Virginia Department of Health Professions
Board of Medicine

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
www.dhp.virginia.gov/medicine

Phone: (804) 367-4600
Fax: (804) 527-4426
Email: expert-witness@dhp.virginia.gov

INSTRUCTIONS
EXPERT WITNESS LETTER

1. Doctors who already hold a Virginia license do **not** require an Expert Witness Letter.

2. Do **not** submit a CV in place of the application. CVs submitted will not be processed.

3. Medical licenses must be **current** and active in the state of practice.

4. Requests for MD, DO, or DPM witnesses must provide information in the appropriate section:
   - One section for US/Canadian medical graduates
   - A separate section for foreign medical graduates

5. Request for Chiropractors (DC) should complete the **green section** of the form.

6. The requester must sign and date the form, attesting that all the information provided is true and correct.

7. The completed request is to be emailed to expert-witness.medbd@dhp.virginia.gov for review.

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REQUEST FOR AN EXPERT WITNESS LETTER

INSTRUCTIONS: Please review the attached instruction sheet for further details.

REQUESTER'S INFORMATION:

Name (Last, First)	**Law Firm**
Email Address	**Phone Number** **( ) -**
Mailing Address (Street and/or Box Number, City, State, Zip Code)	

EXPERT WITNESS' INFORMATION:

Name (Last, First)	**Profession** *choose a profession*
Current License (State, License No.)	**Expiration Date of License** *mm / dd / yyyy*
Medical School	**Date of Graduation** *mm / dd / yyyy*
Training School (at least 1 year of internship or residency in US)	**Date of Completion** *mm / dd / yyyy*

MD/DO/DPM - MEDICAL EXAMINATIONS (US/Canadian), must have one of the following:

	STEP 1	STEP 2	STEP 3
☐ **Federal Licensing Exam (FLEX)**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*
☐ **United States Medical Licensing Exam (USMLE)**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*
☐ **National Board of Medical Examiners (NBME)**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*
☐ **Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*
☐ **Licensed Medical Council of Canada (LMCC)**	**Certification Date:** *mm / dd / yyyy*		

MD/DO/DPM - MEDICAL EXAMINATIONS (Foreign Medical Graduate):

Educational Commission for Foreign Medical Graduates (ECFMG)

Certification Date: *mm / dd / yyyy*

USMLE Step 3 Passing Date: *mm / dd / yyyy*

DC - MEDICAL EXAMINATIONS, must have one of the following:				
	PART 1	**PART 2**	**PART 3 / SPEC**	**PART 4**
☐ **National Board of Chiropractic Examiners (NBCE), after 1/31/1996**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*
☐ **National Board of Chiropractic Examiners (NBCE), 1/31/1991-1/31/1996**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*	
☐ **National Board of Chiropractic Examiners (NBCE), 7/1/1965-1/31/1991**	*mm / dd / yyyy*	*mm / dd / yyyy*	*mm / dd / yyyy*	
☐ **Special Purpose Examination for Chiropractic (SPEC), prior to 7/1/1995** **Certification Date:** *mm / dd / yyyy*				

I attest to the accuracy and completeness of the information provided above.

REQUESTER'S SIGNATURE: _____ **DATE**: *Select Date*

FOR OFFICE USE ONLY

Date Received	Verified License	Approved	Date Emailed