COMMONWEALTH OF VIRGINIA
Board of Medicine
Department of Health Professions
9960 Mayland Drive, Suite 300, Henrico, VA 23233-1463
Phone : 804-367-4570
Fax: (804) 527-4426 WEB PAGE: www.dhp.virginia.gov/medicine

APPLICATION FOR RESTRICTED VOLUNTEER LICENSE

[ ] Licensed Acupuncturist	[ ] Respiratory Therapist	[ ] Radiologic Technologist
[ ] Physician Assistant	[ ] Occupational Therapist	[ ] Radiologic Technologist-Limited

INSTRUCTIONS: If the space provided for any answer is insufficient, the applicant must complete his/her answer on a separate page, signed by him/her, specifying the question to which it relates and enclose the page with this application. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION. ENCLOSE A CHECK MADE PAYABLE TO THE **TREASURER OF VIRGINIA IN THE AMOUNT OF $35.**

Name (Last, First, M.I., Suffix, Maiden Name) Date of Birth –(Mo/Day/Year)	Social Security # or DMV control #

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Area Code and Home Telephone Number	Area Code and Office Telephone Number
E-Mail:	E-Mail:

RECORD OF ALL PROFESSIONAL LICENSURE:

State	Profession	License Number	Issue Date	Expiration Date

- Has your license to practice in any state/jurisdiction been previously suspended or revoked? _____ If yes, give details, jurisdiction(s) and date(s) on a separate page.
- Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statue, 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)? _____ If yes, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court.

§ 54.1-2928.1 of the Code of Virginia requires a doctor with a restricted volunteer license who has not held an active, unrestricted license and been engaged in active practice within the past four years to have the quality of his/her care reviewed by a doctor medicine or osteopathic medicine with an active, unrestricted Virginia license at least every 90 days.

- If you have had an active, unrestricted license and been actively practicing within the last four years, *you must complete the **Chronology** section of this application*.
- If you have not had an active, unrestricted license and been actively practicing within the last four years, list the doctor (s) who will review the quality of your care in the clinic in which you will volunteer.

Name: _____ License number: _____

Name: _____ License number: _____

I acknowledge that the restricted volunteer license sought through this application shall only be valid, in compliance with the law and Board regulations for practice within the limits of my license, without compensation in a clinic which is organized in whole or in part for the delivery of health care services without charge in accordance with provisions of § 54.1-106.

I also attest to knowledge of the laws and regulations governing my branch of the healing arts in Virginia. (see Board website: http://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm)

SIGNATURE: _____ DATE: _____

CHRONOLOGY FOR PRACTICE WITHIN THE PAST FOUR YEARS

NAME OF APPLICANT: _____

If you have had an active, unrestricted license and been actively practicing within the last four years, you must complete **this Chronology** and submit with this application in order to be allowed to engage in volunteer practice without a review of your care by another doctor of medicine or osteopathic medicine.

Form A may be photocopied if additional space is needed.

FROM Month/Year	**TO** Month/Year	**POSITION/ACTIVITY**	**Employer/Contact Person for practice verification and the person's Complete Address, and Telephone #**	**Number of Hours of Clinical Practice Per Year**

Date Received	Fee	Approved:	Date: