Osteopathic Physician Reactivation Request

Board of Osteopathic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 412-2684
Email: MQA.Osteopath@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

Reactivation fees are based on the current status of your license. Contact the department at (850) 488-0595 to determine the required fees.

Additionally, all payments to the Florida Birth Related Neurological Injury Compensation Association (NICA) **must be paid before** any Florida license can be reactivated. Contact the NICA office at (850) 488-8191 to determine your status.

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw must be made in writing.

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) **Florida License #:** OS____________

______________________________ ________ ____________________
Street/P.O. Box Apt. No. City

__________________ ______ ____________ ____________________
State ZIP Country Home/Cell Telephone (Input without dashes)

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 (Input without dashes)

Have you legally changed your name since your license was last active? Yes No

If "Yes," list the change and provide a copy of the name change document. ______________________________

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.

List all 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

Have you practiced on a full-time basis in another jurisdiction while your Florida license was inactive? Yes No

If "Yes," complete the following:

Jurisdiction	Practice Start Date (MM/DD/YYYY)	Practice End Date (MM/DD/YYYY)

Name: ____

2. APPLICANT SIGNATURE

I, ____________________________, depose and say that I am the person referred to in the foregoing application and supporting documents. I hereby 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 Osteopathic Medicine information which is material to my application for reactivation.

I have carefully read the question in the foregoing application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury 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 license to practice Osteopathic Medicine in the state of Florida. I also confirm that I will comply with all requirements for licensure renewal including continuing education credits.

Section 456.013(1)(a), F.S., 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

Applicants who do not currently have a practice address are required to update their online practitioner profile with a practice address when it is available.

Reactivation Information

Below is a list of rules relevant to reactivation.

Florida Administrative Code	Rule Title
64B15-13.002	Continuing Education Requirements for Reactivation
64B15-12.007	Inactive Status License
64B15-13.001	Continuing Education for Biennial Renewal
64B15-13.005	Performance of Pro Bono Medical Services

Before reactivating your license the board requires updated financial responsibility information. The “Financial Responsibility” pages from the “Osteopathic Physician Application for Licensure” are attached for your convenience.

This form is required for ALL applicants.

Board *of* Osteopathic Medicine

Financial Responsibility

Name: ____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 6** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

1. I do not have hospital privileges and I have obtained and will maintain professional liability coverage in an amount of 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.
2. I have hospital staff privileges and I have obtained and maintain 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., or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110, F.S.
3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, F.S., in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, F.S., in the per-claim amounts specified above.
4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to ch. 675, F.S., in an amount no less than $250,000 per claim, with a minimum aggregate availability of credit not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgement indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be non-assignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52, F.S., in the per-claim amounts specified above.
5. I have decided to not carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgements pursuant to the terms and conditions contained in s. 459.0085(5)(g), F.S. I understand that I shall be required to either post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided to pursuant to Florida law.

Name: ____

6. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
2. I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
3. I practice only in conjunction with my teaching duties at a college of osteopathic medicine (residents **do not qualify** for this exemption).
4. I have no malpractice exposure, because I do not practice in the state of Florida. I will notify the department immediately before commencing practice in the state.
5. I am exempt from demonstrating financial responsibility due to meeting all the following criteria (If you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):
   a. I have held an active license to practice in another state for more than 15 years.
   b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
   c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
   d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any state.
   e. I have not been subject, within the last ten year of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to who medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided to pursuant to Florida law.

Section 456.067, F.S.: Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, F.S., s. 775.083, F.S., or s. 775.084, F.S.

Applicant Signature ____ Date _______________
MM/DD/YYYY

If you selected an option out of options one through four in the "Financial Responsibility Coverage" section, proof of liability coverage must be sent directly by the insuring company to the board at:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Board of Osteopathic Medicine
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming exemption based on #5 on the preceding page.

I, ____________________________________, do hereby certify and attest that I meet all the following criteria:
(Name)

a. I have held an active license to practice in another state for more than 15 years.
b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
d. I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any state.
e. I have not been subject, within the last ten year of practice, to license revocation or suspension for any period of time, probation for a period of three years or longer, or a fine of $500.00 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a **sign prominently displayed** in the reception area and clearly noticeable by all patients or to provide a written statement to any person to who medical services are being provided. **Such sign or statement shall state that:** Under Florida law, osteopathic physicians are generally required to carry malpractice insurance otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided to pursuant to Florida law.

Applicant Signature ____ Date ________________
MM/DD/YYYY

State of ___________ County of __________

Sworn to and/or subscribed before me this _______________ day of _______________________, 20___________

by ____

Personally Known __________________ OR Produced Identification __________________

Type of Identification Produced _______________________________

Notary Signature ____________________________ Printed Name of Notary _______________________________

These signature fields cannot be typed. You must print the application and sign it before a notary public.

[NOTARY SEAL]