INSTRUCTIONS FOR REINSTATEMENT APPLICATION OF LICENSE FOR MD AND DO.

Reinstatement occurs after the license has been expired for 2 years. Do not complete this application if your license has been expired for less than 2 years.

A completed application must be returned to this office along with the reinstatement fee of $497.00. Applications and fees must be received together. Only checks or money orders are accepted. Please make your payment instrument payable to the "Treasurer of Virginia."

Certain forms may be faxed to 804-527-4426. The phone number to the Virginia Board of Medicine is 804-367-4600. The Board's email address is medbd@dhp.virginia.gov

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

INFORMATION REQUIRED TO COMPLETE YOUR APPLICATION
(This form is designed to be used as a checklist for submitting required documentation)

☐1 If you answer "yes" to any of the licensure questions #5-16 provide a written explanation on a separate piece of paper and attach it to the application. If you have disciplinary action with another Board, attach a copy of the Board Order or other documentation. If you have medical mal practice claims, attach a narrative that includes dates, your treatment of the patient and any payment made per settlement or judgement. You may also provide a letter from your attorney. If you have misdemeanor or felony convictions attach a copy of the court documents.

☐2. Forward Form B **(Activity questionnaire)** to all hospitals, clinics, doctor's offices and all other locations where you have provided professional service including locations where you only held privileges since your Virginia license expired but for no more than the past 5 years. This form may be copied, if necessary. This document **may** be faxed to the Board by the person completing it or sent via email to medbd@dhp.virginia.gov.

For applicants practicing tele-radiology or tele-pathology, a form B is only required from the medical director of the company to which you are employed. To be accepted, the Form B must be signed by the medical director with a complete professional evaluation.

For applicants practicing all other forms of telemedicine and for Locum Tenens physicians, employment verifications must be received from each locations of service in the past 5 years.

☐3. Verification of a license to practice 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 an MD or DO to inquire about having documentation forwarded to the Virginia Board of Medicine. Many states use VERIDOC.ORG for license verifications. It may be easier to check the VERIDOC website to see if your state participates before going to the state board websites. Verification must come from the jurisdiction and may be sent by email to medboard@dhp.virginia.gov, faxed to (804) 527-4426 or mailed.

☐4 Disciplinary Inquiry: Contact the Federation of State Medical Boards at **http://www.fsmb.org/pdc/** to complete the on-line form.

☐5 ***NPDB Self Query*** **– Complete the online self-query order form.** Be ready to provide:

- Identifying information such as name, date of birth, Social Security number
- State health care license information (if you are licensed)
- Credit or debit card information for the $4.00 fee (charged for each copy you request)

2. **Verify your identity**. This can be done electronically as part of your order or by completing a paper form and having it notarized. You will receive full instructions as you complete your order.
3. **Wait for your response**. Once your identity is verified, the NPDB will process your order. A paper copy of your response will be sent the next business day by regular U.S. mail.

The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board recommends using Fed EX or UPS for tracking purposes. The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service.**

Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to be resubmitted.

☐6. Provide documentation of having completed continuing education hours equal to the requirement for the number of years in which the license has been lapsed.

Please use the following guidelines to determine the continuing education hours needed for reinstatement.

If your license has been expired for 2 to 2.5 years, provide 60 hours of CME.

If your license has been expired for 2.5 to 3 years, provide 75 hours of CME.

If your license has been expired for 3 to 3.5 years, provide 90 hours of CME.

If your license has been expired for 3.5 to 4 years, provide 105 hours of CME.

If your license has been expired for 4 or more years, provide 120 hours of CME.

If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations.

1. The Special Purpose Examination (SPEX) given by the Federation of State Medical Boards.

2. The Comprehensive Osteopathic Medical Variable Purpose Examination—USA (COMVEX-USA) given by the National Board of Osteopathic Examiners.

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

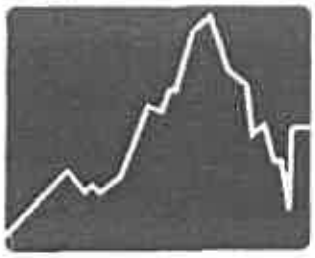
Please note:

Applications will be acknowledged after receipt of the application of items that 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 reinstatement. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

Rev. 03/17
MD and DO
Reinstatement

MD / DO REINSTATEMENT APPLICATION:



COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE
Department of Health Professions
9960 Mayland Drive, Ste. 300
Henrico, Virginia 23233-1463

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

Application for REINSTATEMENT of license To Practice Medicine

To the Board of Medicine of Virginia:
I hereby make reinstatement application for a license to practice as an (check which license applies) _____MD or a _____DO 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.	Maiden Name	Virginia License Number	Social Security No. or VA Control No.*

Please submit address changes in writing immediately.
Please attach check or money order for $497.00 payable to the "Treasurer of Virginia". Application will not be processed without the fee. It will be returned.
Do not submit fee without an application or an application without a fee. **IT WILL BE RETURNED.**

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

APPROVED BY

_____
Date

LICENSE NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
010_-	$497		

*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 to include the location of service since the expiration date of your Virginia license including any periods of non-professional activities or employment. **Please account for all time.** If engaged in private practice, list all hospital affiliations. If none, please explain. **CVs may be attached but do not substitute for completion of this page.**

From	To	Name and Location	Position Held

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

Work Number	Home Number	Email Address

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

4. List all jurisdictions in which you have been issued a full license to practice medicine and the status, active, inactive, expired, suspended or revoked. Indicate number and date issued. Temporary or intern / resident licenses need not be included.

Jurisdiction	Number Issued	License Status (e.g. Active)

QUESTIONS MUST BE ANSWERED. If any of the following questions (5-16) is answered **Yes**, explain in a narrative to be attached to the application and include any relevant documentation from courts or attorneys. Letters may be submitted by your attorney regarding malpractice suits or criminal complaints.

	Yes	No
5. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	___	___
6. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving.	___	___
7. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason?	___	___
8. 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.?	___	___
9. 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?	___	___
10. 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?	___	___
11. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned?	___	___
12. Have you voluntarily withdrawn from any professional society while under investigation?	___	___
13. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties?	___	___
14. 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 (2) years?	___	___
15. Have you been in a health practitioner's monitoring program within the last two (2) years?	___	___
16. Have you had any malpractice suits brought against you in the last ten (10) years? If so, how many? ___	___	___
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?	___	___

14. AFFIDAVIT OF APPLICANT

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

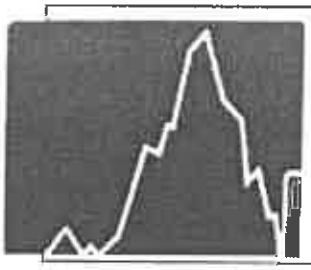
I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia 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 medicine and surgery in the Commonwealth of Virginia.

_____

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

Please print/type name and location of organization completing this form (Should match organization listed on employment activity page of application)

_____

_____

_____

Please clearly print/type name of applicant

Last 4 of Social Security Number _____

The Virginia Board of Medicine, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate'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 this candidate's 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 for 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 candidate regarding 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.)

*Name:*_____ *Last 4 of Social Security Number*_____

You are a (circle one) MD DO DPM Chiropractor

Continued Competency and Assessment Form

You may photocopy this original form to record your learning activities.
The completed forms and all documentation must be maintained for a period of six years following renewal or reinstatement of a license.

USE THIS FORM TO DOCUMENT TYPE 1 (CAT I) CONTINUING EDUCATION, AS WELL AS ALL TYPE 2 (CAT II) CONTINUING EDUCATION. ALL TYPE 1 CERTIFICATES MUST BE ATTACHED IF YOU ARE SUBMITTING THIS FORM IN RESPONSE TO AN AUDIT OR REINSTATEMENT APPLICATION.

Type 2 (CAT II) continuing education is self-designated study as well as participation in activities not certified as Type 1 (CAT I).

PART A: ACTIVITY **Learning Activity, Resources, Strategies and Experiences;** e.g. conferences, consultations, teaching, peer-reviewed journals, grand rounds, quality improvement teams, self-instructional material		PART B: ASSESSMENT (Optional for renewal of license) **Knowledge or Skills You Maintained or Developed.** What questions or problems encountered in your practice were addressed by this learning activity?	# OF HOURS/TYPE NEEDED FOR YEARS LAPSED	
	Date		Expired *2 to 2.5* years **60 hours**	30 hours must be Type 1 30 hours may be Type 2

			Expired 2.5 to 3 years **75 hours**	37.5 hours must be Type 1 37.5 hours may be Type 2
			Expired 3 to 3.5 Years **90 hours**	45 hours must be Type 1 45 hours may be Type 2
			Expired 3.5 to 4 Years **105 Hours**	52.5 hours must be Type 1 52.5 hours may be Type 2
			Expired 4 or more years **120 Hours**	60 hours must be Type 1 60 hours may be Type 2

VIRGINIA BOARD OF MEDICINE CONTINUED COMPETENCY AND ASSESSMENT FORM

Name: _____

Rev. 8/07

MD - Reinstatement - Form A

Print Name: _____

COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE

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

(804) 367-4471 (804) 527-4426 Fax

CLAIMS HISTORY SHEET

If you answered "yes" to Question #11 on page three of the application, please either have your attorney submit a letter regarding malpractice suits or complete one of these sheets for each case you have been involved in.

(Make additional copies of this form as needed)

Claimant: _____

Date of Incident: _____ Date Claim Made: _____

Name of all Defendants, Persons or Entities against whom claim was made: _____

_____

City, County and State of Suit: _____

Name and Address of Defense Attorney: _____

_____

Settlement Amount (if any): _____ Verdict Amount: _____ Date Case Closed: _____

Current Status of Claim (indicate insurance company reserve if case is not closed): _____

_____

Name of Involved Insurance Company: _____

_____

Policy Number: _____ Detailed Description of Claim (use reverse side if necessary): _____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information, privileged, or in their dominion, custody, or control, regarding insurance applications by me, professional liability issued to me, any employment or personnel records involving me and any health, medical psychological or psychiatric records involving me, as well as information obtained by any attorneys who are now representing, or have in the past represented me.

_____ _____

Date Signature