30. Florida Birth Related Neurological Compensation Association

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

☐ $5,000 Participating

☐ $250 Non-participating

☐ $0 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.

_____ Name

_____ Signature Date

_____ Street Address

_____ City, State, Zip

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 payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

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