GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HEALTH
P.O. BOX 222995. CHRISTIANSTED, VI 00822-2995

Please Note:

To apply for a Physician Medical License, (MD), please print pages 1-14.

To Apply for a Physician Assistant License, please print pages 15- 25.

VI DEPARTMENT OF HEALTH
VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
1303 Hospital Ground, Suite 10 | St. Thomas, VI 00802

Tel: St. Thomas (340) 774-7477 ext. 5694
1303 Hospital Ground, STE. 10
St. Thomas, VI 00802

Tel: St. Croix (340) 718-1311
PO Box 222995
Christiansted, VI 00822-2995

Dear Applicant:

The Virgin Islands Board of Medical Examiners (VIBME) received your request for information pertaining to licensure procedures to practice medicine in the U.S. Virgin Islands. Please review these instructions carefully and provide accurate and complete information on your application to avoid delays in processing. Use the checklist provided at the end to ensure that you send all required documentation.

All applicants are required to complete and submit the VI licensure application through the Uniform Application for Physician State Licensure (UA) and the Federation Credentials Verification Service (FCVS) profile on the Federation of State Medical Boards website at http://www.fsmb.org/ under FCVS and Uniform Application (UA) respectively. You should first complete the FCVS application as this process can take from 6 to 8 weeks.

Enclosed are the remaining instructions for Physician licensure in the U.S. Virgin Islands.

Your interest is appreciated and please feel free to contact any of our offices if you need further assistance.

Sincerely,

Frank A. Odlum, MD
Chairperson
V.I. Board of Medical Examiners

Requirements for Medical Licensure in the U.S. Virgin Islands

You must comply with the following licensure requirements:

- Complete and submit an application for credentials verification online with the Federation Credentials Verification Service (FCVS). This includes but is not limited to:
    - Verification of certificate issued by the Educational Council for Foreign Medical Graduates (ECFMG) if an international graduate.
- Complete and submit the online Uniform Application for Physician State Licensure (UA). This includes but is not limited to:
    - A chronological account of all time spent between the date of graduation from medical school and time of application.
    - Information on any malpractice liability claims.
    - Uniform Application Addendum in this packet.
- Submit UA Affidavit and Authorization of Release form.
- Submit the $250.00 application fee payable to the “Government of the VI” directly to the Board office.
- Be a graduate of an accredited school of medicine, having satisfactorily completed at least a three (3) year residency program recognized by the American Medical Association (AMA) or the American Osteopathic Association (AOA) or show proof of AMA or AOA Board certification.
- Be twenty-one (21) years of age or older.
- Have passed the United States Medical Licensing Examination (USMLE) Steps 1, 2 & 3) or its equivalent as provided in Rules & Regulations of the Board.
- VIBME requires the completion of two (2) original and currently dated Professional Recommendation forms from the Chief Medical Officer (or Chief of Service) of the hospital where I have privileges and/or a licensed physician with whom I have worked and who has personal knowledge of my character, personal reputation, background, and professional ability. This form must be mailed directly to the Board office.
- Submit a current (within 6 months of application) National Practitioner Data Bank Self-Query.
- Submit twenty-five (25) American Medical Association (AMA) Category 1 or American Osteopathic Association (AOA) continuing medical education credits dated within one (1) year of application submittal.
- If not yourself, please designate in writing, 1 individual to received application status updates.
- Applications for licensure are reviewed quarterly.

Read the following instructions carefully. For questions about licensure requirements, please call the Virgin Islands Board of Medical Examiners at (STT) 340-774-7477 ext. 5694 or (STX) 340-718-1311.

Instructions for Medical Licensure in the U.S. Virgin Islands

The Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards (FSMB) is a national non-profit representing the 70 medical and osteopathic boards of the United States and its territories, serving as the national resource and voice on behalf of these boards in their protection of the public. Two of the services provided are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

We require the use of FCVS for credentials verification as part of the overall licensure process. FCVS staff verifies primary source documents related to your identity, education, training, and more, creating a personalized profile of credentials that do not need to be re-verified. This profile can be updated and sent to boards and other entities as needed.

To use FCVS, visit http://www.fsmb.org/ and select FCVS from the Licensure or Sign In menu. Sign in and continue as directed. Complete an Initial Application if you are using FCVS for the first time. Complete a Subsequent Application if you need to update your FCVS profile. Designate your profile to be received by the Virgin Islands Board of Medical Examiners.

For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

The Uniform Application for Physician State Licensure (UA)

The UA simplifies the licensure application process by eliminating data entry redundancy. Once the core UA is completed, it can be updated as needed and sent to another participating board when applying for licensure.

As part of the online UA, you will be asked to complete a chronology of activities of all working and non-working time since medical school graduation and provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

To use the UA, visit http://www.fsmb.org/ and select Uniform Application (UA) from the Licensure or Sign In menu. Sign in and continue as directed.

Please note:

- If you see incorrect USMLE, FLEX, or SPEX examination information listed in your UA, please email information to ua@fsmb.org.
- MD and DO license information in the UA cannot be changed by you, as that information is provided directly from the state boards. If you see incorrect or missing pre-filled medical license information in your UA, email ua@fsmb.org with your FCVS ID or nine-digit Federation ID (FID) plus the information to be corrected. Do not select “Other” to add information unless it is for a non-medical professional license.
- All licenses current and previously held must be verified by the issuing board. The Virgin Islands Board of Medical Examiners accepts Veri Doc, online “primary source” verification or use the UA Licensure Verification Form in this packet.

Review all your entries before submitting your UA at the bottom of the Review & Submit page. You will be able to print a copy of your UA immediately after it is submitted.

First time UA users will be charged a one-time service fee of $60. This is a separate fee collected by FSMB, not by state boards, and is separate from FCVS fees. A receipt will be available for printing immediately after payment is made. A separate receipt will be sent to you via email.

For UA assistance, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq. If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem. Please email a screenshot if you see an error.

National Practitioner Data Bank Self-Query

- Visit https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and begin the process for the Self-Query. Follow all instructions given.
- After your Self-Query has been processed by the NPDB, they will send the Self-Query report directly to you. You must first open this report to make sure that the results were not rejected, and all information submitted is correct.
- Send all parts of the Self-Query report directly to our office for final review.
- For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

Please use the checklist on the next page to ensure all required documents are submitted.

VI DEPARTMENT OF HEALTH
VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
1303 Hospital Ground, Suite 10 | St. Thomas, VI 00802

Tel: St. Thomas (340) 774-7477 ext. 5694 Tel: St. Croix (340) 718-1311 Ext: 3849

Uniform Application Checklist

- Completed online Uniform Application
- Completed the Uniform Application addendum in this packet.

Send each of the following items to the VI Board of Medical Examiners:

- Notarized UA Addendum with any additional details required for "Yes" answers.
- UA Affidavit and Authorization of Release of information form.
- VIBME requires the completion of two (2) original and currently dated Professional Recommendation forms from the Chief Medical Officer (or Chief of Service) of the hospital where I have privileges and/or a licensed physician with whom I have worked and who has personal knowledge of my character, personal reputation, background, and professional ability. This form must be mailed directly to the Board office.
- $250.00 application fee payable to the "Government of the VI".
- Notarized Statement of Clinician form.
- 2 Professional Recommendation Forms.
- 25 AMA Category 1 Continuing Medical Education Credits (CMEs) dated within one (1) year of application.
- Oral interview may be required.

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VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
1303 Hospital Ground, Suite 10 | St. Thomas, VI 00802

Tel: St. Thomas (340) 774-7477 ext. 5694 Tel: St. Croix (340) 718-1311

Uniform Application Addendum

Last Name _____ First Name _____ Middle, Suffix _____ Degree _____

Specialty _____Date _____

Additional Applicant Information

Practice type: Solo Practice Group Practice Date of Affiliation: _____

Practice Name: Address:

Citizen of:
(If you were not born in the United States, proof of Citizenship must be submitted)

Continuing Medical Education – Provide 25 AMA Category 1 or AOA Continuing Medical Education credits within 1 year of the date of this application. Please attach copies; the following information **must** be included.

1. Meeting/Course/Symposium
2. Location
3. CME Sponsor
4. Date(s)
5. # CME (Hours)
6. Category and (AMA OR AOA)

Attestation Questions - If the answer is YES to any of the following, you MUST furnish full details on a separate sheet with the Question # noted.

		YES	NO
1.	Have proceedings been instituted to have your license to practice medicine and or hospital privileges (in any jurisdiction) limited, suspended, revoked, denied or subject to probationary conditions?	☐	☐
2.	Have proceedings been instituted to have your DEA or other controlled substance authorization denied, revoked, or suspended?	☐	☐
3.	Have proceedings been instituted to have your specialty board certification denied, revoked, or suspended?	☐	☐
4.	Are you aware of any potential action(s) or proceeding(s) that may be levied against you?	☐	☐
5.	Have you voluntarily relinquished any license, certification, or privileges?	☐	☐
6.	Have you been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?	☐	☐
7.	Have you been reprimanded, sanctioned, censured, excluded, suspended, or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services.	☐	☐
8.	Have you been arrested for or charged with a crime involving children? *If YES, also include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to the applicable Federal punishment for perjury.*	☐	☐
9.	Have you been convicted of a felony or are you presently indicted for a felony?	☐	☐
10.	Have your clinical privileges or employment, medical staff membership or medical staff status at any hospital or healthcare institution been denied, limited, suspended, revoked, not renewed, voluntarily relinquished or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff official or committee or governing board?	☐	☐
11.	Has your request for any specific clinical privilege(s) been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff official or committee or governing board?	☐	☐
12.	Have you been denied membership, or renewal of membership, or have you been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization or professional society, or is any such action pending?	☐	☐
13.	Have you been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military action, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	☐	☐
14.	Are there presently any proceedings or investigations taking place at any hospital or other organization relating to your clinical competence or professional conduct?	☐	☐
15.	Have you withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before a decision was made by a hospitals or health care facility's governing board?	☐	☐
16.	Do you have any condition that would compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting? *If YES, also include a description of accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.*	☐	☐

		YES	NO
17.	Have you engaged in the unlawful use of drugs? *If YES, also identify and describe any rehabilitation program in which you are or were enrolled that assures your abstinence prospectively and your adherence to prevailing standards of professional performance.*	☐	☐
18.	Do you now have, or have you ever had a consumption or utilization problem with any of the following: alcohol, illicit drugs, prescription drugs, controlled substances, or any mind-altering substances? *If YES, also identify and describe any rehabilitation program(s) you were enrolled in that assures that your consumption or utilization of items listed in #17, will not interfere with your practice of medicine, patient care responsibilities, or adherence to prevailing standards of professional performance.*	☐	☐
19.	Will practicing to the fullest extent of your licensure, qualifications and privileges, with or without reasonable accommodation, in any way, pose a risk of harm to your patients?	☐	☐
20.	Have there been, or are there currently, any claims, settlements, or judgments against you, even if not resulting in monetary damages, or have you received any notice of "Intent to File"? I*f your answer is YES, provide detailed information on the Malpractice page in the online Uniform Application. In the "specifics" section, summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative which provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical details to allow proper evaluation by a committee of physicians. Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment.*	☐	☐
21.	Have you had any professional liability insurance coverage canceled, declined, or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	☐	☐
22.	Have you been denied professional liability insurance or has your policy ever been canceled or denied renewal?	☐	☐

List ALL insurance carriers (including insurance companies, hospitals, clinics, employers, etc.) who have provided professional liability coverage since your previous appointment. Professional liability insurance minimum required coverage: $250,000.00/claim. Attach an additional sheet if necessary.

Current Insurance Carrier: _____From:_____ To:

Address: _____Policy Number: _____

City: _____ State: ____ Zip: _____Years with company:_____

Previous Insurance Carrier: _____From:_____ To:

Address: _____Policy Number: _____

City: _____ State: ____ Zip: _____Years with company _____

Previous Insurance Carrier: _____From:_____ To:

Address: _____Policy Number: _____

City: _____ State: ____ Zip: _____Years with company _____

Statement of Clinician

I fully understand that the provision of information which contains significant misrepresentations, misstatements, omissions or inaccuracies shall result in automatic and immediate rejection of my application and that I shall not be entitled to any appellate proceedings. If such misrepresentations, misstatements, omissions, or inaccuracies are discovered after I have received my license, I understand that my license shall be immediately terminated.

All information submitted by me in this application is true to the best of my knowledge and belief.

By applying for licensure, I hereby signify my willingness to appear for any necessary interviews regarding my application. I hereby authorize the Board and their representatives to consult with administrators and members of the medical staffs of hospitals and institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the Board, its staff and its representatives of all documents including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence as well as my moral and ethical qualifications for licensure.

I hereby release from liability all representatives of the Board of Medical Examiners for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the Board, or its staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby authorize the Board to communicate to other hospitals and to other persons or organizations with legitimate interest therein any information concerning my professional competence, character, ethics, and health status that the Board may have or acquire, and, where such communication is made in good faith and without malice, I consent thereto and agree to hold the Board and its authorized representatives free of liability there from.

I understand and agree that I, as an applicant for licensure in the U.S. Virgin Islands, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and current health status or other qualifications and for resolving any doubts about such qualifications.

I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee splitting. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit other physicians or surgeons to collect fees for me, nor to make joint fees, nor permit any associate of mine to do so.

_____
Physician's Printed Name

_____
Physician's Signature

_____
Date of Signature

_____
Date of Photograph

PASTE PHOTOGRAPH SECURELY
IN THIS SPACE

Write signature on light portion of photograph, not across features

VI Board of Medical Examiners

1303 Hospital Ground, Suite 10
St Thomas, VI 00802
340-774-7477 Ext 5694

PROFESSIONAL RECOMMENDATION

This form must be completed and mailed DIRECTLY to the VI Board of Medical Examiners (VIBME) at 1303 Hospital Ground, Suite 10 St Thomas, VI 00802. VIBME requires the completion of two (2) Professional Recommendation forms from the Chief Medical Officer (or Chief of Service) of the hospital where I have privileges and/or a licensed physician with whom I have worked and who has personal knowledge of my character, personal reputation, background, and professional ability. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to send this completed form and release all information in your files, favorable or otherwise directly to the VI Board of Medical Examiners.

Applicant's Name: _____ Date of Birth ___/___/_____

Applicant' Signature:_____ Date: _____

Address:_____ City: _____ State _____ Zip_

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is confidential, this is NOT a public document.

1. Date and type of service: This individual served with me as _____

from _____ **to** _____ **at** _____
Month/Year **Month/Year** **Location**

2. Please indicate with check mark:

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgement				
Relationships with patients				
Ethical/Professional conduct				
Ability to communicate				
Clinical skills				

0. Recommendation (please indicate with a check mark):

- **LI Recommend highly without reservation.**
- **LI Recommend as qualified and competent.**
- **LI Recommend with some reservation (explain)**
- **LI Concerns (explain)**

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments. _____

5. The above report is based on: (please indicate with a check mark)
LI Close personal observation **LI General impression** **LIA composite of evaluations**
LI Other

Name (Print): _____ **Title:** _____ **Phone:**

Signature: _____ **Date:**

One (1) Time Credit Card Payment Authorization

Sign and complete this form to authorize the **"The Government of the VI" (Virgin Islands Department of Health)** to make a one-time charge to your credit card as listed below.
By signing this form (electronically or otherwise), you give **The Government of the VI" (Virgin Islands Department of Health)** permission to debit your account for the amount indicated below. This permission is for a single transaction only and does not provide authorization for any additional unrelated debits or credits.

I _____ authorize **Government of the VI** to charge my
(Cardholder's Full Name) **(Merchant's Name)**

credit card account indicated below the amount of $_____
Amount
This payment is for_____of my **VI** _____ **License #** _____**.**
application, CON, license registration, license type If applicable
license renewal, verification, Other(indicate)

Billing Information

Billing Address_ _____ Cell phone # _____
City, State, Zip_____Email _____

Credit Card Details
☐ Visa ☐ MasterCard
Cardholder**'s** Name as it Appears on Card _____
Account/CC Number_ _____ Expiration Date / CVV_____
Zip Code _____

I authorize the **Government of the VI (Department of Health)** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services indicated and, in the amount indicated above only and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company if the transaction corresponds to the terms indicated in this form. **If this transaction is not for yourself, please include a copy of a government issued identification.**

_____ _____
cardholder original signature date

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: Virgin Islands Board of Medical Examiners
1303 Hospital Ground, Suite 10
St. Thomas, VI 00802

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.]

State of_____ , County of_____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____ , 20____.

Notary Public Signature _____ My Notary Commission Expires

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: Virgin Islands Board of Medical Examiners
P.O. Box 222995Christiansted, VI 00822-2995

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.]

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HEALTH
P.O. Box 222995. CHRISTIANSTED, VI 00822-2995

Please Note:

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THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HEALTH
P.O. BOX 222995. CHRISTIANSTED, VI 00822-2995

VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS

(340) 774-7477 Ext 5694 (STT)
(340) 718-1311 Ext 3849 (STX)

Dear PA Applicant:

The V.I. Board of Medical Examiners received your request for licensure procedures to practice as a Physician Assistant in the U.S. Virgin Islands. The following are the requirements needed for Physician Assistant licensure:

1. Submit application on the forms approved and obtainable from the V.I. Board of Medical Examiners.
2. Submit a recent and un-mounted photograph of passport size of himself/herself autographed and dated in ink across the back.
3. Submit a non-refundable application fee in the amount of **$125.00**, made payable to Government of the V.I.
4. Submit chronological account of **all** time spent between receiving your P.A. degree and the time of this application.
5. Submit proof of completing an accredited education program (copy of certificate/diploma required).
6. Submit proof of National Commission on Certification of Physician Assistants (NCCPA) Certification.
7. Be twenty-one years of age or older (copy of birth paper and/or similar proof).
8. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. Please utilize notarized non-addiction form included in this package.
9. Two original, currently dated character professional reference forms; completed by someone familiar with your clinical skills (use form attached).
10. Primary source license verifications must be completed for all States and jurisdictions where you held or currently hold a license. Verifications must be sent directly to the Board office.
11. Submit 25 AMA Category 1 credits dated within a year of this application.
12. Submit a completed and notarized Authorization for Release of Information.
13. All applicants are required to have their credentials verified by the Federation of State Medical Board Credentialing Verification Service (FCVS). Site: www.fsmb.org.
14. Complete the Delineation of Scope of Practice forms.
15. Complete license application data form.
16. Complete National Practitioner Data Bank (NPDB) self query.

Your interest is appreciated and if we can be of further assistance, please contact the Board at the above numbers.

ADDENDUM 1
BOARD OF MEDICAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS

Print Name_____

Social Security No._____

(**If you were not born in the United States, your own <u>original certificate</u> of Citizenship or of Declaration of Intention or of Derivative Citizenship <u>must</u> be submitted 60 days before examination. Document will be returned by certified mail).**

High School _____Location _____

College _____Location _____

Professional School _____Location _____

*If employed, give name and address of employer _____

Has any State rejected your application or revoked your professional license? (Yes or No)
(If "Yes" attach a separate explanation)

Have you ever been convicted of any crime or unprofessional conduct? (Yes or No)
(If "Yes" attach a separate explanation)

ADDENDUM 2
PHYSICIAN ASSISTANT LICENSE APPLICATION DATA

Physician Assistant Program:

Name: _____

Mailing Address: _____

Issuance Date of Certificate/Degree

State(s) Licensed In:

State: _____ _____ _____ _____

Date of Issue: _____ _____ _____ _____

License Number: _____ _____ _____ _____

If certified by the National Commission on Certification of Physician Assistants, give date of certification_____.

Previous Practice Affiliations: (Use other side if necessary)

Name of Institution and/or Supervising Physician: _____

Mailing Address: _____

Type of Practice: _____ Dates: _____

Name of Institution and/or Supervising Physician:

_____

Mailing Address: _____

Type of Practice: _____ Dates: _____

Name of Institution and/or Supervising Physician:

_____

Mailing Address: _____

Type of Practice: _____ Dates: _____

BOARD OF MEDICAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS

I. DELINEATION OF SCOPE OF PRACTICE

Medical services that can be rendered by physician assistants in your practice:

1). Obtaining patient histories and performing physical examinations;

2). Ordering and/or performing diagnostic and therapeutic procedures (**does not include the writing of outpatient prescription medication)**

3). Formulating a diagnosis and developing a treatment plan;

4). Monitoring the effectiveness of therapeutic interventions;

5). Assisting at surgery;

6). Offering counseling and education to meet patient needs; and

7). Making appropriate referrals with supervising physician collaboration.

If there are any specific services, which should be added to those above, please complete Form A and submit with application for review by the Board.

II. COMMUNICATION

Please list the names of all supervising physicians for _____ (Physician Assistant) along with practice location(s) addresses, e-mail and contact numbers.

Name: _____ Practice Location _____

Home Address: _____

E-mail _____

Phone: _____ (h) _____ (w) _____ (cell)

(fax) _____

(etc)

(etc)

If you are in solo practice, you must complete Form B

III. SUPERVISORY ACCOUNTABILITY

All supervising physicians must possess and maintain an active US Virgin Islands license. The Board requires that a written agreement signed by both the physician assistant and their supervising physician(s). This agreement states that the physician(s) will be responsible for exercising supervision over the physician assistant, as well as retaining all professional and legal accountability for the care rendered by such. A copy of this agreement is to be renewed annually, with a copy forwarded to the board.

Additionally, please complete for C, which describes in what objective and verifiable manner will the physician assistant be evaluated. Evaluations are to be completed every 12 months, at the time of the physician assistant's license renewal.

Instructions for completions of forms:

Form A:

The physician assistant scope of practice is delineated in section I. If there are any other specific duties or levels of care, which you feel the physician assistant that you are supervising should be able to perform and deliver, please list these along with the reason why you feel this should be.

Please remember that a physician assistant's supervision is guided by the training, knowledge, and experience of a particular supervising physician. This should be considered when there will be more than one supervising physician. If you are requesting additional duties and/or levels of care to be delivered, these are physician/specific and will not be viewed as applying to all supervising physicians for that physician assistant. Example: If physician #1 has the training, knowledge, and experience to competently supervise in the delivery of a specific duty, but physician #2 does not, then the physician assistant may not perform that duty while supervised by physician #2.

Form B:

It is a definite requirement that physician assistants be supervised. This includes being able to be in contact with their supervising physicians at all times. If you are in solo practice, Form B delineates, which other physician(s) will supervise your physician assistant in the event of your absence/illness or if you are unable to be in communication with them.

This physician(s) is(are) subject to the same rules and regulations that apply to any other supervising physician and will retain both professional and legal accountability for the care rendered by the physician assistant during your absence.

Please be mindful that, during your absence, the physician assistant may not perform of the additional duties, if any, as listed in Form A, unless the alternate physician has completed Form A.

Form C:

To insure that physician assistants are adequately evaluated by their supervising physicians, please submit how this will be accomplished in your practice. Although no one standard format exists, examples include quarterly chart reviews, quarterly formal meetings, direct observations, etc.

The Board reserves the right to interview both the physician assistant and physician, as well as perform a chart review, to ensure compliance with supervisory accountability.

I have read and agree to abide with the above.

_____ PA Date:

_____ MD Date:

_____ MD Date:

_____ MD Date:

FORM A:

Please list any additional services that can be offered by _____.
Please include an explanation of why these should be offered.
Additionally, please describe any previous training and/or experience that the physician assistant has offering this service. Finally, delineate each supervising physician's training and/or experience, which would enable them to supervise these additional services(s) appropriately.

1. Service_____

   Supervising Physician_____

   Explanation:

   _____

   _____

   _____

2. ETC.

   _____

   _____

   _____

FORM B:

As a physician in solo practice, you must maintain supervisory capacity and accountability for any physician assistant in your employ. In the case of absence, illness, or any situation where you will not be able to be in communication with the physician assistant, you must designate an alternate physician or alternate physicians as supervisors for this physician assistant. (Please see instructions).

Name: _____

Practice Location _____

Home Address _____

Phone _____ (h) _____ (w) _____ (c) _____ (f)

FORM C:

Please list how the physician assistant will be formally supervised. It is insufficient to simply co-sign their medical records as proof of formal supervision.

1.____ Random chart review

2.____ Formal meetings: monthly quarterly, or every six months. (Please circle one)

Please list the dates of when these meetings took place:
_____

_____

_____

3.____ Direct observation: _____

4.____ Other: (Please explain below)

_____
_____
_____
_____
_____
_____
_____

Affidavit and Authorization for Release of Information

UNIFORM APPLICATION FOR PHYSICIAN ASSISTANT STATE LICENSURE

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public. Send this notarized affidavit to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB. Doing so will delay your state licensure.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician Assistant State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license.

Applicant Photograph

Securely tape or glue a recent (less than 3 month old) front-view 2" x 2" passport-type color photo of yourself in this square.

Notary seal must overlap a portion of this photograph but not covering the neck or head.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name

_____
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

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