VIRGINIA BOARD OF HEALTH PROFESSIONS
APPLICATION FOR AN EXCEPTION TO THE PROHIBITIONS OF THE VIRGINIA PRACTITIONER SELF-REFERRAL ACT

1. Name of Applicant:_____

   Street Address:_____

   City/State/ZIP Code:_____

   Telephone: ( )_____ Fax: ( )_____

   Email: _____

   Does the Applicant trade or do business under any other name? ___Yes ___No

   If yes, provide the name(s) and addresses on a separate sheet labeled Attachment A.1.

2. Is the Applicant a practitioner licensed or certified by a board within the Virginia Department of Health Professions? (Check A **OR** B)

   A. ___ Yes. License/Certificate Number_____ Issued by the Board of _____

   OR

   B. ___ No.

   If the entity is not a licensed or certified practitioner, is the entity regulated by another agency of the Commonwealth (e.g., Virginia Department of Health, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Virginia Department of Social Services, etc.)?

   ___Yes ___No

   Name of the State agency regulating the entity:

   _____

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   [NOTE: Please attach photocopies of any license, certificate or other documentation that the practitioner or entity is licensed, certified, or otherwise regulated by an agency of the Commonwealth of Virginia. Label as Attachment A.2. If the practitioner or entity is licensed, certified or accredited by other public or private agency(ies) whose standards might bear on consideration of the application, please provide evidence of that licensure, certification, or accreditation. Label the documentation as Attachment A.]

B. DESCRIPTION OF HEALTH SERVICES TO BE PROVIDED UNDER THE EXCEPTION

1. Please provide a brief description of the health services to be provided to the referred patient under the terms of the exception. Include the name of all practitioners and entities that will make these referrals, the names and locations of all entities to which patients will be referred, and a short statement of the nature and probable annual volume of referrals for each health service.

   [NOTE: If attachments are used for documentation, please label as Attachment B.]

C. DOCUMENTATION OF COMMUNITY NEED

Please provide a brief description of the need for this exemption in the community(ies). Include the name of the city(ies) and county(ies) defined as the community, a summary of demographic, epidemiologic, and socioeconomic information that you deem relevant to the consideration of the Application and evidence that (1) there is no facility in the community providing similar services, and (2) alternative financing is not available for the facility or service. Please reference and summarize all studies, reviews, or other documents used to demonstrate community need and attach one copy of each document.

[NOTE: If documentation is attached, please label as Attachment C.]

D. APPLICANT CERTIFICATIONS

1. EQUALITY OF INVESTMENT OPPORTUNITY

   a. The applicant hereby certifies that individuals other than practitioners are afforded a bona fide opportunity to invest in the entity on the same or equal terms as those offered to any referring practitioner.

   b. The applicant hereby certifies that the services of the entity are marketed and furnished to practitioner-investors and other investors on the same or equal terms.

2. FREEDOM FROM CONFLICT OF INTEREST

   a. The applicant hereby certifies that no investor-practitioner is required or encouraged to refer patients to the entity or otherwise generate business as a condition of becoming or remaining an investor.

   b. The applicant hereby certifies that the entity to which referrals is to be made does not issue loans or guarantee any loans for practitioners who are in a position to refer patients to the entity.

   c. The applicant hereby certifies that the income on the practitioner's investment is based on the practitioner's equity interest in the entity and is no tied to referral volumes.

   d. The applicant hereby certifies that the investment contract between the entity and the practitioner does not include any covenant or clause limiting or preventing the practitioner's investment in other entities.

3. DISCLOSURES

   a. The applicant hereby certifies that if this exception is granted, the practitioner shall disclose his investment interest in the entity to the patient at the time of referral. If alternative entities are reasonably available, the practitioner shall provide the patient with a list of such alternative entities and shall inform the patient of the option to use an alternative entity. The practitioner shall also inform the patient that choosing another entity will not affect his treatment or care.

   b. The applicant hereby certifies that if this exception is granted, information on the practitioner's investment shall be provided upon request to any third-party payor.

   c. The applicant hereby certifies that if this exception is granted, the practitioner shall not make a referral to such entity in the event of a conflict of interests between the practitioner's ownership interests and the best interests of any patients, but shall make alternative arrangements for the referral.

   d. FOR PRACTITIONERS LICENSED BY THE BOARD OF MEDICINE ONLY:
   The applicant, being a practitioner of the healing arts, hereby certifies that he is aware of and in compliance with the provisions of Code § 54.2964 "Disclosure of interest in referral facilities and clinical laboratories." [See Appendix A for list of practitioners regulated by the Board of Medicine.]

[NOTE: Appropriate documentation may be submitted to verify these certifications. Applicants for exceptions are subject to investigation by the Department of Health Professions if insufficient documentation is not submitted with this application. Please label all documentation submitted in support of these certifications as Attachment D.]

THE UNDERSIGNED CERTIFIES THAT THE INFORMATION PROVIDED IN THIS APPLICATION AND ALL ATTACHMENTS TO THIS APPLICATION IS ACCURATE AND TRUE.

The applicant hereby certifies that the information provided in this application for an exception is true and correct.

Name of Applicant (Printed):_____

Title of Applicant:_____

Name of Corporation or Other Organizational Entity, if applicable:

_____

Signature of Applicant or Principal:

_____

Date:_____

SUBSCRIBED AND SWORN TO BEFORE ME, _____, a

Notary Public in and for the city/county of _____ this _____ day

of _____, 20___ by _____(applicant)

_____
Notary Public

THIS APPLICATION MUST BE ACCOMPANIED BY PAYMENT TO THE TREASURER OF VIRGINIA IN THE AMOUNT OF ONE THOUSAND DOLLARS ($1,000.00).

Virginia Department of Health Professions
Board of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Telephone (804) 367-4403

[Copies of this form are available from the above address.]