# PROTOCOL FOR DENTAL LABORATORY APPLICATION REGISTRATION

**Upon receipt of the application, you will be notified within 30 days of the status of your application. Once the application is complete our office will schedule an inspection. Please allow a minimum of 30 days for the inspection to be completed.**

**Please contact our office at (850) 245-4444 ext. 3491 if you have any questions.**


Division of Medical Quality Assurance • Office of Dental Laboratories • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474 Telephone
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# DENTAL LABORATORY REGISTRATION APPLICATION
# FEE: $200.00 NON-REFUNDABLE

**Pursuant to Chapter 466.033, Florida Statutes, this is the official registration form referenced. Failure to complete this application or failure to provide the requested documents shall prevent any further consideration of your registration request. Make check payable to Department of Health and mail to Department of Health, Post Office Box 6330, Tallahassee, FL 32314-6330.**

**PART I – PROFILE DATA**

| | | | |
|---|---|---|---|
| [1] Laboratory Name: | | | |
| [2] Laboratory Address: | | | |
| [3] Owner's Name: | | | |
| [4] Owner's Telephone: Office ( ) | Home ( ) | | |
| [5] Date of Birth: | [6] Social Security Number: *(Enter on separate page provided in the application)* | | |
| [7] Have you ever registered a dental lab? If yes, please provide the registration number: ________________________________ | | | |
| [8] Business type: Please mark the appropriate box. (*Must submit certified copies of all articles of incorporation). | Sole Proprietorship: | Partnership: | Corporation: |
| [9] Fictitious Name Statement: If the laboratory is operating under a name other than the owner, please provide a copy of the "fictitious name" registration from the Secretary of State – (850) 488-9000. Please attach to this completed application. | | | |



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## PART II - PERSONAL AND LICENSURE HISTORY

*ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.*
*If you answer "YES" to ANY of the following questions, explain in full by addendum to the application and include disposition documents. You must make a statement that includes, but is not limited to, the date(s), location(s), and specific circumstances pertaining to the "YES" answer. Any "YES" answer must be substantiated by official documents sent directly to the board office. A "YES" answer is NOT an automatic cause for denial of application.*

| Question | Answer |
|---|---|
| [1] Has any owner, partner, officer, director, stockholder or employee ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a 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 or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. **If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet.* | YES NO |
| [2] Has any owner, partner, officer, director, stockholder or employee ever been a party to any civil, criminal or administrative proceeding involving any violation of Chapter 466, Florida Statutes, or any regulation governing the practice of the dental profession? | YES NO |
| [3] Has any owner, partner officer, director, stockholder or employee ever had a professional license or registration revoked, suspended, or disciplined? | YES NO |
| [4] Does the laboratory meet the requirements for sanitation and safety as outlined in rule 64B27-1.001, Florida Administrative Code? | YES NO |
| *Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, provide explanation on a separate sheet providing accurate details and submit copies of supporting documentation.* | |
| [5a] Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever 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 5b.)* | YES NO |
| [5b] 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 |
| [6a] Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? *(If no, do not answer 6b.)* | YES NO |
| [6b] If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years? | YES NO |
| [7a] Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant 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 7b and 7c.)* | YES NO |
| [7b] Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? | YES NO |
| [7c] Did the termination occur at least 20 years prior to the date of this application? | YES NO |




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**PART III - APPLICANT STATEMENT**

**THE FOLLOWING STATEMENT MUST BE COMPLETED:**

I, _______________________________________________, state that I am the person referred to in the foregoing Dental Laboratory application and supporting documentation, that said application and any supporting documentation are true and accurate.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of opening dental laboratory.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of the dental laboratory under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B27, Florida Administrative Code, in the State of Florida.

I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B27, Florida Administrative Code, and acknowledge that I must abide by them.

________________________________________ ________________________________________
OWNER'S NAME (PRINT OR TYPE) SIGNATURE OF OWNER DATE



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# CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

**Florida Department of Health**

**Name:** ______________________________________________
**Last** **First** **Middle**

**Social Security Number:** ________________________________

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA s. 666(a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.


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