



COMMONWEALTH OF VIRGINIA

BOARD OF COUNSELING
 Department of Health Professions
 9960 Mayland Drive, Suite 300
 Henrico, Virginia 23233-1463
 (804) 367-4610

**APPLICATION FOR REINSTATEMENT OF A REVOKED,
 SUSPENDED OR SURRENDERED LICENSE**

I hereby make application for reinstatement of my **Professional Counselor** license number _____.
 The following evidence of my qualifications is submitted with a **check or money order** in the amount of **\$500.00** made payable to the Treasurer of Virginia. **I understand that the application fee is non-refundable.**

INSTRUCTIONS		PLEASE TYPE OR PRINT		USE BLACK INK
1. Applications lacking a Social Security Number or Virginia Department of Motor Vehicles control number will not be processed. 2. Applications lacking all supporting documentation (including verification of subsequent licensure(s)) will not be processed.				
I. GENERAL INFORMATION				
Full Name (Last, First, Middle, Suffix, Maiden Name)		Degree	Social Security/Virginia DMV Control Number	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)				Home Telephone Number
Business Name and Address (if different from above)				Business Telephone Number
Fax Number		E-Mail Address		
LICENSURE/CERTIFICATION - List all the states in which you now hold or have ever held an occupational license or certificate to practice as a mental health care practitioner. A verification form must be received from each jurisdiction in which licensure was ever held.				
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE	

In accordance with Section 54.1-116 of the *Code of Virginia* you are required to submit your Social Security Number or your **Virginia** control number. Refer to instruction sheet.

ANSWER THE FOLLOWING QUESTIONS:

- | | | |
|---|------------|-----------|
| | YES | NO |
| 1. Have you ever had any disciplinary action taken against an occupational license issued outside Virginia or are any such actions pending? *If yes, see below. | [] | [] |
| 2. 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 for driving under the influence.) *If yes, see below. | [] | [] |
| 3. Have you ever been censured, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? *If yes, see below. | [] | [] |

*If you answered "YES", please provide an explanation on a separate sheet of paper and any supporting documentation.

II. PROFESSIONAL EXPERIENCE (subsequent to surrender of Virginia licensure)

Dates of Employment		Employer	Address	Hours per week	Supervisor (if applicable)	Duties
From	To					

III. ADDITIONAL INFORMATION: Provide any additional information to document continued competency to resume practice in the Commonwealth of Virginia.

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

AFFIDAVIT
(To be completed before a notary public)

State of _____ County/City of _____

Name _____, being duly sworn, attests that he/she has read and agrees to comply with the Standards of Practice and laws governing the provision of rehabilitation services in Virginia and says that he/she is the person who is referred to in the foregoing application for reinstatement in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Signature of Applicant

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

My commission expires on _____.

Signature of Notary Public

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