COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
(804)367-4600 – PHONE (804) 527-4426 – FAX
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APPLICATION FOR REGISTRATION FOR VOLUNTEER PRACTICE

[ ] Acupuncturist	[ ] Doctor of Osteopathy	[ ] Radiologic Technologist
[ ] Athletic Trainer	[ ] Occupational Therapist	[ ] Rad Tech-Limited
[ ] Chiropractor	[ ] Physician Assistant	[ ] Respiratory Therapist
[ ] Doctor of Medicine	[ ] Podiatrist	

INSTRUCTIONS: Complete electronically or print clearly. If the space provided for any answer is insufficient, the applicant must complete his/her answer on a separate page, signed by him/her, specifying the question to which it relates and enclose the page with this application. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION. ENCLOSE A CHECK MADE PAYABLE TO THE **TREASURER OF VIRGINIA IN THE AMOUNT OF $10.**

Name (Last, First, M.I., Suffix, Maiden Name	Social Security Number

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Area Code and Telephone Number	Email address

RECORD OF ALL PROFESSIONAL LICENSURE:

State Profession License Number Issued Date Expiration Date

_____

_____

_____

Has your license to practice in any state/jurisdiction been previously suspended or revoked? If yes, give details, jurisdiction(s) and date(s) on a separate page. No _____ Yes _____

Dates of Volunteer Practice	Location of Volunteer Practice

Name of Sponsoring Organization:
_____ Remote Area Medical (RAM)
_____ Other: Full name of organization: _____
ATTACH A COMPLETED CERTIFICATION FORM FROM THE SPONSORING ORGANIZATION

Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statue, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor (excluding traffic violations, except convictions for driving under the influence)? If yes, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. No _____ Yes _____

I acknowledge that the licensure exemption sought through this application shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board.

SIGNATURE AND DATE: _____

Date Received	Fee	Pending Number	Date Registered