DOCTOR OF THE DAY PROGRAM
APPLICATION

PLEASE CONTACT YOUR SENATOR TO REQUEST SPONSORSHIP PRIOR TO SUBMITTING
(2026 REGULAR SESSION IS JANUARY 13 - MARCH 13)

Name: _____ MD ☐ DO ☐

Mailing Address: _____

Cell Phone: _____ Office Phone: _____

Email: _____ Fax Number: _____

Medical Specialty: _____

Florida Medical License Number & Expiration Date (attach copy): _____

Are you a full-time practicing physician? _____

If so, where? _____

I will be sponsored by Senator _____

Preferred Dates

1: _____

2: _____

3: _____

I hereby affirm and attest that all the information contained in this form is true and correct.

Signature: _____ Date: _____

Completed applications can be sent electronically to: **DoctoroftheDay@leg.state.fl.us**; faxed to: **(850) 414-1909**; or mailed to:

Doctor of the Day
Office of Legislative Services
Room 701, Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1400