

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!

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

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

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](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.

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/>

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

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. If you prefer to use overnight mail, use either FED EX or UPS. Do not send application documents in overnight mail using the USPS.

**NB** 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](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. Employment Activity (Form B) Questionnaire** – List all activities from the date of graduation from your physician assistant program 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 physician assistant 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 - 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 past 2 years.

**For applicants practicing as locum tenens physician assistants, have the company or supervising physician 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 by your supervising physician.**

**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 signed by anyone other than a supervising physician may not be accepted. Form B’s will not be accepted from the applicant. If you are a new graduate with no professional employment history, you do not need to provide a form B.**

**3. Form C: Form C: (May not apply to new graduates)** 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. **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. If you are a new graduate with no licenses in any state or US jurisdiction, you will not need to provide license verifications.

**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.***

- 6. NPDB Self Query – Complete the online Place a Self-Query Order form.** Be ready to provide:
- o Identifying information such as name, date of birth, Social Security number
  - o State health care license information (if you are licensed)
  - o 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.**

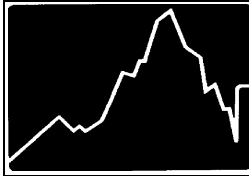
**The Board recommends using Fed EX or UPS for tracking purposes. The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service. Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to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

**Please note: If you are a new graduate with no professional employment or license history, you do not need to provide an NPDB report. If you are licensed in another state, but have not had professional employment, the NPDB report is still required.**

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](mailto:sharon.clanton@dhp.virginia.gov) The web site is [www.dhp.virginia.gov/](http://www.dhp.virginia.gov/)

- |   |   |  |  |
|---|---|--|--|
| <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 |  |  |



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](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: \_\_\_\_\_

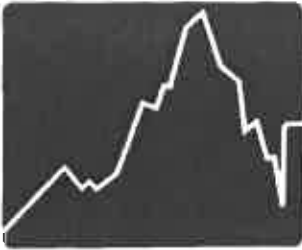
Date (Required): \_\_\_\_\_

Signed by: \_\_\_\_\_

Print or type name: \_\_\_\_\_

Signator Contact Number: (\_\_\_\_\_) \_\_\_\_\_

Title: \_\_\_\_\_

	<p><b>COMMONWEALTH OF VIRGINIA</b></p>
	<p><b>BOARD OF MEDICINE</b></p>
	<p>Department of Health Professions 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463</p>
	<p>(804) 367-4501                      (804) 527-4426 Fax</p>

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 \_\_\_\_\_

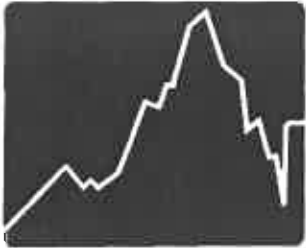
Signed \_\_\_\_\_

**BOARD SEAL**

Title \_\_\_\_\_

State Board \_\_\_\_\_

Printed Name of Applicant \_\_\_\_\_

	<p align="center"><b>COMMONWEALTH OF VIRGINIA</b></p> <p align="center"><b>BOARD OF MEDICINE</b></p> <p align="center">Department of Health Professions 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463</p> <p align="center">(804) 367-4501      (804) 527-4426 Fax</p>
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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