INSTRUCTIONS AND APPLICATION FOR REINSTATEMENT OF LICENSE TO PRACTICE POLYSOMNOGRAPHIC TECHNOLOGY IN VIRGINIA

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.

Mailing Address
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4600 (phone)
804-527-4426 (fax)
804-267-4444 (Help Desk)
Medbd@dhp.virginia.gov

APPLICATION RULES AND GUIDELINES

1. Application fees are nonrefundable. Your application will not be processed until the fee is paid. The reinstatement fee must be submitted along with the application. Make your check or money order payable to the "Treasurer of Virginia."

2. The reinstatement application fee is $180.00.

3. Applications are only acknowledged after receipt of items that are missing. Supporting documentation sent to the Board without an application on file are purged after three (3) months.

4. Applications EXPIRE 180 days from submission if they are not completed. It is your responsibility to ensure all required supporting documentation is submitted to the Board prior to the expiration date. If your application expires, you are required to start the process over by submitting a new application and paying the fee again.

5. When possible, submit your documents electronically. Some forms may be faxed to 804-527-4426 as noted later in these instructions.

6. The Board acknowledges incomplete applications **once** within three to five business days after receipt.

7. If you must mail your documents to the Board, you are encouraged to send them via FedEx or UPS so that you can track their delivery.

8. For mailed applications, the Board does **not** accept supporting documents that are copied *after* they are notarized. Notarized supporting documents should be *sent directly from the program office or school to the Board* via fax or email PDF attachment.

9. Consistent with Virginia law and the mission of the Department of Health Professions, your public address on file with the Board of Medicine is made available to the public. The address for communication with the Board noted on your application can be different from the public address and is not released to the public. The Board of Medicine will allow the Board address of record to be a Post Office Box or practice location. The address of record for communication with the Board noted on your application can be different from the public address and is not released to the public.

10. Additional information may be requested after review by the Board.

11. **Do not begin practice until you are notified of issuance of a license.** Submission of an application does not guarantee a license. A review of your application could result in the finding that you are not eligible pursuant to Virginia governing laws and regulations.

12. Contact emails for this application is RPSGT-Medbd@dhp.virginia.gov

APPLICATION CHECKLIST

☐ **Verification of Professional Licensure**

Have one previously held professional license from a jurisdiction within the United States, its territories and possessions or Canada in which you have been issued a full license sent to the Board. Verification must come directly from the jurisdiction and may be sent by email to RPSGT-Medbd@dhp.virginia.gov, faxed to (804) 527-4426, or mailed.

☐ **NPDB Self-Query**

Request a report here **-** **Place a Self-Query Order** .

Be ready to provide:
o Identifying information such as name, date of birth, Social Security number
o State health care license information (if you are licensed)
o 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.

The Board will accept the digitally certified copy of your NPSB self-query report that can be emailed to RPSGT-Medbd@dhp.virginia.gov .

If you choose to have the NPDB report mailed to you instead, a paper copy of your response will be sent the next business day by regular U.S. mail. DO NOT OPEN IT when you receive it. Place the unopened NPDB report in an oversize envelope and forward it to the Virginia Board of Medicine. (As stated previously, we highly recommend sending this via Fed Ex or UPS for tracking purposes.)

☐ **Evidence of Competency to Return to Practice**

Submit evidence of competency to return to active practice to include an attestation that you have current certification in Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment **and** documentation of **one** of the following:

1. Information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Recertification by passage of an examination for the Registered Polysomnographic Technologist (RPSGT), the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS), or other credential approved by the board for initial licensure; or

3. Attestation of completion of, at least, 10 hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years.

☐ **Name Changes**

Provide copies of documentation supporting any name changes since your initial licensure in Viginia, if applicable.

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 REINSTATEMENT of License to Practice as a Polysomnographic Technologist

To the Board of Medicine of Virginia:

I hereby make application for reinstatement of my license to practice as a polysomnographic technologist 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
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 Phone Number	Email Address

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 $180.00. 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	EXPIRATION DATE	REINSTATEMENT DATE
0135-		**$180**		

*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 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 clinical affiliations. If none, please explain. **<u>CVs may be attached but do not substitute for completion of this page.</u>**

From	To	Name and Location	Position Held

3. Do you intend to engage in the active practice of Polysomnographic Technology in the Commonwealth of Virginia? ☐ Yes ☐ No

If Yes, give location _____

4. List all jurisdictions in which you have been issued a license to practice polysomnographic technology. Include all licenses that are in active, inactive, expired, suspended or revoked status. Indicate license number and date issued.

Jurisdiction	Number Issued	License Status

Yes **No**

QUESTIONS MUST BE ANSWERED. If any of the following questions (5-14 and 16-17) is answered **Yes**, explain and substantiate with documentation.

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/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, convictions for possession of marijuana, does not have to be disclosed.** ☐ ☐

7. Have you ever been denied 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. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of polysomnographic technology? ☐ ☐

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

12. 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? ☐ ☐

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

14. Do you currently have any reason to believe that you would pose a risk to the safety or well-being of your patients? If yes, please provide a full explanation. Note: The Board may ask for additional documentation. ☐ ☐

15. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If no, please provide a full explanation. Note: The Board may ask for additional explanation. ☐ ☐

16. Have you had any malpractice paid claims in the past ten (10) years, or do you have any pending malpractice suits? If so, please provide a narrative for each paid claim or pending case during this time period. ☐ ☐

17. 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:

18. Are you the 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? ☐ ☐

19. Are you active-duty military? ☐ ☐

20. Please check which documentation you are providing to demonstrate current competency to practice as noted in the application instructions.

_____I attest that I have current certification in Basic Life Support for health care providers with a hands-on practice training evaluation segment **and** will provide information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed; or

____ I attest that I have current certification in Basic Life Support for health care providers with a hands-on practice training evaluation segment **and** have completed at least 10 hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years; (**Provide copy of certificate of completion**); or

____ I attest that I have current certification in Basic Life Support for health care providers with a hands-on practice training evaluation segment **and** I have recertified by passing of an examination for the Registered Polysomnographic Technologist (RPSGT), the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS), or other credential approved by the board for initial licensure. (**If you check this section, please have documentation provided from the appropriate entity**).

21. 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 polysomnographic technology 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