Virginia Department of
Health Professions
Board of Audiology and Speech-Language Pathology

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Note: As of June 1, 2019, the Board's phone number will change to: (804) 597-4132

APPLICATION FOR REGISTRATION FOR VOLUNTEER PRACTICE

INSTRUCTIONS: Complete electronically or print clearly. If the space provided for any answer is insufficient, the applicant must complete his/her answer on a separate page, signed by him/her, specifying the question to which it relates and enclose the page with this application. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION. ENCLOSE A CHECK MADE PAYABLE TO THE **TREASURER OF VIRGINIA IN THE AMOUNT OF $10.**

Name (Last, First, M.I., Suffix, Maiden Name

Date of Birth: _____/_____/_____	Social Security No. OR Virginia. DVM Control Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Area Code & Cellphone Number	Area Code & Office Telephone Number	Email Address

RECORD OF ALL PROFESSIONAL LICENSURE:

State	Profession	License Number	Issued Date	Expiration Date

Has your license to practice in any state/jurisdiction been previously suspended or revoked? If yes, give details, jurisdiction(s) and date(s) on a separate page. No _____ Yes _____

Dates of Volunteer Practice	Location of Volunteer Practice

Name of Sponsoring Organization:
_____ Remote Area Medical (RAM)
_____ Other: Full name of organization: _____
ATTACH A COMPLETED CERTIFICATION FORM FROM THE SPONSORING ORGANIZATION

Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statue, 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)? If yes, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. No _____ Yes _____

I acknowledge that the licensure exemption sought through this application shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board.

SIGNATURE AND DATE: _____

Date Received	Fee	Pending Number	Date Registered