



APPLICATION CHECKLIST

Health Care Licensing Application

ORGAN PROCUREMENT ORGANIZATION, TISSUE BANK, EYE BANK

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 765, Part V, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-1, Florida Administrative Code (F.A.C.). Applications must be received **at least 60 days prior** to the expiration of the current license or effective date of a change of ownership to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. **The application will be withdrawn from review if all the required documents are not included with this application or received within 21 days of an omission notice.**

All forms listed below may be obtained from the website: <http://ahca.myflorida.com/Publications/Forms/HQA.shtml>. Send completed applications to: Agency for Health Care Administration, Clinical Laboratory Unit, 2727 Mahan Drive, MS 32, Tallahassee, FL 32308.

A. Initials, Renewals and Change of Ownership Applications must include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- Health Care Licensing Application, Organ Procurement, Tissue Bank, Eye Bank, AHCA Form 3140-2001. **NOTE:** All Agency correspondence will be sent to the mailing address provided in Section 1A (Provider Information) of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 1B (Licensee Information) of this application must be the same as the information registered with the Division of Corporations as provided in section 59A-35.060(4), Florida Administrative Code.
- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).
- Donor selection criteria - (**For renewals** – submit only if the criteria has changed or the form revised. Not required for Tissue Banks certified to store and distribute only.)
- Social and health history forms - (**For renewals** – submit only if the form has been revised. Not required for Tissue Banks certified to store and distribute only.)
- Consent forms (telephone and in person consent) - (**For renewals** – submit only if the form has been revised. Not required for Tissue Banks certified to store and distribute only.)
- For Corporations – a copy of the articles of incorporation for the state in which the business is incorporated - (**For renewals** – submit only if the incorporation has been revised)
- A copy of a current certificate of status, certificate of good standing, or other proof that the corporation was renewed and is active for the current year. This should be issued by the Department of State where the corporation is active.
- Proof of fictitious name registration, if applicable.
- For partnerships: a copy of the partnership agreement - (**For renewals** – submit only if the agreement has been revised)
- A copy of medical director's resume or curriculum vitae **and** state license - (*Medical director must be licensed to practice medicine and surgery*)
- A copy of the current CLIA certificate for any labs to be used (*Not required for Tissue Banks certified to store and distribute only.*)
- A cover letter specifying which services you plan to provide (*recovery, processing, storage, distribution*)
- If accredited, a copy of the accreditation certificate and most recent accreditation report, which includes the facility's response and documentation that the response was accepted by the accrediting organization.
- Copies of any other related state license. For example, if you are filing as a tissue bank and are licensed in New York, Maryland, or California, provide a copy of that tissue bank license or certificate

- If registered with the FDA, provide a copy of the registration certificate
- OPOs must submit proof they are certified by CMS
- A Level 2 background screening for the Administrator and Financial Officer is required every 5 years. Please check all boxes below that apply to this application:

For Organ Procurement Organizations/Tissue Banks/Eye Banks physically located within Florida:

- The Administrator (Agency Director) Financial Officer submitted a Level 2 screening through a **LiveScan vendor** approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan vendors please see the Agency's background screening website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

All screening results must be sent to the **Agency for Health Care Administration** (Agency) for review and eligibility determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you **must provide** the following **ORI FL922020Z** and identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the result, additional screening and fees may be required.

The Agency has created a form that you may use to take to the vendor. You may access this form, Background Screening Validation, on the Agency's website at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml.

- Proof of Level 2 screening within the previous 5 years for the Administrator(Agency Director) Financial Officer from the Agency's Medicaid Division. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.
- Level 2 screening has been conducted within the previous 5 years for the Administrator (Agency Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

For Organ Procurement Organizations/Tissue Banks/Eye Banks NOT physically located within Florida:

- The Administrator (Agency Director) Financial Officer are out of state and do not have access to a Florida LiveScan vendor and will submit a fingerprint card (***you must obtain a fingerprint card from the Agency.*** To request a fingerprint card please contact the Agency's Background Screening Section at (850)412-4503 or email bgscreen@ahca.myflorida.com). The completed fingerprint card must then be submitted to:

- The Agency's contracted vendor, Cogent Systems (www.cogentid.com), along **with a fee of \$55.50** (\$40.50 for the screening + \$15.00 processing fee) The fingerprint card must be filled out completely and the fingerprints taken by law enforcement personnel or individual trained in processing fingerprints. Return the completed card to:

3M Cogent
 ATTN: FL Cardscan
 5025 Bradenton Avenue, Suite A
 Dublin, OH 43017

- Another LiveScan vendor authorized to provide services in Florida that is equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all LiveScan vendors have this ability. You may find LiveScan vendor contact information on the FDLE website: <http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx>.

- Proof of Level 2 screening within the previous 5 years for the Administrator (Agency Director) Financial Officer from the Agency's Medicaid . An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.
- Level 2 screening has been conducted within the previous 5 years for the Administrator (Agency Director) Financial Officer through the Agency's Background Screening Unit or a LiveScan vendor. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional Information needed for INITIAL Applications:

- A copy of the floor plan showing all areas of operation (8½ x 11 paper). Do not send architectural drawings.
 - Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
 - Licensure fee: (**\$1,000.00 for OPO and tissue bank; \$500.00 for eye bank**) - Please make check or money order payable to the Agency for Health Care Administration (AHCA). All fees are nonrefundable.
-

C. Additional Information needed for CHANGE OF OWNERSHIP Applications:

***Note: Change of Ownership Applications must be submitted 60 days before the effective date of the change.**

- A copy of the floor plan showing all areas of operation (8½ x 11 paper). Do not send architectural drawings.
 - Documented evidence of change of ownership such as an asset purchase agreement, stock transfer/sale agreement and/or proof of corporate reorganization
 - Signed agreement to correct any existing licensure deficiencies.
 - Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
 - Licensure fee: (**\$1,000.00 for OPO and tissue bank; \$500.00 for eye bank**) - Please make check or money order payable to the Agency for Health Care Administration (AHCA). All fees are nonrefundable.
-

D. Change During Licensure Period - *Request to change the name or address of provider:*

- Complete and submit sections 1, 2 and 10 of the Health Care Licensing Application, Organ Procurement, Tissue Bank, Eye Bank, AHCA Form 3140-2001.
- Effective date of the change. NOTE: Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date.
- For a change in the address of record: Proof of licensee's right to occupy the building or space such as a copy of a lease, sublease agreement or deed.
- For corporate licensee name changes (other than change of ownership): A current certificate of status or authorization pursuant to Section 607.0128, F.S..
- For provider name changes: Proof of fictitious name registration, if applicable.
- \$25.00 fee for replacement license / reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you **please place checks, money orders and fingerprint cards on top of the application and paperclip** everything together. Please **do not staple or bind documents** submitted to the Agency.



AHCA USE ONLY:	
File #:	_____
Application #:	_____
Check #:	_____
Check Amt:	_____
Batch #:	_____

Health Care Licensing Application ORGAN PROCUREMENT ORGANIZATION, TISSUE BANK, EYE BANK

Under the authority of Chapters 408, Part II and 765, Part V, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-1, Florida Administrative Code (F.A.C.), an application is hereby made to operate an:

- Organ Procurement Organization (OPO)
 Tissue Bank
 Eye Bank

Please check each applicable box to indicate what the OPO, Tissue Bank or Eye Bank intends to do:

- Recovery/retrieval
 Processing
 Storage
 Distribution

1. Provider / Licensee Information

A. Provider Information – please complete the following for the OPO/Tissue Bank/Eye Bank name and location. <i>Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/</i>			
License # (for renewal & change of ownership applications)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #
Name of OPO/Tissue Bank/Eye Bank (if operated under a fictitious name, list that here)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number	E-mail Address	Provider Website
Mailing Address or <input type="checkbox"/> Same as above (All mail will be sent to this address)			
City		State	Zip
Contact Person for this application		Contact Telephone Number	
Contact e-mail address or <input type="checkbox"/> Do not have e-mail		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	
B. Licensee Information – please complete the following for the entity seeking to operate the OPO/Tissue Bank/Eye Bank.			
Licensee Name (may be same as provider name above)		Federal Employer Identification Number (EIN)	
Mailing Address			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one): <input type="checkbox"/> Corporation <input type="checkbox"/> Government <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____			
Nature of Site: <input type="checkbox"/> Hospital <input type="checkbox"/> Independent <input type="checkbox"/> Blood Bank <input type="checkbox"/> Other Office: _____			

2. Application Type and Fees

Indicate the type of application submitted with an "X." **Applications will not be processed if all applicable fees are not included.** Please make check or money order payable to the Agency for Health Care Administration (AHCA). *Pursuant to s. 408.805(4), F.S., fees are nonrefundable.* Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

Initial Licensure

If initial application, was this entity previously licensed as an OPO/Tissue Bank/Eye Bank in Florida?

YES NO

If yes, please provide the name of the agency (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:	License/Certificate#:

Renewal Licensure

Change of Ownership Proposed Effective Date: _____

Name/address change Proposed Effective Date: _____

**With the exception of name/address change, if more than one action is needed, then a separate application and fee must be submitted. Providers may not "X" both "change of ownership" and "renewal" boxes, for example. Two separate applications and two fees are required and the information contained with these applications will, by definition [see 408.803(5), F.S.], be different. Applications with an "X" in more than one box will not be accepted and will be returned.*

Action	Fee	TOTAL FEES
LICENSE FEE (Initial or Change of Ownership only): NOTE: No fee is required for renewal applications	OPO/Tissue Bank \$1,000.00 Eye Bank \$ 500.00	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Please make check or money order payable to the Agency for Health Care Administration (AHCA) <i>Note: Starter checks and temporary checks are not accepted.</i>		

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of Social Security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include Social Security numbers on this form. All Social Security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:

Controlling interests, as defined in section 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization.

Management Company, as defined in s. 59A-35.030 (4), F.A.C., means an entity retained by a licensee to administer or direct the operation of a provider. This does not include an entity that serves solely as a lender or lien holder.

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee (5% of more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest.

B. Board Members and Officers of Licensee

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Licensee

If the licensee is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

D. Administration

TITLE	NAME	TELEPHONE NUMBER	E-MAIL
Administrator(Agency Director)/Managing Employee			
Medical Director (Attach resume or curriculum vitae)			
Financial Officer			

4. Management Company Controlling Interests

Does a company other than the licensee manage the licensed provider?

If NO, skip to section 5 – *Required Disclosure*.

If YES, provide the following information:

Name of Management Company		EIN (No SSNs)	Telephone Number / Fax	
Street Address		E-mail Address		
City	County	State	Zip	
Mailing Address or <input type="checkbox"/> Same as above				
City		State	Zip	
Contact Person	Contact E-mail	Contact Telephone Number		

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company (5% of more ownership interest)

Check here if no individual or entity has 5% or more ownership interest in the licensee and put N/A in "A." below.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

Note: If total does not equal 100%, please attach documentation explaining remaining ownership interest. Information provided above should not be the same information contained in 1B of this application.

B. Board Members and Officers of Management Company

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Management Company

If the management company is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

5. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809(5), F.S., for each controlling interest.

Has the applicant or any individual listed in sections 3 and 4 of this application been convicted of any level 2 offense pursuant to subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held
- A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

B. Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held
- A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

YES NO Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a

felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, within the previous 15 years prior to the date of this application;

YES NO Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, and not been in good standing with the Florida Medicaid program for the most recent 5 years;

YES NO Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from the federal Medicare program or from any other state Medicaid program, have not been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination was less than 20 years prior to the date of this application.

6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the Agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the Agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES NO

If yes, please complete the following for each incidence (attach additional sheets if necessary):

Amount: \$ _____ assessed by: Agency for Health Care Administration Case # _____ CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES NO

Please attach a copy of the approved repayment plan if applicable.

7. Medical Advisory Board

Please provide the following (attach additional sheets if necessary):

NOTE: *This is required for all applicants, including those seeking licensure for storage and distribution.*

Name	Area of Expertise

8. Site Location and Equipment

A. Site Description

Please provide a drawing or a blueprint of the agency's main site which includes the square footage.

Is the space contiguous? YES NO

Is there more than one site? YES NO

If yes, list all sites, except for the main site, and give the square footage of each (attach additional sheets if needed):

Name of Site	Location	Square Footage

Is the agency sharing the site(s) with another health provider? YES NO

If yes, please explain: _____

B. Equipment

List and briefly describe the equipment used (attach additional sheets if needed):

Equipment	Description

9. Donor Selection and Testing

- A. Attach copies of donor selection criteria, health history form, consent form, social history form and applicable protocols (see check list for applicability).
- B. List all laboratory tests performed on donors or donated organs and/or tissues and indicate site of testing. If tests are performed by the applicant, indicate "on-site." Attach additional sheets if needed.

Location	Laboratory Tests Performed

C. For any testing laboratory outside of Florida, please supply:

- State licensure
- Medicare certificate; and/or
- Interstate certification

10. Affidavit

I understand that in order to obtain Florida certification as an OPO, tissue bank, eye bank, I must comply with the provisions as set forth in Chapter 873, Florida Statutes, Sale of Anatomical Matter. In addition, I hereby affirm, under penalty of perjury, that information provided on this form is true to the best of my knowledge and belief. By applying for and if granted certification, the OPO, tissue bank or eye bank and each employee or agency grants the AHCA or its designee permission to enter upon any premise controlled, operated, or owned by the OPO, tissue bank or eye bank and to obtain records to inspect, to audit, and to interview any employees or agents of the agency, 9 a.m. to 5 p.m. local time Monday through Friday. The agency agrees to cooperate with the AHCA or its designee in permitting and facilitating the above activities.

As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.), or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Agency Director's name (Print)

Director 's Signature

Date

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
CLINICAL LAB UNIT
2727 MAHAN DR MS 32
TALLAHASSEE FL 32308-5407

Questions? Review the information available at:
<http://ahca.myflorida.com>. If the director or administrator has
questions after review, call 850-412-4500.



AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(i) Section 784.011, relating to assault, if the victim of the offense was a minor.

(j) Section 784.03, relating to battery, if the victim of the offense was a minor.

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

(m) Section 787.025, relating to luring or enticing a child.

(n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(r) Section 794.011, relating to sexual battery.

(s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(t) Section 794.05, relating to unlawful sexual activity with certain minors.

(u) Chapter 796, relating to prostitution.

(v) Section 798.02, relating to lewd and lascivious behavior.

(w) Chapter 800, relating to lewdness and indecent exposure.

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

(z) Section 810.14, relating to voyeurism, if the offense is a felony.

(aa) Section 810.145, relating to video voyeurism, if the offense is a felony.

(bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S

(a) Any authorizing statutes, if the offense was a felony.

- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (g) Section 817.234, relating to false and fraudulent insurance claims.
- (h) Section 817.505, relating to patient brokering.
- (i) Section 817.568, relating to criminal use of personal identification information.
- (j) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (l) Section 831.01, relating to forgery.
- (m) Section 831.02, relating to uttering forged instruments.
- (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (p) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screened conducted by: _____ Date of Prior Screening: _____

- Agency for Health Care Administration
- Department of Health
- Agency for Persons with Disabilities
- Department of Children and Family Services
- Department of Financial Services

Affidavit

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date