

**Florida Department of Law Enforcement
Medical Examiners Commission**

**Associate Medical Examiner (AME)
Notice of Appointment / Termination of Appointment**

District _____ AME Appointment Date _____ Date Reported _____

In accordance with Section 406.06(2), Florida Statute and Rule 11G-1.002(2), Florida Administrative Code, I am appointing/terminating the below AME.

District Medical Examiner Printed Name

District Medical Examiner Signature

AME APPOINTMENT

Name (Last, First, MI, Degree) _____

Florida License Number _____ Date _____

Board Certifications _____ Date _____
_____ Date _____
_____ Date _____

Medical School _____

Graduation Date _____

Internship Location _____

Completion Date _____

Residency Location _____

Completion Date _____

Pathology Experience (approximate years) _____

Current Employment _____

Comments
(Please note if secondary appointment for cross coverage)

AME TERMINATION

Name (Last, First, MI, Degree) _____

Termination of Appointment Date _____

Reason
(Please provide a brief explanation)

Print Form