STATE OF FLORIDA
BOARD OF ACUPUNCTURE

APPLICATION FOR LICENSURE
WITH INSTRUCTIONS

Department of Health
Board of Acupuncture
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256
(850) 488-0595
www.doh.state.fl.us/mqa/acupunct

December 2009 Edition

Board of Acupuncture
Application Instructions and Checklist

CREDENTIALS

All documents submitted in a language other than English are required to be translated into English by a translator other than an applicant. **Translated documents MUST bear the affidavit of the translator certifying that they are competent in both languages of the documentation, and be subscribed to before a notary public.** 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.

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

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.
  - Application fee: $300.00 (NON-REFUNDABLE)
  - Unlicensed Activity Fee: $5.00
  - *Initial Licensure fee: $400.00, if **licensed** during (10/02/odd year – 02/28/odd year)
    $200.00, if **licensed** during (03/01/ odd year – 9/30/ odd year)

  *Subject to date of issuance of license. All licenses expire on February 28, every even numbered year.
- ❑ One full-faced passport type photograph (size 2X2) taken within the past six months.
- ❑ 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.
- ❑ 2 hours of Prevention of Medical Errors – 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.
- ❑ Name Change Documentation - If you have legally changed your name through marriage or action of the court you must submit all names in which you have been known and submit a copy of a marriage or divorce decree or other court document reflecting the legal name change.
- ❑ Military Documentation **–** If you have ever been in the United States Military, please provide a copy of your DD214 or a copy of your current orders. If you have ever been sanctioned by the military or received a dishonorable discharge, you must also submit a letter explaining the sanction and documentation form the military regarding the sanction and any action taken as a result.

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
  - 5 hours of Laboratory Test
  - 3 hours of Imaging Findings
  - 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
- ❑ Proof of completion of the Clean Needle Technique from Council of Colleges of Acupuncture and Oriental Medicine
- ❑ 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.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Acupuncture
Application for Licensure

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 USCS § 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.**

Do Not Write In This Space Office Use Only
Acupuncture Application Client 3801

State of Florida
Acupuncture Application

Board of Acupuncture
PO Box 6330
Tallahassee, Florida 32399-6330
(850) 488-0595

1. Select Application Category:

☐ Examination (XACT 1022)	☐ Examination enrolled prior to August 1, 1997 (XACT 1023)	☐ Endorsement by NCCAOM Certification (XACT 1020)	☐ Endorsement through another State License (XACT 1030)

2. 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 disasters? ☐ Yes ☐ No

Applicant Data Profile:

3. Name:	**(First)**	**(Middle Initial)**	**(Last)**

4. Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ☐ Yes ☐ No

If yes, list name(s) and date(s) of name change(s):

5. Mailing Address:	**(Street number & Name)**	
	(City , State & Zip Code)	
6. Physical Address	**(Street number & Name)**	
	(City , State & Zip Code)	
7. Phone Numbers:	**(Home Phone Number)**	
	(Business Phone Number)	
8. Correspondence:	Do you prefer to receive Email correspondence? Email Address:	☐ Yes ☐ No

9. Date Of Birth (Month/Day/Year):	**10. Place Of Birth (City/State/Country):**

11. Your furnishing the following information below is purely VOLUNTARY. 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 FR38296 (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: ☐ Female ☐ Male

Race And National Origin: ☐ Caucasian ☐ Hispanic ☐ Black ☐ Native American ☐ Oriental ☐ Other:______

Are you a citizen of the United States? ☐ Yes ☐ No If No, provide alien number:____________________________

12. Have you ever been in the United States Military or Public Health Service? ☐ Yes ☐ No

If "yes", answer the following questions:

a. List branch of service, rank and dates of service: ________________________ ☐ Yes ☐ No

b. Have charges ever been brought against you by any branch of the United States Armed Services? ☐ Yes ☐ No

Statement of Education:

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

Name of School	Location	Date of Attendance	Graduated	Degree
______________	________________	______________	________	______
______________	________________	______________	________	______
______________	________________	______________	________	______
______________	________________	______________	________	______

30. Acupuncture Education:

Name of Acupuncture School: ____

City: ________________________________ State: _________________ Zip: ____________

Country: _____________________________ Graduation Date:_________________________

Applicant Licensure Status:

13. Do you now hold or have you ever held a license (medical or professional service) or certificate of registration to practice Acupuncture or any other healthcare profession, in any state, U.S. territory, or foreign country? (e.g.: Nursing, Chiropractic, Facial and Skin Care Specialist, Physical Therapist, Occupational Therapist, etc.) ☐ Yes ☐ No

If "YES", list all such licenses below and submit license verification for each license. (License verification means a letter from each state indication the license is/was in good standing):

State	License Number	Issue Date	Current Status	Licensure Method
_____	_____________	________	____________	______________
_____	_____________	________	____________	______________
_____	_____________	________	____________	______________
_____	_____________	________	____________	______________

APPLICANT HISTORY – GENERAL

Concerning this section of the application, failure by the applicant to provide the supporting documentation and information requested at the time the application is filed could lead to a delay in the processing of the application, including but no limited to a required appearance before the Board to answer questions, and other measure authorized by law.

PROFESSIONAL LICENSURE

If you answer "yes" to the below questions 14-17 then you must provide the following documentation with the application when it is filed:

1. ***Complete details as to the state(s), license number(s), date(s), and relevant circumstances on attached sheets.***
2. ***A copy of any documentation from the state regarding the final actions/outcome of the issue.***

Question	Answer
14. Have you ever been denied the right to take an Acupuncture Examination or the examination to practice any profession in any state?	☐ Yes ☐ No
15. Have you ever been refused a license or renewal of a license to practice Acupuncture or any other profession in any state?	☐ Yes ☐ No
16. 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? *Concerning the answer to question* ***16*** *the surrender of a license or certificate of registration because of, or in response to, charges or an investigation constitutes "otherwise acted against" within the meaning of the question.*	☐ Yes ☐ No
17. 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?	☐ Yes ☐ No

PROFESSIONAL LICENSURE

If you answer "yes" to question 18 below then you must provide the following documentation with the application when it is filed:

1. ***A statement indicating how many case(s) you have been named in and your involvement in the case.***
2. ***A copy of the complaint and disposition for each case.***

Question	Answer
18. 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?	☐ Yes ☐ No

CRIMINAL HISTORY

If you answer "yes" to the below questions 19-20 then you must provide the following documentation with the application when it is filed:

1. ***All police reports that were generated as part of the investigation or arrest that led to the plea or conviction.***
2. ***Certified court documents that include all charging documents used by the prosecutor, all plea agreements, judgment and sentence for each offense, and jury verdicts if applicable to violation.***
3. ***In your own words, a sworn affidavit explaining the events surrounding and leading up to the plea or conviction.***

Question	Answer
19. 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. 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.	☐ Yes ☐ No
If "yes" answer the following questions:	
A. Does the violation involve allegations of driving under the influence of or driving while impaired by drugs or alcohol?	☐ Yes ☐ No
B. Does the violation involve allegations of sexual misconduct, sexual batter, lewd or lascivious conduct, indecent exposure or any crime involving sexual activity?	☐ Yes ☐ No
20. 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

GENERAL HISTORY

If you answer "yes" to the below questions 21-25 then you must provide the following documentation with the application when it is filed:

1. ***A complete description of all treatments and diagnosis you received for any condition or impairment you experienced, were treated for, or which you were diagnosed.***
2. ***A list of all medications you have been prescribed, that you have taken or that you are taking to treat each diagnose condition.***
3. ***A statement from your treating physician for each condition you were or are being treated for include all DSM IIIR/DSM IV, Axis I, II, and III diagnosis and codes. If there is no Axis to report then the treating physicians must indicate that in their statement.***

21. 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 last five years?	☐ Yes ☐ No
22. 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
23. 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 within the last five years?	☐ Yes ☐ No
24. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder, if you were previously in such a program, did you suffer a relapse with the last five years?	☐ Yes ☐ No
25. 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 within the past five years?	☐ Yes ☐ No

HISTORY - SECTION 456.0635(2), F.S.

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer "YES" to the below questions 26-28 then you must provide the following documentation with the application when it is filed:

1. ***Explain on a separate sheet providing accurate details***
2. ***Submit copies of supporting documents.***

26. (a) Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396?	☐ Yes ☐ No
(b) If yes, has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction?	☐ Yes ☐ No
27. (a) Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?	☐ 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?	☐ Yes ☐ No
28. (a) Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program?	☐ Yes ☐ No
(b) If yes, have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?	☐ Yes ☐ No
(c) If yes, did the termination occur at least 20 years prior to the date of this application?	☐ Yes ☐ No

Section 837.06 Florida Statutes, states: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor in the second degree, punishable as provided in ss. 775.082, 775.083 or 775.084.

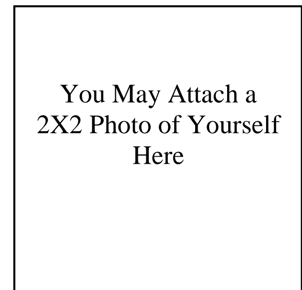
I hereby authorize all hospital(s), institution(s) or organization(s), my references, personal physician(s), employer(s) (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health to release to the organizations, individuals, and groups listed above any information which is material to my application.

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 Chapter 456.013(1), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein and in support of this application are true and correct. I further agree to supplement, as needed, any material change in any condition stated in my application which takes place between the initial filing of my application and the final grant or denial of this license. Should I furnish any false information on or in support of this application or should I fail to supplement this application with information needed to reflect any material change in circumstance or condition, I hereby agree that such action or omission shall constitute cause for the denial, suspension or revocation of my license to practice acupuncture in the State of Florida.

I hereby acknowledge that practice as a licensed Acupuncturist in Florida is governed by Chapters 456 and 457, Florida Statutes, and Chapter 64B1, Florida Administrative Code. I understand that I am under a continuing obligation to understand and keep informed of any change to Chapters 456 and 457, Florida Statutes, and Chapter 64B1, Florida Administrative Code. I have read, understand and agree to comply with the statutes and rules applicable to the practice of my profession in Florida.

I understand the application fee is non-refundable.



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Signature of Applicant Required **Date**

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 RESPONSIBLITITY 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 affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action or criminal penalties as provided in Section 456.067, 456.072, 755.082 and/or 755.084, Florida Statutes.

____
Name (printed)

____________________________________ ________________________________
Signature (required) Date