FLORIDA DEPARTMENT OF HEALTH

FLORIDA FINANCIAL RESPONSIBILITY FORM

NAME: **LICENSE NUMBER:**

MAILING ADDRESS:

CITY: **STATE:** **ZIP:**

Mailing address will not be published on the internet.

1st PRACTICE LOCATION:

CITY: STATE: ZIP:

Practice locations will be published on the internet.

2nd PRACTICE LOCATION:

CITY: STATE: ZIP:

Practice locations will be published on the internet.

Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only one option of the ten provided pursuant to s.458.320, Florida Statutes.

CATEGORY I: FINANCIAL RESPONSIBILITY COVERAGE FOR FLORIDA PRACTICE ONLY

☐1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐2. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.357, F .S.

☐3. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐4. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g) 1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

CATEGORY II: FINANCIAL RESPONSIBILITY EXEMPTIONS FOR FLORIDA OR OUT OF STATE PRACTICE

☐1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐2. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license.

☐3 I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

☐4. I do not practice medicine in the State of Florida, or

☐ 5. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year.

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that **"I have decided not to carry medical malpractice insurance"**. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f)7 or 459.0085(5)(f)7, F. S.

Signature of Physician Date

The Dept. of Financial Services provides a web site listing only authorized insurers pursuant to s.624.09, F.S. Before choosing an insurer, review the web site to insure compliance with the Florida Statutes. http://www.fldfs.com/data/companysearch/indes.asp	Department of Health Board of Medicine 4052 Bald Cypress Way, Bin #C03 Tallahassee, Florida 32399-3253 Tel: (850) 245-4131, Fax: (850) 488-0596