

**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE AS A  
LICENSED SURGICAL ASSISTANT**

**(This form has been designed to be used as a checklist when preparing to submit your application.)**

**APPLICATION FEES ARE NONREFUNDABLE  
BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!**

**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.**

You should familiarize yourself with the qualifications required for licensure by reviewing the laws and regulations governing the practice of surgical assisting in Virginia. They can be found at: [https://www.dhp.virginia.gov/medicine/medicine\\_laws\\_regs.htm](https://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm).

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board.

**NB:** Virginia law considers material misrepresentation of fact in an application for licensure to be unprofessional conduct. Misrepresentation may be by commission or omission. Be sure of your facts and provide full responses to the Board's questions.

A completed application must be returned to this office along with the fee of \$75.00. 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."

The phone number to the Virginia Board of Medicine is 804-367-4600. The Board's email address is [medbd@dhp.virginia.gov](mailto: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 Postal Service. If you wish to send your documents by overnight mail, please use FED EX or UPS.

**PROCEEDING TO THE APPLICATION SIGNIFIES THAT YOU HAVE  
READ AND ACCEPT THE FOREGOING PRINCIPLES REGARDING  
THE BOARD'S PROCESSES.**

\_\_\_ Complete the application and make payment of \$75.00 via check or money order payable to the “Treasurer of Virginia.”

\_\_\_ **Surgical Assistants** - Provide to the Board evidence or documented proof of one of the three following credentials below. You may send a notarized copy to the Board. If you are selecting number one, the Board will not accept a document that has been copied after it has been notarized.

1. A current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting (**NBSTSA**), or the National Commission for Certification of Surgical Assistants (**NCCSA**) or their successors; or
2. Successful completion of a surgical assistant training program during the applicant’s service as a member of any branch of the armed forces of the United States; or
3. Practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020.

**Please note:**

\*If you answer “yes” to any questions numbered 6-18, please provide a written explanation on a separate page and attach it to your application.

Please be aware that Virginia law allows an address that is public and available to those who ask for it, but it also allows for a private address as well. The private address is referred to as the “address of record”, and it is the address to which communications from the Board of Medicine are to be sent. If you give only one address, the Board will consider it as public, and it will be made available to those who ask for it. For the “address of record”, you may use a P.O. Box or a practice location instead of your home address.

\*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.***



## Application for License to Practice as a Surgical Assistant

To the Virginia Board of Medicine:

I hereby make an application for a license to practice as a Surgical Assistant in the Commonwealth of Virginia and submit the following information:

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](mailto:medbd@dhp.virginia.gov)

Please attach check or money order payable to the Treasurer of Virginia for \$75.00. Applications will not be processed without the fee. Do not submit the 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
<b>0136- Surgical Assistant</b>		<b>\$75.00</b>

\*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 including each location of service since completion of a surgical assistant training program, including after obtaining credential as a surgical assistant, hospital affiliations and absences from work. Also, list all periods of non-professional activity or employment. **PLEASE ACCOUNT FOR ALL TIME.** If engaged in private practice, list all clinical affiliations.

From	To	Name and Address of Location Where Service was Provided	Position Held
_____	_____	_____	_____
		_____	
		_____	
_____	_____	_____	_____
		_____	
		_____	
_____	_____	_____	_____
		_____	
		_____	
_____	_____	_____	_____
		_____	
		_____	

3. Do you intend to engage in the active practice of surgical assisting 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 or registered as a surgical assistant: include all active, inactive, expired, suspended or revoked licenses/registrations. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

5. How did you obtain your credential as surgical assistant?  NBSTSA  NCCSA  Completion of a Surgical Assistant training program in the US armed forces  Practice as a surgical assistant in Virginia prior to July 1, 2020

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

**Yes No**

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 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 surgical assisting?
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 surgical assistant.
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 surgical assistant.
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 surgical assistant.
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 a spouse of someone who is on a federal active duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?
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 as a surgical assistant 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](http://www.dhp.virginia.gov) and I understand that fees submitted as part of the application process shall not be refunded.

\_\_\_\_\_  
Signature of Applicant