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Virginia Department of Health Professions
Board of Physical Therapy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
www.dhp.virginia.gov/PhysicalTherapy

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Email:
ptboard@dhp.virginia.gov

Application for Reinstatement to Practice Physical Therapy as a:

Mark only one box

☐ **Physical Therapist - $180.00 FEE**

☐ **Physical Therapist Assistant - $120.00 FEE**

Attach check or money order made payable to the Treasurer of Virginia. ALL FEES ARE NON-REFUNDABLE

1. Legal Full Name (Please Print or Type)

First Name	Middle Name and Maiden Name	Last Name and Suffix
Social Security No. or VA Control No.*	Date of Birth _____ _____ _____ MM DD YY	Place of Birth (City and State)

Address of Record: Street	City	State	ZIP Code
Alternate Public Address: Street	City	State	ZIP Code
Business Name & Address: Street	City	State	ZIP Code

ADDRESS: Virginia law allows persons regulated by boards within the Department of Health Professions to provide an alternative address for public disclosure if they want their address of record to remain confidential, used only for agency purposes. Health professionals may choose to provide a work address, a post office box, or a home address as the public address. If an alternative public address is not provided, the address of record will also be used as the public address and may be disclosed if specifically requested. However addresses of individuals **are not posted** on the "License Lookup" program available through the board's website.

Home Phone:	Work Phone:	Mobile Phone:
E-Mail Address		VA PT/PTA License No:

Graduation Date	Degree	College/University and City, State

Submit address changes in writing immediately. Attach check or money order made payable to the Treasurer of Virginia. Applications will not be processed without the fee or vice versa. Incomplete applications **WILL BE RETURNED.** Applications will remain in process no longer than **one (1) year**. If, at the end of one (1) year, a license is not issued, the application file is **destroyed**. An applicant shall reapply for reinstatement, submit fees, required documentation, and meet the qualifications for licensure in effect at the time of the new application.

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

APPROVED BY _____

LICENSE NUMBER	PENDING NUMBER	BASE STATE	RECEIPT NUMBER

*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 graduation (e.g. hospital department, outpatient centers, etc.). Also list all periods of absences from work and non-professional activity or employment for more than three months. **Account for all time. (You may use additional paper if needed).**

DATES From To	Business Name, Address, Telephone Number, and Position Held

3. National Practitioner Data Bank(NPDB):
You will need to request a current report – *Self Query* - from NPDB. There is a processing fee that must be paid by credit card (VISA, MasterCard, Discover or American Express) to NPDB. They do not accept cash or checks. You may request the *Self Query* report through their website at www.npdb.hrsa.gov

4. Continuing Education: Submit evidence of completion of continuing education for each year in which your license has been expired up to 60 hours obtained within the past four years.

5. Out of State Licensure: List all jurisdictions in which you have been issued a license to practice as a physical therapist or physical therapist assistant: active, inactive, or expired. Indicate license number and date issued. You will need to provide written verification from the issuing regulatory authority, in all jurisdictions, in which you have *ever* held a license, including expired, inactive, and current licenses. Contact each State regarding processing fees.

State/Jurisdiction	License Number	Issue Date / Status

QUESTIONS MUST BE ANSWERED. If any of the following questions (**6-12**) is answered **yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits.

	YES	NO
6. Have you ever been denied a physical therapy or physical therapy assistant license? If **yes**, submit notices, orders, etc., from the regulatory authority authorized to take such actions.	____	____
7. Have you applied for licensure in another jurisdiction and have not received licensure or are you currently applying for licensure in another jurisdiction?	____	____
8. 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? **Including** convictions for driving under the influence; excluding traffic violations. Attach your original criminal history record, a certified copy of any final order, decree, or case decision by a court or regulatory agency with lawful authority to issue such order, decree, or case decision, and any other information you wish to be considered with your application (i.e. information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).	____	____

	YES	NO
9. Have you ever had any of the following disciplinary actions taken against your license to practice PT or PTA or any such actions pending? (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored (e) monetary penalty? If **yes**, submit notices, orders, etc., from the regulatory authority authorized to take such actions.	____	____
10. Have you had any malpractice suits brought against you in the last ten years? If so, how many? _____Provide details. Letters must be submitted by your attorney regarding malpractice suits.	____	____
11. 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 **yes**, please provide a letter from the treating professional, on letterhead, to include diagnosis, treatment, prognosis and fitness to practice.	____	____
12. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties? If **yes**, please provide a letter from the treating professional, on letterhead, to include diagnosis, treatment, prognosis and fitness to practice.	_____	____

13. AFFIDAVIT OF APPLICANT

(a) I have read and understand the Virginia Board of Physical Therapy regulations and am aware that if granted a physical therapist license in Virginia, I am required to comply with any laws and regulations of the Virginia Board of Physical Therapy.

(b) I hereby give permission to the Virginia Board of Physical Therapy to secure additional information concerning me or any statement in this application from any person or any source the Board may desire. I further agree to submit to questioning by the Board or any Agent thereof, and to substantiate my statement(s) if desired by the Board.

(c) I shall present any credentials or documents required or requested by the Board.

(d) I, _____, the applicant herein, depose and say that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualification as an applicant shall be sufficient grounds for the denial, suspension, cancellation, or revocation of my Virginia Board of Physical Therapy license even though it is not discovered until after issuance.

_____ _____

Signature of Applicant **Date**