

**State of Florida
Department of Health**

Board of Osteopathic Medicine

**Application for
Registration as an Unlicensed
Osteopathic Physician**



Board of Osteopathic Medicine
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 488-0595

JEB BUSH
Governor

JOHN O. AGWUNOBI, MD, MBA
Secretary

Application for Registration as an Unlicensed Osteopathic Physician

The following instructions are numbered to correspond with the numbered sections of the application. Each numbered instruction will give specific information regarding filling out the corresponding numbered section of the application.

A response must be given in each section. If a question does not pertain to you, indicate N/A in that section. All questions with Yes/No answers must be answered either YES or NO. No other response will be accepted for YES/NO questions. NOTE: We strongly recommend that the forms you complete are forms received from this office or the medical education coordinator office. "Unofficial" copies are frequently outdated.

Your application should be received by the Board Office **AT LEAST 30 DAYS PRIOR** to the training start date or the expiration of an existing number. NOTE – Our fiscal year ends June 30 and the Board cannot process any applications for at least a week at the end of that month, therefore if your training begins on July 1, or shortly thereafter, your application must be received by the Board Office no later than June 1 to ensure that your number is issued prior to your anticipated start date.

ADDITIONAL/SUPPLEMENTAL DOCUMENTS REQUIRED:

- A copy of your diploma verifying graduation from Osteopathic Medical School (for initial applications only).
- A letter from your program director or coordinator verifying registration/acceptance into their training program. Note to program coordinators – you may submit one cover letter/memo listing all applicants if you send in a group of applications at once.
- A list of all sites that you will be training at while in Florida. This can be included in the letter from the program director/coordinator.

Please be advised that your application will be returned as incomplete if the above documents are not received with your application.

APPLICATION COMPLETION INSTRUCTIONS :

1. **Social Security #:** List your social security number.
 2. **Name:** List your full name.
 3. **Date of Birth:** List your date of birth.
 4. **Place of Birth:** List your place of birth.
 5. **Telephone Numbers:** List both your home and work numbers.
 6. **Mailing Address:** List the address where you receive mail.
 7. **Physical Address:** This should be the address where you reside. It may be the same as the mailing address. If so, please indicate. No PO Boxes.
 8. **Osteopathic Medical Degree:** List the name of your Osteopathic Medical school, the city and state and the date you graduated.
 9. **Florida Postgraduate Training Program:**
 - a) List the name of the hospital or institution/program where you are going to commence training. This should be the hospital or institution in the **State of Florida** for which this form is being completed. Please include the name of the Educational Facility as well as the name of the hospital.
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- b) List the full mailing address of the institution/program, including; floor numbers, room numbers, specific program areas (i.e. anesthesiology etc.). This should be the address of your official place of practice.
 - c) List the name of the Director of the program and/or person who is your immediate supervisor.
 - d) List the phone number where the program director/administrator may be contacted. Include extension, if applicable.
 - e) List your specialty area of training.
 - f) List the dates you plan to begin and end your training. PLEASE NOTE: All registration numbers expire after one year. If you plan to continue your training after one year, you must submit a new application and fee.
10. List any license you hold or have ever held in the space provided. Attach additional sheets if necessary. You must submit an official (mailed directly from the state of licensure to our office) license verification for any license you now hold or have ever held in any state.
- 11 – 21 You must answer YES or NO to each of these questions. If you answer YES, please provide a detailed explanation on a separate sheet of paper. Please be advised that additional information and/or documentation MAY be required.
22. **Physical Description:** Response to this section is self-explanatory.
23. **Affidavit of Applicant:** Please read this section carefully and sign where indicated. If your application is not signed and dated upon receipt, it will be returned to you as incomplete.
24. **PHOTOGRAPH:** One photograph is required for all applicants. The photo must be no smaller than 2" x 2" and be a full front shot of your head and shoulders. The picture must have been taken within 60 days of the date of the application.

YOU MUST NOTIFY US IMMEDIATELY OF ANY OCCURRENCES WHICH WOULD CHANGE OR AFFECT IN ANY WAY, AN ANSWER OR RESPONSE YOU HAVE GIVEN IN THE APPLICATION. FAILURE TO DO SO COULD RESULT IN THE DENIAL OR REVOCATION OF YOUR REGISTRATION.

APPLICATION FOR REGISTRATION AS AN UNLICENSED OSTEOPATHIC PHYSICIAN

FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
PO Box 6330
Tallahassee, FL 32314-6330

Check only one – Client 1902

- Initial Registration - \$100 Fee Required
 Renewal of Registration - \$100 Fee Required

Please type or print in black ink

| | |
|----|---|
| 1. | Social Security #: _____ |
| 2. | Name: _____ (Last) (First) (Middle) |
| 3. | Date of Birth: _____ (MM/DD/YYYY) |
| 4. | Place of Birth: _____ (City/State/Country) |
| 5. | Telephone Number: _____ (Residence – area code/number) (Office – area code/number) |
| 6. | Mailing Address: _____ (Number and Street or PO Box) _____ (City, State and Zip) |
| 7. | Physical Address: _____ (Number and Street - NO PO Box) _____ (City, State and Zip) |
| 8. | Osteopathic Medical Degree obtained from: _____ (Name of School) _____ (City/State) _____ (Date of Graduation – MM/DD/YYYY) |
| 9. | FLORIDA Postgraduate Training Information: |
| | a) Name of Hospital/Training Program: _____ (Please list the hospital/training program in FLORIDA where you plan to train) |
| | b) Full Mailing Address: _____ (Number and Street) _____ (City, State and Zip) |
| | c) Program Director/Administrator: _____ |
| | d) Phone Number: _____ (area code/number) |
| | e) Specialty Area: _____ |
| | f) Dates of Training: _____ (MM/DD/YY) through (MM/DD/YY) |

10. Do you now hold, or have you ever held a license to practice Osteopathic Medicine or any other profession in any US State, territory or foreign country? YES NO

(If Yes, list profession, state, license number and date of issuance)

11. Have you ever been dropped, suspended, placed on probation, expelled, requested to resign or otherwise acted against by any school, college, university or training program? YES NO

12. Was attendance in Osteopathic Medical school or any postgraduate training program for a period other than the normal curriculum or established time frame? YES NO

13. Were you required to repeat any part of your Osteopathic Medical education, or postgraduate training program for any reason? YES NO

14. Have you ever had a any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or licensing authority in any state, territory or country? YES NO

15. Have you ever been convicted of, or entered a plea or guilty, nolo contendere or no contest to a crime, regardless of adjudication, in any jurisdiction? YES NO

16. Have you ever been criminally or civilly with any intentional or negligent action related to use or misuse of drugs, alcohol or illegal substances? YES NO

17. In the last 5 years, have you been enrolled in, required to enter into or participated in any drug or alcohol recovery program or impaired practitioner program? YES NO

18. In the last 5 years, have you undergone treatment for or had a recurrence of a diagnosed mental disorder? YES NO

19. In the last 5 years, have you been treated for or had a recurrence of a diagnosed physical impairment? YES NO

20. Do you have any condition that might affect your ability to practice your profession or that might affect your ability to safely perform any procedures or tasks that are within the scope or your practice? YES NO

21. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s.459.015, F. S.? YES NO

22. Physical Description:

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978. This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: Caucasian Black Hispanic Asian Native American Other: _____

Sex: Male Female

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

23. Affidavit of Applicant:

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

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 any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations 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 understand that 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. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(specification of date, event or condition upon which this consent expires)

Signature of Applicant

Date

24.

Attach
2 x 2 inch
photograph
here