

AC# 3627997

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
10/23/2009	SS 854	3074

3627997

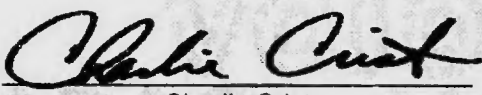
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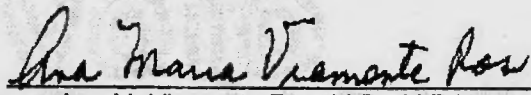
The SCHOOL PSYCHOLOGIST
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **NOVEMBER 30, 2011**

DAVID ANDREW CARLYLE

The **SCHOOL PSYCHOLOGIST**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **NOVEMBER 30, 2011**
DAVID ANDREW CARLYLE
6566 CHESEWOOD DRIVE NORTH
JUPITER, FL 33458



Charlie Crist
GOVERNOR



Ana M. Viamonte Ros, M.D., M.P.H.
STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **NOVEMBER 30, 2011**

Your license number is **SS 854**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to www.flhealthsource.com
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and click on "Login".
6. If you do not know your account ID and password, click on "Get Login Help" or call our Customer Contact Center at (850) 488-0595 for assistance.

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____

LAST FIRST MIDDLE

TO: _____

LAST FIRST MIDDLE

DH 2103. 5/98