Complete forms must be mailed to:

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

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

Name:		
Street Address:		
City:	State:	Zip:

Select one of the three options below. Visit www.nica.com for information about each option.

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

Amount enclosed $_____

If you chose "$0.00 Exempt," provide appropriate documentation to the Board of Medicine and to NICA.

I have read the qualifying information provided by NICA, and I choose the option above based on that information.

Signature: _____ Date: _____

All applicants must complete, sign, and date this form. If you are a participating or non-participating physician, you must also include your payment in the form of a cashier's check or money order, made payable to the Department of Health.

If you are a **physician claiming exemption**, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

Any questions about NICA or this form should be directed to NICA at www.nica.com or (850) 488-8191.