Rev. 04/18

INSTRUCTIONS AND APPLICATION FOR REINSTATEMENT OF A LICENSE TO PRACTICE AS A CERTIFIED PROFESSIONAL MIDWIFE (CPM)

This is not the application for certified nurse midwives. If you are a certified nurse midwife contact the Board of Nursing at 804-367-4515.

NOTE
AN APPLICATION THAT IS NOT COMPLETE EXPIRES ONE YEAR AFTER IT IS SUBMITTED TO THE BOARD. IT IS THE RESPONSIBILITY OF THE APPLICANT TO ENSURE THAT ALL NECESSARY SUPPORTING DOCUMENTS ARRIVE AT THE BOARD PRIOR TO THE EXPIRATION DATE. IF THE ORIGINAL APPLICATION EXPIRES, THE APPLICANT MUST SUBMIT ANOTHER APPLICATION, PAY THE APPLICATION FEE AGAIN AND ENSURE THAT NEW SUPPORTING DOCUMENTS ALSO GET TO THE BOARD.

Certified Professional Midwife (CPM) License Reinstatement Instructions and Application for licenses in EXPIRED status for more than two years ONLY.

Reinstatement occurs after the license has been expired for 2 years. Do not complete this application if your license has been expired for less than 2 years or if you are trying to reactivate a license in inactive status.

A completed application must be returned to this office along with the reinstatement fee of $472.00. Applications and fees must be received together. Only checks or money orders are accepted. Please make your payment instrument payable to the "Treasurer of Virginia."

Certain forms may be faxed to 804-527-4426. The phone number to the Virginia Board of Medicine is 804-367-4600. The Board's email address is medbd@dhp.virginia.gov

Mailing Address
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

The Board of Medicine discourages the use of the United States Postal Service to send documents. If possible, and if noted below, you are encouraged to have your documents sent by pdf attachment or FAX. The Board is unable to trace documents not delivered by the post office. If you wish to send your documents by overnight mail, please use FED EX or UPS.

☐1. Verification of professional licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a full license must be received by the Board. **Please contact the applicable jurisdiction where you have been issued a license to practice as a Certified Professional Midwife to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed.

☐2. ***NPDB Self Query*** **– Complete the online Place a Self-Query Order form**. Be ready to provide:
o Identifying information such as name, date of birth, Social Security number
o State health care license information (if you are licensed)
o Credit or debit card information for the $4.00 fee (charged for each copy you request)

Verify your identity. This can be done electronically as part of your order or by completing a paper form and having it notarized. You will receive full instructions as you complete your order.

Wait for your response. Once your identity is verified, the NPDB will process your order. A paper copy of your response will be sent the next business day by regular U.S. mail.

The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board recommends using Fed EX or UPS for tracking purposes.**

The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service.

Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to be resubmitted.

☐3. Certification of Credentials from NARM. Certification should be requested from the North American Registry of Midwives, PO Box 420 Summertown, TN 38483 Phone 1-931-964-4234 or applications2@narm.org. Verification of certification may not be faxed to the Board of Medicine.

☐4. Copies of documentation supporting any name change since your initial licensure in Virginia.

☐5. If you answer "yes" to any question 6-18, provide documentation to the Board from your attorney or you may provide a narrative explaining your answer. Please provide court documentation for any convictions.

Please note:

*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, public addresses on file with the Board of Medicine are made available to the public. The Board address noted on your application may be different from the public address and is not released to the public. This notice is to reiterate that the Board of Medicine will allow the Board address of record to be a Post Office Box or practice location.

*Applications will be acknowledged after receipt if items are missing.

*Applications not completed within 12 months may be purged without notice from the board.

*Additional information may be requested after review by Board representatives.

**Application fees are non-refundable.*

* Do not begin practice until you have been notified of approval. Submission of an application does not guarantee a license. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

*Certain forms may be faxed to 804-527-4426.

Virginia Department of Health Professions

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Application for REINSTATEMENT of License to Practice as a Certified Professional Midwife

To the Board of Medicine of Virginia:

I hereby make application for reinstatement of my license to practice as Certified Professional Midwife in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle
Date of Birth _____ _____ _____ MO DAY YEAR	Social Security No. or VA Control No.*	Maiden Name if applicable
Public Address: This address will be public information:	House No. Street or PO Box	City State and Zip
Board Address: This address will be used for Board Correspondence and may be the same or different from the public address.	House No. Street or PO Box	City State and Zip
Work Phone Number	Home/Cell Phone Number	Email Address

Please submit address changes in writing immediately to medbd@dhp.virginia.gov

Please attach check or money order payable to the Treasurer of Virginia for $472.00. Applications will not be processed without the fee. Do not submit fee without an application. **IT WILL BE RETURNED.**

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

APPROVED BY

_____

Date

LICENSE NUMBER	PROCESSING NUMBER	FEE	EXPIRATION DATE	REINSTATEMENT DATE
0129-		**$472**		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices since the expiration date of your Virginia license including any periods of non-professional activities or employment. **Please account for all time.** If engaged in private practice, list all clinical affiliations. If none, please explain. **CVs may be attached but does not substitute for completion of this page.**

From	To	Name and Location	Position Held

3. Do you intend to engage in the active practice of midwifery in the Commonwealth of Virginia? ☐ Yes ☐ No

If Yes, give location _____

4. List all jurisdictions in which you have been issued a license to practice midwifery. Include all licenses that are in active, inactive, expired, suspended or revoked status. Indicate license number and date issued.

Jurisdiction	Number Issued	License Status

	Yes	No
5. Are you certified by NARM?	☐	☐

QUESTIONS MUST BE ANSWERED. If any of the following questions (6-18) is answered **Yes**, explain and substantiate with documentation.

6. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	☐	☐
7. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.)	☐	☐
8. Have you ever been denied privileges or voluntarily surrendered your clinical privileges for any reason?	☐	☐
9. Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or requested to withdraw from any professional school, training program, hospital, etc?	☐	☐
10. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier?	☐	☐
11. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of midwifery?	☐	☐
12. Have you voluntarily withdrawn from any professional society while under investigation?	☐	☐
13. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?	☐	☐
14. Within the past five years, have you been disciplined by any entity?		
15. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Certified Professional Midwife.	☐	☐
16. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Certified Professional Midwife.	☐	☐

17. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Certified Professional Midwife. ☐ ☐

18. Within the past 5 years, have you any condition or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ☐ ☐

Military Service:

19. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? ☐ ☐

20. Are you active duty military? ☐ ☐

21. AFFIDAVIT OF APPLICANT

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 Chiropractic in the Commonwealth of Virginia.

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

_____
Signature of Applicant