BOARD OF MEDICINE

APPLICATION MATERIALS FOR INITIAL REGISTRATION & RENEWAL OF INTERN/RESIDENT/FELLOW & HOUSE PHYSICIAN

PURSUANT TO

458.345, F.S.

DEPARTMENT OF HEALTH

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******NOTICE TO ALL APPLICANTS******

When returning your application to the Department, mail only the application form and any supplemental documentation forms as required.

SECTION I:

APPLICATION INSTRUCTIONS

- **Read all instructions thoroughly before completing the application.**

- **Keep these instructions for your records.**

No person under this section may be employed or utilized as

- **a house physician**
- **an intern**
- **a resident physician**
- **an assistant resident physician, or**
- **fellow in fellowship training in a teaching hospital in this state as defined by s. 408.07(45) or s. 395.805(2), F.S.**

for more than 2 years without a valid, active license or renewal of registration under this section.

Registration shall automatically expire after 2 years without further action by the board or the department unless an application for renewal is approved by the Board of Medicine. It is your responsibility to apply for renewal. You will not be sent a notice. If you do not apply for renewal the registration will become null and void at the time of expiration. If you discontinue practice at your registered location, it is your responsibly to notify the Board of Medicine. Upon termination of your employment the registration becomes null and void.

IMPORTANT NOTICE

Effective July 1, 2012, 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:

1. Has 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 unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed.

   Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:

   - For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;
   - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;
   - For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;

2. Has 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), 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;

3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;

4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;

5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

NOTE: This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

- Application forms and documents returned to the Board office, will be clocked in and processed in the order in which they are received.
- All registration applications and applicable fees must be submitted to the Board office at least 60 days prior to the date in which the physician is scheduled to begin training/employment.
- The physician is ultimately responsible for ensuring they obtain a registration number prior to commencing training.
- When the registration number is issued, a letter of notification will be mailed to the physicians <u>mailing address listed on the application</u>.

PITFALLS: The following items may cause serious delays in the registration process; therefore we strongly recommend the following:

1. That the applicant takes personal responsibility for preparing the application; read the applicable laws and rules, and follows all instructions.

2. Refrain from beginning employment as a resident physician, assistant resident physician, intern, fellow, or house physician, until you have been issued a registration number.

3. Questions (9-22) answered with a "yes"; require that the applicant provide the Board office with the requisite documentation and also may require an appearance before the Credentials Committee of the Board of Medicine for consideration of registration.

4. All registrations must be accompanied by the appropriate fee:
   - $200.00 – Initial registration for resident physician, assistant resident physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s.408.07(44) or s.395.805(2).
   - $300.00 – Initial registration for House physician.
   - $220.00 – House physician renewal registration fee.
   - No fee is required for renewal of resident physician, assistant resident physician, intern or fellow.

Send the **original application and fee**, payable to the Board of Medicine to the following address:

Department of Health
HMQAM
P.O. Box 6330
Tallahassee, FL 32399-6330

All other **additional documentation sent either by the applicant or any other source**, should be mailed to:

Department of Health
MQA/BOM
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

The validation (deposit) process may take 7 to 10 working days before the application is received in the Board office. If the appropriate fee(s) is not received with the registration application, the fee will be returned to the originating entity and the registration request will not be processed until the appropriate fee is received.

PLEASE NOTE: All sections of the application must be complete and accurate. The last page of the application must be signed and dated by the applicant.

MEDICAL DEGREE Registrants are required to furnish a copy of their original medical school diploma, and a translation if in a language other than English. Translations must meet the following Board of Medicine's criteria:

- The translations must be verbatim, meaning all information appearing on the document must appear on the translation.
- Pre-printed information, e.g. the Letterhead of the University, Title, Etc.
- Stamps, Seals, half Seals, if legible, if not, they must be indicated as seals, not legible.
- All signatures, if legible, if not, indicate not legible.
- All Text on the document.
- Translations prepared in foreign countries often have certifications located on the translation. If these certifications appear, they must be translated.

If the medical school diploma has not been issued, please request an original letter addressed to the Florida Board of Medicine be sent from your medical school listing your date of graduation.

"YES/NO" QUESTIONS: If questions 9-24 are answered "Yes", you must provide a statement explaining the basis for such answer in the space provided. If the application fails to provide sufficient space for the requested information, use an additional page. Always number the additional information to be provided with the corresponding number in the application.

Documentation to be provided, but not limited to:

- If ever held any professional/medical license in any State in the U.S., Guam, Puerto Rico, U.S. Virgin Islands or Canada, provide licensure verification directly from the applicable Medical Board.
- A statement providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s). Submit copies of any litigation or any other proceedings in any court of law or equity, any criminal court, any arbitration Board or before any governmental Board or Agency, to which you have been a party, either as a plaintiff, defendant, co-defendant, or otherwise.
- Conviction(s): misdemeanor and/or felony; submit copies of charges, indictment and judgment.

Upon receipt of the explanation(s) provided and supporting documentation, you will be notified of any evaluation and/or any additional documentation needed.

SECTION II:

APPLICATION FORM

- Please make sure the application is completely filled out. **OMISSIONS WILL CAUSE A DELAY IN THE APPLICATION PROCESS.**

- **Social Security number:**
  Provide. 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, Sections 653 and 654; and Sections 456.004(9), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

- **Medical School:**
  Provide the name of school, address, city, state, country and the month/day/year of graduation. Submit a copy of your medical school diploma. (Diplomas in a language other than English must be translated).

  If the medical school diploma has not been issued, please submit an original letter addressed to the Florida Board of Medicine from your medical school listing your date of graduation.

- **Postgraduate Training/Employment/Non-Employment:**
  Must be listed on registration application. List in chronological order from the date of graduation from medical school to the present all employment and non-employment activities. All activities of 30 days or longer must be accounted for.

- **"Yes/No" Questions:**
  Should any questions numbered 9-24, be answered "yes", you must provide a statement on a separate sheet of paper explaining the basis for such answer, and include supporting documentation. Number any additional information provided with the corresponding number in the application.

  REGISTRATIONS ARE VALID FOR TWO YEARS OR UNTIL RENEWED OR FULL LICENSE IS ACQUIRED.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine
Application

Name: _____
Last First Middle

Social Security Number: _____

* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect social security numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of social security numbers is required by Section 456.013 (1)(a), Florida Statutes.

4052 Bald Cypress Way, Bin # C03
Tallahassee, Florida 32399-3257
Phone: (850) 245-4355
Website: www.doh.state.fl.us/mqa/

REGISTRATION APPLICATION FOR INTERN/RESIDENT/FELLOW OR HOUSE PHYSICIAN

(Client 1510)

Registration Method (Check only one)

☐ I am applying for registration to participated in a training program (Intern/Resident/Fellowship) $200.00 FEE
☐ I am applying for registration renewal. TRN#_____ Expiration Date_____NO FEE

☐ I am applying for House Physician Registration. $300.00 FEE
☐ I am applying for House Physician Renewal HSE#_____ Expiration Date_____$220.00 FEE

Registration fees are non-refundable

APPLICATION SHOULD BE TYPED

1. Employment Date: _____ University/Hospital: _____
   Program Specialty: _____ Director of Medical Education: _____
   Program Address: _____ Clinical Sites: _____
   Name/Telephone# of Administrator: _____ _____
   _____

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2. Name:_____
   (First) (Middle) (Last)

3. Mailing Address:_____
   (No & Street) (City) (State) (Zip)

4. Place of Birth_____ Date of Birth_____
   (City/State/Country) (Month/Day/Year)

5. Telephone Number:_____ _____
   (Residence-area code/number) (Office-area code/number)

6. Medical Degree was obtained from:_____
   (Medical School) (City, State & Country) (Month/Day/Year)

7. List in chronological order **from date of graduation from medical school to the present** all postgraduate training/employment/non-employment. If additional space is needed please attach to application:

EMPLOYMENT/ HOSPITAL	ADDRESS	EMPLOYMENT DATES		POSITION
		FROM	TO	

8. Are you or have you ever held a medical license in any state in the United States, Guam, Puerto Rico, U.S. Virgin Islands or Canada? Yes____ No____

_____

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance)

9. 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? Yes____ No____
(If you responded "no", skip to #10.)

9a. If "yes" to 9, 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____

9b. If "yes" to 9, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes) Yes____No____

9c. If "yes" to 9, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Yes____No____

9d. If "yes" to 9, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed? (If "yes", please provide supporting documentation) Yes____No____

10. 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)? Yes____No____

10a. If "yes" to 10, 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____

11. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 11a.) Yes____No____

11a. 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____

12. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 12a or 12b) Yes____No____

12a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes____No____

12b. Did the termination occur at least 20 years before the date of this application? Yes____No____

13. 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? Yes____No____

14. If "yes" to any of the questions 9 - 13 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? Yes____ No____
(If "yes", please provide official documentation verifying your enrollment status.)

15 Have you ever had any application for professional license, registration or any application to practice medicine/surgery denied by any state, territory or country? Yes____ No____

16. In the last five 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____

17. 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____

18. 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 medicine within the past five years? Yes____ No____

19. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? Yes____ No____

20. 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____

21. 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 medicine within the last five years? Yes____ No____

22. Have you ever been convicted of, or entered a plea of guilty, nolo contender 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 a minor traffic offense for purposes of this question. Yes____ No____

23. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s. 458.331(2)(b), F.S.? Yes____ No____

24. Have you ever had employment terminated for cause? Yes____ No____

<u>ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 9-24 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.</u>

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

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Sex: ☐ Male ☐ Female

26. STATEMENT OF APPLICANT:

I,_____, state that I am the person referred to in the foregoing registration application and supporting documentation.

I hereby authorized all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all government agencies and instrumentality's (local, state, federal or foreign) to release to the Florida Board of Medicine any information which is material to my registration application pursuant to 458.345, F.S.

I have carefully read the questions in the foregoing registration application and have answered them completely, without reservations of any kind, and I state that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this registration application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my registration as a physician in the State of Florida.

I understand 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.

_____

(Signature of Applicant) *(Date)*