# MEDICAL FACULTY CERTIFICATE (MFC) RENEWAL

Date: _____ MFC #: _____

Print or Type Name: _____

Mailing Address: _____
_____

## Criminal History and Medicaid / Medicare Fraud Questions:

As required by section 456.0635(3), F.S., please answer Yes or No to the following questions below. If you answer 'YES' to any of the following questions, please send a written explanation for each such question, including the county and state of each termination, plea, or conviction, the date of each termination, plea, or conviction, and copies of supporting documentation, to the address below. Supporting documentation may include court dispositions or agency orders.

**Department of Health**
**Division of Medical Quality Assurance - Bureau of Operations**
**4052 Bald Cypress Way, Bin #C-10**
**Tallahassee, FL 32399-3260**

**1.** ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no," skip to question 2.)**

**a.** ☐ Yes ☐ No If "yes" to 1, did the arrest or felony charge resulting in the conviction or plea occur before July 1, 2009? **(If you responded "yes", skip to question 2.)**

**b.** ☐ Yes ☐ No 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 or conviction, and completion of any sentence or subsequent period of probation?

**c.** ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation? (This question does not apply to felonies of the third degree under section 893.13(6) (a), F.S.)

**d.** ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree under section 893.13(6)(a), F.S., has it been more than 5 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?

**e.** ☐ Yes ☐ No If "yes" to 1, are you currently enrolled in a pretrial diversion or drug court program that allows the withdrawal of the plea or dismissal of the charges for the felony offense upon successful completion of the program? (If yes, please provide supporting documentation.)

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**Criminal History and Medicare/Medicaid Questionnaire**

**2.** ☐ Yes ☐ No Since July 1, 2009, have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **(If you responded "no," skip to question 3.)**

**a.** ☐ Yes ☐ No If "yes" to 2, did the sentence and any subsequent period of probation for such conviction or plea end more than 15 years before the date of this application?

**3.** ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to section 409.913, Florida Statutes? **(If you responded "no," skip to question 4.)**

**a.** ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

**4.** ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no," skip to question 5.)**

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

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

**5.** ☐ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Please check the OIG website if you do not know if you are listed.

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

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

# CONTINUING MEDICAL EDUCATION AFFIDAVIT

**I, (print name) _____ hereby affirm that I have completed the following continuing medical education courses to renew my Medical Faculty Certificate, MFC# _____.**

| | | |
|---|---|---|
| **HIV/AIDS (required for 1st renewal only)** | **Yes___** | **No ___** |
| **Preventing Medical Errors (required every renewal)** | **Yes___** | **No ___** |
| **Domestic Violence (required for every 3rd renewal)** | **Yes___** | **No ___** |
| **Thirty-eight (38) Category 1, AMA, General CME (required every renewal)** | **Yes___** | **No ___** |

**Signature of Physician: _____**

**State of Florida, County of _____**

**Subscribed and sworn to before me this _____ day of _____, 20___**

**Signature of Notary: _____**

**My commission expires: _____**

**Notary Stamp or Seal:**

# FINANCIAL RESPONSIBILITY



The Financial Responsibility options are divided into two categories, coverage and exemptions. **Check only one option of the ten provided** as required by section 458.320, F.S.

## Category I: Financial Responsibility Coverage

1.___ I do not have hospital staff privileges, I do **not** perform surgery at an ambulatory surgical center and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

2.___ I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F.S., for a letter of credit and section 625.52, F.S., for an escrow account.

3.___ I do not have hospital staff privileges, I do **not** perform surgery at an ambulatory surgical center 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 section 624.09, F.S., from a surplus lines insurer as defined under section 626.914(2), F.S., from a risk retention group as defined under section 627.942, F.S., from the Joint Underwriting Association established under section 627.351(4), F.S., or through a plan of self-insurance as provided in section 627.357, F.S.

4.___ I have hospital staff privileges or I perform surgery at an ambulatory surgical center and I have 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 section 624.09, F.S., from a surplus lines insurer as defined under section 626.914(2), F.S., from a risk retention group as defined under section 627.942, F.S., from the Joint Underwriting Association established under section 627.351(4), F.S., or through a plan of self-insurance as provided in section 627.357, F.S.

5.___ I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to section 458.320(5)(g)1, F.S. I understand 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. I understand that such a sign or notice must contain the wording specified in section 458.320(5)(g), F.S.

# FINANCIAL RESPONSIBILITY
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## Category II: Financial Responsibility Exemptions

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

7.___ I hold a limited license issued pursuant to section 458.317, F.S., and practice only under the scope of the limited license.

8.___ I do not practice medicine in Florida.

9.___ 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 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F.S. or the medical practice act in any other state; and
(e) I have not be subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of 3 years or longer, or a fine of $500 or more for a violation of Chapter 458, 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 458.320(5)(f), F.S., for specific notice requirements.

10.___I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

**If you select an exemption based on number 9, you must also complete the affidavit on the following page.** DH-MQA 1229 (08/20), Rule 64B-9.001

# Financial Responsibility Affidavit of Exemption

***This affidavit is only required if you are claiming an exemption based on number 9 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 2 claims resulting in an indemnity exceeding $25,000 within the previous 5-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F.S. or the medical practice act in any other state; and
(e) I have not been subject, within the past 10 years of practice, to license revocation, suspension, or probation for a period of 3 years or longer, or a fine of $500 or more for a violation of Chapter 458, 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 458.320(5)(f), F.S., for specific notice requirements.

Dated: _____ Signature: _____

STATE OF _____

COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20___, by

_____.

_____
Signature of Notary Public

Print, Type, or Stamp Commissioned Name of Notary Public: _____

Personally Known_____ OR Produced Identification _____

Type of Identification Produced _____

# Florida Department of Law Enforcement Name Search Information

**Print Name:** _____

**Aliases (AKA):** _____

**Address:** _____

**Citizenship:** _____

**Social Security #:** _____ **Sex: Male ____ Female ____**

**Date of Birth:** ___/ ___/_____ **Place of Birth:** _____

**Race:** _____**Height:** _____ **Weight:** _____ **Eye Color:** _____ **Hair Color:** _____

**Signature of Applicant** **Date of Signature**

## Medical Faculty Certificate Number: MFC#_____

Active Renewal Fee $255.00

Dispensing Registration add $100.00*

*Add $100.00 to renewal fee if currently registered to dispense medicinal drugs. If you are not registered to dispense and would like to register at renewal, indicate your dispensing request in writing and submit the additional fee of $100.00 along with your renewal fee.

**Mail renewal application and fee to:**
**Florida Department of Health**
**Medical Quality Assurance**
**Board of Medicine**
**P.O. Box 6330**
**Tallahassee, FL 32314-6330**