



DEPARTMENT OF HEALTH
MQA/Practitioner Reporting & Examination Services
4052 Bald Cypress Way, BIN#C-90
Tallahassee, Florida 32399-3290

EXAMINER/EXAMINATION CONSULTANT RESUME

Note: Please complete this resume form in consideration for your employment as an Examiner/Examination Consultant with the Department of Health. Please print or type all information.

NAME, ADDRESS AND TELEPHONE:

Name: _____

Work Address: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Fax: _____

E-Mail Address: _____ Cell: _____

GENERAL BACKGROUND INFORMATION:

1. Do you have a relative(s)* currently enrolled in an educational institution pursuing a course of study in the subject matter of this profession? **YES NO**

If yes, please indicate relationship, course of study, institution:

*For the purposes of this question, "relative" is defined as an individual who is related to the examiner/consultant as father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister.

2. Are you presently employed by an education institution in Florida in which you are teaching or associated with the subject matter of this profession? **YES NO**

If yes, please indicate the institution and your position:

3. Have you ever served as an Examiner or Consultant for the State of Florida? **YES NO**

GENERAL BACKGROUND INFORMATION CONTINUED:

4. Have you ever had your professional or occupational license revoked, suspended, or otherwise acted against by the State of Florida? **YES NO**

If yes, explain:

5. Have you ever had your professional or occupational license revoked, suspended, or otherwise acted against by a licensing agency in another state, territory, or country? **YES NO**

If yes, explain:

6. Are you currently under investigation by the Department of Health or by any state or federal agency? **YES NO**

If yes, explain:

7. Have you ever been convicted of a felony or first degree misdemeanor? **YES NO**

If yes, what charges?

Where convicted? _____ Date: _____

8. Are you presently employed in an OPS or career service position, or under contract and receiving payment from one or more agencies of the State of Florida, including the Department of Health and the State University System? **YES NO**

If yes, name of State Agency or University:

In what capacity?

9. Are you currently participating or planning to participate in any examination preparatory courses or lectures for the purpose of training candidates to take any Department of Health examination? **YES NO**

If yes, explain:

GENERAL BACKGROUND INFORMATION CONTINUED:

This page is for Dentists and Dental Hygienists ONLY. Dentists/Dental Hygienists, please answer the below questions and continue to the last page. If this section is not applicable, please indicate this and continue to the last page. This section is not applicable.

10. How, if in any* way, are you involved with a regional organization having dental and/or dental hygiene examinations as a significant endeavor of such regional organization?

*This includes, but is not limited to, any official or unofficial memberships, consultant, advisor or honorary type positions, committee appointments, paid or unpaid.

11. Regarding any involvement identified in question 11 above, please identify each organization with which you are involved and specify the extent of your involvement with each such identified regional organization.
12. What, in detail, is your involvement with any of the following listed organizations: NERB, ADEX, CRDTS, CITA, WREB, and SRTA? Regarding such involvement with the identified or comparable organizations not specifically identified, please specify the nature of any professional, volunteer, or contractual relationship and how such relationship would influence or otherwise impact your role as a consultant concerning the Florida examinations.
13. How, if in any way, are you involved with other testing organizations not identified in response to question 13 above that do not have dental or dental hygiene testing as a primary endeavor of the organization?
14. What is the extent of your involvement with each of the other testing organizations identified in the question above?

PROFESSIONAL INFORMATION

Professional Licensure Currently Held:

Professional Area	License Number	Date Licensed (Yr)

Educational Background Related to Your Profession:

Name of Institution	State	Date Attended (Mo/Yr)	Certificate/Degree Awarded	Major area of Study

Employment Related to Your Profession: (List three recent positions held. Begin with present position.

If self-employed, please indicate.)

Employer Name/City	Job Title	Employment Dates (Yr)

Certification:

I hereby certify that all statements made on this or any attached resume are true to the best of my knowledge. I understand that any misrepresentation of material facts may invalidate my employment with the Department of Health.

Signature: _____ Date: _____