*Rev. 12/21*

# INSTRUCTIONS AND APPLICATION FOR REINSTATEMENT OF A RESPIRATORY THERAPIST LICENSE

**Respiratory Therapist License Reinstatement Instructions and Application for licenses in EXPIRED status for more than two years ONLY.**

**NOTE**
**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 THE APPLICATION FEE AGAIN AND ENSURE THAT NEW SUPPORTING DOCUMENTS ALSO GET TO THE BOARD.**

**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.**

A completed application must be returned to this office along with the reinstatement fee of $180.00. 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.

**Mailing Address**
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. If possible, and if noted below, you are encouraged to have your documents sent by pdf attachment or FAX. The Board is unable to trace documents not delivered by the post office. If you wish to send your documents by overnight mail, please use FED EX or UPS.

☐1. Verification of your professional 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 applicable jurisdiction where you have been issued a license to practice as a respiratory therapist to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to respther-medbd@dhp.virginia.gov, faxed to(804) 527-4426, or mailed.

☐2. ***NPDB Self Query*** **– Complete the online Place a Self-Query Order form**. 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. 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, when you receive your report in the mailfrom NPDB. **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board ofMedicine. 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.**

☐3. Submit evidence of competency to return to active practice to include **one** of the following:

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a respiratory therapist shall submit evidence of competency to return to active practice to include one of the following:

**1.** Information on continued practice in another jurisdiction during the period in which the license has been inactive or lapsed: (Active Practice is defined as a minimum of 160 hours of professional practice as a respiratory therapist within the 24-month period immediately preceding renewal or reinstatement. Please have documentation provided by your employer and have the jurisdiction in which you have been engaged in active practice provide a verification of your license to practice to the Board); or

**2.** Ten hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years; or

**3.** Recertification by passage of an examination from NBRC.

Certificates of completion for continuing medical education (CME) issued by course sponsors/providers or from the NBRC can be submitted by email, FAX, UPS, FED EX or USPS. The fax number for the Board is **804-527-4426**. Email address is respther-medbd@dhp.virginia.gov

☐4. Copies of documentation supporting any name change since your initial licensure in Virginia, if applicable.

☐5. If you answer "yes" to any question in #5-17, provide a narrative explaining your answer and relevant records to include a final decision regarding the incident. You may also have your attorney write a letter of explanation. Please provide court documentation for any convictions.

**Please note:**
*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, public addresses on file with the Board of Medicine are made available to the public. The Board address noted on your application may be different from the public address and is not released to the public. This notice is to reiterate that the Board of Medicine will allow the Board address of record to be a Post Office Box or practice location.

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

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 Respiratory Therapist

To the Board of Medicine of Virginia:

I hereby make application for reinstatement of my license to practice as a respiratory therapist in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

| | | |
|---|---|---|
| Last | First | Middle |
| Date of Birth<br>_____ _____ _____<br>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 |
|---|---|---|---|---|
| **0117-** | | **$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. **CVs may be attached but do not substitute for completion of this page.**

| From | To | Name and Location | Position Held |
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3. Do you intend to engage in the active practice of Respiratory Therapy 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 respiratory therapy. Include all licenses that are in active, inactive, expired, suspended or revoked status. Indicate license number and date issued.

| Jurisdiction | Number Issued | License Status |
|---|---|---|
| | | |
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**Yes** **No**

**QUESTIONS MUST BE ANSWERED.** If any of the following questions (5-17) 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 an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) ☐ ☐

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 Respiratory Therapy? ☐ ☐

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 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? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Respiratory Therapist. ☐ ☐

15. 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? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Respiratory Therapist. ☐ ☐

16. 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? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Respiratory Therapist. ☐ ☐

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 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? ☐ ☐

19. Are you active duty military? ☐ ☐

**20. Please check which documentation you are providing to demonstrate current competency to practice as noted in item #4 in the application instructions.**

_____I will provide information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed; (Have provided to the Board a letter from your employer(s) verifying practice at your location(s) of service and other jurisdiction state license verification); or

_____I attest that I 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 copies of certificates of completion); or

____I have Recertified by passing of an examination from the National Board of Respiratory Care (NBRC). (If you check this section, please have documentation provided from NBRC.

**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 Chiropractic 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