INSTRUCTIONS FOR COMPLETING REINSTATEMENT OF RESPIRATORY CARE PRACTITIONER LICENSE

The completed application should be returned to this office along with the reinstatement fee of **$180.00**. APPLICATIONS **WILL NOT** BE PROCESSED UNLESS THE FEE IS ATTACHED. Checks or money orders should be made payable to the **Treasurer of Virginia.**

☐1. Forward Activity questionnaires (Form B) to all places of employment (hospitals, clinics, etc.) where you have practiced since your license in Virginia lapsed. If over five years only go back five years. This documentation **may** be faxed to 804-527-4426.

☐2. Forward State questionnaires (Form C) to all jurisdictions where you have ever been licensed, certified or registered. Please contact the applicable jurisdictions to inquire about processing fees. They may require a fee. This documentation **may** be faxed **directly** from the jurisdiction to 804-527-4426.

☐3. Continuing Education – Pursuant to 18 VAC 85-40-65 you are required to provide evidence of continuing education as described in 18 VAC 85-40-66. This documentation **may** be faxed to 804-527-4426

☐4. If you have been discharged from the U.S. Military service within the past five years, submit a photostatic notarized copy of your discharge papers. This documentation **may** be faxed.

☐5. Copies of documentation supporting any name change since your initial licensure in Virginia.

Please note:
*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.

*Applications will be acknowledged one time after receipt if items appear to be missing.

* Applications may or may not be acknowledged more often, however you may contact the board office at any time for a status report.

*Applications not completed within 6 months may be purged without notice from the board.

(over)

Please note (cont.)

*Additional information may be requested after review by Board representatives.

*Application fees are non-refundable.

*A formal letter will be sent to you after approval of reinstatement. Do not begin practice until you have been notified of approval. 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.

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

*Contact person: Bradley Verry 804-367-4613, Email – bradley.verry@dhp.virginia.gov

Rev 11/10
RCP Reinstatement

COMMONWEALTH OF VIRGINIA

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

(804) 367-4613 (804) 527-4426 Fax

Application for REINSTATEMENT of License to Practice Respiratory Care

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH IN THIS SPACE

To the Board of Medicine of Virginia:
I hereby make application for reinstatement of my license to practice Respiratory Care in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle	
Street	City	State	ZIP Code
Date of Birth ____ ____ ____ Mo. Day Yr.	Place of Birth	Social Security No. or VA Control No.*	
Graduation Date ____ ____ ____ Mo. Day Yr.	Prof. School Degree	School, City, State	MAIDEN NAME

Please submit address changes in writing immediately.
Please attach check or money order. Application will not be processed without the fee. It will be returned.
Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY

_____ Date

LICENSE NUMBER	PROCESSING NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
0117-		$180.00		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices since the expiration date of your Virginia license including any periods of non-professional activities or employment for more than three months. **Please account for all time.** If engaged in private practice, list all hospital affiliations. If none, please explain. **CVs may be attached but does not substitute for completion of this page.**

From	To	Name and Location	Position Held

Please provide a telephone number where you can be reached during the day. This information is not mandatory and if provided, will not be used for any purpose other than as a contact if staff has questions about your application.

Work Number	Home Number	Email Address

QUESTIONS MUST BE ANSWERED. If any of the following questions (7-15) is answered **Yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits, or you may complete Form A.

3. Do you intend to engage in the active practice of respiratory care in the Commonwealth of Virginia? ☐ Yes ☐ No

4. Specify type of practice: ☐ Hospital ☐ Home Care ☐ Education ☐ Research ☐ Other, specify _____

5. List all jurisdictions in which you have been issued a license or certificate to practice respiratory care: active, inactive or expired. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

	Yes	No
6. Have you ever taken an NBRC, Inc. credentialing examination? If so, what professional credentials do you presently hold with the NBRC, Inc.? _____	____	____
7. Have you ever been denied the privilege of taking a respiratory care examination?	____	____
8. Have you ever been denied a certificate/license or the privilege of taking an examination before any state, territory, or country?	____	____
9. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.)	____	____
10. Have you ever been denied privileges or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, internship, hospital, nursing home, or other health care facility, or health care provider?	____	____
11. Have you ever had any of the following disciplinary actions taken against your certificate/license to practice respiratory care or are any such actions pending? (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored	____	____
12. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned?	____	____
13. Have you had any malpractice suits brought against you in the last ten years? If so, how many? _____ Provide details.	____	____
14. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? If so, please provide a letter from the treating professional.	____	____
15. Do you have a physical disease, mental disorder, or any condition which could affect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis and fitness to practice.	____	____

16. AFFIDAVIT OF APPLICANT

(THIS SECTION MUST BE NOTARIZED)

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all 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 individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice respiratory care in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available at www.dhp.virginia.gov And I understand that fees submitted as part of the application process shall not be refunded.

RIGHT THUMB PRINT

May be self applied
If right thumb is missing, use left and so indicate

_____
Signature of Applicant

City/County of _____ State of _____

Subscribed and sworn to before me this _____ day of _____ 20____.

My Commission expires _____.

NOTARY SEAL

_____
Signature of Notary Public

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RCP - Reinstatement Form A

Print Name:_____

COMMONWEALTH OF VIRGINIA

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

(804) 367-4613 (804) 527-4426 Fax

CLAIMS HISTORY SHEET

If you answered "yes" to Question #13 on page three of the application, please either have your attorney submit a letter regarding malpractice suits or complete one of these sheets for each case you have been involved in.

(Make additional copies of this form as needed)

Claimant: _____

Date of Incident: _____ Date Claim Made: _____

Name of all Defendants, Persons or Entities against whom claim was made: _____

_____

City, County and State of Suit: _____

Name and Address of Defense Attorney: _____

_____

Settlement Amount (if any): _____ Verdict Amount: _____ Date Case Closed: _____

Current Status of Claim (indicate insurance company reserve if case is not closed): _____

_____

Name of Involved Insurance Company: _____

_____

Policy Number: _____ Detailed Description of Claim (use reverse side if necessary): _____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

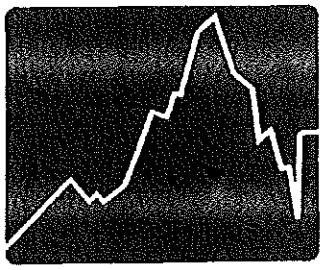
I hereby authorize any person, company, insurer, hospital or other organization to release any and all information, privileged, or in their dominion, custody, or control, regarding insurance applications by me, professional liability issued to me, any employment or personnel records involving me and any health, medical psychological or psychiatric records involving me, as well as information obtained by any attorneys who are now representing, or have in the past represented me.

_____ _____

Date Signature

Rev. 11/10
RCP - Reinstatement Form B

Print Name:_____



COMMONWEALTH OF VIRGINIA

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

(804) 367-4613 (804) 527-4426 Fax

The Virginia Board of Medicine, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the board so the information you provide can be given consideration in the processing of this candidate's application in a timely manner.

Please print or type name, address, city and state, of employment setting verifying this information:

_____

_____

_____

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:

	(Please 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)
   1. Recommend highly and without reservation _____
   2. Recommend as qualified and competent _____
   3. Recommend with some reservation (explain) _____
   4. Do not recommend (explain) _____

4. Of particular value to us in evaluating any candidate regarding 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: _____ Signed _____

_____ _____
Please 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.)

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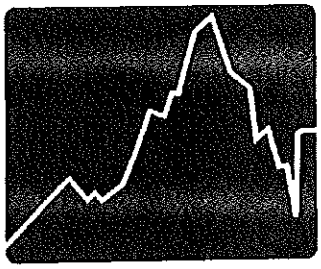
RCP - Reinstatement Form C

Print Name:_____



COMMONWEALTH OF VIRGINIA

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

(804) 367-4613 (804) 527-4426 Fax

Dear Sirs:
The person listed below is applying for reinstatement of their license to practice respiratory care. The Virginia Board of Medicine requires that this 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

VIRGINIA BOARD OF MEDICINE
CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

The Law

In 1997, the General Assembly of Virginia passed a law (§ 54.1-2912.1) to ensure the continued competency of practitioners licensed by the Board of Medicine. It directed the Board to include in its regulations continuing education, testing, and/or any other requirement which would address the following: a) the need to promote ethical practice, b) an appropriate standard of care, c) patient safety, d) application of new technology, e) appropriate communication with patients and f) knowledge of the changing health care system.

Rationale for the Regulation

The Virginia Board of Medicine recognizes that the professional responsibility of practitioners requires *continuous learning* throughout their careers, appropriate to the individual practitioner's needs. The Board also recognizes that practitioners are responsible for choosing their own continuing education and for evaluating their own learning achievement. ***The regulation of the Board is designed to encourage and foster self-directed practitioner participation in education.***

What is "Continuing Learning"? - Continuing learning includes processes whereby practitioners engage in activities with the conscious intention of bringing about changes in attitudes, skills, or knowledge, for the purpose of identifying or solving ethical, professional, community or other problems which affect the health of the public.

Content of the Regulation

Number of Hours Required:

In order to renew an active license **biennially**, on or after January 1, 2005, the practitioner must complete the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM, which is provided by the Board and must indicate completion of at least **20 hours of continuing respiratory care education as approved and documented by a sponsor recognized by the AARC.**

Maintenance and audit of records:

The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM must be used for recording continuing learning activities. The practitioner is required to retain in his or her records the **completed form with all supporting documentation** for a **period of four years** following the renewal of an active license.

The Board will periodically conduct a **random audit** of one to two percent of its active licensees to determine compliance. The practitioners selected for the audit must provide the completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and any supporting documentation within 30 days of receiving notification of the audit.

Instructions for Completing
The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

PART A: ACTIVITY

Learning Activity, Resources, Strategies & Experiences - List resources, strategies & experiences that you used to develop or maintain the selected knowledge or skill listed in Part B; e.g., conferences, quality improvement

teams, consultations, discussions with colleagues, preceptorship, teaching, reading peer reviewed journals and textbooks, and self instructional media.

Date(s) of Activities - List the date(s) that you were engaged in the learning activity.

PART B: ASSESSMENT (OPTIONAL)

Knowledge or Skills Maintained or Developed - Think about questions or problems encountered in your practice. Describe the knowledge or skills you addressed during the learning activity listed in Part A. Consider ethics, standards of care, patient safety, new technology, communication with patients, the changing health care system, and other topics influencing your practice.

HOURS/TYPE

Hours Actually Spent in Learning Activity: List the hours actually spent in the learning activity to nearest ½ hour. Total hours should be at least 20 hours biennially.

PART C: OUTCOME (OPTIONAL)

Outcome - Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic. *(You may include personal notes regarding the outcome of participating in this activity, e.g., learning activities you plan for the future, questions you need to answer or barriers to change.)*

CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

Please photocopy this original form to record your learning activities.

The completed forms and all documentation must be maintained for a period of four years.

PART A: ACTIVITY		PART B: ASSESSMENT (Optional for renewal of license)	# OF HOURS/TYPE	PART C: OUTCOME (Optional for renewal)
Learning Activity, Resources, Strategies & Experiences; e.g. conferences, consultations, teaching, peer-reviewed journals, grand rounds, quality improvement teams, self-instructional material	**Date**	**Knowledge or Skills You Maintained or Developed.** What questions or problems encountered in your practice were addressed by this learning activity?		**Outcome:** Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic.

CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM: SUMMARY AND VERIFICATION

This page should be completed at the end of your two-year renewal cycle and inserted as the final page of your CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM.

Record at least 20 hours of continuing learning activities you completed during the preceding two-year period of professional license. Recorded hours should indicate 20 hours of activities approved and documented by a sponsor recognized by the AARC within the last biennium. The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and all documentation should be maintained in your records for four years.

As you consider your completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM, please reflect upon your practice and in the space below identify problems or questions you expect to address during the next biennial period of license renewal:

_____

_____

_____

As required by law and regulation, I certify that I have completed the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and have participated in 20 hours of continuing medical education or learning activities as required for renewal of licensure in the Commonwealth of Virginia.

_____ _____

Signature Date