

COMMONWEALTH OF VIRGINIA  
**Department of Health Professions - Board of Medicine**  
**Perimeter Center**  
**9960 Mayland Drive, Suite 300**  
**Henrico, VA 23233-1463**  
**(804)367-4600 – PHONE      (804) 527-4426 – FAX**  
web: [www.dhp.virginia.gov](http://www.dhp.virginia.gov) email: [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov)

**APPLICATION FOR REGISTRATION FOR VOLUNTEER PRACTICE**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncturist      | <input type="checkbox"/> Doctor of Osteopathy   | <input type="checkbox"/> Radiologic Technologist |
| <input type="checkbox"/> Athletic Trainer   | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Rad Tech-Limited        |
| <input type="checkbox"/> Chiropractor       | <input type="checkbox"/> Physician Assistant    | <input type="checkbox"/> Respiratory Therapist   |
| <input type="checkbox"/> Doctor of Medicine | <input type="checkbox"/> Podiatrist             |  |

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

Area Code and Telephone Number	Email address
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**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
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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 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)? 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
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