VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
APPLICATION FOR AN ADVISORY OPINION – VIRGINIA 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 names and addresses of all other names on a separate sheet labeled Attachment I.

2. Is the applicant a practitioner licensed or certified by a board within the Virginia Department of Health Professions? ___Yes ___No

   If yes, please provide the license or certification number and the name of the Board issuing the license or certification:

   _____License/Certificate Number Board of _____

   If the applicant entity is not a licensed or certified practitioner, is the entity licensed, certified or otherwise regulated by an agency of the Commonwealth of Virginia? ___Yes ___No

   Name of the State agency that licenses, certifies, or otherwise regulates the entity:

NOTE: Please attach photocopies of any license, certificate or other documentation of regulated status. If the applicant is licensed, certified or accredited by other public or private agency(ies) whose standards might bear on consideration of this application, please provide evidence of that licensure, certification, or accreditation. Label the documentation as Attachment II.

3. Please state briefly the substance of this request for an advisory opinion (i.e., on what current or proposed activities and investments do you seek advice on the applicability of the Act?).
4. Please describe briefly the nature of the health care services being provided or proposed, including the expected annual volume of referrals.
5. Please describe the nature of the investment interest, and attach copies of any existing or proposed documents between the practitioner and the entity including, but not limited to, leases, contracts, organizational documents, etc. Label documentation as Attachment III.

CERTIFICATION

The following certification must be provided by the applicant practitioner or the principal of the entity requesting this advisory opinion.

The applicant hereby certifies that the information provided in this application for an advisory 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 DEPARTMENT OF HEALTH PROFESSIONS IN THE AMOUNT OF FIVE HUNDRED DOLLARS ($500.00).

Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Telephone (804) 367-4400

Copies of this form are available from the above address.