

	<b>COMMONWEALTH OF VIRGINIA</b>	
	<b>RETURN TO:</b>	
	<b>Board of Medicine, ATT: Jennie F. Wood</b> <b>Department of Health Professions</b> <b>9960 Mayland Dr., Suite 300</b> <b>Henrico, VA 23233</b>	
	<b>Ph-804-367-4571</b>	

**Application for  
REINSTATEMENT of License  
To Practice as a Licensed  
Acupuncturist**

To the Board of Medicine of Virginia:  
I hereby make application for a license to practice  
as a Licensed Acupuncturist 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. Application will not be processed without the fee. It will be returned.  
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

Date

LICENSE NUMBER <b>0121-</b>	PROCESSING NUMBER	FEE n/a	EXPIRATION DATE	REINSTATEMENT DATE
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\*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.



**QUESTIONS MUST BE ANSWERED.** If any of the following questions (6-13) is answered Yes, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits.

3. Do you intend to engage in the active practice of licensed acupuncture in the Commonwealth of Virginia?  Yes  No

If Yes, give location

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4. List all jurisdictions in which you have been issued a license to practice acupuncture: active, inactive or Expired. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

5. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any licensing authority? If Yes, please explain giving the location.

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Yes No

6. 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.)

\_\_\_\_\_

7. Have you ever been revoked, denied privileges or voluntarily surrendered your clinical privileges while under investigation; been censured or warned, or requested to withdraw from the staff of any medical school, residency or fellowship training, hospital, nursing home, or other health care facility, or health care provider/entity?

\_\_\_\_\_

8. Have you ever had any of the following disciplinary actions taken against your license to practice medicine, DEA permit, state controlled substances registration, Medicaid, or any such actions pending?

(a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored (e) limitation placed on scheduled drugs?

\_\_\_\_\_

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

\_\_\_\_\_

10. Have you voluntarily withdrawn from any professional society while under investigation?

\_\_\_\_\_

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

\_\_\_\_\_

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.

\_\_\_\_\_

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.

\_\_\_\_\_

14. 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 acupuncture in the Commonwealth of Virginia.

RIGHT THUMB PRINT

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

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

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

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

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

NOTARY SEAL

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