**

☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

13. LIVESCAN PRIVACY STATEMENT

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

☐ **Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH2015Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: _____

14. APPLICANT SIGNATURE

I have carefully read the questions in the application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I 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 information which is material to my application for licensure.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 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 upon it.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

Applicants who do not currently have a practice address are required to update their online practitioner profile with a practice address when it is available.

This form is required for ALL applicants.

Board *of* Osteopathic Medicine
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 6** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I do not have hospital privileges and I have obtained and will maintain professional liability coverage in an amount of not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ 2. I have hospital staff privileges and I have obtained and maintain liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S., or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110, F.S.

☐ 3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, F.S., in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement 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 judgement 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 non-assignable 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 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, F.S., 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 ch. 675, F.S., in an amount no less than $250,000 per claim, with a minimum aggregate availability of credit not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement 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 judgement 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 non-assignable 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 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, F.S., in the per-claim amounts specified above.

☐ 5. I have decided to not carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgements pursuant to the terms and conditions contained in s. 459.0085(5)(g), F.S. 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 or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry 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 to pursuant to Florida law.

Name: _____

☐ 6. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

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

☐ 2. I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at a college of osteopathic medicine (residents **do not qualify** for this exemption).

☐ 4. I have no malpractice exposure, because I do not practice in the state of Florida. I will notify the department immediately before commencing practice in the state.

☐ 5. I am exempt from demonstrating financial responsibility due to meeting all the following criteria (If you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):

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 a part-time practice of no more than 1,000 patient contact hours per year.
c. I have 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 nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any 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 three years or longer, or a fine of $500.00 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 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 to pursuant to Florida law.

Section 456.067, F.S.: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, F.S., s. 775.083, F.S., or s. 775.084, F.S.

Applicant Signature _____ Date _____
MM/DD/YYYY

☐ **If you selected an option out of options one through four in the "Financial Responsibility Coverage" section, proof of liability coverage must be sent directly by the insuring company to the board at:**

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Board *of* Osteopathic Medicine
Financial Responsibility Affidavit of Exemption

This affidavit is <u>only</u> required if you are claiming exemption based on #5 on the preceding page.

I, _____, do hereby certify and attest that I meet all the following criteria:
(Name)

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 a part-time practice of no more than 1,000 patient contact hours per year.

C. I have 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 nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any 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 three years or longer, or a fine of $500.00 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 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 to pursuant to Florida law.

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the application and sign it before a notary public.

[NOTARY SEAL]

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

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

NOTICE OF:

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

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

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

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

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

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

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

PRIVACY STATEMENT

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

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

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

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

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

Board *of* Osteopathic Medicine
Electronic Fingerprinting

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

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Board of Osteopathic Medicine is **EDOH2015Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

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

Citizenship: _____

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

Keep this form for your records.

This form is required for ALL applicants.

Board *of* Osteopathic Medicine
Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

All applicants must choose one of the three options described below. Check **only one.**

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

Exempt- $0.00	Non-participating- $250.00	Participating- $5,000.00

Amount Enclosed: $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

Participating and Non-participating applicants must complete and attach this form and appropriate fees to the application or submit to the Board of Osteopathic Medicine at:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Applicants claiming exemption must complete this form, and return it with proof of qualification for the exemption to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

AND

NICA
P.O. Box 14567
Tallahassee, FL 32317-4567

Exemptions Include:

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Osteopathic Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, F.S., who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

I have read the information provided by NICA at www.nica.com and I have selected the option above.

Applicant Signature _____ Date _____
MM/DD/YYYY

This form is required for ALL applicants.

Board *of* Osteopathic Medicine
Florida Birth-Related Neurological Injury Compensation Association (NICA) Form

All applicants must choose one of the three options described below. Check **only one.**

Visit www.nica.com/medical-providers/ for information on NICA participating, non-participating, and exempt.

☐ Exempt- $0.00	☐ Non-participating- $250.00	☐ Participating- $5,000.00

Amount Enclosed: $_____

For applicants who choose **"Participating"**, NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose **"Non-participating,"** a mandatory annual fee of $250.00 is paid by every physician in Florida who is not Participating or Exempt.

☐ **Participating and Non-participating applicants** must complete and attach this form and appropriate fees to the application or submit to the Board of Osteopathic Medicine at:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

☐ **Applicants claiming exemption** must complete this form, and return it with proof of qualification for the exemption to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

AND

NICA
2360 Christopher Place
Tallahassee, FL 32308

Exemptions Include:

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Osteopathic Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, F.S., who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: _____

Address: _____
Street and Number City State ZIP

I have read the information provided by NICA at www.nica.com and I have selected the option above.

Applicant Signature _____ Date _____
MM/DD/YYYY

Board *of* Osteopathic Medicine
Exhibit I- 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 s. 456.039 (1)(b), F.S. You must submit a completed form for each occurrence. Copies of reports previously submitted under the requirements of s. 456.049, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: _____ MM/DD/YYYY

Date reported to licensee: _____ MM/DD/YYYY

Date claim reported to insurer or self-insurer: _____ MM/DD/YYYY

Injured person's full name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Age: _____ Sex: _____

List all defendants with their health care provider license number involved in this claim:

Defendant	Health Care Provider License #

Date of suit, if filed: _____ MM/DD/YYYY

Date of final claim disposition: _____ MM/DD/YYYY

Date of judgement/settlement, if any: _____ MM/DD/YYYY

Amount of judgement/settlement, if any: $_____

Was there an itemized verdict? ☐ Yes ☐ No **If "Yes," attach a copy of the settlement verdict.**

Indemnity paid on behalf of this defendant: $_____

Loss Adjustment expense paid to defense counsel: $_____

All other loss adjustment expense paid: $_____

If no judgement or settlement, provide the following: Date: _____ MM/DD/YYYY Reason: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

☐ Critical Care Unit	☐ Emergency Room	☐ Labor & Delivery Room
☐ Nursery	☐ Operating Suite	☐ Patient's Room
☐ Physical Therapy Dept.	☐ Radiology	☐ Recovery Room
☐ Special Procedures Room	☐ 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 description 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 description 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, F.S. I recognize that providing any false statements made in writing with the intent to mislead the department staff in the performance of their official duties shall be punishable as provided in s. 775.082 and 775.083, F.S.

Applicant Name _____

Applicant Signature _____ Date _____
MM/DD/YYYY

Complete verifications must be sent directly from the licensing agency to the board office at MQA.Osteopath@flhealth.gov, or mailed to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Board *of* Osteopathic Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Osteopathic Medicine.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.