Virginia Department of Health Professions
Board of Social Work

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: socialwork@dhp.virginia.gov
Phone: (804) 367-4441 **E-Fax:** (804) 977-9915
Website: www.dhp.virginia.gov/social

APPLICATION for REINSTATEMENT FOLLOWING DISCIPLINARY ACTION
Checklist Instructions

IMPORTANT NOTICE:
Prior to **mailing** the enclosed application for Reinstatement Following Disciplinary Action and below supporting documentation to the Board for consideration, we recommend that you review the Regulations Governing the Practice of Social Work available on the Board's website at www.dhp.virginia.gov/social to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC140-20-30(B) of the Regulations Governing the Practice of Social Work, all fees submitted to the Board are **non-refundable**.

We also strongly encourage you to review your application packet to ensure all forms are complete and includes all required forms and documentation. A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to mail all the below information in **one** complete packet to the Board office for consideration.

REQUIRED DOCUMENTATION

☐ **APPLICATION**: The attached application must be completed and mailed to the Virginia Board of Social Work.

☐ **FEE**: A **$500.00** fee by check or money order made payable to the **Treasurer of Virginia** must be mailed with your application. Your application will not be reviewed or consider until you have submitted payment. Pursuant to 18VAC140-20-30(B), all fees submitted to the Board are **non-refundable**.

☐ **VERIFICATION OF LICENSURE/CERTIFICATION:** If you have ever held a health or mental health license or certification, whether current or expired, please send the enclosed verification form to the issuing jurisdiction (s). This verification is to be completed by the issuing jurisdiction (s) and mailed back to you and included in your application packet. *(Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia's Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.)* **–or-** You can provide an online verification printed from the licensing jurisdiction's website if the online verification provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

☐ **NPDB SELF-QUERY:** A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query at https://www.npdb.hrsa.gov/

ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

☐ **PROOF OF NAME CHANGE**: Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you had an active license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Acceptable forms of documentation include a **photocopy** of a marriage license, court order or divorce decree.

☐ **CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS**: If you answer "YES" to any of the questions in **Part III** of the application, please include a detailed explanation **and** supporting documentation. **If you have no new convictions since your previously submitted application with the Board, please indicate in your detailed explanation that there have been no new convictions since your previous submission.** *Please refer to Guidance Document 140-2, available on the Board's website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.*

GENERAL INFORMATION

- Following receipt of the reinstatement application following disciplinary action, an administrative proceeding will be scheduled. After a hearing, the board may, at its discretion grant the reinstatement.
- Please notify the Board in writing within 30 days of a name change or address change by completing the **Name/Address Change Form** available on the Board's website at www.dhp.virginia.gov/social.
- An incomplete application for licensure will be retained on file for one (1) year. If not completed within one year of receipt, a new application and fee will be necessary.

- Providing false or misleading information as well as omitting information in response to information requested in the application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration or license.
- Pursuant to Virginia Code § 54.1-2400.02 addresses of licensees/supervisees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available please complete both sections with same address on the application.
- Pursuant to Virginia Code § 54.1-116 (A), 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 for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FALIED TO DISCLOSE ONE OF THESE NUMBERS.
- Application and required documentation should be **mailed** to:

Department of Health Professions
Attn: Board of Social Work
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

End of instructions

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APPLICATION for REINSTATEMENT FOLLOWING DISCIPLINARY ACTION
Paper Application

FOR OFFICE USE ONLY (Finance Division)			
Fee Amount Paid $	**Applicant ID #**	**Receipt #**	**Date Processed**

TO BE COMPLETED BY APPLICANT

Part I. Applicant Identification & Contact Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Social Security Number or Virginia DMV Control Number *	Date of Birth: (MM/DD/YYYY)
___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___

Published Address: *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 practice location if you wish.*

Address:		
City:	State:	Zip Code: ___ ___ ___ ___ ___

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

Address:		
City:	State:	Zip Code: ___ ___ ___ ___ ___

Home Number:	Alternate Number:
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email Address:

Virginia Social Work License Number:	Date License Expired: (MM/DD/YYYY)
___ ___ ___ ___ ___ ___ ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___

Part II. Licensure History Information: Other than Virginia**,** *list in order of attainment all the states in which you now hold or have ever held a health or mental health license or certification, whether current or expired. If not applicable, enter N/A*

State	Type of License/Certificate	License/Certificate Number	Issued Date	Current Status

Part III. Licensure Questions: *Applicant must answer the following questions. Affirmative responses to any questions on this application will require additional information to be submitted. Please refer to Guidance Document 140-2 for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments. Failure to disclose any information related to these questions may be grounds for denial, reprimand, or imposition of terms, suspension or revocation of your license and /or registration.*	
1. Have you ever been denied the issuance of a license, certificate, or registration, or denied the privilege of taking an occupational licensure, certification or registration examination? ***If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied and attach documents referenced in Guidance Document 140-2.***	☐ 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, on a separate sheet of paper please provide a full detailed explanation.***	☐ Yes ☐ No
3. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations) ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No
4. Have you ever voluntarily surrendered a license, certification or registration while under investigation? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No
5. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? ***If Yes, on a separate sheet of paper please provide a full detailed explanation.***	☐ Yes ☐ No
Additional Questions	
1. **A**. 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, on a separate sheet of paper please provide a full detailed explanation*** **B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No ☐ Yes ☐ No
2. **A**. Within the past five years, have you been disciplined by any entity? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** **B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No ☐ Yes ☐ No
3. 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 Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No
4. 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 Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No
5. 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 Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No
6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***	☐ Yes ☐ No

Part IV. Military Service	
1. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia?	☐ Yes ☐ No
2. Are you active-duty military?	☐ Yes ☐ No

Part V. Professional Employment Experience: *List in chronological order the entire professional employment experience you have had after receiving your master's degree in social work. List present position first and date back to your master's degree. (Use additional paper, if necessary.)*

Employer's Name & Address:

Job Title:

Dates of Employment:
Start Date (MM/YYYY): End Date (MM/YYYY):

Duties Performed:

Employer's Name & Address:

Job Title:

Dates of Employment:
Start Date (MM/YYYY): End Date (MM/YYYY):

Duties Performed:

Employer's Name & Address:

Job Title:

Dates of Employment:
Start Date (MM/YYYY): End Date (MM/YYYY):

Duties Performed:

Part VI. Certification:. *This application is not valid unless properly certified by your original signature.*

I certify by my signature below that I am the person applying for reinstatement of my license and meet the qualifications required by Virginia laws and regulations. I certify that I have carefully read the laws and regulations Governing the Practice of Social Work in the Commonwealth of Virginia, which are available at https://www.dhp.virginia.gov/social/.

Further, I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

SIGNATURE:	**DATE:**

ORIGINAL SIGNATURE REQUIRED

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

IMPORTANT NOTICE:
This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license or certification. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be mailed to the Virginia Board of Social Work or the State Board can send the form electronically to the Virginia Board at socialwork@dhp.virginia.gov

TO BE COMPLETED BY APPLICANT: Complete the top portion **only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification **(fee may be required)**.

Part I. Applicant's Identification & Contact Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Last 4 digit of Social Security Number: XXX-XX- ___ ___ ___ ___	Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Address:

City:	State:	Zip Code: ___ ___ ___ ___ ___

Email Address:

TO BE COMPLETED BY STATE BOARD: Please provide official verification of applicant's licensure information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form to the Virginia Board, please use the subject line: Applicant Licensure Verification *(ref: Applicant's Name)***

Part II. Applicant's Licensure Information

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	Expiration Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

License Obtained by:
☐ Examination ☐ Endorsement ☐ Reciprocity ☐ Grandfathered ☐ other _____

Status of License:
☐ Current ☐ Lapsed ☐ Inactive ☐ other _____

Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? ***If yes, please attach certified copy of order issued by State Board.***	YES ☐ NO ☐

I certify the above information to be true in every respect, according to the record on file with the

_____ *(Title of Board)*

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

STATE SEAL

Telephone Number: _____

Email Address: _____

Date: _____