

INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE BEHAVIOR ANALYSIS

(This form has been designed for you to use as a checklist for processing your application)

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

___ Application Fee – The \$130 application fee is non-refundable.

___ Contact the Behavior Analyst Certification Board via email at verifications@bacb.com. Include “Virginia State Verification” in your subject line. BACB will email the verification to the Board of Medicine. Include our address in your request. medbd@dhp.virginia.gov.

Request the following information. If all information is not received, your application could be delayed.

- The applicant is currently certified by the BACB as a “Board Certified Behavior Analyst” (“BCBA”)
- Date issued _____ Expiration Date _____
- Certification is currently disciplined? _____ If yes, please include dates.
- Certification disciplined in the past? _____ If yes, please include dates.

___ Employment Activity Questionnaire (Form B). List activities on the chronological page of the application to include postgraduate training and all other activities since graduation from your professional school. Forward Form B (Activity Questionnaire) to those places of professional training/practice/employment listed for the past five years. If engaged in private practice, without affiliations, have another Behavior Analyst submit a letter attesting to your practice. CV’S ARE NOT ACCEPTABLE. Form B must be sent to the Board by the person completing it. The Board will accept this document by mail, fax or via email in a pdf document.

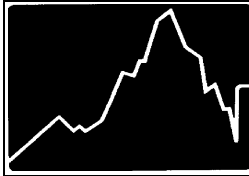
___ License Verification– If Virginia is your first license then there will be no license verification to obtain. Verification from all jurisdictions in which you have been issued a full license, certification or registration must be received by the Board. Please contact the applicable licensure board to inquire about processing fees. Verifications may be faxed directly from the jurisdiction.

Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233
Fax 804-527-4426
Email – medbd@dhp.virginia.gov

___ Experience Verification Form – If Virginia is your first state license and your BACB Experience Verification Forms were completed in Virginia, provide copies of the Experience Verification Form(s) that you provided to the BACB for your certification.

___ Notification of Certification – If Virginia is your first state license, provide a copy of the letter you received from the BACB or other documentation which notified you of your BACB certification. Copies of certificates are not acceptable.

- | | | | |
|---|---|--|--|
| <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

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: _____