Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: qmhp@dhp.virginia.gov
(804) 367-3053 (Tel)
(804) 997-9772 (Fax)

# REINSTATEMENT INSTRUCTIONS

# FOR A QUALIFIED MENTAL HEALTH PROFESSIONAL-ADULT (QMHP-A)

To avoid delays, please mail a **COMPLETE** application packet by submitting all of the documentation listed below to the Board of Counseling at the above listed address. Incomplete packets will not be reviewed.

**Application Fee**: A fee of **$75.00** is required for an application to be processed. All fees paid by check or money order must be made payable to the "Treasurer of Virginia". This fee is non-refundable. The application is valid for one year from date of receipt.

**The below supplemental documentation must accompany your application and fee in one packet by mail:**

☐ Continuing Education (CE) Certificates: Submit evidence of a **minimum of 20 hours of continuing education consistent with requirements of 18VAC115-80-80.**

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# REINSTATEMENT
# QUALIFIED MENTAL HEALTH PROFESSIONAL – ADULT (QMHP-A) PAGE 1

Military/Military Spouse

Are you active duty military personnel? ☐ Yes ☐ No

Are you a spouse of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia? ☐ Yes ☐ No

| FIRST NAME | MIDDLE NAME | LAST NAME AND SUFFIX |
|---|---|---|
| DATE OF BIRTH<br>____ ____ ____<br>MM DD YY | SOCIAL SECURITY NO. OR VA CONTROL NO.* | |

| ADDRESS OF RECORD**: STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|
| ALTERNATE PUBLIC ADDRESS***: STREET | CITY | STATE | ZIP CODE |

| HOME PHONE: | WORK PHONE: | MOBILE PHONE: |
|---|---|---|
| E-MAIL ADDRESS | | |

Licenses/Certifications: List all mental health or health professional licenses, certificates, or registration that you hold or have ever held.

| LICENSE # | CURRENT LICENSE STATUS | ISSUE DATE | TYPE OF LICENSE |
|---|---|---|---|
| | | | |
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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 process 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.

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

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If you answer "yes" to any question, **include a detailed explanation AND supporting documentation.**

Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.

1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation. ☐ Yes ☐ No

3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. ☐ Yes ☐ No

5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s). ☐ Yes ☐ No

6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations).If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2. ☐ Yes ☐ No

7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LQMHP-A. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

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8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing QMHP-A. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing QMHP-A. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.) ☐ Yes ☐ No

| Applicant's Initials | Statements of Assurance |
|---|---|
| | I have read, understand and intend to comply with the regulations that govern the Virginia Board of Counseling. |
| | I will practice only within the competency area for which I am qualified by training or experience and shall not provide clinical mental health services for which a license is required. |
| | I understand that as a QMHP-A, I will not engage in independent or autonomous practice. |
| | I will practice in a manner that is in the best interest of the public and does not endanger the health, safety or welfare of the public. |

**I attest that the information contained within the application is true and accurate to the best of my knowledge and belief.**

| Applicant's Signature: | Date: |
|---|---|
| | |