Application for Out-of-State Telehealth Provider Registration

Completed applications must be sent to:

Telehealth
4052 Bald Cypress Way, Bin C-11
Tallahassee, FL 32399-1708

OR

Email: MQA.Telehealth@flhealth.gov

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM / DD / YYYY

Mailing Address: (The address where your mail and registration should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Telephone Number

Gender: ☐ Male ☐ Female

Email Notification: Provide your email address on the line below if you choose to be notified of the status of your application via email. You will be responsible for checking your email regularly and updating your email address with the Department of Health. 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. Contact the office by phone or in writing instead.

Email Address: _____

2. LICENSE REGISTRATION INFORMATION

To qualify as a telehealth provider in Florida, you must have an out-of-state license or certification that is the same or substantially similar to those listed in section 456.47(1)(b), Florida Statutes.

A. List the health care profession for which you are licensed. List the name of the profession, for example: Medical Doctor, Osteopathic Physician, Advanced Nurse Practitioner, Licensed Mental Health Counselor, etc. Do **not** use abbreviations.

Profession: _____

B. Provide the license or certification information for the profession listed in part A. The license must be active and unencumbered from another state, District of Columbia, or U.S. territory. If the license is not the same as one listed in section 456.47(1)(b), Florida Statutes, you must include documentary evidence with this application that your license is substantially similar to one listed. Although applicants frequently have multiple state licenses, list the license that is equivalent to the telehealth registration profession requested.

License / Certification Number	State / Territory	Original Date Issued MM / DD / YYYY	Expiration Date MM / DD / YYYY

Telehealth staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

3. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to 42 U.S.C. § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____

Social Security number issued by the United States Social Security Administration

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, sections 653 and 654; and sections 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

4. EDUCATION HISTORY

Section 456.47(4)(h), Florida Statutes, requires the Department of Health to publish completed health care training and education of all telehealth registrants on its website, including completion dates, any certificates or degrees obtained, specialties, and board certifications.

A. List any training and education related to the license or certification you are registering in chronological order, whether completed or not (if incomplete, list N/A for completion date):

School Name	Degree / Certificate	Completion Date MM / YYYY

B. List any postgraduate training related to the license or certification you are registering in chronological order, whether completed or not (if incomplete, list N/A for completion date):

Program Name	Specialty Area	Completion Date MM / YYYY

C. List any board certifications or specialties if applicable:

Board Name	Certification / Specialty	Certification Date MM / YYYY

5. DISCIPLINARY HISTORY

Section 456.47(4)(b), Florida Statutes, provides that telehealth registrants cannot have been the subject of disciplinary action relating to their license or certification within the last five years of applying for registration.

A. Have you had disciplinary action taken against your license to practice any health care related profession, up to and including revocation, by the licensing authority in any state, jurisdiction, or country? ☐ Yes ☐ No

B. Have you surrendered a license to practice any health care related profession in any state, jurisdiction, or country while any such disciplinary charges were pending against you? ☐ Yes ☐ No

C. Do you have any disciplinary investigation or action pending against any license? ☐ Yes ☐ No

If you answered "Yes" to parts A, B, or C, complete the following:

Profession	License Number	State	Action Date MM / DD / YYYY	Final Action

☐ Applicants are required to send a copy of the **Administrative Complaint** and **Final Order** for each disciplinary action listed in the table above.

Applicant Name: _____

6. FINANCIAL RESPONSIBILITY

Section 456.47(4)(e), Florida Statutes, requires **all telehealth providers** to maintain professional liability coverage or financial responsibility that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state. The coverage amount must be equal to or greater than the requirements in sections 456.048, 458.320 (for the practice of medicine), or 459.0085 (for the practice of osteopathic medicine), Florida Statutes.

Choose only ONE option that best describes your situation.

Your choice should be consistent with financial responsibility information provided to a hospital or other entity. Failing to choose an option or choosing more than one will invalidate this section and delay your registration. Department staff cannot advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company, or financial institution.

☐ A. I have obtained and will maintain professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 from an authorized insurer under section 624.09, Florida Statutes, a surplus lines insurer under section 626.914(2), Florida Statutes, the Joint Underwriting Association under section 627.351(4), Florida Statutes, a self-insurance plan under section 627.357, Florida Statutes, or a risk retention group under section 627.942, Florida Statutes.

OR

☐ B. I have obtained and will maintain an unexpired irrevocable letter of credit or escrow account as defined by chapter 675, Florida Statutes, which is in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000.

7. MEDICAL MALPRACTICE INSURANCE

Section 456.47(4)(h), Florida Statutes, requires the Department of Health to publish the medical malpractice insurance provider and policy limits, including whether the policy covers claims in Florida, of all telehealth providers on its website.

A. List your medical malpractice insurance provider:

Insurance Provider: _____

B. List the policy limits of liability:

Policy Limits: $_____ / $_____
Per Claim Amount Aggregate Amount

C. Does your insurance policy cover claims that arise in Florida? ☐ Yes ☐ No

Applicant Name: _____

8. DESIGNATION OF REGISTERED AGENT

A registered agent is an individual or entity which is designated to receive service of process notices or other correspondence from the Florida Department of Health. Section 456.47(4)(b), Florida Statutes, provides that every out-of-state telehealth provider must have a designated registered agent, who has an address in Florida. The sole purpose of a registered agent is to ensure the department has an official established contact when needed. In accordance with section 607.0501, Florida Statutes, they must be registered with the department of state, but it is not necessary that they be affiliated with a health care provider/facility.

The registered agent selected must be listed in the Florida Department of State, Division of Corporations' database. The database is not intended to provide assistance in locating a registered agent, only to verify the registered agent status of the individual selected. Once identification and communication with a registered agent has been established, visit https://dos.myflorida.com/sunbiz/ and click **"Search Records"** then choose **"Registered Agent Name."** Type in the registered agent's name to verify that the name and address match the registered agent information provided in the application for registration. **The department is unable to recommend a registered agent.**

In the Florida Department of State, Division of Corporations' database, all registered agents will be associated with an LLC. The details of this LLC are not material to the application for registration - department staff do not review the LLC and there is no requirement to create an LLC. When verifying the registered agent selected, staff will match the name and address listed on the application in the database under the section titled **"Registered Agent Name & Address."** The database is maintained by the Department of State; Department of Health staff have no ability to make changes to the website. For any questions about how to use the website listed above, use the Division of Corporations' guide at https://dos.myflorida.com/sunbiz/search/guides/corporation-records or contact the Division of Corporations.

The registered agent will provide guidance on how to designate them and may require a fee for their services. The department is not responsible for any costs associated with designating or contracting with registered agents.

Provide the name and street address of the identified registered agent. The agent's name must be on the Registered Agent Name List maintained by the **Division of Corporations** as described above. Changes to the registered agent and/or office after registration must be reported to the department on the "Change of Registered Agent and/or Registered Office" form (DH5038-MQA).

Name of Registered Agent: _____

Physical Address: _____ _____
Street (cannot be a P.O. Box) Apt./Suite No.

_____ **Florida** _____
City State ZIP

9. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for telehealth registration in the state of Florida.

I recognize that providing false information may result in disciplinary action against my registration or criminal penalties pursuant to section 456.067, Florida Statutes.

Florida law requires me to immediately inform the board, or the Department of Health if there is no board, of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the registration and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant's Signature: _____ **Date:** _____
Applicants may print the application and sign it or sign digitally. MM / DD / YYYY