



Virginia Department of  
**Health Professions**  
Board of Psychology

9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
[www.dhp.virginia.gov/psychology](http://www.dhp.virginia.gov/psychology)

Email:  
[psy@dhp.virginia.gov](mailto:psy@dhp.virginia.gov)  
(804) 367-4697 (Tel)  
(804) 527-4435 (Fax)

## SCHOOL PSYCHOLOGIST-LIMITED APPLICATION FOR REINSTATEMENT OF A LAPSED LICENSE

I hereby make application for reinstatement of my psychology license number \_\_\_\_\_. The following evidence of my qualifications is submitted with a **check or money order** in the amount of **\$125.00** made payable to the Treasurer of Virginia. **I understand that the application fee is non-refundable.**

INSTRUCTIONS	PLEASE TYPE OR PRINT	USE BLACK INK
1. Applications lacking a Social Security Number or Virginia Department of Motor Vehicles control number will not be processed. 2. Applications lacking all supporting documentation (including verification of subsequent licensure(s)) will not be processed.		
<b>I. GENERAL INFORMATION</b>		
Full Name (Last, First, Middle, Suffix, Maiden Name)	Degree	Social Security/Virginia DMV Control Number
Mailing Address (Street and/or Box Number, City, State, ZIP Code)		Home Telephone Number
Business Name and Address (if different from above)		Business Telephone Number
Fax Number	E-Mail Address	
Are you the spouse of a member of the U. S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia?		<b>YES    NO</b> <input type="checkbox"/> <input type="checkbox"/>
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE

In accordance with Section 54.1-116 of the *Code of Virginia* you are required to submit your Social Security Number or your *Virginia* control number. Refer to instruction sheet.

**Ethics Attestation:** Please answer the ten questions below.

**If you answer yes to any question, include a detailed explanation AND supporting documentation. Refer to Guidance Document 125-2 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?  | 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?   | Yes | No |
| 3.  | Within the past five years, have you been disciplined by any entity?<br>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?<br>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?<br>(This includes convictions for driving under the influence, but does not include other traffic violations).<br>If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #125-2.   | 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?<br>"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing psychologist. 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 |
| 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 psychologist. 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 psychologist. 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 |

**II. PROFESSIONAL EXPERIENCE (subsequent to expiration of Virginia licensure)**

Dates of Employment		Employer	Address	Hours per week	Supervisor (if applicable)	Duties
From	To					

**III. ADDITIONAL INFORMATION:** Provide any additional information to document continued competency to resume practice in the Commonwealth of Virginia.

**The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.**

**AFFIDAVIT**  
**(To be completed before a notary public)**

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

Name \_\_\_\_\_, being duly sworn, attests that he/she has read and agrees to comply with the Standards of Practice and laws and regulations governing the practice of psychology in Virginia and says that he/she is the person who is referred to in the foregoing application for licensure as a psychologist in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

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

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

My commission expires on \_\_\_\_\_.

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

**SEAL**