AGENCY FOR HEALTH CARE ADMINISTRATION
BUREAU OF MANAGED HEALTH CARE
2727 MAHAN DRIVE, MAIL STOP #26
TALLAHASSEE, FL 32308-5403

HEALTH CARE PROVIDER APPLICATION FOR CERTIFICATION

Name:	**Florida DOH License Number:**
Profession:	**License Expiration Date:**
Facility Name:	**Facility Type:**
Federal Employer Identification Number:	**Facility Contact Person:**
Address:	**Telephone Number:**
	Fax Number:

HEALTH CARE PROVIDER OR FACILITY AGREES TO THE FOLLOWING:

1. To have access to and be familiar with the applicable Workers' Compensation Manuals/Rules.
2. To follow the policies and procedures therein.
3. To have knowledge of all statements authorized under my signature and to be responsible for the content of all bills submitted pursuant to the fraud provision in s. 440.105, Florida Statutes.
4. Completion of the specific Workers' Compensation certification training course pursuant to 59A-29, Florida Administrative Code, on _____(MM/DD/YY), in _____(city), Florida, by _____(course sponsor name).

CERTIFICATION TRAINING COURSE: ☐ Initial ☐ Repeat ☐ Exempt*

1. Has your professional license or the license of the facility been revoked, suspended, or voluntarily relinquished within the past twelve months? Yes ☐ No ☐
2. Have you been, placed on probationary status by a professional credentialling body within the past twelve months? Yes ☐ No ☐
3. Have you or your facility been convicted within the past twelve months or are you currently under charges for any felony, crime, or ethical violation? Yes ☐ No ☐
4. Are you currently decertified pursuant to 59A-29.006, Florida Administrative Code? Yes ☐ No ☐

IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS, ATTACH AN EXPLANATION AND A FINAL DECREE.

*Exempt pursuant to 59A-29.004, Florida Administrative Code.

The following photocopy attachments are required with this application if you are **NOT LICENSED** by the Department of Health, either:

- CURRENT FLORIDA MEDICAL SCHOOL TEACHING CERTIFICATE;
- CURRENT TEMPORARY CERTIFICATE IN AN AREA OF CRITICAL NEED PURSUANT TO S. 458.315, FLORIDA STATUTES, FOR MEDICALLY CRITICAL AREAS.

Signature:	Date:

IMPORTANT! The Agency will return a copy of this page within 90 days of receipt as proof of your certification. In order to ensure and expedite this process, please print or type your mailing address in the box below.

MAILING ADDRESS:

FOR OFFICIAL USE ONLY: CERTIFICATION: ☐ CONFERRED ☐ DENIED REASON FOR DENIAL: _____ _____ _____ Additional requirements needed: ☐ Yes ☐ No	AGENCY CERTIFICATION STAMP