INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE AS A PHYSICIAN ASSISTANT IN VIRGINIA

APPLICATION FEES ARE NONREFUNDABLE

BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!

Applications expire after one year. Applications not completed within one year require a new application and fee.

This is the application for a full and unrestricted license to practice as a physician assistant in Virginia.

You should familiarize yourself with the qualifications required for a full license by reviewing the laws and regulations governing the practice of physician assistants in Virginia. They can be found at: 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 8-12 weeks, so plan accordingly if you are pursuing a practice position in Virginia.

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

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.

INSTRUCTIONS FOR COMPLETING A PHYSICIAN ASSISTANT LICENSURE APPLICATION

(This form has been designed to be used as a check-off sheet when preparing to submit your application.)

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

☐***1. Complete the online application.*** https://www.dhp.virginia.gov/medicine/medicine_forms.htm#PA which includes paying the nonrefundable application fee of $130.00. Application fees may only be paid using Visa, MasterCard or Discover.

☐***2. Form B:*** *Forward Form #B* ***(Employment/Activity Questionnaire)*** *to all locations where professional services were provided in the employment chronology section of the licensure application for the last 5 years or since graduation from your PA program if within the last 5 years.* ***This document must be completed by a current or former supervising physician.*** *This form may be copied as necessary. This documentation* ***may*** *be faxed or email to medbd@dhp.virginia.gov.* ***(May not apply to new graduates).***

☐***3. Form C:*** *Forward Form #C* ***(License Verification)*** *to those jurisdictions in which you have been licensed, certified or registered. This form may be copied as necessary. Please contact the applicable jurisdictions to inquire about processing fees. This documentation* ***may*** *be faxed directly from the jurisdiction. (May not apply to new graduates)* ***Be sure to check with VERIDOC.ORG*** *as some states use this service for their license verifications in which case you will not need to contact the Boards where you hold other licenses or complete Form C.*

☐***4. Form L: Proof of Professional Education****: This form must be completed by your professional school as directed. This documentation* ***may not*** *be faxed. If using FCVS this documentation will be provided.*

☐***5. NCCPA:*** *If you are a new applicant,* ***or*** *your previous Virginia license expired over 2 years ago, you must request one of the following: 1) statement of current certification* ***or*** *2) a letter of eligibility submitted* ***DIRECTLY FROM*** *the NCCPA, Inc., 12000 Findley Road, Suite 200, Duluth GA 30097; (678) – 417-8100. Verification of current certification may be mailed to the board office or emailed directly from NCCPA. Faxes are not acceptable. After initial licensure, you must maintain a current NCCPA status or you will not be considered licensed by the board.* ***Personal copies of your certificate are not acceptable.*** *If using FCVS a statement of current certification will be provided.*

Please note:

►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/fcvs.html

► Applications not completed within 12-months are considered inactive and will need to be resubmitted.

► Additional information may be requested at any time during the process.

► Application fees are non-refundable.

►Certain forms may be faxed to 804-527-4426.

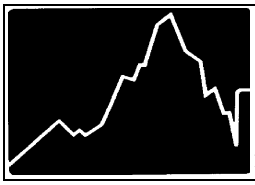
►Do not begin to practice until you are issued a license. Paper copies of licenses are not required to begin practice. Hospital credentialers should use the Board's license lookup located here: https://dhp.virginiainteractive.org/Lookup/Index which meets Joint Commission requirements for primary source verification.

►Contact person : ShaRon Clanton Email: **sharon.clanton@dhp.virginia.gov** The web site is **www.dhp.virginia.gov/**

FORM B - PLEASE CHECK APPROPRIATE PROFESSION

_____, _____
Please Print Last Name Please Print First

- ❑ Acupuncturist
- ❑ Athletic Trainer
- ❑ BCaBA
- ❑ BCBA
- ❑ Chiropractic
- ❑ Genetic Counselor
- ❑ Medicine and Surgery
- ❑ Midwife
- ❑ Occupational Therapist
- ❑ Occupational Therapist Assistant
- ❑ Osteopathy and Surgery
- ❑ Physician Assistant
- ❑ Podiatry
- ❑ Polysomnographic Technologist
- ❑ Radiologic Technologist
- ❑ Radiologic Technologist - Limited
- ❑ Radiologist Assistant
- ❑ Respiratory Therapist



Rev. 7/17

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: _____

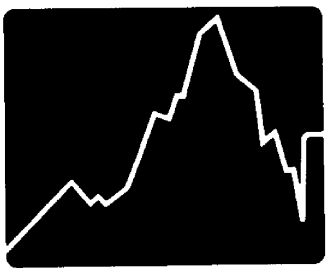
Date (Required): _____

Signator Contact Number: (_____) _____

Signed by: _____
Print or type name: _____
Title: _____

(This report will become a part of the applicant's file and may be reviewed by the applicant upon request.)

SS#/DMV# _____



COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE

Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

(804) 367-4501 (804) 527-4426 Fax

Dear Sirs:
The person listed below is applying for licensure as a Physician Assistant in the State of Virginia. The Board of Medicine requests that the form be completed by each jurisdiction in which he/she holds or has held a license/certificate. Please complete the form and return it to the address below. Thank you.

Commonwealth of Virginia
Department of Health Professions
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

_____
Name of Applicant (please print or type)

_____
License #

==========

State of _____ Name of Licensee _____

Graduate of _____

License number _____ Issued effective _____

By reciprocity/endorsement _____ by examination _____

License is: Current ☐ Lapsed ☐

Has the applicant's license ever been suspended or revoked? ☐Yes ☐No

If yes, for what reason? _____

Derogatory information, if any _____

Comments, if any _____

_____

Signed _____

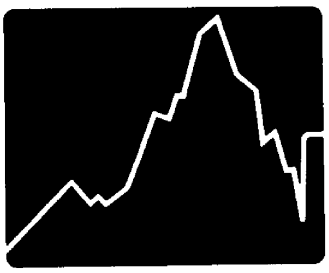
BOARD SEAL

Title _____

State Board _____

NOTE TO APPLICANT: PLEASE PROVIDE LICENSE NUMBER AND FORWARD TO STATE INDICATED

Printed Name of Applicant _____



COMMONWEALTH OF VIRGINIA

BOARD OF MEDICINE
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

(804) 367-4501 (804) 527-4426 Fax

Submit this form to your medical school for completion and instruct them to return the completed form directly to the Virginia Board of Medicine.

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

It is hereby certified that _____ of _____
name city/state

successfully completed an ARC-PA accredited educational program at_____ on
school

_____.
date

Did this course of study include at least 35 hours of Pharmacology? ☐Yes ☐No

SCHOOL SEAL

_____
President, Secretary or Dean

Completed form must be mailed to:

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