Virginia Department of Health Professions
Board of Counseling

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REHABILITATION PROVIDER APPLICATION FOR REINSTATEMENT

I hereby make application for reinstatement of my rehabilitation provider certificate number _____. The following evidence of my qualifications is submitted with a check or money order in the amount of $125.00 made payable to the Treasurer of Virginia.

All fees are non-refundable and non-transferable.
Applications, registrations and fees are valid for one (1) year from receipt. If your application is not approved within one (1) year, a new application and fee will be required.

Military/Military Spouse: □ **Yes** □ **No**
Are you active duty military personnel?

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? □ **Yes** □ **No**

I. GENERAL INFORMATION. Applications lacking a Social Security or Virginia Department of Motor Vehicles Number will not be processed. This number will be used for identification and will not be disclosed for other purposes except as provided for by law.

Name (Last, First, M.I., Suffix, Maiden Name)	Social Security Number or **Virginia** DMV number	Date of Birth

Print your name as you would like it to appear on your wall certificate:

Licensure Address (Street and/or Box Number, City, State, ZIP Code)[1]	Home Telephone Number
Alternate Mailing Address)	Business Telephone Number

Fax Number:	E-Mail Address:

II. EDUCATION. Indicate one of the following: (a) The name and location of the college or university where a baccalaureate degree was awarded or (b) Current Virginia RN license number. Applicants documenting a baccalaureate degree must submit with this application official transcripts in the original unopened envelopes as received from the university.

Educational Institution:	Virginia RN license #:
Date Degree Conferred:	

III. LICENSURE/CERTIFICATION - List all the states or institutions from which you now hold or have ever held a professional license or certificate in order of attainment. For out-of-state licenses or certificates, include Form 3 with your application.

STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE

[1] Licensure address is public information

IV. Ethics Attestation: Please answer the ten questions below. **If you answer yes to any question, include a detailed explanation and supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction.**

1. 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, please provide a full explanation.	Yes	No
(A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?	Yes	No
2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation.	Yes	No
3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity.	Yes	No
(A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?	Yes	No
4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation.	Yes	No
5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s).	Yes	No
6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations). If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2.	Yes	No
7. 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 rehabilitation counselor. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	Yes	No
8. 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 rehabilitation counselor. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	Yes	No
9. 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 rehabilitation counselor. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation Directly to the Board.)	Yes	No
10. Within the past 5 years, 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.)	Yes	No

V. PROFESSIONAL EXPERIENCE (subsequent to expiration of Virginia certification)

Dates of Employment		Employer	Address	Hours per week	Supervisor	Duties
From	To				(if applicable)	

VI. ADDITIONAL INFORMATION: Provide any additional information to document continued competency to resume practice in the Commonwealth of Virginia.

VII. The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

AFFIDAVIT
(To be completed before a notary public)

State of_____ County/City of_____

Name_____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for certification to practice as a rehabilitation provider in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

_____
Signature of Applicant

Subscribed to and sworn to before me this _____ day of _____, 19_____.

My commission expires on _____. _____
Signature of Notary Public

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