



APPLICATION CHECKLIST

Applicants **must** include the following attachments as stated in Chapters 408, Part II and 395, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-10, 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 fee. 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 **The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.**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, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop #31, Tallahassee, FL 32308.

A. Initial and Renewal Applications must include:

- The licensure fee (**\$100.00 for Initial Applicants; \$51.00 for Renewal Applicants**). Please make check or money order payable to the **Agency for Health Care Administration (AHCA)**. All fees are nonrefundable.
- Health Care Licensing Application, Health Care Risk Manager, AHCA Form RM-001
- Health Care Licensing Application Addendum, AHCA Form 3110-1024, Complete sections 1B and 4 of this form. (Required for initial applicants only.)
- A Level 2 background screening is required every 5 years.
 - A Level 2 screening was submitted through an approved **LiveScan vendor**. 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.
 - Applicant is located out of state and does not have access to a Florida LiveScan vendor. (**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). A fingerprint card and fee will be submitted to:
 - The Agency's contracted vendor is Cogent Systems. 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 Ave, Ste A
Dublin, OH 43017
Website: www.cogentid.com
 - The fingerprint card may also be sent to other LiveScan vendors authorized to provide services in Florida as long as they are 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. For more information you may find LiveScan vendor contact information on the FDLE website: <http://www.fdle.state.fl.us/Content/Criminal-History/Livescan-Service-Providers-and-Device-Vendors.aspx>.

All screening results **must be sent** to the **Agency for Health Care Administration (Agency)** for review and employment 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 created a form that you may use to take to the vendor. You may access this form 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 from the Agency for Health Care Administration, Department of Children and Families, Department of Health, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority to operate a continuing care retirement community) is included with this application. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Change During Licensure Period - *Request to change your name or address:*

- Complete and submit sections 1, 2 and 7 of the Health Care Licensing Application, Health Care Risk Managers, AHCA Form RM-001
- \$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 or money order 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 HEALTH CARE RISK MANAGER

Under the provision of Chapters 408, Part II and 395, Florida Statutes, (F.S.) and Chapters 59A-35 and 59A-10, Florida Administrative Code, (F.A.C.), an application is hereby made for licensure as a health care risk manager as indicated below:

1. Personal Information

Please complete the following.			
HCRM License # (for renewal applications) 550-		Name	
List all Aliases (AKA)			
Race	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Place of Birth
Mailing Address (All mail will be sent to this address)			
City		County	State Zip
Telephone Number	Fax Number	E-mail Address	
Previously licensed as Health Care Risk Manager? <input type="checkbox"/> No <input type="checkbox"/> Yes HCRM License Number 550-		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	
Home Address or <input type="checkbox"/> Same as above			
City		State	Zip
Business Name			
Business Address			
City		County	State Zip
Telephone Number		E-mail Address	

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if applicable fees are not included. All 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
- Renewal Licensure
- Change during licensure period

Name change to: _____

Address change

Action	Fee	TOTAL FEES
LICENSE FEE	<input type="checkbox"/> Initial \$ 100.00 <input type="checkbox"/> Renewal \$ 51.00	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Renewal Late Fee	\$ 25.50	\$
Other: _____		\$
TOTAL FEES INCLUDED WITH APPLICATION:		\$
<i>Please make check or money order payable to the Agency for Health Care Administration (AHCA)</i>		

3. Renewal Applicants Only

Renewal Applicants – please complete the following information then skip to section 7 - *Affidavit* to complete the application. Renewal applications must be received by the expiration date or an initial application will be required.

If employed as a Health Care Risk Manager at a hospital or ambulatory surgical center licensed under Chapter 395, F.S., please provide the following:

Name of Employer/Facility		Effective Date or End Date (circle one)	
Address			
City		State	Zip
Telephone	Fax Number	E-mail	
Name of Employer/Facility		Effective Date or End Date (circle one)	
Address			
City		State	Zip
Telephone	Fax Number	E-mail	
Name of Employer/Facility		Effective Date or End Date (circle one)	
Address			
City		State	Zip
Telephone	Fax Number	E-mail	
Name of Employer/Facility		Effective Date or End Date (circle one)	
Address			
City		State	Zip

Telephone	Fax Number	E-mail
-----------	------------	--------

Sections 4 through 7 must be completed by Initial Applicants. Renewal applicants skip to section 7.

4. Background Information

EDUCATION		
Name of High School Attended	<input type="checkbox"/> Diploma	Date Received
	<input type="checkbox"/> GED	
City	State	

RESIDENCY – Please list all residence street addresses you have lived for the past 5 years:				
DATES FROM/TO	ADDRESS	CITY	STATE	ZIP

EMPLOYMENT – Please list all places of employment for the past 5 years. If unemployed or attending school during this time, please state; if self-employed, give name of firm and nature of business:				
DATES FROM/TO	EMPLOYER	ADDRESS	POSITION	REASON FOR LEAVING

5. Required Disclosure

Have you ever had a professional license, occupational license, certification or eligibility to hold a license or certification denied, declined, suspended, revoked, placed on probation, or administrative fine levied by any regulatory agency?

No Yes

If yes, give full details: _____

Have you been arrested or indicted by any state or federal authorities in the United States within the last twelve months?

No Yes

Are there criminal charges currently pending against you or any entity you control in any state or federal court within the United States or its possessions or in any other country?

No Yes

Have you ever been convicted of or pled guilty or nolo contendere to:

A crime involving moral turpitude? No Yes

A felony? No Yes

A crime punishable by imprisonment of one year or more under the law of any state, territory or county, regardless of whether or not a judgment or conviction has been entered? No Yes

If yes to any of the above give full details:

What was the crime? _____

Where and when were you charged? _____

Did you plead Guilty? Nolo Contendere?

Were you convicted? No Yes

Was adjudication withheld? No Yes

Please provide a brief description of the nature of the offense: _____

6. Qualifications for Licensure

In the appropriate section below, check all of the applicable criteria. Complete only one section.

NOTE: Documentation of credentials (professional licenses & certifications), education (degrees & transcripts), and experience is required and should be submitted with application. Lack of documentation will deem your application incomplete.

Attainment of Nominee Level or advanced credential status from the International Healthcare Security and Safety Foundation.

Attainment of credentials as a Fellow or Diplomat of the American Society for Healthcare Risk Management.

Attainment of credentials as a Health Care Professional as defined in Rule 59A-10.032(15), F.A.C. **and** check one of the following:
Please provide Florida License Number: _____.

Satisfactory completion of a 120-hour risk management educational program approved pursuant to Rule 59A-10.037(1), F.A.C. *Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency.*

Experience which qualifies under paragraphs (a), (b), (c), (g) and (h) of Rule 59A-10.036, (2) F.A.C. *Experience must be documented on the Certificate of Employment for Health Care Risk Manager (AHCA/RM-002).*

Attainment of credentials as a Health Care Administrator as defined in Rule 59A-10.032(14), F.A.C. **and** check one of the following:

Satisfactory completion of a 120-hour risk management educational program approved pursuant to Rule 59A-10.037(1), F.A.C. *Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency.*

Experience that qualifies under paragraphs (a) and (g) of Rule 59A-10.036, (2), F.A.C. *Experience must be documented on the Certificate of Employment for Health Care Risk Manager (AHCA/RM-002).*

Satisfactory completion of an educational program accredited by the Committee on Allied Health Education Accreditation for Medical Record Administrators or Medical Record Technicians 59A-10.033(1)(2)(e), F.A.C. **and** satisfactory completion of a 120-hour risk management educational program approved pursuant to Rule 59A-10.037(1), F.A.C. *Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency.*

Attainment of credentials as a Basic Risk Manager as defined in Rule 59A-10.032(16), F.A.C **and** check one of the following:
Please provide Florida Department of Insurance License Number: _____.

- Satisfactory completion of an 80-hour health care educational program approved pursuant to Rule 59A-10.037(2), F.A.C. Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency.
- Experience which qualifies under paragraphs (c), (d), (e), (f) and (g) of Rule 59A-10.036, (2), F.A.C. Experience must be documented on the Certificate of Employment for Health Care Risk Manager (AHCA/RM-002).

Attainment of a degree from an accredited law school pursuant to Rule 59A-10.033(2)(g), F.A.C., **and** check one of the following:

- An advanced degree in health law from an accredited law school or a degree in a health related field from an accredited institution of higher learning.
- Satisfactory completion of an 80-hour health care educational program approved pursuant to Rule 59A-10.037(2), F.A.C. Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency.
- Experience with health care risk management or medical malpractice claims administration as a result of being employed or retained for a period of one year by a health care facility to advise, direct or coordinate a risk management program. *Experience must be documented on the Certificate of Employment for Health Care Risk Manager (AHCA/RM-002).*

Satisfactory completion of a one year (384-hour) health care risk manager-training program approval pursuant to Rule 59A-10.034, F.A.C. Entities offering an approved educational program will forward a copy of your Certificate of Completion directly to the Agency. **No health care risk manager training program is currently approved by the Agency.**

Satisfactory completion of two years of college level studies approved pursuant to Rule 59A-10.033(1)(2)(i) and 59A-10.035, F.A.C.

Satisfactory completion of one year of practical experience in health care risk management, which meets the requirements of Rule 59A-10.036, F.A.C. *Experience must be documented on the Certificate of Employment for Health Care Risk Manager (AHCA/RM-002).*

Practical experience must be with an authorized insurer as defined in s. 624.09(1), F.S., a medical malpractice risk management trust fund as defined in s. 627.357(2)(a), F.S., a hospital or ambulatory surgical center as defined in s. 395.002, F.S. and 59A-10.002(2)(3)(15), F.A.C. or a health maintenance organization as defined in s. 641.19(12), F.S.

7. Affidavit

I, _____, hereby swear or affirm, under penalty of perjury, that the statements in this application are true and correct.

Signature of Applicant

Date

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308

Questions? Review the information available at <http://ahca.myflorida.com/> or contact the Hospital and Outpatient Services Unit at (850) 412-4549