FLORIDA
BOARD OF MEDICINE
TEMPORY CERTIFICATE TO PRACTICE MEDICINE FOR EDUCATIONAL PURPOSES FOR ALLOPATHIC PHYSICIANS

s.458.3137, F.S.

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 USCS § 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.

TEMPORY CERTIFICATE TO PRACTICE MEDICINE FOR EDUCATIONAL PURPOSES
1508

PLACE PHOTO HERE

NOTE: FULL FRONT AND SHOULDER PHOTO TAKEN WITHIN 60 DAYS PRECEDING DATE OF APPLICATION

1. I state that I have been invited by a plastic surgery training program that is affiliated with a medical school within this State and an educational symposium cosponsored by the American Society of Plastic Surgeons, the Plastic Surgery Education Foundation, or the American Society for Aesthetic Plastic Surgery, and am a recognized expert in a specific area of plastic surgery as demonstrated by peer-review publications, invited lectureships, and academic affiliations. Please choose from the following affiliations.

[ ] University of Florida
[ ] University of Miami
[ ] University of South Florida
[ ] Florida State University
[ ] The Florida International University
[ ] The University of Central Florida
[ ] The Mayo Medical School at the Mayo Clinic in Jacksonville

[ ] American Society of Plastic Surgeons
[ ] Plastic Surgery Education Foundation
[ ] American Society for Aesthetic Plastic Surgery

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

a. Have you ever changed your name through marriage or through action of a court? Yes____ No____

_____
(If yes, list name(s) and date(s) of name change(s))

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. MEDICAL EDUCATION:

COLLEGE/UNIVERSITY NAME	COLLEGE/UNIVERSITY ADDRESS (CITY/STATE/COUNTRY)	ATTENDANCE DATES (MONTH/YEAR)		TYPE OF DEGREE DATE RECEIVED
		FROM	TO	

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

EMPLOYMENT/ HOSPITAL	ADDRESS	EMPLOYMENT DATES (MONTH/YEAR)		POSITION/TITLE
		FROM	TO	

9. Are you a citizen of the United States? Yes_____No_____

   a. If foreign born, give date and place of Naturalization: _____

10. Have you ever been in the United States Military and/or Public Health Service? Yes_____No_____

    a. If yes, list branch of service, rank, and dates of service:_____

11. Do you hold or have you ever held any professional/medical license in any state in the United States, Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes_____No_____

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

    _____

12. Have you had any application for professional medical license denied by any state board or other governmental agency of any state or country? Yes_____No_____

13. 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 Medical Practice Act, unprofessional or unethical conduct? Yes_____No_____

14. Have you ever had any Medical/professional license revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state territory or country? Yes_____No_____

15. 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, F.S.? Yes_____No_____

16. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? Yes_____No_____

    a. If yes, provide institution name(s) and complete mailing address:
    _____

    _____

17. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any hospital, health maintenance organization, health institution, ambulatory surgical center, nursing home, clinic or medical facility? Yes_____No_____

18. Have you ever been asked, or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action or during any pending investigations into your practice? Yes_____No_____

19. Have you ever had any medical staff privileges restricted or not renewed by any hospital, institution, clinic or medical facility in lieu of disciplinary action? Yes_____No_____

20. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, 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_____

21. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 21a.) Yes_____No_____

21a. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? Yes_____No_____

22. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 22a.) Yes_____No_____

22a. 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_____

23. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 23a and 23b.) Yes_____No_____

23a. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? Yes____No_____

23b. Did the termination occur at least 20 years prior to the date of this application? Yes_____No_____

24. Have you ever been terminated for cause from participating in the Florida Medicaid program or sanctioned by any state Medicaid program? If yes, explain. Yes_____No_____

25. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? Yes_____No_____

26. Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00? Yes_____No_____
(If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.)

27. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? Yes_____No_____

28. Have you ever been made an offer to compromise or entered into any other arrangement for other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? Yes_____No_____

29. Have you ever been denied, or surrendered, a DEA Registration? Yes_____No_____

30. 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_____

31. 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_____

32. 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_____

33. 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_____

34. 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_____

35. 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_____

36. Have you ever had employment terminated for cause? Yes_____No_____

37. Have you ever had an application for membership denied by a Medical/professional society or association membership? Yes_____No_____

38. Have you ever had a Medical/professional society or association membership suspended? Yes_____No_____

39. Have you ever been notified to appear before a Medical/professional society or association in regard to charges/complaints filed against you? Yes_____No_____

40. Have you ever had any sanctions taken against you by a specialty board recognized by the American Board of Medical Specialties? Yes_____No_____

41. Are you certified by any Specialty Board recognized by the American Board of Medical Specialties? Yes_____No_____

42. Prevention of Medical Errors: I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu. Yes_____No_____

43. 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 s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐ **1.** I do **not** have hospital staff privileges and I have established an irrevocable letter or 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 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 s. 625.52, F. S., for an escrow account.

☐ **3.** I do **not** have hospital staff privileges 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 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.

☐ **4.** I **have** hospital staff privileges 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 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.

☐ **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 s. 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 s. 458.320(5)(g), F. S.

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 s. 458.317, F. S., and practice only under the scope of the limited license.

☐ **8.** **I do not practice medicine in the State of 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 two claims resulting in an indemnity exceeding $10,000 within the previous five-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 ten years of practice, to license revocation, suspension, or probation for a period of three 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), Florida Statutes, 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).

Under penalties of perjury, I declare that I have read the foregoing response in sub-question 9 of question 43, and the facts stated in it are true. A person who knowingly makes a false declaration under Section 92.525(2), F.S. is guilty of the crime of perjury by false written declaration, a felony of the third degree, punishable as provided in s. 755.082, s. 775.083, or s. 775.084

Signature of physician: _____ **Date:** _____

44. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to read the NICA information about each exemption at www.nica.com. Check only one.

[ ]	[ ]	[ ]	
$5,000	$250	$0	_____
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

_____

Signature Date

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your application.

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

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

45. Physical Description: COLOR OF EYES: _____ WEIGHT_____
COLOR OF HAIR:_____ HEIGHT_____
OTHER MEANS OF IDENTIFICATION:_____

46. STATEMENT OF APPLICANT: I,_____, state that I am the person referred to in the foregoing registration application and supporting documentation, and that the attached photograph is a true likeness of myself.

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 458.317, 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 application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my temporary certificate 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)*

Instructions for Completing the Application

IMPORTANT NOTICE:

Effective July 1, 2009, 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 has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, 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;
(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

Where to send the application: The original application accompanied by the applicable fee, should be addressed to the following:

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

Use of this address will ensure receipt of the application and fee(s). After posting of fee(s), the Bureau will forward the application to the Board of Medicine for processing of the application.

Where to send any additional documentation: Any additional documentation, sent either by the physician or by any other source on behalf of the physician, should be mailed to the following:

Department of Health
HMQAM/Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

No application will be considered complete until the following supporting documentation has been received in the Board office:

- Application fee: $300.00 (non-refundable)
  Initial license fee: $429.00
  NICA fee: $250.00 or $5,000.00 (please read enclosed NICA information)
- An original letter from the American Society of Plastic Surgeons, the Plastic Surgery Educational Foundation or the American Society for Aesthetic Plastic Surgery and from one of the medical schools located in the State of Florida verifying that you are applying in connection with a nationally sponsored educational symposium.
- One current photograph of the applicant;
- Copy of name change document if applicable;
- Copy of the original medical school degree

- Proof that you are a recognized expert in a specific area of plastic surgery as demonstrated by peer-review publications, invited lectureships, and academic affiliations.
- Copy of American Specialty Board certificate(s) if applicable;
- Two current original letters of recommendation addressed to the Florida Board of Medicine from medical physicians;
- Verifications directly from the Medical School, AMA, State Medical Board(s) and NPDB (Refer to the following for contact information of these entities)

Translations are required for all documentation not in English.

The applicant is responsible for requesting the following documentation be submitted directly to the Board of Medicine from the applicable entity:

- Request from the American Medical Association (AMA) an AMA Physician Profile sheet. The AMA may be contacted at the following:

  AMA
  515 North State Street
  Chicago, IL 60610
  (800)621-8335 or www.ama-assn.org

- Request from the National Practitioner Data Bank (NPDB) and Health Integrity Protection Data Bank reports. The NPDB/HIPDB may be contacted at the following:

  NPDB/HIPDB
  P.O. Box 10832
  Chantilly, VA 22021
  (800) 767-6732 or www.npdb-hipdb.com

- Request licensure verification from each State Medical Board in which the applicant holds or has ever held a medical license. A list of State Medical Boards is enclosed with the application packet. The application provides a form which may be used for this purpose and duplicated.

  Licensure Verifications received from www.veridoc.org are acceptable.

Please be advised, certain response(s) from any source may require additional clarification from the applicant.

The following instructions are in direct correlation with the numbered questions on the application.

1. Choose from the following medical school affiliations and/or sponsors.

2. **Name:** List first, middle and last name as it would appear on a birth certificate and/or legal name change document. Nicknames or shortened versions are unacceptable.
If there is a discrepancy between the applicant's name on the application and supporting documentation, please submit a written clarification.
If the applicant has ever legally changed their name through marriage or action of the court, submit a copy of the legal name change document.

3. **Mailing Address:** List the address where correspondence regarding your application should be received.

4. **Place & Date of Birth:** Provide city/state/country and month/day/year.

5. **Telephone Number(s):** Provide phone numbers of which you may be reached.

6. **Medical Degree:** List the name of the medical school of which the applicant graduated from. Include the city, state and/or country in which the medical school is located, and provide the date the applicant obtained the medical degree. Submit a copy of the original medical degree.

7. **Education:** List all medical school(s) attended. Provide institution address, dates of attendance (month/year) and the type of degree obtained Submit a copy of all medical school transcript(s). Acceptable documentation may be copies of official documents or submitted directly from the medical school(s). In the event the transcript is lost or destroyed, see Rule 64B8-4.009(4), Florida Administrative Code, for procedure to be followed.

8. **Employment Activities:** List all activities from the date of graduation from medical school to the present. If additional space is needed, attach a separate sheet.

9. **Citizenship:** Answer yes or no. If yes, and foreign born, complete section 10a.

10. **Military and/or Public Health Service:** Answer yes or no. If yes, complete section 11a. and submit a copy of the Honorable military discharge document.

11. **Medical License(s):** Answer yes or no. If yes, complete section 12a.
Request license verification be submitted to the Florida Board of Medicine direct from all State Medical Boards in which the applicant has ever held/holds a medical license.

If questions 12 - 15 are answered "yes", the applicant is required to submit written clarification. Also, request directly from the applicable State Board supporting documentation to include, notice(s), complaint(s), charge(s) and final order(s).

If question 16 is answered "yes", the applicant is required to submit complete mailing addresses of each hospital, institution, clinic or medical facility. The application provides a form which may be used for this purpose and duplicated.

If questions 17- 19 are answered "yes", the applicant is required to submit written clarification to include complete mailing address for the applicable facility.

If question 20 -24 are answered "yes", the applicant is required to submit written clarification and supporting documentation.

If question 25-26 are answered "yes", the applicant is required to provide the following:

- A statement indicating date of each incident and the number of cases.
- An explanation of details for each case and your involvement.
- A copy of complaint, judgments and/or settlements for each case where there was a judgment or settlement in an amount that exceeds $100,000.00.
- If you answered "yes" to question 25, in addition to submitting the above documents, submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment.

If questions 27-29 are answered "yes", the applicant is required to submit written clarification and supporting documentation.

If questions 30-35 are answered "yes", the applicant is required to submit the following:

- A written clarification of the reason(s) and date(s) of treatment, listing all physicians/therapists/counselors/hospitals/institutes where treatment was received;
- Each physician/therapist/counselor is required to submit a report directly to the Florida Board of Medicine regarding treatment. If applicable, include all DSM III R/DSM IV, Axis I and II diagnoses and codes. In addition, list all prescribed medications;

If questions 36-40 are answered "yes", the applicant is required to submit written clarification and supporting documentation.

If question 41 is answered "yes", the applicant is required to provide a copy of the Specialty Board certificate(s).

Continuing Medical Education – Question 42:
Prevention of Medical Errors: Check the box to certify that you have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education since June 1, 2002. The education must meet requirements defined in § 456.013(7), Florida Statutes, and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

Please note: You will be required by Chapter 456, F.S., to take an HIV/AIDS course approved by the board for your first renewal and a two (2) hour Domestic Violence Course approved by the board prior to your third renewal.

Financial Responsibility – Question 43: Check only one of the ten Financial Responsibility options to comply with §458.320, Florida Statutes. The options are divided into two categories: coverage and exemptions. If you

are not licensed in Florida through another licensure provision, you may choose the exemption provision until you are licensed and began practicing in Florida

Florida Birth Related Neurological Compensation Association – Question 44: if you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

Physical Description question 45: Complete your physical description

Statement of Applicant question 46: This section of the application must be completed. The applicant's name must be printed in the first blank and signed in the second. This section is copied and used as a release for information, therefore the printed name must be legible and the signature must be a legal signature.

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
TPS 1508
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253
(850) 245-4131

APPLICANT COMPLETE QUESTIONS 1-3 AND REMIT TO THE MEDICAL SCHOOL.

TO:_____
NAME OF MEDICAL SCHOOL

_____
ADDRESS OF MEDICAL SCHOOL

_____
CITY - STATE - ZIP - COUNTRY

Medical School: Please complete numbers 3 and 5, and authenticate by signature and seal (School or Notary). Return this form to the Florida Board of Medicine. Thank you!

FROM: Medical Graduate

1. NAME: _____
2. PROFESSION: _____
3. DATE OF BIRTH: _____
4. TYPE OF DEGREE: M.D. DATE DEGREE GRANTED: _____
5. COMMENTS:_____

_____

VERIFIED BY:_____
SIGNATURE

SEAL

_____
NAME

_____
TITLE

LICENSURE VERIFICATION REQUEST

TEMPORY CERTIFICATE TO PRACTICE MEDICINE FOR EDUCATIONAL PURPOSES

1. TO:_____
State

_____
Street Address

_____
City/State/Zip

I, the physician listed below, have made application for licensure in the State of Florida. Please forward verification of licensure directly to the Florida Board of Medicine.

(This form may be duplicated)
DOCTOR: COMPLETE #1 THROUGH #8 AND MAIL TO THE APPLICABLE STATE BOARD.
A copy of each request for licensure verification must accompany your application for licensure

2. DATE:_____

3. NAME:_____
First Middle Last

4. ADDRESS:_____
Street & Number City State Zip

5. PLACE OF BIRTH:_____
City State Country

6. DATE OF BIRTH:_____
Month Day Year

7. MEDICAL SCHOOL:_____
City State Country

8. YEAR OF GRADUATION:_____
Month Day Year

State Board, please return your completed form to:
The Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

TEMPORY CERTIFICATE TO PRACTICE MEDICINE FOR EDUCATIONAL PURPOSES SECTION

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, BIN #C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 488-0596-Fax

Staff Privilege Verification Form

The physician listed below submitted an application for Florida licensure and is under investigation by this authority. Please complete number 1 through 4 of this form, and return directly to the Board of Medicine. Thank you.

To: Medical Staff Office
Attn: Chief of Staff

_____
Facility

_____
Address

_____
City, State, Zip

From: Florida Board of Medicine -- Medical Endorsement/Examination Section

Name:_____

1. Does (s)he have full staff privileges in his/her specialty? Yes___ No___

   If no, explain _____

2. Does (s)he perform competently? Yes___ No___

   If no, explain_____

3. Has (s)he been regularly reappointed? Yes___ No___

   If no, explain_____

4. Have any restrictions ever been placed on this individual beyond the original period of probation? Yes___ No___

   If yes, explain_____

Remarks:_____

Date:_____

Signature of
Chief of Staff: _____
No **stamped** signatures please