

**Department of Health  
Board of Clinical Laboratory Personnel  
4052 Bald Cypress Way, Bin #C07  
Tallahassee, FL 32399-3257  
(850) 245-4355**

## **GENERAL INFORMATION**

### **Application for Public Health Laboratory Scientist (Director, Supervisor, Technologist and Technician)**

#### **HOW TO APPLY FOR FLORIDA CLINICAL LABORATORY PERSONNEL LICENSURE**

1. **FLORIDA LAWS & RULES:** You may download a copy of Section 483, Part III, Florida Statutes at <http://www.floridasclinicallabs.gov/> . It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure.

2. **APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:**

Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after initial filing with the department.

3. **NATIONAL EXAM INFORMATION:**

Chapter 483, Part III, F. S., states that public health laboratory scientist applicants desiring licensure at the director, supervisor and technologist levels must take and pass a national examination. Personnel who meet the education requirements may become licensed if certified by one of these national examinations.

**Director and Supervisor:**

American Society of Microbiology  
(202) 942-9281

National Registry of Certified Chemists  
(703) 979-9001

**Technologist:**

American Society for Microbiology  
(202) 942-9281

National Registry in Clinical Chemistry Certification  
(703) 979-9001

National Registry of Microbiology Certification  
in Public Health Microbiology  
(202) 942-9281

If you are certified by organizations other than those listed, you may not be eligible for licensure.

4. **YES/NO QUESTIONS:**

All questions with "Yes or No" answer must be marked with either a "Yes or No". No other response is acceptable. For questions which require a brief explanation or description of "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). Certified or civil notary documentation of final disposition to "Yes" answers is required.

5. **FEDERAL PRIVACY ACT:**

Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. **In this instance, disclosure of a social security number is mandatory pursuant to Title 42 United States Code, Sections 653 and 654, and sections 456.013, 409.2577 and 409.2598, F.S.** Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Barring any exemption under Florida law or federal law, social security numbers must be recorded on all professional and occupational licensure applications and will be used for license verification. **Note: If you do not fill in your social security number, your application may be delayed.**

**SUPPORTING DOCUMENTS – THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:**

**1. Fee Schedule:** A certified check, or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

**Initial licensure level:**

Application Fee	\$25.00
Licensure Fee	\$25.00
Unlicensed Activity Fee	\$5.00
<b>Total Fee:</b>	<b>\$55.00</b>

**Additional Specialty to Existing Licensure Level:**

Application Fee	\$25.00
Licensure Fee	\$25.00
<b>Total Fee:</b>	<b>\$50.00</b>

**2. HIV/AIDS and Medical Errors:** Florida law requires that all initial licensure applicants to complete Florida Board approved courses in HIV/AIDS and two (2) hours on the prevention of medical errors education prior to licensure.

**PLEASE NOTE:** To obtain information for the HIV/AIDS and Prevention of Medical Errors courses, contact CE Broker @ 1-877-434-6323 or [www.cebroke.com](http://www.cebroke.com)

**3. Applicant Education and Training Data:** Official transcripts must be sent directly to this office from your college or university. If you were educated in an institution outside of the United States, it is your responsibility to have your education evaluated to determine the U. S. equivalency.

If you have attended an accredited program or an approved technical training program that is not part of your college degree, submit a notarized copy of the training certificate you were issued or submit a notarized copy of your diploma or certificate of graduation. If you have completed a Florida training program, include the training program approval number.

**NOTE: Even though you may have submitted these documents with a prior application, you may be required to resubmit them.**

It is the responsibility of the applicant to know the requirements for licensure before an application is submitted. Determine what is necessary according to your own qualifications. Official transcripts must be sent directly from the school; student copies are not acceptable (see additional sections concerning foreign transcripts and U. S. equivalency). A notarized copy of a diploma or a DD-214 (military) may document training, but the employer must verify experience. Applicants are advised to submit as much documentation of education, experience, and training with the original application.

**4. Verification of Experience - (Do not include testing done in research, physician office laboratories or veterinary work.)**

Forward the verification of experience form to your employer for completion. A letter from the employer may be used to document experience but it must contain all of the information requested on the verification of employment form. Have your employer verify the tests you performed. This form is used to determine whether you have performed tests in the full range of each area of the laboratory.

**5. Name Change:** Notify the board office in writing of any change in name or address. If you have changed your name (by marriage, divorce or court order) since your last application (including license renewal), you must submit a certified copy of the marriage, divorce or court record in order to change your name for licensure purposes.

## FOREIGN EDUCATION EQUIVALENCY REQUIREMENTS

All foreign graduates who intend to utilize credit earned in colleges or universities outside of the United States to qualify for licensure will need to provide evidence of U. S. equivalency of such credit hours. The credentials evaluation must be performed by one of the acceptable credential evaluation services and include a breakdown of all college level courses by subject. Credit hours must be listed in semester hours. The credentials evaluation should be sent directly to the board office from the evaluator. If transcripts cannot be ordered from the foreign institution, certified copies of the original documents used in the evaluation must be submitted to the agency.

**NOTE: Bachelor's degrees from Puerto Rico and the Philippines do not need a credentials evaluation; however, official transcripts must be submitted from the institution.**

### ACCEPTABLE FOREIGN CREDENTIALS EVALUATION SERVICES:

1. JOSEF SILNY & ASSOCIATES  
INTERNATIONAL EDUCATIONAL  
CONSULTANTS  
7101 SW 102 AVENUE  
MIAMI, FL 33173  
PHONE: (305) 273-1616  
FAX: (305) 273-1338
2. FOUNDATION FOR INTERNATIONAL  
SERVICES, INC.  
14926 35<sup>th</sup> AVENUE WEST, SUITE 210  
LYNWOOD, WA 98087  
PHONE: (425) 248-2262  
FAX: (425)248-2262  
[www.fis-web.com](http://www.fis-web.com)
3. EDUCATION CREDENTIAL  
EVALUATORS, INC.  
P. O. BOX 92970  
MILWAUKEE, WI 53202-0970  
PHONE: (414) 289-3400  
FAX: (414) 289-3411
4. CENTER FOR APPLIED RESEARCH,  
EVALUATION & EDUCATION, INC.  
P.O. BOX 18358  
ANAHEIM, CA 92817  
PHONE: (714) 237-9272  
FAX: (714) 237-9279
5. INTERNATIONAL EDUCATION  
RESEARCH FOUNDATION, INC.  
P. O. BOX 3665  
CULVER CITY, CA 90231  
PHONE: (310) 258-9451  
FAX: (310) 342-7086
6. WORLD EDUCATION SERVICES, INC.  
P.O. BOX 01-5060  
MIAMI, FL 33101  
PHONE: (305) 358-6688  
[www.wes.org](http://www.wes.org)
7. FOREIGN ACADEMIC CREDENTIALS  
SERVICES, INC.  
P. O. BOX 400  
GLEN CARBON, IL 62034  
PHONE: (618) 307-6036  
(618) 656-5291  
FAX: (618) 656-5292
8. WORLD EDUCATION SERVICES, INC.  
BOWLING GREEN STATION  
P.O. BOX 5087  
NEW YORK, NY 10274-5087  
PHONE: (212) 966-6311  
FAX: (212) 739-6100  
[www.wes.org](http://www.wes.org)

**BOARD OF CLINICAL LABORATORY PERSONNEL  
-- PUBLIC HEALTH --**

**APPLICATION CHECKLIST**

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- \_\_\_ 1. Application:
- All questions answered on all pages and if question not applicable, mark with N/A
  - All "Yes" answers must be accompanied by an explanation, as instructed.
  - Public Records Disclosure Form SSN
- \_\_\_ 2. Fees:
- Please make certified check or money order payable to DOH-Board of Clinical Laboratory Personnel
- \_\_\_ 3. Proof of HIV/AIDS
- \_\_\_ 4. Proof of Medical Errors
- \_\_\_ 5. Official College Transcript
- \_\_\_ 6. Verification of National Certification
- American Society of Microbiology providing Specialty
  - National Registry of Certified Chemists (**Supervisor ONLY**)
  - National Registry of Microbiology Certification in Public Health Microbiology providing Specialty
- \_\_\_ 7. Verification of Employment/Experience

Please make cashier check or money order payable to the Department of Health. Return application and fees to:

Department of Health  
Revenue Services  
P.O. Box 6330  
Tallahassee, FL 32314-6330

Mail all supporting documents/correspondence to: (documents sent separate from application/no money)

Department of Health  
Board of Clinical Laboratory Personnel  
4052 Bald Cypress Way, Bin #C07  
Tallahassee, FL 32399-3257



## CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

### Florida Department of Health Board of Clinical Laboratory Personnel

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

**Name:** \_\_\_\_\_  
                    **Last**                                    **First**                                    **Middle**

**Social Security Number:** \_\_\_\_\_

**APPLICANT HISTORY:** (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO
2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice clinical laboratory personnel within the past five years? [ ] YES [ ] NO
4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice clinical laboratory personnel? [ ] YES [ ] NO
5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO
6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice clinical laboratory personnel within the last five years? [ ] YES [ ] NO

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4052 Bald Cypress Way, Bin # C07  
Tallahassee, Florida 32399-3257

# BOARD OF CLINICAL LABORATORY PERSONNEL PUBLIC HEALTH LICENSURE

(Client 6601)

PLEASE PRINT OR TYPE IN BLACK INK

INITIAL LICENSURE: \$55.00

ADDITIONAL SPECIALTY TO EXISTING LICENSE: \$50.00

Application Fee (non-refundable) - \$25.00  
Initial License Fee - \$25.00  
Unlicensed Activity Fee - \$5.00

Application Fee (non-refundable) - \$25.00  
License Fee - \$25.00

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**CATEGORY: (Director, Supervisor, Technologist and Technician)**

**Please Note: YOU MAY SELECT ONLY ONE LICENSURE LEVEL PER APPLICATION**

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**Director:** (xact 1057)     **Supervisor:** (xact 1056)     **Technologist:** (xact 1055)     **Technician:** (xact 1050)  
 **Microbiology**  
 **Chemistry**

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## PROFILE DATA:

**1. NAME:** \_\_\_\_\_  
(Last) (First) (Middle)  
a. Have you changed your name through marriage or through action of a court, or have you been know by any other name?  
 Yes  No

\_\_\_\_\_  
If yes, list name(s) (Last, First, Middle) and Date(s) of changes

**2. MAILING ADDRESS:** \_\_\_\_\_  
(Street and Number) (Apt. #) (City) (State) (Zip)

**PRIMARY LOCATION:** \_\_\_\_\_  
(Street and Number) (Apt. #) (City) (State) (Zip)

**3. TELEPHONE:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home: Area Code/Phone Number Work: Area Code/Phone Number

**4. LICENSE NUMBER IF CURRENTLY LICENSED IN FLORIDA:** \_\_\_\_\_

**5. PERSONAL DATA:**

a. Date of Birth: \_\_\_\_\_

b. E-mail Address: \_\_\_\_\_

**Email Notification:** If you want to notified of the status of your application by email please check the "YES" box and write your email address on the line provided above. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office [info@floridasclinicallabs.gov](mailto:info@floridasclinicallabs.gov) . Under Florida law, email addresses are public records. If you do not want your e-mail 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.  YES  NO

c. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (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  African-American/Black  Hispanic  Asian  Native American  Other

SEX:  Male  Female

d. Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?  Yes  No

NAME: \_\_\_\_\_

**6. APPLICANT EDUCATION AND TRAINING DATA:**

a. Education: \_\_\_\_\_  
(Name of School(s) you attended)

Did you Graduate?  Yes  No

Degree: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

a. Name of accredited training program attended: \_\_\_\_\_  
Did you complete the program?  Yes  No Year Completed: \_\_\_\_\_

**7. NATIONAL CERTIFICATION:**

American Society of Microbiology: Specialty: \_\_\_\_\_  
 National Registry of Clinical Chemistry Certification: Specialty: \_\_\_\_\_  
 National Registry in Microbiology Certification in Public Health Microbiology: Specialty: \_\_\_\_\_

**8. EXPERIENCE – Use the enclosed verification form to verify experience.**

**9. APPLICANT HISTORY:**

- a. Regardless of adjudication, have you ever been convicted of a violation of, or pled nolo contendere to, any Federal, State, Local statute, regulation, or ordinance, or entered into any plea, negotiated plea, bargain, or settlement relating to a misdemeanor or felony?  Yes  No
- b. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.  Yes  No
- c. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances?  Yes  No

**IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.**

**10.** Have you been convicted of, or entered a plea of guilty or nolo contendere, 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 felon offense(s) in another state or jurisdiction? **(If you responded NO, skip to 11)**  YES  NO

- a. If “yes” to 10, for felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?  YES  NO
- b. If “yes” to 10, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).  YES  NO
- c. If “yes” to 10, for 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, sentence and completion of any subsequent probation?  YES  NO

NAME: \_\_\_\_\_

- d. If “yes” to 10, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? **(If “yes”, please provide supporting documentation)**  
[ ] YES [ ] NO
11. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to 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)? [ ] YES [ ] NO
- a. If “yes” to 11, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO
12. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If “No”, do not answer 12a.)** [ ] YES [ ] NO
- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? [ ] YES [ ] NO
13. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If “No”, do not answer 13a or 13b.)** [ ] YES [ ] NO
- a. Have you been in good standing with a state Medicaid program for the most recent five years? [ ] YES [ ] NO
- b. Did the termination occur at least 20 years before to the date of this application? [ ] YES [ ] NO
14. 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? [ ] YES [ ] NO
15. If “yes” to any of the questions 10 through 14 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession’s licensing board or the Department of Health?  
**(If “yes”, please provide official documentation verifying your enrollment status.)** [ ] YES [ ] NO
16. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? [ ] Yes [ ] No
17. Have you had any application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state? [ ] Yes [ ] No
18. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? [ ] Yes [ ] No
19. Have you been refused a license to practice, or the renewal thereof in any state or other jurisdiction? (The intent of this question does not pertain to the failure of previous examination) [ ] Yes [ ] No

**20. APPLICANT STATEMENT:**

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

I state 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 Sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers (past and present), and all government agencies and instruments (local, state, federal, or foreign) to release to the Department of Health any information, files and/or records requested by the Department of Health in connection with the processing of this application. I further authorize the Department of Health to release to the organization, individuals, and groups listed above any information which is material to my application.



I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted with any material change in circumstances or conditions which might affect the Board of Clinical Laboratory's decision concerning my eligibility for licensure (Section 456.013, Florida Statutes). Failure to do so may result in denial of licensure and/or other action by the Board of Clinical Laboratory Personnel.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservation of any kind and I declare that the answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of the license for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of licensure renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

I understand that an incomplete application shall expire one year after initial filing with the Department of Health as stated in Section 456.013(1)(a), Florida Statutes.

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(Signature of Applicant)

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(Date)

Please make cashier check or money order payable to the Department of Health. Return application and fees to:

Department of Health  
Revenue Services  
P.O. Box 6330  
Tallahassee, FL 32399-6330

Mail all supporting documents/correspondence to: (documents sent separate from application/no money)

Department of Health  
Board of Clinical Laboratory Personnel  
4052 Bald Cypress Way, Bin #C07  
Tallahassee, FL 32399-3257

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**Tallahassee, FL 32399-3257**

**VERIFICATION OF EMPLOYMENT**

**APPLICANT: Complete only the upper portion of this form. Do not fill out employer section.** Forward to your laboratory Supervisor/Director or Personnel Director for completion. The form must be signed by both. Do not write over/white-out information, or fill in the list of tests or the form will be returned to you.

I \_\_\_\_\_, authorize you to verify my employment to the Board of Clinical Laboratory Personnel.

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

**EMPLOYER: Please complete the information below:**

Dates of employment: Month/Year: \_\_\_\_\_ to Month/Year: \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

**“X” SPECIALTY WORKED (You may use a separate sheet)**

Microbiology \_\_\_\_\_  
(Test performed)

Clinical Chemistry \_\_\_\_\_  
(Test performed)

Did this person demonstrate competency in all areas of experience marked above?  Yes  No  
(If “No” attach a separate sheet with an explanation)

The above information is correct to the best of my knowledge.

\_\_\_\_\_  
(Signature of Supervisor/Director or Personnel Director)

\_\_\_\_\_  
(Date)