



APPLICATION for REINSTATEMENT FOLLOWING DISCIPLINARY ACTION Checklist Instructions

IMPORTANT NOTICE:

Prior to **mailing** the enclosed application for Reinstatement Following Disciplinary Action 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/Boards/SocialWork/) available on the Board's website at www.dhp.virginia.gov/Boards/SocialWork/ 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/Boards/SocialWork/), 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.
- FEE:** A **\$500.00** 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 consider until you have submitted payment. Pursuant to [18VAC140-20-30\(B\)](http://www.dhp.virginia.gov/Boards/SocialWork/), all fees submitted to the Board are **non-refundable**.
- VERIFICATION OF LICENSURE/CERTIFICATION:** If you have ever held a health or mental health license or certification, **whether current or expired**, please send the **Out of State Licensure Verification Form** to the issuing jurisdiction (s). This verification form should be completed by the issuing jurisdiction (s) and sent 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 from the licensing jurisdiction's website if the website is considered "**primary source verified**". The online verification must provide **all** of the following information: the licensee's 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/>

ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

- 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](http://www.dhp.virginia.gov/Boards/SocialWork/), 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

- Following receipt of the reinstatement application following disciplinary action, an administrative proceeding will be scheduled. After a hearing, the board may, at its discretion grant the reinstatement.

- Please notify the Board in writing within 30 days of a name change or address change by completing the [Name/Address Change Form](#) .
- 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 FOLLOWING DISCIPLINARY ACTION
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 been disciplined by any entity related to your work in a health or mental health setting? If Yes, on a separate sheet of paper provide a full detailed explanation and any associated orders or letters from the entity.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. 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>3. Have you ever been 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.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If Yes, on a separate sheet of paper please provide a full detailed explanation. (Note: The Board may ask for additional documentation.)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If No, on a separate sheet of paper please provide a full detailed explanation. (Note: The Board may ask for additional documentation.)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Have you ever been censured, 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 description of the circumstances and any supporting documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. 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><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. 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). 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. 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>9. Have you voluntarily surrendered a license, certification, or registration while under investigation? If Yes, on a separate sheet of paper please provide a full detailed explanation, jurisdiction(s), date(s) and any supporting documentation.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. Have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity. If Yes, please provide a full explanation and any associated orders or letters from the entity. (Note: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Part IV. Military Service

<p>1. Are you a spouse of someone who is on 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 or the District of Columbia?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Are you active-duty military?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Part V. Certification: *This application is not valid unless properly certified by your original, electronic, or e-signature.*

I certify by my signature below that I am the person applying for licensure 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 and agree to comply with the current Standards of Practice and Laws and Regulations Governing the Practice of Social Work in Virginia.

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.

I agree to the above certification.

SIGNATURE:	DATE:
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ORIGINAL, ELECTRONIC, OR E-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