

**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE MEDICINE IN VIRGINIA FOR GRADUATES OF ALLOPATHIC MEDICAL SCHOOLS AND OSTEOPATHIC MEDICAL SCHOOLS**

*(This form has been designed to be used as a checklist when preparing to submit your application.)*

***APPLICATION FEES ARE NONREFUNDABLE***

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

This is not the application for a training license to practice as a resident or fellow. This application for a full and unrestricted MD or DO license to practice medicine in Virginia.

You should familiarize yourself with the qualifications required for a full license by reviewing the laws and regulations governing the practice of medicine 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. You should not expect the process to take less than 3-4 months, so plan accordingly if you are pursuing a practice position in Virginia.

The Virginia Board of Medicine accepts the verified documentation provided by the Federation Credentials Verification Service (FCVS), in case you choose to engage FCVS to help you with your application. <http://www.fsmb.org/licensure/fcvs/>

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 30 days for your application checklist to appear 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 "Application Question" in the subject line. E-mails will be answered within 2 business days.

The Board of Medicine discourages the use of the United States Postal Service to send documents. If possible, and if noted below, you are encouraged to have your documents sent by pdf attachment or FAX. The Board is unable to trace documents not delivered by the post office.

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

**If you answer “yes” to any of the licensure questions #2-12 provide a written explanation on a separate piece of paper and attach it to the application. If you have disciplinary action with another Board, attach a copy of the Board Order or other documentation. If you have medical mal practice claims, attach a narrative that includes dates, your treatment of the patient and any payment made per settlement or judgement. You may also provide a letter from your attorney. If you have misdemeanor or felony convictions provide a copy of the court documents.**

**1. Complete the online application.** <https://www.license.dhp.virginia.gov/apply/> which includes paying the nonrefundable application fee of \$302.00. Application fees may only be paid using Visa, MasterCard or Discover. .

**2. Examination Scores – If you took all three steps of the USMLE examination or the FLEX examination,** contact the Federation of State Medical Boards (FSMB) at (817) 868-4000 or [www.fsmb.org](http://www.fsmb.org) to have your scores submitted to the Board. Scores MAY NOT be faxed and MUST come directly from the FSMB. **If using the FCVS credentialing service, scores will be included.** [www.fsmb.org/licensure/fcvs/](http://www.fsmb.org/licensure/fcvs/)

**If you took the National Board of Osteopathic Medical Examinations or the COMLEX** you may request copies of your transcripts at <http://www.nbome.org/transcript-request.asp> or by calling (866) 479-6828. Scores MAY NOT be faxed and MUST come directly from the National Board. **If using the FCVS credentialing service, scores will be included.** [www.fsmb.org/licensure/fcvs/](http://www.fsmb.org/licensure/fcvs/)

**If you took the National Board of Medical Examiners or a combination of the USMLE examination,** contact the National Board of Medical Examiners at (215) 590-9500 or [www.nbme.org](http://www.nbme.org) to have your scores submitted to the Board. Scores MAY NOT be faxed and MUST come directly from the National Board. **If using the FCVS credentialing service, scores will be included.** [www.fsmb.org/licensure/fcvs/](http://www.fsmb.org/licensure/fcvs/)

**If you took the LMCC examination,** contact the Medical Council of Canada (MCC) at (613) 521-6012. Scores MAY NOT be faxed and MUST come directly from the MCC. **If using the FCVS credentialing service, scores will be included.**

**If you took a state examination,** contact the state agency or licensure board to have your scores submitted to the Board. Scores MAY NOT be faxed and MUST come directly from the agency maintaining your score. **If using the FCVS credentialing service, scores will be included.**

**3. Transcripts – Official medical school transcripts must be received by the Virginia Board of Medicine.** Medical school transcripts must be official and bear the school seal. Transcripts will only be accepted if they come directly from the medical school to the Board or if sent to the Board by the applicant in the same unopened envelope in which they were received. **If using the FCVS credentialing service, or Electronic Portfolio of International Credentials (EPIC)** [www.ecfmgepic.org/](http://www.ecfmgepic.org/) transcripts will be included. **Primary source transcripts in any language other than English need to be accompanied with a certified translation. The Board will accept transcripts from a document repository company affiliated with your medical school.**

**4. Employment Activity (Form B) Questionnaire** – List all activities from the date of graduation from medical school including but not limited to internships, residencies, fellowships, employment, affiliations, private practice, periods of non-activity or unemployment, observerships and volunteer service in the “Employment Activity” section of the application beginning with your first activity following medical school graduation. If you are employed by a group practice or locum tenens company, please list all locations where you have provided service or held privileges. Follow this link to obtain a Form B:

[Form B - Hospital/Employment History Questionnaire](#)

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

A completed Form B Activity Questionnaire or a letter of recommendation must be received from all locations of service, places of practice or professional employment, observerships, professional research positions or professional volunteer service listed for the 2 years immediately preceding application. Internships, residencies and fellowships must have a

Form B if the training occurred within the last 5 years. If the training occurred more than 5 years ago, you may provide a copy of the certificate of completion in lieu of a Form B. All post graduate training received in the United States or Canada must be accounted for regardless of when it occurred.

If engaged in private practice, without hospital affiliation, have another physician who is not related submit a letter attesting to your practice.

**For applicants practicing telemedicine, a Form B is only required from the chief medical officer of the company to which you are employed. To be accepted, the Form B must be signed by the CMO or medical director with a complete professional evaluation along with all locations of service.**

**For applicants practicing as locum tenens physicians, have the company you are affiliated with provide a complete list of all locations and dates where you have provided service. Form B employment verifications must be received from each location of service for the past 2 years.**

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 by the person completing the document.

**Form B's will not be accepted from the applicant.**

**5. Postgraduate training –**

**All post graduate training, including internships, transitional year, residency and clinical fellowships received in the United States or Canada must be accounted for regardless of when it was obtained or completed.** A completed Form B Activity Questionnaire signed by the Program Director or a letter of recommendation signed by the Program Director must be received from all places of postgraduate training including internships, residencies and fellowships completed in the United States, its territories or Canada listed. If your postgraduate training occurred more than 5 years ago, you may fulfill this requirement by sending copies of your certificates of completion. Otherwise, have your program complete and forward Form B. PDF attachments may be emailed to [medbd@DHP.Virginia.gov](mailto:medbd@DHP.Virginia.gov), faxed to (804) 527-4426 or mailed. **If using the FCVS credentialing service, postgraduate training verification is included. If you are a foreign graduate using EPIC, you may request that EPIC Verification Reports for your transcripts as well as your United States or Canadian postgraduate training be sent to the Board through EPIC. Visit <http://www.ecfmgepic.org/instructions-virginia.html> for instructions.**

**6. License Verification**

Verification of medical licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a full license must be received by the Board. The Board does not require verification of training licenses. **Please contact the applicable jurisdiction where you have been issued a license to practice medicine 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. **This documentation is NOT provided by the FCVS credentialing service. Many medical boards use [www.veridoc.org](http://www.veridoc.org) to send their license verifications. Check with Veridoc to see if your other state license boards use Veridoc.**

**7. NPDB Self Query – Complete the online [Place a Self-Query Order](#) form.** Be ready to provide:

- Identifying information such as name, date of birth, Social Security number
- State health care license information (if you are licensed)
- Credit or debit card information for the \$4.00 fee (charged for each copy you request)

**Verify your identity.** This can be done electronically as part of your order or by completing a paper form and having it notarized. You will receive full instructions as you complete your order.

**Wait for your response.** Once your identity is verified, the NPDB will process your order. A paper copy of your response will be sent the next business day by regular U.S. mail.

The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board recommends using Fed EX or UPS for tracking purposes. The Board**

**of Medicine is unable to track any mail or other package that is sent via the United States Postal Service. Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to be resubmitted.**

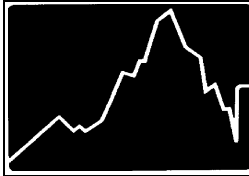
**Item # 8 is only for graduates of medical schools outside of the U.S. and Canada.**

**8. ECFMG Certification:** To request your ECFMG certification, follow this link <https://cvsonline2.ecfm.org/> to have your ECFMG certification provided to the Board. **If you are using FCVS credentialing service, this document will be included.**

Please note:

- ▶ 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).
- ▶ 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: \_\_\_\_\_