****

**Out-of-State Practitioner Reporting Form**

Virginia Code § 54.1-2408.4, enacted by Chapter 464 of the 2022 Acts of Assembly, permits health care practitioners licensed, certified, or registered in another state or the District of Columbia to temporarily practice in the Commonwealth for 90 days provided certain provisions are met. These individuals may **only** practice temporarily for 90 days after receiving an offer of employment or contract for services from: **(1) a hospital licensed by the Virginia Department of Health, (2) a nursing home, (3) a dialysis facility, (4) the Virginia Department of Health, or (5) a local health department.**

**\*\*Any practitioner licensed in a profession which utilizes a compact that Virginia and the practitioner’s state of licensure are parties to should only practice in Virginia using a compact privilege for that profession.\*\***

Eligible employers and contract service recipients **must fill out** the below information and submit to the applicable Board **before the practitioner begins temporarily practicing in Virginia**.

**Complete all fields below:**

**Facility Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Street City State Zip**

**Facility designation: Licensed hospital Nursing home Dialysis Facility**

**Va. Dept. of Health Local health dept.**

**Is this submission for a 60-day extension of a previously reported individual? Yes No**

**Facility POC:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name Phone Number**  **24 Hour Phone Number**

**E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I certify that I or my facility has obtained a report from the National Practitioner Data Bank (“NPDB”) for all individuals listed on this form subject to NPDB reporting.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Facility POC Signature Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Practitioner’s Name** | **License Type** | **State of**  **License** | **License Identification**  **Number** | **Estimated Start date for employment or contract services** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please submit all pages of this form to** [**ptboard@dhp.virginia.gov**](mailto:ptboard@dhp.virginia.gov)**.**