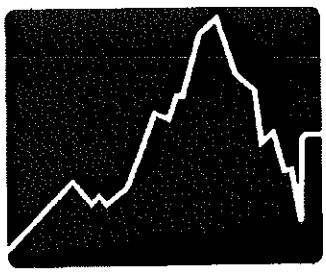
Rev. 03/2010-jfw
LAC Reinstatement



COMMONWEALTH OF VIRGINIA

RETURN TO:
Board of Medicine, ATT: Jennie F. Wood
Department of Health Professions
9960 Mayland Dr., Suite 300
Henrico, VA 23233

Ph-804-367-4571

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	PROCESSING NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
0121-		**n/a**		

*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 the expiration date of your Virginia license including any periods of non-professional activities or employment for more than three months. **Please account for all time.** If engaged in private practice, list all hospital affiliations. If none, please explain. **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 (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

_____

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.

_____

	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

_____
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 _____.

_____
Signature of Notary Public

NOTARY SEAL