License Renewal Application

Active and Inactive Status

Expedite your application-renew online at: www.flhealthsource.gov

Return with fee payment by mail to:
DEPT of Health/ Board of Occupational Therapy Practice
P.O. Box 6330
Tallahassee, FL 32314-6330

or return by email to:
mqa.occupationaltherapy@flhealth.gov

License Number: ______________________________

List the profession for which you renewing: ______________________________
(Examples: Medical Doctor, Osteopathic Physician, Registered Nurse, Licensed Practical Nurse, etc.)

General Information:

Name: ______________________________
Last/Surname First Middle

Do you wish to change your name: ☐ **YES** ☐ **NO**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the Department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation. If the name change cannot be completed, your license will be renewed using the current name.

Mailing Address: The address where your correspondence and license should be mailed.

Do you wish to update your mailing address: ☐ **YES** ☐ **NO**

____
Street and #/P.O. Box Suite/Apt#

____
City State/Province Zip/Postal Code Country

Physical Address: A Post Office Box is not acceptable. This address will be posted of the Department of Health's website. If you do not have a current practice address your mailing address will be used.

Do you wish to update your physical address: ☐ **YES** ☐ **NO**

____
Street and number Suite/Apt #

____
City State/Province Zip/Postal Code Country

Do you wish to update your physical address to 'Not Practicing': ☐ **YES** ☐ **NO**

By checking the 'YES' box, you are indicating that you do not practice. The Department website will reflect 'Not Practicing' and your mailing address will be printed on your license.

Other Contact Information:

Do you wish to update or add a telephone or email address to your record: ☐ **YES** ☐ **NO**

Telephone: ______________________________
Primary Alternate

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.

Criminal History and Medicaid / Medicare Fraud Questions:

As required by Section 456.0635(3), Florida Statutes, please answer Yes or No to the following questions below. If you answer 'YES' to any of the following questions, please send a written explanation for each such question, including the county and state of each termination, plea, or conviction, the date of each termination, plea, or conviction, and copies of supporting documentation, to the address below. Supporting documentation may include court dispositions or agency orders.

Department of Health
Division of Medical Quality Assurance
Bureau of Operations
4052 Bald Cypress Way, Bin #C-10
Tallahassee, FL 32399-3260

1. ☐ Yes ☐ No 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? **(If you responded "no", skip to question 2.)**

- **a.** ☐ Yes ☐ No 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 or conviction, and completion of any sentence or subsequent period of probation?
- **b.** ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).
- **c.** ☐ Yes ☐ No If "yes" to 1, 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 or conviction, and completion of any sentence or subsequent period of probation?
- **d.** ☐ Yes ☐ No If "yes" to 1, are you currently enrolled in a drug court program that allows the withdrawal of the plea for the felony offense upon successful completion of the program? (If yes, please provide supporting documentation)

2. ☐ Yes ☐ No Since July 1, 2009, 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)? **(If you responded "no", skip to question 3.)**

- **a.** ☐ Yes ☐ No If "yes" to 2, did the sentence and any subsequent period of probation for such conviction or plea end more than 15 years before the date of this application?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If you responded "no", skip to question 4.)**

- **a.** ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no", skip to question 5.)**

- **a.** ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?
- **b.** ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No 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?

General Renewal Questions:

Do you wish to change your current license status? ☐ Yes ☐ No

If yes, please select from the list provided below:

- ☐ Active to Inactive Status
- ☐ Active to Retired Status
- ☐ Active to Military Status
- ☐ Inactive to Active Status
- ☐ Inactive to Retired Status
- ☐ Inactive to Military Status
- ☐ Military to Active Status
- ☐ Military to Inactive Status
- ☐ Military to Retired Status

Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Profession Specific Renewal Questions:

This question ONLY applies to Medical Doctors, Osteopathic Physicians, Advanced Registered Nurse Practitioners, Podiatric Physicians, and Dentists:

Are you currently registered to dispense medicinal drugs to your patients? ☐ Yes ☐ No

a. If YES, do you want to continue dispensing medicinal drugs? ☐ Yes ☐ No
b. If NO, would like to register to dispense medicinal drugs? ☐ Yes ☐ No

This question ONLY applies to Physician Assistants:

I acknowledge that I have not been convicted of a felony in the previous two years. ☐ Yes ☐ No

Are you a physician assistant who has registered for prescribing privileges? ☐ Yes ☐ No

a. If YES, do you want to renew your prescribing privileges? ☐ Yes ☐ No
b. If YES, I acknowledge that I have completed a minimum of 10 medical education hours in the specialty practice I have prescriptive privileges in. ☐ Yes ☐ No

This question ONLY applies to Chiropractic Physicians:

Are you a chiropractic physician certified to supervise certified chiropractic physician assistants? ☐ Yes ☐ No

a. If YES, do you want to renew your supervising physician certification? ☐ Yes ☐ No

This question ONLY applies to Advanced Registered Nurse Practitioner, Certified Registered Nurse Anesthetist, and Certified Nurse Midwife:

Were you licensed as an Advanced Registered Nurse Practitioner Certified Registered Nurse Anesthetist, and Certified Nurse Midwife in Florida prior to July 1, 2016? ☐ Yes ☐ No

a. If YES, provide the following information:

Certifying Board: ______________________________
Certification: ______________________________
Certification Number: ______________________________
Expiration Date: ______________________________

This question ONLY applies to Hearing Aid Specialists:

Do you possess a certificate from a manufacturer or independent testing agent certifying that the testing room meets the requirements of s. 484.0501(6), Florida Statutes? ☐ Yes ☐ No ☐ Not Applicable

Do you possess a certificate from a manufacturer or independent testing agent stating that all audiometric testing equipment used by the licensee has been calibrated acoustically to American National Standards Institute standards on an annual basis? ☐ Yes ☐ No ☐ Not Applicable

Statement of Applicant:

By submitting the appropriate renewal fees to the Department, I certify compliance with all requirements for renewal. I have carefully read the questions in the foregoing application and have answered them completely. These statements are true and correct. I recognize that providing false information may result in disciplinary action against my license, or criminal penalties. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the department within 30 days.

______________________________ ______________________

Signature **Date**