Rev. 11/10

INSTRUCTIONS FOR COMPLETING A REINSTATEMENT APPLICATION FOR ATHLETIC TRAINING

(This form has been designed for you to use as a checklist for processing your application)

The completed application must be returned to the Board office along with the reinstatement fee of $180.00, check made payable to the Treasurer of Virginia. Applications will not be processed unless the fee is attached. Fees sent before the receipt of an application will be returned. Applications submitted with the application fee will be returned. Also, the applicant is responsible for forwarding all of the required forms to the appropriate institutions, states and other agencies.

☐ **Application and Fee** - The completed 4-page application must be returned to this office with the statutory licensure fee of **$180.00**, made payable to the Treasurer of Virginia.. This document **may not** be faxed.

☐ **Form B** - Activity Questionnaire - List activities on the chronological page of the application, (p.2) to include all activities since the expiration date of your Virginia license. Forward form #B (activity questionnaire) to those places of practice/employment listed. If engaged in private practice, have another acupuncturist submit a letter attesting to your practice. **CV'S ARE NOT ACCEPTABLE. IF SUBMITTED IN LIEU OF PAGE 2, YOUR APPLICATION WILL BE RETURNED FOR COMPLETION. (Page 2 may be copied for additional activities and attached to application.)** This documentation **may** be faxed.

☐ **Form C** - Forward form C **(Jurisdiction Clearance)** 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.

☐ **Proof of Current NATABOC certification** - Provide a copy of your current BOC registration.

☐ **Military Service** - If you have been discharged from the United States Military Service within the past ten years, submit a photostatic notarized copy of your discharge papers. This documentation **may** be faxed.

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 not completed within 6 months will be purged without notice from the board.

*Additional information may be requested after the Executive Director has reviewed the file.

*Application Fees are non-refundable.

*A formal letter will be sent to you after approval of licensure; 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 A.T.-Reinstatement

Department of Health Professions
Commonwealth of Virginia

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

(804) 527-4613

Application for Reinstatement of a License to Practice as an Athletic Trainer

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH IN THIS SPACE.

I hereby make application to reinstate a license to practice as an Athletic Trainer in the Commonwealth of Virginia and submit the following statements:

Last	First	Middle
Street Address	**City/State**	**Zip Code**

Date of Birth	Place of Birth	Social Security/VA Control #	Maiden Name if Applicable
____/____/____			

Professional School Name & Location	Professional School Graduation Date	Professional School Degree
	____/____/____	

Please accompany with this application a check or money order made payable to the Treasurer of Virginia in the required amount. If the money does not accompany the application, the application **will** be returned. Please submit address changes in writing immediately.

*In accordance with §54.1-1116 in the **Code of Virginia**, you are required to submit your Social Security number/Control number (issued by the Virginia Department of Motor Vehicles.). This number will be used by the Department of Health Professions for identification purposes only and will not be disclosed for any other purposes except as mandated by law. Federal and State law requires that this number be shared with other state agencies for child support enforcement activities. **Failure to disclose this number will result in the denial of a license to practice in the Commonwealth of Virginia.**

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

APPROVED BY:

_____

Applicant #	Check #	Class #	Fee
		0126	$130.00

1. List in chronological order all professional practices since graduation, including absences from work. Also list all periods of non-professional activity or employment for more than three months. **PLEASE ACCOUNT FOR ALL TIME.** A completed Form B must be received for all places listed for the **last five years.**

From	To	Name & Location	Position Held

2. 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 the program specialist has questions about your application.

Home #:	Work #:	Email Address:

The following questions must be answered in order for your application to be considered complete. If any of the following questions (#5-13) is answered yes, please provide supporting documentation. Letters must be submitted by your attorney regarding malpractice suits (or you may complete and submit Form A yourself.)

3. List all jurisdictions in which you have been issued a license, certificate, or registration to practice as an athletic trainer. Include the number and date issued of all active, inactive or expired licenses.

Jurisdiction	Number Issued	Active/Inactive/Expired

4. Have you ever taken the National Athletic Trainers' Association Board of Certification Examination? ☐Yes ☐No
If so, please provide date(s). _____.

5. Have you ever been denied the privilege of taking an athletic trainer examination for licensure, certification or registration? ☐Yes ☐No

6. Have you ever been denied an athletic trainer license, certificate, or registration? ☐Yes ☐No

7. 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.) ☐Yes ☐No

8. 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, or any other facility. ☐Yes ☐No

9. Have you ever had any of the following disciplinary actions taken against your license or certification to practice as an athletic trainer or any such actions pending? (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored ☐Yes ☐No

10. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned? ☐Yes ☐No

11. Have you had any malpractice suits brought against you in the last ten (10) years? If so, how many? _____ (Provide details on Form A) ☐Yes ☐No

12. 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. ☐Yes ☐No

13. 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. ☐Yes ☐No

(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 as an athletic trainer in the Commonwealth of Virginia.

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

RIGHT THUMB PRINT
(May be self-applied)

_____
Signature of Applicant

City/County of _____ State of _____

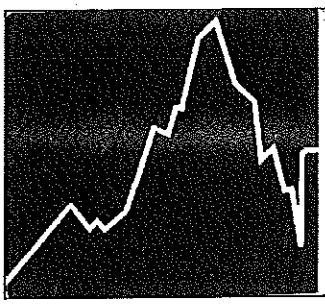
Subscribed and sworn to before me this _____ day of _____ 20_____.

My Commission expires _____.

_____
Signature of Notary Public

NOTARY SEAL

Print Name: _____



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
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(804) 367-4613

CLAIMS HISTORY

If you answered "yes" to Question #11 on page three of the application, please either have your attorney submit a letter regarding malpractice suits or complete one of these forms for each case you have been involved.

(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.

_____ _____

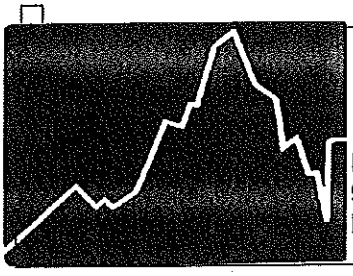
Signature Date

Rev. 11/10 –A.T. - Reinstatement

Form B

Print Name: _____

☐



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Please print or type name, address, city and state, of employment setting.

_____

_____

_____

_____

Please print or type name of Applicant

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. I hereby authorize all schools, 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 _____ (Month/Year) to _____ (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)
   - 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 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: _____

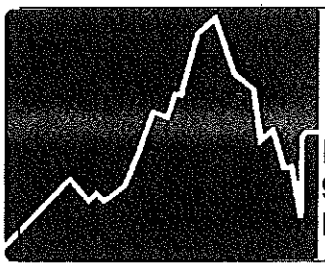
Signed by: _____
Print or type name: _____
Title: _____

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

Rev. 11/10 – A.T.- Reinstatement

Form C

Print Name: _____



Department of Health Professions
Commonwealth of Virginia

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

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To Whom It May Concern:

The person listed below is applying for a license to practice athletic training 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/Certificate #

==========

Name of Licensee _____ State/Commonwealth of _____

License/Certification number _____ Issued effective _____

Licensed/CertifiedThrough (check one)

☐ NATABOC Examination ☐ State Board of Examination

☐ Endorsement from (Name of State) _____

License is: Current ☐ Lapsed ☐

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

If yes, for what reason?

_____

Derogatory information, if any

_____

Comments, if any

_____

_____

BOARD SEAL

Signed _____

Title _____

State Board _____

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