



APPLICATION for REINSTATEMENT OF LICENSURE Checklist Instructions

IMPORTANT NOTICE:

Prior to **mailing** the enclosed application for Reinstatement of Licensure and below supporting documentation to the Board for consideration, we recommend that you review the [Regulations Governing the Practice of Social Work](http://www.dhp.virginia.gov/social) available on the Board's website at www.dhp.virginia.gov/social to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC140-20-30(B) of the [Regulations Governing the Practice of Social Work](http://www.dhp.virginia.gov/social), all fees submitted to the Board are **non-refundable**.

We also strongly encourage you to review your application packet to ensure all forms are complete and includes all required forms and documentation. A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to mail all the below information in **one** complete packet to the Board office for consideration.

REQUIRED DOCUMENTATION

- APPLICATION:** The attached application must be completed and mailed to the Virginia Board of Social Work.
- REINSTATEMENT FEE:** A reinstatement fee by check or money order made payable to the **Treasurer of Virginia** must be mailed with your application. Your application will not be reviewed or considered until you have submitted payment. Pursuant to [18VAC140-20-30\(B\)](http://www.dhp.virginia.gov/social), all fees submitted to the Board are **non-refundable**.
 - *Licensed Baccalaureate Social Workers (LBSW): \$120.00 fee*
 - *Licensed Master's Social Work (LMSW): \$135.00 fee*
 - *Licensed Clinical Social Worker (LCSW): \$195.00 fee*
- VERIFICATION OF LICENSURE/CERTIFICATION:** If you have ever held a health or mental health license or certification, whether current or expired, please send the enclosed verification form to the issuing jurisdiction (s). This verification is to be completed by the issuing jurisdiction (s) and mailed back to you and included in your application packet. *(Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia's Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.)* ~~or~~ You can provide an online verification printed from the licensing jurisdiction's website if the online verification provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.
- NPDB SELF-QUERY:** A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query at <https://www.npdb.hrsa.gov/>
- CONTINUING EDUCATION (CE) CERTIFICATES:**
 - *Licensed Baccalaureate Social Workers (LBSW) and Licensed Master Social Worker (LMSW) will be required to submit a minimum of **7.5 contact hours of continuing education** for each year the license was lapsed, not to exceed four years. A minimum of **1.5** of those hours must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia.*
 - *Licensed Clinical Social Workers (LCSW) will be required to submit a minimum of **15 contact hours of continuing education** for each year the license was lapsed, not to exceed four years. A minimum of **3** of those hours must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia.*

Please refer to 18VAC140-20-105 of the [Regulations Governing the Practice of Social Work](http://www.dhp.virginia.gov/social) for a list of board-approved activities.

ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

EVIDENCE OF COMPETENCY: *(Only applicable if license has lapsed for ten (10) or more years)* An applicant for reinstatement whose license has been lapsed for (10) or more years shall also provide evidence of competency to practice by documenting:

1. Active practice in another U.S. jurisdiction for at least 24 out of the past 60 months immediately preceding application; **or**

2. Active practice in an exempt setting for at least 24 out of the past 60 months immediately preceding application; **or**
3. Practice as a supervisee under supervision for at least 360 hours in the 12 months immediately preceding licensure in Virginia. The supervised practice shall include a minimum of 60 hours of face-face direct client contact and 9 hours of face-to-face supervision.

PROOF OF NAME CHANGE: Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you had an active license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Acceptable forms of documentation include a **photocopy** of a marriage license, court order or divorce decree.

CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS: If you answer “YES” to any of the questions in **Part III** of the application, please include a detailed explanation **and** supporting documentation. **If you have no new convictions since your previously submitted application with the Board, please indicate in your detailed explanation that there have been no new convictions since your previous submission.** Please refer to [Guidance Document 140-2](#), available on the Board’s website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.

GENERAL INFORMATION

- Applications are processed in the order received. Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements for the [Regulations Governing the Practice of Social Work](#) will be processed within **30 days** of receipt of a **complete** application packet.
- Check your license/registration status by going to: [License Lookup](#) (*license information is posted in real time).
- Please notify the Board in writing within 30 days of a name change or address change by completing the **Name/Address Change Form** available on the Board’s website at www.dhp.virginia.gov/social.
- An incomplete application for licensure will be retained on file for one (1) year. If not completed within one year of receipt, a new application and fee will be necessary.
- Providing false or misleading information as well as omitting information in response to information requested in the application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration or license.
- Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees/supervisees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available please complete both sections with same address on the application.
- Pursuant to [Virginia Code § 54.1-116 \(A\)](#), 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 for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. **NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FALIED TO DISCLOSE ONE OF THESE NUMBERS.**
- Application and required documentation should be **mailed** to:

Department of Health Professions
Attn: Board of Social Work
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

End of instructions



APPLICATION for REINSTATEMENT OF LICENSURE
Paper Application

FOR OFFICE USE ONLY (Finance Division)

Fee Amount Paid \$	Applicant ID #	Receipt #	Date Processed
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TO BE COMPLETED BY APPLICANT

Part I. Applicant Identification & Contact Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
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Social Security Number or Virginia DMV Control Number * _____	Date of Birth: (MM/DD/YYYY) ____ / ____ / _____
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Published Address: *This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or practice location if you wish.*

Address:

City:	State:	Zip Code:
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Address of Record: *The address information you provide below is your address of record with the Board. Please be advised that all notices from the Board, to include licenses and other legal documents, will be sent to the address of record provided. If you provided a different public address above, this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.*

Address:

City:	State:	Zip Code:
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Home Number: (____) _____ - _____	Alternate Number: (____) _____ - _____
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Email Address:

Virginia Social Work License Number: _____	Date License Expired: (MM/DD/YYYY) ____ / ____ / _____
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Part II. Licensure History Information: *Other than Virginia, list in order of attainment all the states in which you now hold or have ever held a health or mental health license or certification, whether current or expired. If not applicable, enter N/A*

State	Type of License/Certificate	License/Certificate Number	Issued Date	Current Status

Part III. Licensure Questions: Applicant must answer the following questions. Affirmative responses to any questions on this application will require additional information to be submitted. Please refer to **Guidance Document 140-2** for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments. Failure to disclose any information related to these questions may be grounds for denial, reprimand, or imposition of terms, suspension or revocation of your license and/or registration.

<p>1. Have you ever been denied the issuance of a license, certificate, or registration, or denied the privilege of taking an occupational licensure, certification or registration examination? If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency or practice? If Yes, on a separate sheet of paper please provide a full detailed explanation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations) If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Have you ever voluntarily surrendered a license, certification or registration while under investigation? If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? If Yes, on a separate sheet of paper please provide a full detailed explanation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Additional Questions</p>	
<p>1. A. 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? If Yes, on a separate sheet of paper please provide a full detailed explanation</p> <p>B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. A. Within the past five years, have you been disciplined by any entity? If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p> <p>B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. 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? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.</i> If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. 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? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.</i> If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. 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? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.</i> If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Part IV. Military Service	
1. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you active-duty military?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part V. Continued Competency	
Have you completed the continued competency hours equal to the number of years your license has lapsed, not to exceed four years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the box that applies to you	
<u>LBSWs & LMSWs</u>	
<input type="checkbox"/> I am attesting to the completion of the required Continuing Education for _____ years, which total a minimum of _____ CE hours (7.5 hours per year). I have submitted copies of my CE hours for evaluation with this application.	
<u>LCSWs</u>	
<input type="checkbox"/> I am attesting to the completion of the required Continuing Education for _____ years, which total a minimum of _____ CE hours (15 hours per year). I have submitted copies of my CE hours for evaluation with this application.	

Part VI. Certification: <i>This application is not valid unless properly certified by your original signature.</i>	
<p>I certify by my signature below that I am the person applying for licensure/certificate/registration and meet the qualifications required by Virginia laws and regulations. I certify that I have carefully read the laws and regulations Governing the Practice of Social Work in the Commonwealth of Virginia, which are available at https://www.dhp.virginia.gov/social/.</p> <p>Further, I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.</p> <p>I agree to the above certification.</p>	
SIGNATURE:	DATE:

ORIGINAL SIGNATURE REQUIRED



APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

IMPORTANT NOTICE:

This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license or certification. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be mailed to the Virginia Board of Social Work or the State Board can send the form electronically to the Virginia Board at socialwork@dhp.virginia.gov

TO BE COMPLETED BY APPLICANT: Complete the top portion **only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification (**fee may be required**).

Part I. Applicant's Identification & Contact Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Last 4 digit of Social Security Number: XXX-XX- ____ - ____		Date of Birth: (MM/DD/YYYY) ____ / ____ / ____ - ____	
Address:			
City:	State:	Zip Code: ____ - ____ - ____	
Email Address:			

TO BE COMPLETED BY STATE BOARD: Please provide official verification of applicant's licensure information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form to the Virginia Board, please use the subject line: Applicant Licensure Verification (ref: Applicant's Name)**

Part II. Applicant's Licensure Information

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ____ / ____ / ____ - ____	Expiration Date: (MM/DD/YYYY) ____ / ____ / ____ - ____
License Obtained by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Reciprocity <input type="checkbox"/> Grandfathered <input type="checkbox"/> other _____	
Status of License: <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive <input type="checkbox"/> other _____	
Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? <i>If yes, please attach certified copy of order issued by State Board.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>

I certify the above information to be true in every respect, according to the record on file with the

_____ (Title of Board)

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

Telephone Number: _____

Email Address: _____

Date: _____

STATE SEAL



EVIDENCE OF COMPETENCY TO PRACTICE

IMPORTANT NOTICE:

An applicant for reinstatement whose license has been lapsed for ten (10) or more years should complete the top portion of this form **only**, then provide this form to the professional reference who can verify your competency to practice. The completed form containing the original signatures, should be returned to the applicant for inclusion in their packet to be mailed to the Virginia Board of Social Work.

TO BE COMPLETED BY APPLICANT:

I, _____ (*printed legal name of applicant*), hereby authorize past and present employers, businesses, professional associates and personal references to release to the Virginia Board of Social Work (“Board”) any information requested by the Board in connection with the processing of my application for reactivation of my Virginia license.

Signature of Applicant

Date

TO BE COMPLETED BY REFERENCE:

Last Name of Reference:	First Name:	Middle/Maiden Name:	Suffix:
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Type of License Held:	License Number:
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Address of Reference:

City:	State:	Zip Code: _____
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Phone Number: (___ ___) ___ ___ - ___ ___	Email Address:
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Relationship to Applicant:

I, _____ (*printed legal name of reference*), declare under perjury under the laws of the Commonwealth of Virginia that _____ (*printed name of applicant*), candidate for reinstatement of licensure in the Commonwealth of Virginia, was in active practice (*select one option*)

in another United States jurisdiction for at least (24) out of the past (60) months immediately preceding application;

in an exempt setting for at least (24) out of the past (60) months immediately preceding application;

at _____ (*name of location*)

_____ (*street address of location*)

_____ (*City*) _____ (*State*) _____ (*Zip Code*)

from _____ (*Start Date: MM/DD/YYYY*) to _____ (*End Date: MM/DD/YYYY*).

Signature of Reference

Date