Rev. 03/17

INSTRUCTIONS FOR REINSTATEMENT OF A CHIROPRACTIC LICENSURE APPLICATION

A completed application must be returned to this office along with the reinstatement fee. Effective April 16, 2008, the fee for reinstatement is$472.00. APPLICATIONS WILL NOT BE PROCESSED UNLESS THE FEE IS ATTACHED. Checks or money orders should be made payable to the "Treasurer of Virginia".

INFORMATION REQUIRED TO COMPLETE YOUR APPLICATION

(This form has been designed to be used as a checklist for submitting required documentation.)

☐1. Forward Form B **(Activity questionnaire)** to each and every location where you have provided chiropractic services you have practiced since your license in Virginia lapsed. If the license has lapsed for more than five years, only provide Form B's for the past five years. If you have been self-employed, please have the Form B completed by two professional colleagues or have 2 letters of recommendation provided to the Board. This form may be copied, if necessary. This document **may** be faxed to the Board by the person completing it.

☐2. Verification of Chiropractic licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a full license must be received by the Board. **Please contact the applicable jurisdiction where you have been issued a license to practice as a chiropractor to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed.

.

☐4. Provide documentation indicating completion of continued competency hours equal to the requirement for the number of years listed below, not to exceed four years preceding reinstatement of license. Copies of certificates issued for Category I are required. Additional information addressing continued competency requirements are described under general regulations §18VAC 85-20-235 (A)(1)&(2). This documentation may be faxed.

License lapsed for two years – 60 hours of continuing learning activities
License lapsed for three years – 90 hours of continuing learning activities
License lapsed for four years - 120 hours of continuing learning activities

What are "Type 1" hours?

a. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

All 60 continuing competency hours each biennium may be Type 1 hours.

What are "Type 2" hours?

Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

☐ 5. Copies of documentation supporting any name change since your initial licensure in Virginia.

☐ 6. If you answer yes to question 12 regarding malpractice claims, provide documentation to the Board from your attorney, or you may provide a narrative describing your treatment of the patient, the allegation made as well as any payment due to settlement or judgment.

Please note:

*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, with the application of new technology, which makes this information more accessible, there has been growing concern of those licensees who supply their residence address for mailing purposes. This notice is to reiterate that the Board of Medicine maintains only one address for each licensee and will allow the address of record to be a Post Office Box or practice location.

*Applications will be acknowledged after receipt if items are missing.

*Applications not completed within 12 months may be purged without notice from the board.

*Additional information may be requested after review by Board representatives.

*Application fees are non-refundable.

* Do not begin practice until you have been notified of approval. Submission of an application does not guarantee a license. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

*Certain forms may be faxed to 804-527-4426.

Contact person: ShaRon Clanton ShaRon.Clanton@dhp.virginia.gov

COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE
Department of Health Professions
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (804) 527-4426 Fax
medbd@dhp.virginia.gov

Application for REINSTATEMENT of License to Practice as a Chiropractor

To the Board of Medicine of Virginia:

I hereby make application for reinstatement of my license to practice as a Chiropractor in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle	
Street	City	State	ZIP Code
Date of Birth _____ _____ _____ Mo. Day Yr.	Place of Birth	Social Security No. or VA Control No.*	

Please submit address changes in writing immediately to medbd@dhp.virginia.gov

Please attach check or money order payable to the Treasurer of Virginia For $4720.00. Application will not be processed without the fee. Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY

_____

Date

LICENSE NUMBER	PROCESSING NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
0104-		**$472**		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices since the expiration date of your Virginia license including any periods of non-professional activities or employment for more than three months. **Please account for all time.** If engaged in private practice, list all hospital affiliations. If none, please explain. **CVs may be attached but does not substitute for completion of this page.**

From	To	Name and Location	Position Held

Please provide a telephone number where you can be reached during the day. This information is not mandatory and if provided, will not be used for any purpose other than as a contact if staff has questions about your application.

Work Number	Home Number	E-mail Address

QUESTIONS MUST BE ANSWERED. If any of the following questions (6-15) is answered **Yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits or criminal convictions.

3. Do you intend to engage in the active practice of chiropractic in the Commonwealth of Virginia? ☐ Yes ☐ No

   If Yes, give location _____

4. List all jurisdictions in which you have been issued a license to practice chiropractic: active, inactive or expired. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

		Yes	No
5.	Are you certified by the National Chiropractic Examiners?	☐	☐
6.	Have you ever been denied a license or the privilege of taking a licensure/competency examination by any Testing entity or licensing authority?	☐	☐
7.	Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.)	☐	☐
8.	Have you ever been denied privileges or voluntarily surrendered your clinical privileges for any reason?	☐	☐
9.	Have you ever had any disciplinary actions taken against any of your professional license/certificate/permit/ Registration related to your professional practice, are any actions pending or are you currently under investigation?	☐	☐
10.	Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned?	☐	☐
11.	Have you voluntarily withdrawn from any professional society while under investigation?	☐	☐
12.	Have you had any malpractice suits brought against you in the last ten years? If so, how many? _____ Provide details.	☐	☐
13.	Have you been physically or emotionally dependent upon the use of alcohol /drugs or treated by, consulted with or been under the care of a professional for any substance abuse within the last two years? If so, please provide a letter from the treating professional.	☐	☐
14.	Do you have a physical disease, mental disorder or any condition, which could affect your performance of Professional duties?		
15.	Have you been in a health practitioner's monitoring program within the last two (2) years?	☐	☐
16.	Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave Employment to accompany your spouse to Virginia?		

17. AFFIDAVIT OF APPLICANT

(THIS SECTION MUST BE NOTARIZED)

I, _____, am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and my application.

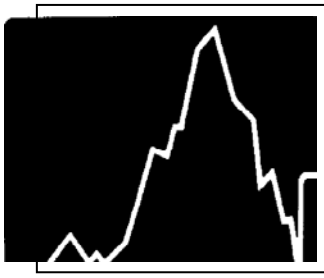
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice Chiropractic in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available at www.dhp.virginia.gov and I understand that fees submitted as part of the application process shall not be refunded.

_____

Signature of Applicant

Rev. 03/17 CIRCLE THE CORRECT PROFESSION MD DO DPM Chiropractor Form B



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Phone (804)-367-4600
Fax (804) 527-4426
email: medbd@dhp.Virginia.gov

Print/type name of organization/individual exactly as it appears on your application chronology. .

_____ _____
Clearly print/type name of applicant _____
_____

The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.

Signature of Applicant _____

1. Date and type of service: This individual served with us as _____ from _____ (Month/Year) to _____ (Month/Year). If you are responding from a training program, please provide the number of months of postgraduate training awarded_____.

2. Please evaluate: (Indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge					
Clinical judgment					
Relationship with patients					
Ethical/professional conduct					
Interest in work					
Ability to communicate					

3. Recommendation: (please indicate with check mark)
   - Recommend highly and without reservation ☐; Recommend as qualified and competent ☐
   - Recommend with some reservation (explain) _____
   - Do not recommend (explain) _____

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

   _____
   _____

5. The above report is based on: (please indicate with check mark)
   - Close personal observation ☐; General impression ☐; A composite of evaluations ☐;
   - Other: _____

Date (Required): _____ Signed by: _____
Print or type name: _____
Title: _____

(This report will become a part of the applicant's file and may be reviewed by the applicant upon request.)