Rev. 1/2024

INSTRUCTIONS FOR REINSTATEMENT APPLICATION OF LICENSE FOR MD AND DO

(This form is designed to be used as a checklist for submitting required documentation)

<u>NOTE</u>

AN APPLICATION THAT IS NOT COMPLETE EXPIRES ONE YEAR AFTER IT IS SUBMITTED TO THE BOARD. IT IS THE RESPONSIBILITY OF THE APPLICANT TO ENSURE THAT ALL NECESSARY SUPPORTING DOCUMENTS ARRIVE AT THE BOARD PRIOR TO THE EXPIRATION DATE. IF THE ORIGINAL APPLICATION EXPIRES, THE APPLICANT MUST SUBMIT ANOTHER APPLICATION, PAY A NEW APPLICATION FEE, AND ENSURE THAT NEW SUPPORTING DOCUMENTS ARE SUBMITTED TO THE BOARD.

This is the reinstatement instructions and application for MD and DO licenses in <u>expired</u> status for more than two years ONLY.

<u>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 or if you are trying to reactivate a license in inactive status.</u>

Complete the application along with payment of the license reinstatement fee of $497.00. Application and fee must be received together.

The phone number to the Virginia Board of Medicine is 804-367-4600. The Board's email address is <u>medbd@dhp.virginia.gov</u>

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

The Board of Medicine discourages the use of the United States Postal Service to send documents. The Board is unable to trace documents not delivered by courier/overnight mail. If you wish to send your documents by overnight mail, please use FED EX or UPS. If requested in the instructions below, you may have your documents sent by electronic mail pdf attachment to medbd@dhp.virginia.gov or by facsimile to (804) 527-4426.

<u>INFORMATION REQUIRED TO COMPLETE YOUR APPLICATION</u>

☐1. If you answer "yes" to any of the licensure questions in #5-16, please 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 malpractice 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. <u>List</u> 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.

For applicants practicing as locum tenens physicians, or if you are practicing telemedicine, have the company you are affiliated with provide a complete list of <u>all locations and dates</u> where you have provided service.

☐3. **Jurisdiction Clearance – License Verification.** Verification of medical license from a jurisdiction 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 jurisdiction where you have been issued a license to practice medicine to inquire about having official verification forwarded to**

the Virginia Board of Medicine. Verification must come from the jurisdiction and may be sent by email to md-medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed. **Many medical boards use www.veridoc.org to send their license verifications. Check with Veridoc to see if your other state license boards use Veridoc.**

☐4. ***NPDB Self Query* – Complete the online Place a Self-Query Order form at https://www.npdb.hrsa.gov/** 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)

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.

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.

Please note that the Board will accept a digitally-certified electronic copy of the NPDB report that is emailed to the Board, in lieu of a mailed report.

Should you choose to mail your report to the Board, 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 6 months of receipt of the NPDB report will have to be resubmitted.

☐5. Provide documentation of having completed continuing education hours equal to the requirement for the number of years in which the license has been lapsed. <u>Acceptable continuing education hours are those completed within the last immediate past four (4) years prior to applying for license reinstatement.</u>

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.

☐6. If applicable, provide a copy of any documentation supporting a 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.

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: md-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
Date of Birth ________ ________ ________ Mo. Day Yr.	Maiden Name	Virginia License Number	Social Security No. or VA Control No.*
Public Address: This address will be public information	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 Number		Email Address

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.

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 active, inactive or expired. Indicate number and date issued. Temporary or intern / resident licenses need not be included.

Jurisdiction	Number Issued	Active/Inactive/Expired

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. **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed**	____	____
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 paid claims in the last 10 years, or do you have any pending malpractice suits? If your answer is, "yes" please provide a written explanation on a separate sheet of paper.	____	____
17. Are you a spouse of someone who is on a federal active duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state of the District of Columbia? ?	____	____

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