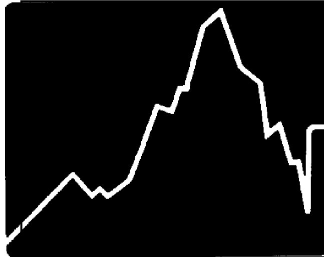
Rev. 8/07 UNIVERSITY LIMITED



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463 **(804) 367-4570**

Application for a Limited License to Foreign Medical Graduates pursuant To 54.1-2936

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH IN THIS SPACE.

(Please check the box that applies.)
I hereby make application for a license to practice as a
☐ professorial full-time faculty member or ☐ a full-time fellow
of medicine in the Commonwealth of Virginia
and submit following statements.

Last	First	Middle
Street Address	City/State	Zip Code

Date of Birth	Place of Birth	Social Security/VA Control #	Maiden Name if Applicable
______/______/______			

Professional School Name & Location	Professional School Graduation Date	Professional School Degree
	______/______/______	

Please accompany with this application a check or money order made payable to the Treasurer of Virginia in the required amount. If the money does not accompany the application, the application **will** be returned. Please submit address changes in writing immediately.

*In accordance with §54.1-1116 in the **Code of Virginia**, you are required to submit your Social Security number/Control number (issued by the Virginia Department of Motor Vehicles.). This number will be used by the Department of Health Professions for identification purposes only and will not be disclosed for any other purposes except as mandated by law. Federal and State law requires that this number be shared with other state agencies for child support enforcement activities. **Failure to disclose this number will result in the denial of a license to practice in the Commonwealth of Virginia**.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY: ____

Applicant #	Check #	Class #	Fee
		0109A **0109B**	**$55.00**

1. Please answer all questions:

(A) Citizen of ____
(B) Present Immigration Status ____
(C) Planned length of stay in the United States: ____________ Months ____________ Years ☐ Permanently
(D) I have spent _________ years in the study of Medicine in the institutions named below:

From	To	Name & Location	Position Held

2. List in chronological order all professional practices since graduation. List all locations and indicate internships, residences, practices and teaching experiences.)

From	To	Name & Location	Position Held

3. Please provide a telephone number where you can be reached during the day. This information is not mandatory and if provided will not be used for any purpose other than as a contact if the licensing specialist has questions about your application.

Home #:	Work #:	Email Address:

(THIS SECTION MUST BE NOTARIZED)

I, ____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities(local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information , which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice medicine in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available on www.dhp.virginia.gov , and I fully understand that fees submitted as part of the application process shall not be refunded.

RIGHT THUMB PRINT
(May be self-applied)

____
Signature of Applicant

City/County of ______________________________________ State of ____________________________________

Subscribed and sworn to before me this ___________________ day of ______________________________ 20__________.

My Commission expires ________________________.

____
Signature of Notary Public

NOTARY SEAL

Certificate of Professional Education

It is hereby certified that ____ of ______________________________________
Name of Applicant Country

Is known to this school as a graduate of ______________________________________ who has attained prominence in the field of
Name of Institution

____ and who will have the faculty position of ___________________________________
Specialty Position

And we hereby request that the doctor be considered for licensure under Section §54.1-2936 A or B of the Medical Practice Act Code of Virginia.

____
Signature of Dean