Rev. 01/2025

REQUIREMENTS AND INSTRUCTIONS FOR INTERN/RESIDENT LICENSE

Applicants should apply for an intern/resident training license immediately upon notification of appointment for postgraduate clinical training.

Upon completion and approval of the intern/resident temporary license application, a license will be issued and mailed to the training program address listed on the application.

The intern/resident temporary license is valid only within the hospitals and outpatient clinics operating under the approved graduate medical education program for which it is approved and cannot be used to practice outside that program.

☐ **The licensure application:** Follow the instructions provided on the application.

☐ **Complete the online application at** https://www.license.dhp.virginia.gov/apply/ which includes paying the nonrefundable application fee of $55.00. Application fees may only be paid using Visa, MasterCard or Discover.

☐ **Memorandum (Form A) –** Pursuant to Section 54.1-2961(See enclosed code section) the training program must complete Form A to certify the beginning and ending dates of training, and to note that character reference letters are on file in the program director's office. The link to this form is located directly beneath the link to this application. This form **may** be faxed to (804) 527-4426.

☐ **Certificate of Professional Education (Form B) –** Graduates of institutions approved or accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the AMA, or the Accreditation of Canadian Medical Schools or its appropriate subsidiary agencies must provide proof of professional education on Form B. Form B must be completed after the date of graduation. The link to this form is located directly beneath the link to this application.
Form Bs **may not** be faxed.

Graduates of an institution outside of the United States and Canada shall submit a notarized copy of their professional school diploma with an English translation. Diplomas **should not** be faxed.

☐ **ECFMG Certification:** To request your ECFMG certification follow this link https://cvsonline2.ecfmg.org/ or you may provide the Board with a currently notarized copy of your ECFMG certificate. ECFMG verification **should not** be faxed.

Please note:

*If mailing your application, the Board will not accept a supporting document that has been copied after it has been notarized. Application and notarized supporting documents may be sent to the Board directly by the program office or school by fax or email PDF attachment.

*The Board office will acknowledge incomplete applications **once** within 3-5 business days after receipt. You may check the Board's License Lookup at www.dhp.virginia.gov to see if your license has been issued. The license certificate will take approximately 7 to 10 business days from the date of issue to reach your address of record. Verification of licenses or license certificates **are available online via license look up at https://dhp.virginiainteractive.org/Lookup/Index** . Your cooperation will help expedite the processing of your application.

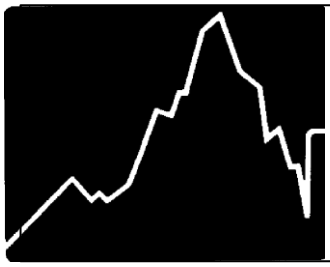
*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public upon request. Street addresses, post office box numbers or rural route numbers are not available on-line on the board's website. However, if you prefer, the Board of Medicine will allow the address of record to be a post office box or practice location.

*Applications not completed within 180 days may be purged without notice from the board.

*Additional information may be requested after review by a representative of the board.

*Application fees are non-refundable.

***Contact emails:** intern-medbd@dhp.virginia.gov; resident-medbd@dhp.virginia.gov ; **or** fellow-medbd@dhp.virginia.gov



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Telephone: (804) 367-4600
Facsimile: (804) 527-4426

MEMORANDUM

To: **Virginia Board of Medicine**

From: **Associate Dean of Graduate Medical Education or Program Director**

Name of Training Institute: _____

Attention: _____

Complete Mailing Address: _____

_____

Telephone: _____

This is to certify that _____ will be enrolled in _____
Name of Intern/Resident Specialty

at _____, _____
Name of training facility in Virginia Street Address

_____
City, State and Zip Code

from _____ with an expected completion date of _____
(Month/Day/Year) (Month/Day/Year)

Dr. _____ is a graduate of _____
Name of Intern/Resident Medical School

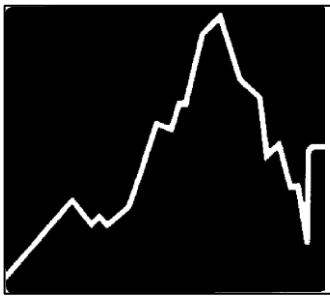
We have character reference letters on file for him/her in the program office.

_____
President, Secretary or Dean, or Program Director

_____
Signature

Rev. 8/21 INTERN/RESIDENT FORM

Print Name: _____



Department of Health Professions
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9960 Mayland Drive, Suite 300
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Facsimile: (804) 527-4426

CERTIFICATE OF PROFESSIONAL EDUCATION (FORM B)

(For graduates of approved programs only)

It is hereby certified that _____
(Name of Applicant)

enrolled in _____ on _____
(Course of Study) (Date)

and received a diploma from _____
(Name of Institution)

conferring the degree of _____ on _____.
(Degree) (Date)

_____
(President, Secretary or Dean)

SCHOOL SEAL

Completed form must be sent to:

Attention - Intern/Resident/Fellow Applications
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Or email to: intern-medbd@dhp.virginia.gov; resident-medbd@dhp.virginia.gov ; or fellow-medbd@dhp.virginia.gov

This form will not be considered valid if submitted prior to actual date of graduation.

Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Ste. 300
Henrico, Virginia 23233-1463

FAX (804)-527-4426
Phone (804) 367-4600

TRANSFER REQUEST

Name of Licensee_____

Training License #_____

To: **Virginia Board of Medicine**

From: **Associate Dean of Graduate Medical Education or Program Director**

Name of Training Institute: _____

Attention: _____

Complete Mailing Address: _____

_____

Telephone: _____

This is to certify that_____ will be enrolled in _____
Name of Intern/Resident Specialty

at_____, _____
Name of training facility in Virginia Street Address

_____
City, State and Zip Code

from_____ with an expected completion date of _____
(Month/Day/Year) (Month/Day/Year)

Dr._____ is a graduate of _____
Name of Intern/Resident Medical School

We have character reference letters on file for him/her in the program office.

_____
President, Secretary or Dean, or Program Director

_____
Signature

Contact Emails: intern-medbd@dhp.virginia.gov; resident-medbd@dhp.virginia.gov ; or fellow-medbd@dhp.virginia.gov