Temporary Certificate for Physician Assistants to Practice in an Area of Critical Need

Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253
Website: https://flboardofmedicine.gov/
Email: BOM_Initia1Apps@flhealth.gov
Phone: (850) 245-4131
Fax:850-488-0596

DH-MQA 5088, 6/2024, Rules 64B8-30.003 and 64B15-6.003, F.A.C.

Important Eligibility Information

This temporary and restricted licensure avenue is for physician assistants who hold a **current and valid license** to practice in any jurisdiction of the United States 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 (VA) clinic;
- a community health center funded by section (s.) 329, s. 330, or s. 340 of the United States Public Services Act;
- another agency or institution approved by the State Surgeon General that provides health care services 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.

Visit the Health Professional Shortage Area (HPSA) website for more information: https://data.hrsa.gov/tools/shortage-area/hpsa-find.

*The recipient of a temporary certificate for practice in an area of critical need must, **within 30 days after accepting employment**, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.*

Expedite your application by applying online at www.flhealthsource.gov.

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Fax: (850) 488-0596
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Physician Assistant Temporary Certificate (1520) **No Fee**

Expedite your application by applying online at www.flhealthsource.gov.

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

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

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

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, s. 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. 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, Florida Statutes. 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. APPROVED FACILITY

Facility Name:		**Anticipated Start Date** (MM/DD/YYYY)**:**
Facility Director Name:		
Address (P.O. Box not acceptable)**:**		**Suite:**
City:	**State:**	**ZIP:**
Country:	**Telephone Number:**	
Type of Facility: ☐ Community Health Center ☐ Correctional Facility ☐ County Health Department ☐ VA Clinic ☐ Other: _____		

☐ **Intent to Employ Letter - All applicants** are required to submit a letter from the agency/institution that intends to employ you and must be addressed to the Board of Medicine.

4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. List name changes including marriage, naturalization, divorce, or any other means. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice medicine as a physician assistant or any other regulated professional license(s)? ☐ Yes ☐ No

C. List all regulated professional licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

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** 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.

D. Have you actively practiced medicine as physician assistant during the past three years? ☐ Yes ☐ No

If "No," list the year you last practiced medicine as a physician assistant: _____ YYYY

E. 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 question E, you must provide the following:

☐ A copy of the **Complaint(s)**, **Amended Complaint(s)**, and **Judgment**. If litigation is pending, the attorney representing the case must submit a letter addressed to the Council on Physician Assistants explaining the current litigation status.

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

F. 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 ☐ N/A

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 charge(s)/event(s).

5. 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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

6. EDUCATION / TRAINING HISTORY

A. List the physician assistant training program you attended.

Program Name/Location	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)
	to	

☐ **Mail the "Physician Assistant Program Verification Request" form** to your Physician Assistant Program.

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

B. List all undergraduate, graduate, and professional education in chronological order (not limited to physician assistant education).

Educational Facility Name/Address	Major and Degree	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)
		to	
		to	
		to	

Name: ______________________________

7. EMPLOYMENT HISTORY

In chronological order, list all employment in the previous three years. Give the full name and address of the facility. Attach additional sheets if necessary.

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

Name of Employer:		**Position Title:**	
Employer Address:			
Employment Start Date: **(MM/DD/YYYY)**		**Employment End Date:** **(MM/DD/YYYY)**	
Reason for Leaving:			

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, Florida Statutes, 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 license to practice as a physician assistant revoked, suspended, placed on probation, received a citation, or other action taken in any state, territory, or country? ☐ Yes ☐ No

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

If you responded "Yes" in questions A-B, 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**.

C. Are you currently under investigation or prosecution in any jurisdiction for an act that would constitute a violation under s. 456.072, Florida Statutes, or s. 458.331, Florida Statutes? ☐ Yes ☐ No

If you responded "Yes" to question C, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the investigation or prosecution.

☐ **A letter** from the state board/entity explaining the results of the investigation or prosecution.

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

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

D. Have you ever had health care related employment terminated for cause? ☐ Yes ☐ No

If you responded "Yes" to question D, you must provide the following:

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

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. Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

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), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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), Florida Statutes)? ☐ Yes ☐ No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, 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

Name: _____

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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

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, Florida Statutes? ☐ 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 BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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

Name: _____

12. 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 **EDOH4700Z**. 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.

13. 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, Florida Statutes.

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 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), Florida Statutes, 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

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, Florida Statutes, 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* 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 Medicine is **EDOH4700Z**.
- 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.

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Medicine
Council on Physician Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine License Verification Request

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

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

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Council on Physician Assistants.

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
* Was a temporary certificate issued prior to full licensure?
* 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.

Complete verifications must be mailed directly from the verifying agency to:

Board *of* Medicine
Council on Physician Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine
Physician Assistant Program Verification Request

Applicant Name: _____ Date of Birth: _____
MM/DD/YYYY

Physician Assistant Program Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

The individual listed above has applied to the Florida Council on Physician Assistants for licensure as a physician assistant. A diploma was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by completing the following. This form must include a signature and seal.

Type of Degree Awarded: ☐ Bachelor's ☐ Master's ☐ Other: _____

Degree Issued Date: _____
MM/DD/YYYY

Comments (if any): _____

_____

_____

_____

Verified by:

Name of Verifier: _____

Signature of Verifier: _____

Date: _____ Title of Verifier: _____
MM/DD/YYYY

[SEAL]