

**INSTRUCTIONS FOR COMPLETING AN ATHLETIC TRAINER LICENSURE APPLICATION**

*(This form has been designed to be used as a checklist for submitted required documentation.)*

**The applicant is responsible for forwarding all required forms to the appropriate institutions, states, and other agencies.**

***APPLICATION FEES ARE NONREFUNDABLE***

**BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!**

**DO NOT BEGIN PRACTICING BEFORE YOU ARE ISSUED A LICENSE.**

This is the application for a license to practice as an Athletic Trainer.

You should familiarize yourself with the qualifications required for a license by reviewing the laws and regulations governing the practice of athletic trainers in Virginia. They can be found at:  
[http://www.dhp.virginia.gov/medicine/medicine\\_laws\\_regs.htm](http://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm)

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board.

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 10 days for your application checklist to be first updated on the Board's website.

Supporting documentation will be added to your checklist as it is received. Processing of documents may take up to 10 business days after they are received. If you find your checklist does not exist or does not indicate necessary documents have been received, e-mail the Board at [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), with "Athletic Trainer Application Question" in the subject line. E-mails will be answered within 2 business days.

Your application checklist may be viewed by logging into your application and clicking on the "View Checklist" link located in the Pending Licenses section. This link will not be visible for applicants who have not yet paid the application fee. If you have submitted your application and required fee online, but no longer see your checklist in the Pending Licensing section, your license may have been issued by the Board. Before calling the Board, please visit <https://dhp.virginiainteractive.org/Lookup/Index> to view your newly issued license. This website is primary source license verification that meets the Joint Commission's requirements for license verification. If you need technical assistance with your checklist contact the agency's helpdesk at 804-367-4444. The helpdesk cannot provide assistance regarding information about your documents.

Supporting documentation sent to the Board when there is no application on file will be purged after six months.

NB: Virginia law considers material misrepresentation of fact in an application for licensure to be a Class 1 misdemeanor. Misrepresentation may be by commission or omission. Be sure of your facts and provide full responses to the Board's questions.

**PROCEEDING TO THE APPLICATION SIGNIFIES THAT YOU HAVE READ AND ACCEPT THE FOREGOING PRINCIPLES REGARDING THE BOARD'S PROCESSES.**

- Complete the online application** <https://www.license.dhp.virginia.gov/apply/>, which includes paying the nonrefundable application fee of \$130.00. Application fees may only be paid using Visa, MasterCard or Discover.
- Employment Activity Questionnaire (Form B) – Employment Activity (Form B) Questionnaire**

A completed Form B Activity Questionnaire or a letter of recommendation must be received from all locations of practice or professional employment or professional volunteer service listed for the past 5 years.

**Form B's sent to the Virginia Board of Medicine by the applicant will not be accepted.**

**Completed Form B's may be attached as a PDF and sent to [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), faxed to (804) 527-4426 or mailed.**

- Jurisdiction Clearance – License Verification**  
Verification of licenses to practice as an Athletic Trainer from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a license must be received by the Board. **Please contact the applicable jurisdiction where you have been issued a license to practice as an Athletic Trainer 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 [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), faxed to (804) 527-4426 or mailed.
- Certification of credentials from BOC** - Certification should be requested from the Board of Certification at 1415 Harney Street, Suite 200, Omaha, NE 68102, phone (877) 262-3926 ext. 118 or 114 fax (402) 561-0598-, or [www.bocatc.org](http://www.bocatc.org). This documentation **may not** be faxed.
- Provisional License to Practice as an Athletic Trainer** – In addition to the licensure application, an applicant who has applied to take the certification examination may be granted a provisional license to practice. The licensure application must be complete prior to approval of the traineeship, including evidence from BOC of approval to take the certification examination.

**Please note:**

\*Upon written request from an applicant and his employer and for good cause shown, an applicant who provides documentation of current BOC Certification and, if licensed or certified by another jurisdiction in the United States, documentation that his license or certificate is current and unrestricted may be granted authorization to practice as an athletic trainer for 45 days pending submission of all other required documentation and issuance of a license. At the discretion of the board, additional time not to exceed 15 days, may be allowed to complete the application process.

\*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, with the application of new technology which makes this information more accessible there has been growing concern of those licensees who supply their residence address for mailing purposes. This notice is to reiterate that the Board of Medicine maintains only one address for each licensee and will allow the address of record to be a Post Office Box or practice location.

- ▶ Virginia is a direct verification state. All supporting documents must come from the original source unless specifically noted in the instructions.
- ▶ Applications not completed within 12 months may be purged without notice from the board.
- ▶ Additional information not already listed may be requested at any time during the process.
- ▶ Application fees are non-refundable.
- ▶ The Board's mailing address is **The Virginia Board of Medicine  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233**

▶ Email inquiries are normally responded to within 2 business days. Send your email inquiries to [medbd@DHP.Virginia.gov](mailto:medbd@DHP.Virginia.gov) with **Athletic Trainer Application** in the subject line.

▶ 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.

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|---|---|--|--|
| <input type="checkbox"/> Acupuncturist    | <input type="checkbox"/> Genetic Counselor                | <input type="checkbox"/> Osteopathy and Surgery        | <input type="checkbox"/> Radiologic Technologist           |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Medicine and Surgery             | <input type="checkbox"/> Physician Assistant           | <input type="checkbox"/> Radiologic Technologist - Limited |
| <input type="checkbox"/> BCaBA            | <input type="checkbox"/> Midwife                          | <input type="checkbox"/> Podiatry                      | <input type="checkbox"/> Radiologist Assistant             |
| <input type="checkbox"/> BCBA             | <input type="checkbox"/> Occupational Therapist           | <input type="checkbox"/> Polysomnographic Technologist | <input type="checkbox"/> Respiratory Therapist             |
| <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Occupational Therapist Assistant |  |  |



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**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](mailto:medbd@dhp.virginia.gov)**

**Please provide name and address of setting/organization exactly as it appears on your application chronology.**

\_\_\_\_\_  
Clearly print/type name of applicant

Name of Setting: \_\_\_\_\_

Address: \_\_\_\_\_

Last 4 of Social Security Number XXX-XX-\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past, and present) and 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 my application.**

Signature of Applicant \_\_\_\_\_

1. Date and type of service: This individual served with us as \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_.  
(Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark)  Recommend highly and without reservation  Recommend as qualified and competent  
 Recommend with some reservation (explain) \_\_\_\_\_  
 Do not recommend (explain) \_\_\_\_\_

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you. \_\_\_\_\_  
\_\_\_\_\_

5. The above report is based on: (please indicate with check mark)  
 Close personal observation  General impression  A composite of evaluations  
 Other: \_\_\_\_\_

Date (Required): \_\_\_\_\_

Signed by: \_\_\_\_\_

Print or type name: \_\_\_\_\_

Signator Contact Number: (\_\_\_\_\_) \_\_\_\_\_

Title: \_\_\_\_\_