

## 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

|          | me:<br>Last/Surname   | First   | Middle  | Date of Birth:  |
|----------|---|---|---|---|
| Ма       | illing Address: (The addre  | ess where your mail and regi  | stration should be sent)                                |   |
| Str      | eet/P.O. Box  |   | Apt. No.  | City  |
| Sta      | ate   | ZIP   | Country   | Telephone Number  |
| Ge       | nder: Male  | Female  |   |   |
| Ema      | il Address:   |   |   | <u></u>   |
| . LI     | CENSE REGISTRATIO   | N INFORMATION   |   |   |
| To       | o qualify as a telehealth   |   |   | cense or certification that is the same or  |
| To<br>su | o qualify as a telehealth<br>ubstantially similar to tho<br>. List the health care pr | provider in Florida, you m<br>se listed in section 456.4<br>ofession for which you ar | 7(1)(b), Florida Statutes.<br>e licensed. List the name | cense or certification that is the same or of the profession, for example: Medical lental Health Counselor, etc. Do <u><b>not</b></u> use |

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

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

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.

license that is equivalent to the telehealth registration profession requested.

## 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 <a href="https://www.ssa.gov">www.ssa.gov</a> or by calling 1-800-772-1213.

|            | Applicant Name:  |                  |       |                  |                              |  |
|------------|--|------------------|-------|------------------|------------------------------|--|
| 4.         | EDUCATION HISTORY  | DUCATION 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. |                  |       |                  |                              |  |
|            | <b>A.</b> 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  |                  | •     | e / Certificate  | Completion Date<br>MM / YYYY |  |
|            |  |                  |       |                  |                              |  |
|            |  |                  |       |                  |                              |  |
|            | B. List any postgraduate traini     whether completed or not (i  |                  |       |                  | in chronological order,      |  |
|            | Program Name   |                  | Spe   | cialty Area      | Completion Date<br>MM / YYYY |  |
|            |  |                  |       |                  |                              |  |
|            |  |                  |       |                  |                              |  |
|            | C. List any board certifications or specialties if applicable:   |                  |       |                  |                              |  |
|            | Board Name   | ·                | •     | tion / Specialty | Certification Date MM / YYYY |  |
|            |  |                  |       |                  |                              |  |
|            |  |                  |       |                  |                              |  |
| <b>5</b> . | 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>B.</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          | State | Action Date      | Final Action                 |  |

Applicants are required to send a copy of the <u>Administrative Complaint</u> and <u>Final Order</u> for each disciplinary action listed in the table above.

|                  |                        | Applicant Name:   |
|------------------|------------------------|---|
| FII              | NAN                    | CIAL RESPONSIBILITY   |
| fin<br>loc<br>se | ancia<br>ated<br>ction | 1 456.47(4)(e), Florida Statutes, requires <u>all</u> <b>telehealth providers</b> to maintain professional liability coverage or al responsibility that includes coverage or financial responsibility for telehealth services provided to patients not in the provider's home state. The coverage amount must be equal to or greater than the requirements in s 456.048, 458.320 (for the practice of medicine), or 459.0085 (for the practice of osteopathic medicine), Statutes.                              |
| <u>Cr</u>        | 100S                   | e only ONE option that best describes your situation.   |
| to<br>sta        | choc<br>aff ca         | noice should be consistent with financial responsibility information provided to a hospital or other entity. Failing use an option or choosing more than one will invalidate this section and delay your registration. Department nnot advise you on which option to choose. If you have questions regarding an option, consult your personal punsel, 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.  |
| ME               | EDIC                   | AL MALPRACTICE INSURANCE  |
| ins              |                        | a 456.47(4)(h), Florida Statutes, requires the Department of Health to publish the medical malpractice ace provider and policy limits, including whether the policy covers claims in Florida, of all telehealth providers or site.  |
| Α.               | Lis                    | t your medical malpractice insurance provider:  |
|                  | Ins                    | urance Provider:  |
| В.               | Lis                    | t the policy limits of liability:   |
|                  | Ро                     | licy Limits: \$ / \$  |
|                  |                        | Per Ciaim Amount Addredate Amount   |

Yes

No

C. Does your insurance policy cover claims that arise in Florida?

6.

7.

|    | 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 correspondence from the Florida Department of Health. Section 456.47(4)(b), Florida Statutes, provides out-of-state telehealth provider must have a designated registered agent, who has an address in Florida purpose of a registered agent is to ensure the department has an official established contact when need accordance with section 607.0501, Florida Statutes, they must be registered with the department of statutes are provider/facility.   | that every<br>. The sole<br>led. In   |  |  |
|    | The registered agent selected must be listed in the Florida Department of State, Division of Corporations The database is not intended to provide assistance in locating a registered agent, only to verify the registereds of the individual selected. Once identification and communication with a registered agent has bee visit https://dos.myflorida.com/sunbiz/ and click "Search Records" then choose "Registered Agent Nathe registered agent's name to verify that the name and address match the registered agent information the application for registration. The department is unable to recommend a registered agent.  | stered agent<br>n established,<br>nme." Type in                               |  |  |
|    | In the Florida Department of State, Division of Corporations' database, all registered agents will be asso LLC. The details of this LLC are not material to the application for registration - department staff do not read there is no requirement to create an LLC. When verifying the registered agent selected, staff will may and address listed on the application in the database under the section titled "Registered Agent Name The database is maintained by the Department of State; Department of Health staff have no ability to may to the website. For any questions about how to use the website listed above, use the Division of Corpora at https://dos.myflorida.com/sunbiz/search/guides/corporation-records or contact the Division of Corporation and the contact the Division of Corporation at https://dos.myflorida.com/sunbiz/search/guides/corporation-records or contact the Division of Corporation and the contact the Division of Corporation at https://dos.myflorida.com/sunbiz/search/guides/corporation-records or contact the Division of Corporation and the contact the Division of Corporation at https://dos.myflorida.com/sunbiz/search/guides/corporation-records or contact the Division of Corporation and the contact the Corporation and the contact the Corporation and the corporation and the corporation and the corporation and the corpora | eview the LLC<br>atch the name<br>& Address."<br>ake changes<br>ations' guide |  |  |
|    | The registered agent will provide guidance on how to designate them and may require a fee for their ser department is not responsible for any costs associated with designating or contracting with registered agent   |   |  |  |
|    | Provide the name and street address of the identified registered agent. The agent's name must be on the Agent Name List maintained by the <b>Division of Corporations</b> as described above. Changes to the registand/or office after registration must be reported to the department on the "Change of Registered Agent a Registered Office" form (DH5038-MQA).  | stered agent  |  |  |
|    | 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 Florida.   | ne state of   |  |  |
|    | 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 affiling with the department.   | ter the initial   |  |  |
|    | Applicant/a Cignotura  |   |  |  |
|    | Applicant's Signature: Date:   | DD ()000(   |  |  |

Applicants may print the application and sign it or sign digitally.

MM / DD / YYYY