



TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY MEMBERS OF THE ARMED FORCES APPLICATION

Mailing Address for Application and Fees: P.O. Box 6330 | Tallahassee, FL 32314-6330, 850-488-0595

Fees: Application Fee - \$65.00 (non-refundable) | Background Screening Fee - \$48.00 (non-refundable)

INSTRUCTIONS

Keep these instructions and a copy of the completed application, for future reference.

All questions must be answered in order to complete the form in its entirety. Failure to do so will cause the application to be incomplete and you will be requested to complete any missing questions or pages, as applicable.

If you need to explain or clarify any question or if any of the sections in the application do not contain sufficient space for the requested information, attach the additional information to the application.

REQUIRED DOCUMENTATION

- 1. APPLICATION FORM AND FEES:** The application must be completed in full. Attach the cashier's check or money order made out to the Department of Health for \$113.00 to page 1 of the application.
- 2. PROOF OF MARRIAGE:** Proof of marriage must be provided to verify marriage to a member of the Armed Forces of the United States who is on active duty in Florida.
- 3. LICENSE/CERTIFICATE VERIFICATION:** Verification must be received to establish an active license, certification or registration for your profession issued by another state, District of Columbia, or possession or territory of the United States. This verification must include information that indicates that your license is not the subject of a disciplinary proceeding. You will not qualify for this license if you have been or currently are the subject of disciplinary proceedings in any jurisdiction in which you hold a license to practice a profession regulated in Florida under chapter 456, Florida Statutes.
- 4. OFFICIAL ACTIVE DUTY MILITARY ORDERS:** A copy of military orders showing your spouse is assigned to an active duty station in Florida.
- 5. PROOF THAT YOU ARE ENTITLED TO FULL LICENSURE:** You must submit the full licensure application for the profession in which you are seeking temporary licensure along with any supporting documentation required by that application. Documentation that is required for both applications, such as license verifications, are only required to be submitted once. *Full licensure application fees are not required for temporary licensure.*
- 6. TWO COMPLETE FINGERPRINT CARDS:** *(Second set is optional, but if one set of fingerprints is found to be incomplete, this may cause a delay in obtaining the license)*
To request fingerprint cards please visit <http://www.fldoh.sofn.net/>. This website is designed to allow Florida Department of Health-MQA Candidates a means to register their demographic information and the option to purchase FD258 fingerprint cards to process their fingerprint-based criminal history background screening checks in accordance with Florida law.

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To Register:

1. ENTER personal demographic data required to submit fingerprints.
2. OPTION to purchase FD 258 fingerprint cards.
 - If you choose not to purchase fingerprint cards you must make sure the police department or agency you choose to roll your fingerprints uses an FD 258. If the FD 258 is not used the fingerprints will not be accepted. You will be required to submit another set and your application will be delayed.
3. PAY: If fingerprint cards are purchased.
 - \$4.00 for regular USPS mail
 - \$10.00 for priority mail

OBTAIN RECEIPT generated online. Print the Bar Code Receipt and mail it to the address listed on the receipt with the completed fingerprint cards.

7. NATIONAL PRACTITIONER DATA BANK (NPDB):

National Practitioner Data Bank Report - Applicants are required to complete a self query to the NPDB and upon receipt of the query, provide the board office with a copy. A fee is charged to furnish this information. For more information, please visit the [NATIONAL PRACTITIONER DATA BANK](#).

You may contact NPDB at
NPDB
P.O. Box 10832
Chantilly, VA 22021
(800)767-6732

Once you receive your report, forward it to the board office address provided on the full licensure application.

ADDITIONAL INFORMATION

WITHDRAWAL OF APPLICATION

If you decide to withdraw your application, you must make the request in writing. The request must be received prior to the granting of licensure. The fees are non-refundable.

ADDRESS CHANGES

Please notify the board office immediately of any address change.

FOR DENTISTS ONLY

An applicant who is issued a temporary professional license to practice as a dentist must practice under the indirect supervision, as defined in s. 466.003, of a dentist licensed pursuant to ch. 466, Florida Statutes.

Where to send the applications and attached cashier's check or money order:

Florida Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330

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Personal Information *LIST YOUR FULL, LEGAL NAME AS IT SHOULD APPEAR ON YOUR LICENSE*

LICENSE PROFESSION/TYPE (e.g., RN, Dental Hygienist): _____

NAME: (Last) _____ (First) _____ (Middle) _____

MAILING ADDRESS: _____ (Apt. #) _____
(Mailing address will display on the Internet if you have not provided a practice location address.)

City: _____ **State:** _____ **Zip:** _____ **Country:** _____

WORK NUMBER: (_____) _____ - _____ **HOME NUMBER:** (_____) _____ - _____

NAME OF SPOUSE: (Last) _____ (First) _____ (Middle) _____

SPOUSE'S BRANCH OF SERVICE: _____

SPOUSE'S DUTY STATION: _____

DATE DUTY BEGAN OR WILL BEGIN IN FLORIDA: ____/____/____ *Contact the board office if this date changes.*

CORRESPONDENCE VIA E-MAIL: By checking "yes" you are agreeing to allow the Department to contact you with information regarding your application via email. If you choose this option please check your email account frequently and notify the Department of any change to your email address. Print legibly.

YES **NO E-mail Address (optional):** _____

Name Changes

List any name you have been known by:

Licensure/Certification Data

List a current license, certification or registration for your profession issued by any state, District of Columbia, or possession or territory of the United States that you are using to obtain this license.

State	License Type	License Number	Original Issue Date	Expiration Date

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History

- | | |
|---|--|
| 1. Have you ever been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have you ever had a health care provider license revoked or suspended? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Have you ever been reported to the National Practitioner Data Bank? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. If your answer to question 3 was yes; Have you successfully appealed to have your name removed from the National Practitioner Data Bank? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Have you previously failed the Florida examination required to receive a license to practice the profession for which you are seeking a temporary license? | <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> N/A |

NOTE: any reply of "yes" may result in denial of issuance of a Temporary License In accordance with Florida Statute 456.024(3)(h)

Application Checklist

- _____ Completed temporary license application. *All questions must be answered. If a question is not applicable, mark it with N/A. Questions left blank will delay the licensure process.*
- _____ Required \$113.00 fee payable by cashier's check or money order.
- _____ Proof of current marriage to a member of the Armed Forces of the United States.
- _____ License verification for the license listed in the Licensure/Certification Data section on page 3.
- _____ Copy of official active duty military orders as proof that your spouse is currently assigned to a duty station in Florida.
- _____ Two (2) fingerprint cards. *Failure to submit fingerprint cards will delay your application. (Second set is optional, but if one set of fingerprints is found to be incomplete, this may cause a delay in obtaining the license)*
- _____ NPDB report. *Applicants are required to complete a self query to the NPDB and upon receipt of the query, submit a copy of the report as part of this temporary licensure application process.*
- _____ Completed full licensure application for the profession in which you are seeking temporary licensure along with any supporting documentation required by the application.

Statement of Applicant

I declare these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.0083 and 775.084, Florida Statutes.

I hereby authorize all hospital(s), institution(s) or organization(s), personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), to release to the Florida Department of Health any information which is material to my application for 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 are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license to practice in the State of Florida.

Signature of Applicant (required)

_____/_____/_____
Date Signed (required)

