

**INSTRUCTIONS FOR COMPLETING REINSTATEMENT OF  
OCCUPATIONAL THERAPY LICENSURE**

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. Fees sent before the receipt of an application will be returned. Applications submitted without the application fee will be returned. **Checks should be made payable to the "Treasurer of Virginia"**.

- 1. Forward Activity questionnaire (Form B) to all places of employment where you have practiced since your license in Virginia lapsed, not to exceed five years. This documentation may be faxed to 804-527-4426.
- 2. Forward State questionnaire (Form C) to all jurisdictions (other than Virginia) where you have ever been licensed, certified or registered. Please contact the applicable jurisdictions to inquire about processing fees. This documentation may be faxed directly from the jurisdiction to 804-527-4426.
- 3. Continued competency requirement – Pursuant to 18VAC 85-80-80D, you are required to provide evidence of continuing learning activities as described in 18VAC 85-80-71(A). This documentation may be faxed to 804-527-4426.

\*If your license has been lapsed for two years, provide evidence of 20 hours.

\*If your license has been lapsed for three years, provide evidence of 30 hours.

\*If your license has been lapsed for four or more years, provide evidence of 40 hours.

**Board-approved practice** requirements are described in Virginia regulations, 18VAC-85-80-80 (B) and (C). If applicable, the board-approved practice form must be completed and approved by the Board before practice can begin. Once the board-approved practice is complete, the supervising occupational therapist must provide an attestation of satisfactory completion of the board-approved practice.

- 4. If you have been discharged from the U.S. Military service within the past five years, submit a 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.

(over)

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.

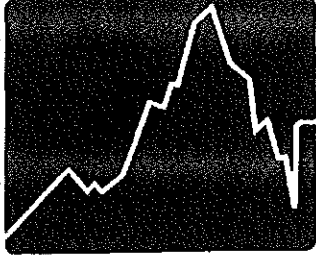
\*Additional information may be requested after review by board representatives.

\*Application fees are non-refundable.

\*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](mailto:bradley.verry@dhp.virginia.gov)

	<b>COMMONWEALTH OF VIRGINIA</b>  <b>BOARD OF MEDICINE</b> Department of Health Professions 9960 Mayland Drive, Ste. 300 Henrico, Virginia 23233-1463  (804) 367-4613    (804) 527-4426 Fax
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## Application for REINSTATEMENT of License to Practice Occupational Therapy

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

**SECURELY PASTE A  
PASSPORT-TYPE  
PHOTOGRAPH IN THIS SPACE**

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. Applications will not be processed without the appropriate fee.  
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 \_\_\_\_\_

LICENSE NUMBER	PROCESSING NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
<b>0119-</b>		<b>\$180.00</b>		

\*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. including hospital department, outpatient centers, etc.) Also list all periods of absence from work and non-professional activity or employment for more than three months. Please account for all time. 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 (5-14) is answered **Yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits, or you may submit Form #A .

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

Jurisdiction	Number Issued	Active/Inactive/Expired

Yes No

4. Have you ever taken the National Board for Certification in Occupational Therapy? If so, provide date

\_\_\_\_\_

\_\_\_\_\_

5. Have you ever been denied the privilege of taking an occupational therapy examination for licensure or certification?

\_\_\_\_\_

6. Have you ever been denied an occupational therapy license or certificate?

\_\_\_\_\_

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.)

\_\_\_\_\_

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, internship, hospital, nursing home, or other health care facility, or health care provider?

\_\_\_\_\_

9. Have you ever had any of the following disciplinary actions taken against your license or certification to practice Occupational Therapy or are any such actions pending?  
 (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored

\_\_\_\_\_

10. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned?

\_\_\_\_\_

11. Have you had any malpractice suits brought against you in the last ten years? If so, how many? \_\_\_\_\_  
 Provide details.

\_\_\_\_\_

13. 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.

\_\_\_\_\_

14. 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.

\_\_\_\_\_

15. 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 occupational therapy 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](http://www.dhp.virginia.gov) and understand that fees submitted as part of the application process shall not be refunded.

RIGHT THUMB PRINT  
  
May be self applied

\_\_\_\_\_  
Signature of Applicant

*If right thumb is missing, use left and so indicate*

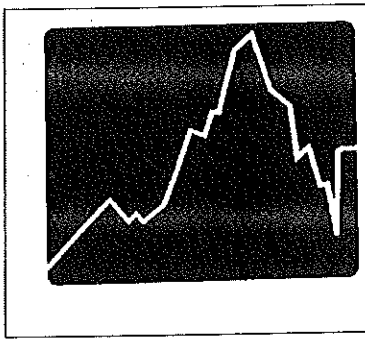
City/County of \_\_\_\_\_ State of \_\_\_\_\_

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

My Commission expires \_\_\_\_\_.

NOTARY SEAL

\_\_\_\_\_  
Signature of Notary Public



**COMMONWEALTH OF VIRGINIA**

**BOARD OF MEDICINE**

Department of Health Professions  
9960 Mayland Drive, Ste. 300  
Henrico, Virginia 23233-1463

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

**CLAIMS HISTORY SHEET**

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 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: \_\_\_\_\_

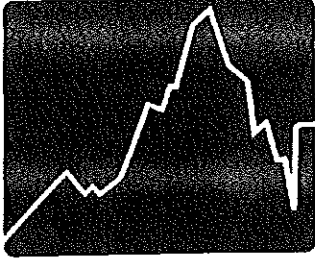
Policy Number: \_\_\_\_\_ Detailed Description of Claim (use reverse side if necessary): \_\_\_\_\_

**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

	<p><b>COMMONWEALTH OF VIRGINIA</b></p> <p><b>BOARD OF MEDICINE</b></p> <p>Department of Health Professions                  9960 Mayland Drive, Ste. 300                  Richmond, Virginia 23233-1463</p> <p>(804) 367-4613    (804) 527-4426 Fax</p>
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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)

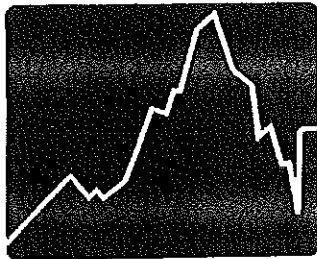
Close personal observation     General impression     A composite of evaluations     Other \_\_\_\_\_

Date: \_\_\_\_\_ Signed \_\_\_\_\_

Title \_\_\_\_\_ Please print or type name \_\_\_\_\_

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



	<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, Ste. 300 Richmond, Virginia 23233-1463</p>
	<p align="center">(804) 367-4613    (804) 527-4426 Fax</p>

Dear Sirs:

The person listed below is applying for reinstatement of their license to practice occupational therapy. 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 Dr., #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 \_\_\_\_\_

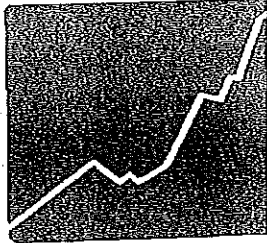
Comments, if any \_\_\_\_\_

Signed \_\_\_\_\_

**BOARD SEAL**

Title \_\_\_\_\_

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



**COMMONWEALTH OF VIRGINIA**  
**Board of Medicine**

Department of Health Professions  
9960 Mayland Drive, Suite 300  
Richmond, Virginia 23233-1463

(804) 367-4570

**BOARD-APPROVED PRACTICE**

An occupational therapist who has allowed his license to lapse for a period of two years but less than six years, and who has not engaged in active practice as defined in 18VAC85-80-10, shall serve a board-approved practice of 160 hours to be completed in two consecutive months under the supervision of a licensed occupational therapist. An occupational therapist who has allowed his license to lapse for six years or more, and who has not engaged in active practice, shall serve a board-approved practice of 320 hours to be completed in four consecutive months under the supervision of a licensed occupational therapist.

(Please Print or Type)

Name of Applicant: \_\_\_\_\_

Name and Title of Supervisor: \_\_\_\_\_

Supervisor's Virginia License Number: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Name and Address of Facility: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We, the undersigned, have read and understand Regulation 18VAC85-80-80 and agree to abide by the conditions contained herein.

\_\_\_\_\_  
Signature of Trainee

\_\_\_\_\_  
Signature of Supervisor

160 hours

320 hours

**FOR OFFICE USE ONLY**

APPROVED BY \_\_\_\_\_  
Deputy Executive Director/Licensure

\_\_\_\_\_  
Date Approved

**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 medical 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**, 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 contact hours of continuing learning activities**.

**10 contact hours** shall be **Type 1** continuing learning activities as documented by a sponsor or organization recognized by the profession of occupational therapy to designate learning activities for credit or other value.

An additional **10 contact hours** shall be **Type 2** continuing learning activities which may or may not be approved for credit by a sponsor or organization recognized by the profession to designate learning activities for credit or other value. Occupational therapists shall document their own participation in Type 2 learning activities.

#### **Maintenance and audit of records:**

The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM must be used for planning and 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 six 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, continuing education courses, specialty certification, in-service workshops, consultations, discussions with colleagues, self-study courses, research in preparation for 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

**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 medical 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. (1 semester hour = 15 contact hours, 1CEU = 10 contact hours)

**Types of Activities:** List the type of activity from the categories described below:

**Type 1 continuing learning activities**

**10 hours required biennially**

Must be offered by a sponsor or organization which is recognized by the profession and which provides documentation of hours to the practitioner. May include formal course work, in-service training, continuing education classes, or specialty certification.

**Type 2 continuing learning activities**

**10 hours required biennially**

May or may not be approved by a sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning; occupational therapists document their own participation on the attached form. Type 2 activities may include independent reading or research, consultation with another therapist, preparation for a presentation, or self-study through multi-media.

### PART C: OUTCOME

**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.)*

