

**STATE OF FLORIDA
BOARD OF ACUPUNCTURE**

**APPLICATION FOR LICENSURE
WITH INSTRUCTIONS**



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

Board of Acupuncture Application Instructions and Checklist

U U U U U U U U U U **ATTENTION** U U U U U U U U U U

- Please retain the application instructions for your records. Do not return them with your application.
- Make a copy of everything you send including the application. You may need to reference it during the application process.
- Read all instructions thoroughly before completing the application. Most questions will be answered by reading the enclosed instructions, application, and supplemental documentation forms.
- Failure to send in required documents may result in the delay of your application processing.
- Mail the completed ORIGINAL application and cashier's check or money order to the department at the address noted below.

MAILING ADDRESS: Please use the below addresses as they apply.

APPLICATION AND FEES MUST BE MAILED TO:	ALL ADDITIONAL DOCUMENTS MUST BE MAILED TO:
Department of Health Board of Acupuncture P.O. Box 6330 Tallahassee, FL 32399-6330	Department of Health Board of Acupuncture 4052 Bald Cypress Way Bin C06 Tallahassee, FL 32399-3256

REQUIRED DOCUMENTATION

CREDENTIALS - All documents submitted in a language other than English are required to be translated into English by a certified translator other than an applicant. Translated documents **MUST** state that the translator is competent in both languages of the documentation. The original English translation **MUST** be submitted with a copy of the document that was translated. Translation of any document relative to an applicant's application shall be at the expense of the applicant.

CRIMINAL HISTORY DOCUMENTATION – If you answered yes to any of the criminal history questions on the application you will need to send in the following:

- Self-explanation: A brief, legible explanation of the events and what you are doing to insure they do not occur again
- Arrest Documentation: Including the arrest date, arrest charge and court sentencing. This may be obtained from the clerk of court in the county the offense occurred.
- Final Disposition: Including proof of successful completion of sentencing, if applicable. This may be obtained from the clerk of court in the county the offense occurred. You must submit this document for each offense.

HEALTH HISTORY DOCUMENTATION – If you answered yes to any of the health history questions on the application you will need to send in the following:

- Self-explanation as described above in the criminal history section
- Letter from your physician(s) or other health care worker stating your current status and ability to practice your profession

PROFESSIONAL DISCIPLINARY HISTORY – If you answered yes to any of the professional disciplinary history on the application you will need to send in the following:

- Self-explanation as described above in the criminal history section
- All official disciplinary documentation from the state licensing board where you were disciplined

YOUR APPLICATION WILL NOT BE CONSIDERED COMPLETE UNTIL THESE RECORDS ARE RECEIVED.

MINIMUM CHECK LIST FOR ALL APPLICANTS:

- Complete the Confidential and Exempt from Public Records Disclosure Form
 - Completed application, printed (clearly) or typed.
 - A cashier's check or money order made payable to the Department of Health.
- Fees are subject to the date the license is issued. All licenses expire on February 28, every even numbered year.

- **Application fee:** \$200.00 (**NON-REFUNDABLE**)
- **Unlicensed Activity Fee:** \$ 5.00
- **Initial Licensure Fee:** \$200.00
- **TOTAL FEES:** \$405.00

- NCCAOM Exam Results/Status Report that indicates successful completion of examination. You may log on the NCCAOM website at www.nccaom.org to obtain additional information. **Note:** Please submit your application after successfully completing the NCCAOM examination.
- Proof of English is required if examination was taken in a language other than English. Provide documentation of earning a passing score of the Test of English as a Foreign Language (TOEFL) or Test of Spoken English (TSE) examination. You may log on the TOEFL site at <http://www.ets.org/toefl/> to obtain additional information.
- Financial Responsibility / Professional Liability Coverage Acknowledgement
- Proof of Age - Submission of a birth certificate or a legible copy of your driver license is acceptable.
- 20 hour Florida Law and Rules course - This course is required for initial licensure and may or may not be included in your Acupuncture transcript. If this course is not listed in your Acupuncture transcript you may log on to CE Broker at www.cebroker.com to find information on obtaining this course.
- 15 hours of universal precautions

SUPPLEMENT DOCUMENTATION FOR EXAMINATION APPLICANTS

2 Year Program – students enrolled in a program prior to August 1st, 1997

- ❑ Official transcript sent from your Acupuncture school
 - 900 hours of Supervised Instruction in Traditional Oriental Acupuncture
 - 600 hours of Supervised Clinical Experience

All applicants under this provision must have started classes no later than February 1, 1998.

4 Year Program - ACAOM candidate or accredited 4-year Masters Program in Oriental Medicine

- ❑ Official Transcript of 60 college credits from an accredited postsecondary institution as a prerequisite to enrollment in an authorized course of study in acupuncture and oriental medicine.
- ❑ Official Transcript sent from your Acupuncture_school
 - 2700 hours of supervised instruction
 - 20 hours of Florida Laws and Rules
 - 8 hour program that incorporates the safe and beneficial use of laboratory tests and imaging findings in the practice of acupuncture and oriental medicine
 - 15 hours of Universal Precaution or Clean Needle Technique from Council of Colleges of Acupuncture and Oriental Medicine
 - First Aid
 - CPR

SUPPLEMENTAL DOCUMENTATION FOR ENDORSEMENT APPLICANT

- ❑ Official Transcript sent from your Acupuncture school
- ❑ The Exam Results/Status Report from NCCAOM that indicates certification which includes either a:
 - Foundations of Oriental Medicine Module;
 - Acupuncture with Point Location Module;
 - Biomedicine Module;
 - Chinese Herbology
- ❑ Proof of completion of the Clean Needle Technique from Council of Colleges of Acupuncture and Oriental Medicine (endorsement through another state license)
- ❑ Verification of licensure from the licensing agency of each state by which you are now or have been licensed. This verification must come directly from the licensing board.
- ❑ Basis for issuing state license including examination requirements which the applicant was required to successfully complete in order to be licensed in that state.



APPLICATION FOR ACUPUNCTURE LICENSURE
PLEASE TYPE OR PRINT IN BLUE OR BLACK INK

MEDICAL QUALITY ASSURANCE
FLORIDA BOARD OF ACUPUNCTURE

Post Office Box 6330
Tallahassee, FL 32314
(850) 488-0595
www.FLHealth.gov

FAILURE TO SUBMIT FEES, TO COMPLETE THIS APPLICATION, OR TO ATTACH ANY REQUIRED DOCUMENTATION WILL RESULT IN AN INCOMPLETE APPLICATION. YOUR APPLICATION WILL NOT BE CONSIDERED FOR APPROVAL UNTIL IT IS COMPLETE.

PLEASE INDICATE WHICH METHOD YOU ARE APPLYING BY:

- | | |
|---|--|
| <input type="checkbox"/> Examination
(XACT 1022) | <input type="checkbox"/> Examination enrolled prior to August 1, 1997
(XACT 1023) |
| <input type="checkbox"/> Endorsement by NCCAOM Certification
(XACT 1020) | <input type="checkbox"/> Endorsement through another State License
(XACT 1030) |

1. PERSONAL INFORMATION

NAME: Last/Surname _____ First _____ Middle _____

DATE OF BIRTH (M/D/Y) _____

MAILING ADDRESS: _____ Suite/Apt. No. _____

City _____ State _____ Zip _____ Country _____

PHYSICAL LOCATION: _____ Suite/Apt. No. _____

City _____ State _____ Zip _____ Country _____

HOME TELEPHONE: _____ **BUSINESS TELEPHONE:** _____

E-Mail Address: _____

EQUAL OPPORTUNITY DATA:

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 CFR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: Male Female RACE: White Black Asian/Pacific Islander Hispanic Other _____

NAME _____

2. PRE-ACUPUNCTURE EDUCATION HISTORY

College(s) and/or University(s) accepted as the prerequisite for enrollment in your acupuncture and oriental medicine program:

<u>Name of School</u>	<u>Location</u>	<u>Date of Attendance</u>	<u>Graduation Date</u>	<u>Degree</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. ACUPUNCTURE EDUCATION

Name of Acupuncture School: _____

City: _____ State: _____ Zip: _____

Country: _____ Graduation Date: _____

4. APPLICANT BACKGROUND Attach additional sheets, if necessary

A. List any other name(s) by which you have been known in the past.

B. What name(s) did you use when you received your acupuncture education?

C. What name did you use when you were first licensed? (If you have ever been licensed before):

D. List all healthcare licenses you have ever held (**active, inactive or lapsed**). Submit a License Verification Form to all states where you have ever held licensure. (ATTACH ADDITIONAL SHEET, IF NECESSARY.)

<u>State/Country</u>	<u>Profession</u>	<u>License No.</u>	<u>Issue Date</u>	<u>Expiration Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NAME _____

5. PROFESSIONAL DISCIPLINARY HISTORY (Review instructions for required documentation)

- A. Yes No Have you ever been denied the right to take an Acupuncture examination or the examination to practice any profession in any state?
- B. Yes No Have you ever been refused a license or renewal of a license to practice Acupuncture or any other profession in any state?
- C. Yes No Have you ever had a license or certificate of registration to practice Acupuncture, or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in any proceeding in any state?
- D. Yes No Is there a complaint currently pending against you in any jurisdiction or an investigation of your professional conduct or competence in or related to the practice of a profession?
- E. Yes No Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was an alleged negligence, malpractice, or lack of professional competence?

6. CRIMINAL HISTORY (Review instructions for required documentation)

- A. Yes No 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 records of conviction. **Driving under the influence (DUI) or driving while impaired (DWI) is not a minor traffic offense for purposes of this question.** The fact that a plea, conviction or disposition of a criminal case is on appeal does not affect your obligation to disclose the plea or conviction under this question.
- B. Yes No Have charges ever been brought against you by any branch of the United States Armed Services

7. SECTION 456.0635(2), FLORIDA STATUTES

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.

- 7. 1. Yes No (a.) Have you been convicted of, or entered a plea of guilty or nolo contendere to, 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 felony offense(s) in another state or jurisdiction? (If you responded “no”, skip to # 7.2.)
 Yes No (b.) If “yes” to 7.1.a., have you successfully completed a drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed? (If “yes”, please provide supporting documentation)

NAME _____

Yes No (c.) If "yes" to 7.1.a., for felonies of the first or second degree, has it been more than 15 years before the date of application?

Yes No (d.) If "yes" to 7.1.a., for felonies of the third degree, has it been more than 10 years before the date of application, except for felonies of the third degree under Section 893.13(6), Florida Statutes?

Yes No e.) If "yes" to 7.1.a., for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of application?

7.2. Yes No (a.) Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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 (b.) If "yes" to 7.2.a., has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

7.3. Yes No (a.) Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 7.3.b.)

Yes No (b.) If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

7.4. Yes No (a.) 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 7.4.b. or 7.4.c.)

Yes No (b.) Have you been in good standing with a state Medicaid program for the most recent five years?

Yes No (c.) Did the termination occur at least 20 years before the date of this application?

7.5. Yes No 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?

13. ADDITIONAL INFORMATION

Yes No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?



**CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS
DISCLOSURE***

14. HEALTH HISTORY (Supporting documentation should be sent directly to the Board Office)

Supporting documentation must include: **1)** a letter from the applicant explaining the medical condition(s) or occurrence(s) and current status; and **2)** letter(s) from a licensed professional summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any “yes” answer. Documentation should be current within the last year.

- A. Yes No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?
- B. Yes No 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?
- C. Yes No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice acupuncture within the past five years?
- D. Yes No 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 acupuncture?
- E. Yes No 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?
- F. Yes No 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 your profession within the past five years?

Name: _____
Last First Middle

Social Security Number: _____

* 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 _____

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by section 456.013(1), F.S. Failure to do so may result in denial of licensure or disciplinary action by the Board.

I understand that furnishing false information on or in support of this application shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida in the profession for which I am applying and could result in criminal charges as provided in sections 456.067, 775.083 and 837.06, F.S. I hereby acknowledge that practice as a licensed Acupuncturist in Florida is governed by Chapters 456 and 457, F.S., and Rule Chapter 64B1, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 457, F.S., and Rule Chapter 64B1, F.A.C.

Applicant Signature: _____

Date Signed: _____



FLORIDA BOARD OF ACUPUNCTURE LICENSE VERIFICATION REQUEST

After completion of this form, please forward this form to the licensing agency of each state by which you are now or have been licensed. This verification must come directly from the licensing board.

Applicant Name: _____ SSN: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Acupuncture.

Applicant Signature: _____ Date: _____

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STATE LICENSING AGENCY

PLEASE NOTE:

All verifications shall be completed in English and mailed or sent electronically directly from the state(s) or jurisdiction(s) and must include the following criteria:

- Typed on an official state form or letterhead
- Include an official Board seal
- Signature and title of state Board official

The following information must be included in all verifications:

- Licensee name
- License number
- State or jurisdiction of licensure
- Dates of issuance/expiration
- Licensure method; exam type or endorsement
- Licensure status
- Is license in good standing?
- Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?

Complete verifications must be mailed to or sent electronically directly from the official state licensing board to:

Florida Board of Acupuncture
4052 Bald Cypress Way
Bin C06, Tallahassee, FL **32399-3256**

FAX: 850.921.6184 or **Email address: MQA_Acupuncture@flhealth.gov**

NAME _____

PROFESSIONAL LIABILITY COVERAGE ACKNOWLEDGEMENT

Please select **only one** of the following statements that best describes your liability coverage:

CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- I hereby certify that I have professional liability coverage in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.
- I hereby certify that I have an irrevocable letter of credit, established pursuant to Chapter 675, in an amount not less than \$10,000 per claim, with a minimum aggregate availability of credit no less than \$30,000.
- I hereby certify that I have obtained a surety bond in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- I practice only in conjunction with my teaching duties at an accredited acupuncture school.
- I do not practice in the State of Florida.

I understand that providing false information may result in disciplinary action or criminal penalties as provided in Section 456.067, 456.072, 775.082, 775.083, and 775.084, Florida Statutes.

Name (printed)

Signature (required)

Date