

# BOARD OF ATHLETIC TRAINING

## STATE OF FLORIDA

### EXAMINATION APPLICATION FOR LICENSURE

You must read the laws and rules in order to determine your eligibility for licensure. Chapter 468, Part XIII, Florida Statutes (F.S.), and Rule Chapter 64B33, Florida Administrative Code (F.A.C.), can be found on our web site at [www.doh.state.fl.us/mqa/athtrain](http://www.doh.state.fl.us/mqa/athtrain).

#### **Requirements for licensure as an athletic trainer:**

- Submit a completed application with required fees;
- Be at least 21 years of age;
- Has obtained a baccalaureate degree from a college or university accredited by an accrediting agency recognized and approved by the U.S. Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification.;
- If graduated after 2004, has completed an approved athletic training curriculum from a college or university accredited by a program recognized by the Board of Certification;
- Has passed the Board of Certification Entry Level Certification examination and is certified by the Board of Certification;
- Has current certification in cardiovascular pulmonary resuscitation with an automated external defibrillator from the American Heart Association, American Red Cross, American Safety and Health Institute, National Safety Council, or an entity approved by the board as equivalent;
- Has completed a board approved 2 hour continuing education course relating to the prevention of medical errors.

#### **APPLICATION INSTRUCTIONS**

##### **I. FEES**

Attach a check or money order payable to the Department of Health. Do not submit cash with the application.

##### Full Biennium Fees

Application Fee---\$100.00 [Nonrefundable]  
License Fee ----- 125.00  
Unlicensed Activity ---5.00  
TOTAL FEES -----\$230.00

##### Second Half Biennium Fees

Application Fee-\$100.00 [Nonrefundable]  
Licensee Fee ----- 75.00  
Unlicensed Activity -5.00  
TOTAL FEES ---\$180.00

Please see the following schedule:

Date Application is Submitted	Fee to Submit with The Application
09/16/11 through 04/20/12	\$180.00
04/21/12 through 09/15/13	\$230.00
09/16/13 through 04/20/14	\$180.00
04/21/14 through 09/15/15	\$230.00
09/16/15 through 04/20/16	\$180.00
04/21/16 through 09/15/17	\$230.00

## **II. OFFICIAL TRANSCRIPTS**

You must request an official transcript from the accredited institution(s) from which you received your degree or have taken coursework. These transcripts must be sent directly to the Board office from the registrar's office of the institution or they will not be considered official.

## **III. EXAMINATION AND CERTIFICATION INFORMATION**

The Board of Certification Entry Level Certification examination has been approved by the Board, pursuant to Rule 64B33-2.001(1)(b), F.A.C. Applicants must submit a CERTIFIED copy of his or her Board of Certification, Inc. (BOC) certificate. For information on examination registration procedures, applicants may call (877) 262-3926 or write: BOC, 1415 Harney Street, Suite 200, Omaha NE 68102 or visit their web site at [www.bocatc.org](http://www.bocatc.org).

## **IV. CPR CERTIFICATION**

You must submit a copy of your current certification in Cardiovascular Pulmonary Resuscitation with an automated external defibrillator at the professional rescue level from the American Red Cross, the American Heart Association, American Safety and Health Institute, the National Safety Council, or an entity approved by the Board as equivalent.

## **V. CONTINUING EDUCATION REQUIREMENTS**

Prior to licensure you must complete a board approved two hour course on the prevention of medical errors. A copy of your certificate of completion should be forwarded to the Board office.

## **VI. COMPLETING THE FORMS**

All sections of the application must be completed. Print neatly in blue or black ink or type the information. All completed forms must be original, including signatures. If sufficient space is not included on the application, please attach additional sheets identifying the specific section of the application for which additional information is being provided. Please call (850) 245-4474 if you have questions.

### **1. Applicant Profile Data**

Your "practice location address" will show on the Internet license verification screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, renewals, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address.

## 2. Applicant Licensure Status

List the names of all the states, U.S. territories, or foreign countries in which you hold or have ever held a license, certificate, or registration to practice athletic training.

## 3. Photo

Attach one passport-style head and shoulder photograph (less than 6 months old) to the form. Your name must be printed on the back of the photograph.

## 4. Education

List the name and location of the institution(s), the dates of attendance and the type of degree and date received.

## 5. Applicant History - Professional

If you answer "YES" to any questions in this section, please provide a complete and detailed statement of the circumstances which are the basis for such answer, as well as the names and addresses of all physicians, counselors, hospitals, facilities, treatment programs providing treatment and the dates of treatment. In addition, you must have each of the treatment providers submit a complete record of such treatment to include diagnosis, prognosis, admission and discharge summaries, etc. directly to: Department of Health, Board of Athletic Training, 4052 Bald Cypress Way, BIN C08, Tallahassee, FL 32399-3258.

## 6. Applicant History - General

If you answer "YES" to any question in this section, please provide a complete and detailed statement of the circumstances surrounding each event that is the basis for such answer. In addition, you must provide certified copies of any and all Complaints, Orders, Indictments, Judgments or other documents of disposition.

7. Applicant History – Pursuant to Section 456.0635, Florida Statutes: Follow directions in this section.

## 8. Certification

Read this section carefully. Your signature is required. By signing this statement you are attesting you have provided true and correct information on the application and supporting documents.

9. Social Security Number: Your social security number is required.

## 10. Applicant History – Health

The board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. Please read these questions very carefully. If you answer "yes" to any question(s) in this section, you must provide the Board complete details. You may be asked to submit a current mental health status report from a licensed mental health professional.

## LICENSE/CERTIFICATION VERIFICATION FORM

This form is only to be completed if you hold or have held a license in another state, U.S. territory, or foreign country. You must mail this form to the office that issued the license or certification. That office must complete and mail the form directly to the Board office.

**It will not be considered official if received from the applicant.**



**STATE OF FLORIDA**  
**Examination Application**  
**For Licensure**  
**Athletic Training (1001)**

**1. APPLICANT PROFILE DATA** (PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
*Practice Location Address	Street and No.		Apt. No.
	City	State	Zip
			Date of birth: _____/_____/_____

DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY

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 names and dates of changes below:

Home Telephone: area code (        )	Business Telephone: area code (        )	Eye Color: _____
E-Mail Address: (Optional)		Hair Color: _____
Place of Birth: (City, State)		Height: _____
		Weight : _____
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

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.

Race:  Caucasian  African-American  Hispanic  Asian  Native American  Other \_\_\_\_\_

\* Your Practice Location Address Will Show On The Internet License Verification Screen

Our Internet license lookup provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

**2. APPLICANT LICENSURE STATUS**

Do you hold or have you ever held a license to practice athletic training in any state, U.S. territory, or foreign country?  YES  NO

If YES, list all licenses and the issuing state, territory, or foreign country:

**3. PLEASE TAPE ONE PHOTO HERE**

APPLICANT NAME \_\_\_\_\_

<b>4. EDUCATION</b>			
Name and Location of Institution	Dates of Attendance	Degree Earned	Graduation Date

<b>5. APPLICANT HISTORY – PROFESSIONAL</b>	
A. Have you ever been denied a license to practice as an athletic trainer or other health care practitioner or the renewal thereof by any state, U.S. territory or foreign country?	<input type="checkbox"/> YES <input type="checkbox"/> NO
B. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?	<input type="checkbox"/> YES <input type="checkbox"/> NO
C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	<input type="checkbox"/> YES <input type="checkbox"/> NO
E. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>If you answered "YES" to any question in Section 5, you must provide the Board complete details. A "yes" answer does not mean the application will be denied; however, failure to provide the correct information may result in licensure denial.</p>	

**6. APPLICANT HISTORY – GENERAL**

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any 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

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.

**7. Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.**

1a. 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? **(If no, do not answer 1b.)**  YES  NO

1b. 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 such conviction?  YES  NO

2a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If no, do not answer 2b.)**  YES  NO

2b. 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

3a. 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? **(If no, do not answer 3b and 3c.)**  YES  NO

3b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?  YES  NO

3c. Did the termination occur at least 20 years prior to the date of this application?  YES  NO

**8. CERTIFICATION**

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department 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 Sections 456.072, F.S. and 456.013(1)(2), 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 truthfully and completely without reservations of any kind. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

I hereby acknowledge that I have read the regulations in Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 468, Part XIII, F.S., and Rule Chapter 64B33, F.A.C.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



# LICENSE/CERTIFICATION VERIFICATION

(MAIL A COPY OF THIS FORM TO EACH STATE THAT YOU HOLD OR EVER HELD A LICENSE)

APPLICANT NAME \_\_\_\_\_

Print clearly in black ink or type the information.

Applicant's Address:	
Title of License:	License Number:
<b>THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:</b>	
BOARD OF ATHLETIC TRAINING 4052 Bald Cypress Way, BIN #C08 TALLAHASSEE, FLORIDA 32399-3258	
The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.	
Title of License:	License Number:
Original Issue Date:	Expiration Date:
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Delinquent <input type="checkbox"/> Other (Explain)	
Licensure Method: <input type="checkbox"/> Grandfathering <input type="checkbox"/> Reciprocity/Endorsement <input type="checkbox"/> Examination	
If licensed by examination, please complete the following:	
Name of Exam:	Date of Exam:
Level of Exam:	Score Achieved:
Has any disciplinary action been taken against this license? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", please provide our office with any documentation regarding the disciplinary action.	
Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of:



## **MAKE COPIES OF ALL DOCUMENTS**

**(For your records) prior to mailing the originals to the board office.**

### **MAIL APPLICATION PACKET AND FEE TO:**

BOARD OF ATHLETIC TRAINING  
PO Box 6330  
TALLAHASSEE, FL 32314-6330

### **MAIL ANY OTHER CORRESPONDENCE TO:**

BOARD OF ATHLETIC TRAINING  
4052 BALD CYPRESS WAY, BIN #C08  
TALLAHASSEE, FL 32399-3258

If information is mailed from a source other than the applicant, the applicant's full name must appear on the correspondence or documentation.

If you have further questions you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

PLEASE NOTE:

**YOUR PRACTICE LOCATION ADDRESS WILL SHOW ON THE INTERNET LICENSE VERIFICATION SCREEN.** Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, newsletters, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address.

### **DISCLOSURE OF SOCIAL SECURITY NUMBER**

Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 456.013(12), 409.2577, and 409.2598, Florida Statutes. 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. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.