Rev. 12/18

REQUIREMENTS AND INSTRUCTIONS FOR INTERN/RESIDENT/FELLOW LICENSE

Applicants should apply for an intern/resident/fellow training license immediately upon notification of appointment for postgraduate clinical training. This license application only applies to MD, DO and DPM training programs.

Upon completion and approval of the intern/resident/fellow temporary license application, a license will be issued and mailed to the training program address listed on the application.

If your answer to any application question 4-16 is "yes" please provide an explanation on a separate page and attach it to your application.

The intern/resident/fellow temporary license is valid only within the legally established and licensed hospitals operating under an approved graduate medical education program for which it is intended and cannot be used to practice outside the program.

☐ **The licensure application:** Follow the instructions provided on the application. The application **may not** be faxed.

☐ **Licensure fee:** Check or money order in the amount of $55.00 made payable to the "**Treasurer of Virginia"**.

***Please note: Application and fee must be submitted together. If received separately, they will be returned.**

☐ **Memorandum (Form A) –** Pursuant to Section 54.1-2961 of the Virginia Code, the training program must complete Form A to certify the beginning and ending dates of training and to note that character reference letters are on file in the program director's office. This form **may** be faxed to (804) 527-4426, mailed to the Board's address noted on the application or emailed.

☐ **Certificate of Professional Education (Form B) –** Graduates of institutions approved or accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the AMA, or the Accreditation of Canadian Medical Schools or its appropriate subsidiary agencies must provide proof of professional education on Form B. Form B must be completed after the date of graduation. Form Bs **may not** be faxed or emailed.

Graduates of an institution outside of the United States and Canada not approved by the accrediting agency recognized by the board shall submit a notarized copy of their professional school diploma with an English translation. Diplomas **may not** be faxed or emailed

☐ **ECFMG Certification:** To request your ECFMG certification follow this link https://cvsonline2.ecfmg.org/ or you may provide the Board with a currently notarized copy of your ECFMG certificate. ECFMG verification **may not** be faxed.

Please note:

- The Board office will acknowledge incomplete applications **once** within 3-5 business days after receipt. You may check the Board's License Lookup at **https://dhp.virginiainteractive.org/Lookup/Index** to see if your license has been issued. The paper license may take approximately 15 business days from the date of issue to reach your program's office. Be advised that while you must be issued a license number to practice medicine in Virginia, the actual paper license is not required for practice or to be credentialed. Verification of licenses is available at **https://dhp.virginiainteractive.org/Lookup/Index.** This website meets The Joint Commission requirements for license verification.
- Please be aware the 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 upon request. Street addresses, post office box numbers or rural route numbers are not available on-line on the board's website. However, if you prefer, the Board of Medicine will allow the address of record to be a post office box or practice location.
- **Applications not completed within 12 months may be purged without notice from the board.**
- Additional information may be requested after review by a representative of the board.
- Application fees are non-refundable.
- **Contact person Pam Smith Email: pam.smith@dhp.virginia.gov**

Virginia Department of Health Professions

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

Application for a Temporary License for Intern/Resident/Fellowship Training Program

To the Board of Medicine of Virginia: I hereby make application for a license to practice as an Intern / Resident / Fellow in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle
Date of Birth _____ _____ _____ MO DAY YEAR	Social Security No. or VA Control No.*	Maiden Name if applicable
Training Program Mailing Address:	House No. Street or PO Box	City State and Zip
Board Address: This address will be used for Board Correspondence and may be the same or different from the public address.	House No. Street or PO Box	City State and Zip
Work Phone Number	Home/Cell Phone Number	Email Address

Date of Graduation:	Degree Obtained (MD/DO/DPM)
Name of Professional School from where you graduated:	
Is this school located outside of the United States or Canada	☐ If NO – Please have Form B completed and forwarded to the Board.
	☐ If **YES** – Please have your ECFMG forwarded to the Board.

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 $55.00. Applications 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
0116 – Res/Int/Fel		**$55.00**

*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 including each location of service since graduation, including internships, residencies, hospital affiliations and absences from work. Also list all periods of non-professional activity or employment. **PLEASE ACCOUNT FOR ALL TIME**. If engaged in private practice, list all clinical affiliations.

From	To	Name of Location of Practice	Address of Location	Position Held

Indicate the hospital where you are scheduled to begin your training program.

From	To	Program or Hospital Name	Location	Position to be Held

3. List all jurisdictions in which you have been issued a license to practice medicine: include all active, inactive, expired, suspended or revoked licenses. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

Yes **No**

QUESTIONS MUST BE ANSWERED. If any of the following questions (4-16) is answered **Yes**, explain and substantiate with documentation.

4. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority? ☐ ☐

5. 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.) ☐ ☐

6. Have you ever been denied privileges or voluntarily surrendered your clinical privileges for any reason? ☐ ☐

7. Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or Requested to withdraw from any professional school, training program, hospital, etc? ☐ ☐

8. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier? ☐ ☐

9. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of medicine? ☐ ☐

10. Have you voluntarily withdrawn from any professional society while under investigation? ☐ ☐

11. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? ☐ ☐

12. Within the past five years, have you been disciplined by any entity? ☐ ☐

13. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the Obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. ☐ ☐

14. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. ☐ ☐

15. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. ☐ ☐

16. Within the past 5 years, have you any condition or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ☐ ☐

Military Service:

17. 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? ☐ ☐

18. Are you active duty military? ☐ ☐

19. AFFIDAVIT OF APPLICANT

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