Osteo

3407184

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

HEALTH

Vision: To be the Healthiest State in the Nation

Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General & Secretary

PHYSICIAN DISPENSING REGISTRATION

OFFICE USE ONLY

NOTE: YOU MAY NOT DISPENSE UNTIL THIS REGISTRATION HAS BEEN APPROVED.

Important – Complete one form per licensee.

A dispensing practitioner shall not dispense a controlled substance listed in Schedule II or III as provided in Section 893.03, F.S. unless exempted from this section by s. 465.0276, FS.

Dispensing – is defined as selling medicinal drugs to patients in the office. A practitioner who writes prescriptions or provides complimentary professional samples is not a "dispensing practitioner," and therefore does not need to register with the department.

Dispensing fee – The fee for registration as a dispensing practitioner is **$100.00** over and above the required license renewal fee. An annual inspection of your dispensing records will be conducted.
Dispensing Approval – You cannot begin dispensing until you are registered

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Name & license No:	ANNA LOWELL / OS14831		ME
Facility Name:	North Tampa – Planned Parenthood		
Practice Location:	236 East Bearss Ave		
☐ Add ☐ Delete	Street name and number Zip 33613	City TAMPA	State FL
Facility Name:	See page 2		
Satellite Location:			
☐ Add ☐ Delete	Street name and number Zip	City	State

A Lowell — **Signature of Physician**

07/07/18 — **Date of signature**

☐ **PLEASE CANCEL MY DISPENSING STATUS EFFECTIVE** _____ **Effective Date**

DH-MQA 1070, Rules 64B8-4.029 and 1.007, FAC, Revised 7/2011

OSTEOPATHIC UNIT
JUL 20 2018
RECEIVED

ADDING / DELETING DISPENSING LOCATIONS

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION			
Name & license No:	ANNA LOWELL / 0514831 ME		
Facility Name:	Kissimmee – Planned Parenthood		
Practice Location:	610 Oak Cannons Blvd.		
☐ Add ☐ Delete	Street name and number 34741 Zip	City Kissimmee	State FL
Facility Name:	Sarasota – Planned Parenthood		
Satellite Location:	734 Central Ave.		
☐ Add ☐ Delete	Street name and number 34103 Zip	City Sarasota	State FL
Facility Name:	Naples – Planned Parenthood		
Satellite Location:	1425 Creech Rd		
☐ Add ☐ Delete	Street name and number 34103 Zip	City Naples	State FL
Facility Name:	Fort Meyers – Planned Parenthood		
Satellite Location:	8595 College Pkwy Ste. 250		
☐ Add ☐ Delete	Street name and number 33919 Zip	City Fort Myers	State FL

Please submit this request form to:

Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin # C-03
Tallahassee, FL 32399-3253
Fax: (850) 488-0595

A Lowell — 07/07/18

Signature of Physician — **Date of signature**

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Effective Date

To cancel dispensing practitioner status from your medical license, the licensee must submit a signed request to the Board office to the address listed above.

340/879

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OFFICE USE ONLY

07/24/2018 100.00
ID: 14638 Type: F
BT: 3001769
R#: 918003832

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Facility Name:	See page 2		
Satellite Location:			
☐ Add ☐ Delete	Street name and number Zip	City	State

A Lowell — 07/07/18

Signature of Physician — **Date of signature**

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Satellite Location:	736 Central Ave.		
☐ **Add** ☐ **Delete**	Street name and number Zip 34103	City Sarasota	State FL
Facility Name:	Naples – Planned Parenthood		
Satellite Location:	1425 Creech Rd		
☐ **Add** ☐ **Delete**	Street name and number Zip 34103	City Naples	State FL
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Board of Medicine
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Tallahassee, FL. 32399-3253
Fax: (850) 488-0596

ALowell — 07/07/18

Signature of Physician — **Date of signature**

☐ **PLEASE CANCEL MY DISPENSING STATUS EFFECTIVE** _____
Effective Date

To cancel dispensing practitioner status from your medical license, the licensee must submit a signed request to the Board office to the address listed above.

July 26, 2018

Dr. Anna Marie Lowell , DO
5940 Wilkinson Road
Apt 109
Sarasota, FL United States 34233

Re: Request to dispense

Dear Dr. Lowell:

Your request to dispense medicinal drugs to patients out of your office has been received. Dispensing status has been added to your license. You should receive your dispensing license in approximately 4-6 weeks.

Below are the Florida Statutes that provides information regarding dispensing medicinal drugs to your patients. You can download these statutes from our web site at http://www.doh.state.fl.us/mqa/osteopath

465.0276 - Dispensing Practitioner
465.035 – Dispensing of medicinal drugs pursuant to facsimile of prescription
465.185 – Rebates prohibited; penalties
499.005 – Prohibited acts
499.007 – Misbranded drug or device
499.028 – Drug samples or complimentary drugs; starter packs; permits to distribute
499.0054 – Advertising and labeling of drugs, devices, and cosmetics
893.04 – Pharmacist and practitioner
893.07 - Records

If you have any questions or concerns, please do not hesitate to contact me by or e-mail me at MQA_Osteopath@doh.state.fl.us or phone at (850) 245-4565.

Sincerely,

Application Summary

Application Detail

License Type:	**Osteopathic Physician**
Profession Number:	**1901 - Osteopathic Physician**
File Number:	**14638**
Application:	**Osteopathic Physician License Application**
Application Date:	**07/03/2017**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am designating as NICA Participating.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am designating as NICA Exempt. Note, if you are not Exempt, then you will be considered as NICA Non-Participating.	**No**

Personal Detail

Title:	**Dr.**
First Name:	**Anna**
Middle/Second Name:	**Marie**
Last Name/Surname:	**Lowell**
Birthdate:	**09/06/1986**

Gender:	**Female**
Race:	**Other**
Social Security Number:	*******[redacted]**

Addresses

Main Address

Address:	**4013 Wyckoff Drive**
	UNKNOWN
	Virginia Beach, VA
	23452
	US
Phone Number:	**757-339-5195**
Extension:	
E-mail Address:	**annalowell@gmail.com**
Home	
Fax	

Physical Location

Address:	**NOT PRACTICING**
Home	
Fax	

License Attributes Selected

Specialty	**NICA Fee**

Education History

School Name:	**NOVA SOUTHEASTERN UNIVERSITY**
Street Address Line 1:	**3301 College Avenue**
City:	**Fort Lauderdale**
State:	**FLORIDA**
Postal/Zip:	**33314**
Country:	**UNITED STATES OF AMERICA**
Attended From (mm/dd/yyyy):	**08/01/2010**
Attended To (mm/dd/yyyy):	**05/18/2014**

Education Discipline

Are you currently in default on any health education loan or scholarship obligation?	**No**

Postgraduate Training

Program Name:	**Mount Sinai Downtown Residency in Urban Family Medicine**
Program City:	**New York**
Program State or Country:	**NEW YORK**
Program Type:	**RESIDENCY**
Specialty Area:	**FP - FAMILY PRACTICE**
Attended From:	**07/01/2014**
Attended To:	**06/30/2017**
Program Approval:	**ACGME**
Did you receive credit?	**Yes**

Other State Licensure

Do you now hold or have you ever held a license to practice Osteopathic Medicine or any other profession in any US State or territory, or foreign country? **No**

Year Began Practice

Enter the date where you legally began to practice Medicine. This would be the date you began practicing Medicine and could be the date you began your postgraduate training. Only the year will display on your practitioner profile.

Date Began Practice: **07/01/2014**

Osteopathic Practicing

Has it been more than two years since you practiced osteopathic medicine in any jurisdiction? **No**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **No**

Specialty Board Certifications

Are you certified by an speciality board recognized by the AOA, ABMS, ABIPP, or AAPS? If yes, list below and and provide verification of each certification. **No**

DEA

Have you ever been denied, or surrendered a DEA Registration? **No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [redacted]

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed related (alcohol/drug) disorder that has impaired your ability to practice within the past five years?

[redacted]

If any of the questions are answered "YES", explain in full on a separate sheet of paper. Your statement must include, but is not limited to:The Date(s), Location(s),Specific circumstances,Practitioners Treatment Involved.If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: Treatment Received Medications Dates of Treatment If pplicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), Admission Discharge

Criminal History

Have you ever been convicted or found guilty, regardless of adjudication, or pled guilty or nolo contedere (no contest) to a criminal misdemeanor or felony in any jurisdiction? **No**

If "Yes", submit the arrest and court records along with a disposition of the case to the Board.

License Discipline History

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? **No**

Institution Discipline History

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? **No**

Entity Discipline History

Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? **No**

Privileges Restricted

Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? **No**

Application Denial

Have you had any application for a license to practice any profession, including Osteopathic Medicine, denied by any state board or the licensing authority of any state, territory or country? **No**

Special Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

FDANP Medicaid

Have you ever been sanctioned by an state Medicaid program?	**No**

FDANP - Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 459.015, Florida Statutes?	**No**

Medicaid/Medicare (Applicants)

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Electronic Fingerprinting

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,
- RETENTION OF FINGERPRINTS,
- PRIVACY POLICY, AND
- RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. Specified agency means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours. Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.
Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement can be viewed here: https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**07/03/2017**

Availability for Disaster

Will you be available to provide health care services in special needs shelters or help staff disaster medical assistance teams during times of emergency or major disaster?	**Yes**

If you respond 'Yes', your name will be added to a data listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Financial Responsibility

Financial Responsibility	**Financial Exemption**

CATEGORY II: Financial Responsibility Exemptions If you select an exemption based on # 10, you must also complete the affidavit that will be emailed to you upon submission of this application. 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions. 7. I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license. 8. I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.) 9. I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state. 10. I am exempt from demonstrating financial responsibility due to meeting all of the following criteria** See note below: (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 1,000 patient contact hours per year. (c) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period. (d) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state. (e) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Financial Exemption	**9. NOT PRACTICING IN FLORIDA**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

A "yes" answer to either of the above two questions requires the following: A self-explanation listing your involvement in each case Completed Exhibit 1 Form for each case (follows application) A copy of the complaint and disposition for each case In addition to the above, for judgments occurring after November 2, 2004 the entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a DVD (don not send originals). The record must include: Initial and/or amended complaint Trial transcripts Evidentiary exhibits Final judgment

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

A "yes" answer to either of the above two questions requires the following: A self explanation listing your involvement in each case Completed Exhibit 1 Form for each case (follows application) A copy of the complaint and disposition for each case In addition to the above, for judgments occurring after November 2, 2004 the entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a DVD (don not send originals). The record must include: Initial and/or amended complaint Trial transcripts Evidentiary exhibits Final judgment

Faculty Appointments

Do you currently hold a faculty appointment at a medical school, or Have you had responsibility for graduate medical education within the last 10 years?	**No**

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials?	**No**

US Military / Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

A "yes" answer to the above question requires the following:A self explanation providing accurate details (including, but not limited to, the date(s), location(s), specific and circumstances)Documentation from the military regarding the charges/event

Fees

Application Fee	**$200.00**
Unlicensed Activity	**$5.00**
License Fee	**$300.00**
NICA	**$250.00**
Total Amount Due:	**$755.00**

Attestation

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Osteopathic Medicine 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 Osteopathic Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Attestation Answer: Yes