GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
- 0 -
DEPARTMENT OF HEALTH
PO BOX 222995 – CHRISTIANSTED, VI 00822-2995

VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS

Ph. 340-774-7477x 5694 (STT)
340-718-1311 XT 3849 (STX)

To Whom It May Concern:

The Virgin Islands Board of Medical Examiners is in receipt of your request for licensure requirements to practice Podiatry in the U.S. Virgin Islands.

United States trained graduate with a degree from an accredited school of Podiatry may be considered for licensure in the Virgin Islands.

Enclosed is an application form and the requirements for licensure in the U.S. Virgin Islands.

Your interest is appreciated. If we can be of further assistance, please do not hesitate to contact our office.

Sincerely,

V.I. Board of Medical Examiners
c/o Professional Licensure & Health Planning

REQUIREMENTS FOR PODIATRY LICENSURE IN THE U.S.VIRGIN ISLANDS

Applications for licensure shall be mailed to the **Office of Professional Licensure & Health Planning, PO Box 222995, Christiansted, VI 00822-2995.**

1. Submit application on the form prescribed by and obtainable from the Office of Professional Licensure and Health Planning;

2. Submit a recent, dated un-mounted passport sized photograph of himself/herself, autographed across the back;

3. Submit a chronological account of all time spent between the date of graduation from Podiatry school and time of application;

4. Official proof (transcript) of graduation from an accredited school of Podiatry;

5. Be twenty-one years of age or over (birth certificate or similar evidence thereof);

6. Be of good moral character as shown by completion at least two professional recommendation forms (attached);

7. Notarized statement, signed by applicant, attesting to non-addiction to intemperate use of alcoholic stimulants or narcotic drugs (form attached);

8. Complete Notarized Authorization for Release of Information form;

9. Official license verification from all states and/or jurisdictions for all licenses current and previously held mailed or emailed directly to the Board office;

10. Official proof of American Podiatric Medical Licensing Examination (APMLE) Parts I, II and III scores;

11. Completion of a minimum 1 year CPME residency program. If it has been four or more years since the completion of the residency program, you must show:

    (i) proof of an active license and active practice with no disciplinary actions of podiatric medicine in another U.S. state or territory for at least two of the immediately preceding four years; or

    (ii) successful completion of a board approved post graduate program or board approved course within the year preceding the filing of the application; or

(iii) 10 consecutive years of continuous, active license and active practice with no disciplinary actions of podiatric medicine in another U.S. state or territory immediately preceding the submission of the application; and completion of at least the same continuing education requirements during those 10 years as required of podiatric physicians licensed in the U.S. Virgin Islands."

12. Official proof of board certification;

13. National Practitioner Data Bank (NPDB) self query;

14. All applicants are required to complete a fingerprinted background check;

15. A candidate applying for licensure shall submit with his/her application the fee of **$250.00** by certified check, bank money order or U.S. postal money order payable to "Gov't of the VI";

16. An application is considered complete when all required documents, background information and fees are on file with the Board's office; and

17. Additional information may be obtained from the Office of Professional Licensure & Health Planning by calling (340) 718-1311 xt. 3849 (St Croix) or STT (340)774-7477 xt. 5694 (St Thomas) office.

APPLICATION FOR PODIATRY LICENSE
IN UNITED STATES VIRGIN ISLANDS

Name in Full_____ Date_____
Last First Initial

Office Address_____Telephone_____

Mailing Address_____

Cell _____Email Address_____ Last 4 Digits of SS#_____

Date of Birth_____

Premedical Education: College or University_____

Degree_____ Date of Graduation_____

Medical Education: Podiatry College_____

Degree_____ Date of Graduation_____

Internship: Hospital_____ Date_____ Rotating_____ Special_____

_____ Date_____ Rotating_____ Special_____

Licensures_____ Lic.#_____ Registry #_____
State or Providence/Date Issued

Reciprocity_____ Examination_____

_____ Lic.#_____ Registry #_____
State or Providence/Date Issued

Reciprocity_____ Examination_____

Has your license to practice Podiatry in **any** jurisdiction **ever** been suspended or revoked? If so, give full details on separate sheet.

Residencies_____ Date_____
Hospital and Type of Residency

_____ Date_____
Hospital and Type of Residency

Preceptorship_____ Date_____

_____ Date_____

Teaching Appointments_____ Date_____

_____ Date_____

Postgraduate Education_____ Date_____
Institution Preceptor Address

_____ Date_____
Institution Preceptor Address

Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed? If so, explain in full detail on separate sheet.

Membership in Podiatry Societies_____

_____

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any Podiatry organization? If so, give full details on separate sheet.

VI DEPARTMENT OF HEALTH
VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
PO BOX 222995- CHRISTIANSTED, VI 00822-2995
PODIATRY

NOTARIZED NON-ADDICTION AFFIDAVIT

I, _____ am not addicted to the intemperate use of alcohol, illicit drugs, any

(first, middle, last, suffix)

prescription medications including controlled substances or any mind altering substances that may alter or impair my judgement and ability to carry out the duties of the profession.

Affidavit - NOTE: Any false or misleading information in or in connection with any application may be cause for debarment on the ground of lack of good moral character.

_____ _____
Signature Date

_____
Print Name

Subscribed and sworn to before me this _____day of _____ 20_____

_____
Notary Public

_____
My Commission Expires

AUTHORIZATION FOR RELEASE OF INFORMATION

In connection with my application for licensure for the practice of Podiatry in the United States Virgin Islands, I hereby authorize and consent to the release of any and all information requested by the Virgin Islands Board of Medical Examiners.

Additionally, I release from liability any hospital or agency releasing such information to the VI Board of Medical Examiners in good faith.

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- Make inquiries concerning such information about me to my employer (past and present), hospital(s), or institution (s), my reference(s), all governmental agencies and instrumentalities (local, state, federal, or foreign);

- Authorize the release of such information and copies of related records and documents to the Office of Professional Licensure & Health Planning;

- Authorize (PLHP) to disclose to such persons, employers, hospitals, institutions, organizations, references, governmental agencies and instrumentalities identifying and other information about me sufficient to enable (PLHP) to make such inquiries;

- Release from liability all those who provide information to the Virgin Islands Board of Medical Examiners in good faith and without malice in response to such inquiries.

_____ _____

Signature Date

_____

Print Name

Subscribed and sworn to before me this ____day of _____ 20____

_____

Notary Public

_____

My Commission Expires

Mail Verification to:

VI Board of Medical Examiners - Podiatry
PO BOX 222995
Christiansted, VI, 00822-2995

VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
PO Box 222995 - Christiansted, VI 00822-2995

VERIFICATION OF PODIATRY LICENSURE

Complete this section of the license verification form and mail to each **State Podiatry Board** in which you are now or have been licensed to practice Podiatry. You may copy this form if additional copies are needed. **State Board is to forward this form or its own verification form directly to: VI Board of Medical Examiners, Office of Professional Licensure, PO Box 222995, Christiansted, VI 00822-2995.**

TO: _____ (Name of Board)

_____

Address

I, _____, hereby authorize the _____ Board of Podiatry to release to the Virgin Islands Board of Medical Examiners any information concerning my licensure status, disciplinary records and any other information, which is material to my application for licensure. Additionally, I release your agency from liability for the release of such information to the V.I. Board of Medical Examiners in good faith.

_____ _____

Applicant Signature Date

Address _____

_____

My License No. in your State: _____ Exp. Date: _____

THIS SECTION IS TO BE COMPLETED AND SIGNED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE VI BOARD OF MEDICAL EXAMINERS AT THE ABOVE ADDRESS.

Name of State Board: _____

Full Name of Licensee: _____

License No.: _____ Issuance Date: _____ Exp. Date: _____

By: Examination/Reciprocity with the following state: _____

National Board _____ Local State Board Examination _____

Is license current and in good standing? ___ If NO, furnish details.

_____

_____

_____

Has any disciplinary action ever been taken against the above named Podiatrist? _____ If YES, furnish details

_____

_____

Comments, if any: _____

_____

BOARD SEAL

Signed: _____

Title: _____

State Board of: _____

Date: _____

VI Board of Medical Examiners
PO Box 222995
Christiansted, VI 00822-2995
340-774-7477 xt 5694

PODIATRY PROFESSIONAL RECOMMENDATION

This form must be completed and mailed DIRECTLY to VI Board of Medical Examiners (VIBME) c/o the Professional Licensure & Health Planning at PO Box 222995, Christiansted, VI 00822-2995. Please complete 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				

3. **Recommendation (please indicate with a check mark):**
   - ☐ **Recommend highly without reservation**
   - ☐ **Recommend as qualified and competent**
   - ☐ **Recommend with some reservation (explain)**
   - ☐ **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)**
   ☐**Close personal observation** ☐**General impression** ☐**A composite of evaluations**
   ☐**Other**

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

Signature: _____**Date:**_____