**GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES**
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**DEPARTMENT OF HEALTH**

*"Wellness is Our Way of Life"*

# APPLICATION FOR HEALTH-RELATED OCCUPATION BUSINESS LICENSE

**(FILLABLE FORM - PLEASE TYPE ONLY)**

DATE: _____

NAME: _____ _____ _____ _____
*first* *middle* *last* *suffix*

DATE OF BIRTH:(MM/DD/YYYY) ____ / _____/ _____

SOCIAL SECURITY # (LAST FOUR DIGITS):_____

MAILING ADDRESS: _____CITY_____STATE____ZIP CODE_____

RESIDENTIAL ADDRESS:_____CITY_____STATE____ZIP CODE_____

INTENDED NAME /PLACE OF BUSINESS: _____

OCCUPATION / TYPE OF BUSINESS:_____ DCLA CONTROL# _____

PHYSICAL BUSINESS ADDRESS: _____CITY_____STATE____ZIP CODE_____

EMAIL ADDRESS: _____

MOBILE PHONE NUMBER: _____ WORK PHONE NUMBER: _____

## EDUCATION/TRAINING

| SCHOOL NAME / ADDRESS | DATES MM/YYYY | GRAD. Y/N | DEGREE / #HRS | CONTACT NAME / TELEPHONE # |
|---|---|---|---|---|
| | START | Y - N | DEGREE TYPE | |
| | FINISH | | #HOURS | |
| | START | Y - N | DEGREE TYPE | |
| | FINISH | | #HOURS | |
| | START | Y - N | DEGREE TYPE | |
| | FINISH | | #HOURS | |
| | START | Y - N | DEGREE TYPE | |
| | FINISH | | #HOURS | |

PLEASE COPY AND ADD BLANK SHEET(S) IF NECESSARY.

## STATE /PROFESSIONAL/CERTIFICATIONS

| STATE / ORGANIZATION | LICENSE# / TYPE | EXPIRATION | CONTACT NAME / TELEPHONE / ADDRESS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## WORK EXPERIENCE

| EMPLOYER'S NAME & ADDRESS | DATES MM/YYYY | POSITION | CONTACT NAME / TELEPHONE # |
|---|---|---|---|
| | START<br>FINISH | | |
| | START<br>FINISH | | |
| | START<br>FINISH | | |
| | START<br>FINISH | | |

COPY AND ADD ADDITIONAL SHEETS IF NECESSARY.

Has applicant ever undergone disciplinary hearing? ❑YES ❑NO
If (YES), Please Explain:

Has the applicant been convicted of felony or misdemeanor? ❑YES ❑NO
If (YES), Please Explain and attach a copy of disposition.

Has there been a malpractice settlement? ❑YES ❑NO If (YES) How many? _____

When was latest? _____ For what? _____

What was the award? _____ What was the settlement? _____

I hereby affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.
**I** further wave, for process of this application, any confidentiality provisions concerning the information required to be provided to this application.

_____ _____ _____ _____
APPLICANT SIGNATURE DATE WITNESS SIGNATURE DATE

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

_____
Notary Public

_____
My Commission Expires

**BE SURE TO ATTACH: *(CHECK LIST)***

1. ❑ LEGIBLE COPY OF GOVERNMENT ISSUED IDENTIFICATION;
2. ❑ HAVE **OFFICIAL** SCHOOL TRANSCRIPT(S) FORWARDED TO PROFESSINAL LICENSURE & HEALTH PLANNING OFFICE;
3. ❑ HAVE **OFFICIAL** STATE LICENSE VERICATION(S) FROM ALL STATES EVER LICENSED FORWARDED TO BOARD OFFICE;
4. ❑ INCLUDE DETAILED NARRATIVE DESCRIBING PROPOSED BUSINESS (SERVICE, LOCATION, MOUs, CONTRACTS, ETC...);
5. ❑ COPY OF CREDENTIALS;
6. ❑ **NOTARIZED** NON-ADDICTION LETTER;
7. ❑ TWO (2) CURRENT, ORIGINAL SIGNED PROFESSIONAL RECOMMENDATION FORMS (FROM COLLEAGUES OR LICENSED PROFESSIONALS FAMILIAR WITH YOUR CLINICAL SKILLS);
8. ❑ COPY OF VI POLICE RECORD; AND IF LIVING IN THE USVI LESS THAN 2 YEARS, YOU ALSO NEED TO SUBMIT A POLICE RECORD FROM LAST CITY/STATE OR COUNTRY OF RESIDENCE PRIOR TO MOVING TO THE USVI;
9. ❑ SUBMIT PROOF OF NATIONAL CERTIFICATION IN YOUR RESPECTIVE OCCUPATION;
10. ❑ PROOF OF LIABILITY INSURANCE;
11. ❑ COMPLETE **NOTARIZED** AUTHORIZATION OF RELEASE FORM;
12. ❑ SUBMIT COPIES OF DIPLOMAS, CERTIFICATIONS, LICENSES, ETC...;
13. ❑ SUBMIT A CURRENT (DATED WITHIN 6 MONTHS OF VI APPLICATION) NATIONAL PRACTITIONER DATA BANK SELF-QUERY.
    A. VISIT **HTTPS://WWW.NPDB.HRSA.GOV/EXT/SELFQUERY/SQHOME.JSP** AND BEGIN THE PROCESS FOR THE SELF-QUERY. FOLLOW ALL INSTRUCTIONS GIVEN.
    B. AFTER YOUR SELF-QUERY HAS BEEN PROCESSED BY THE NPDB, THEY WILL SEND THE SELF-QUERY REPORT DIRECTLY TO YOU.
    C. YOU MUST FIRST OPEN THIS REPORT TO MAKE SURE THAT THE RESULTS WERE NOT REJECTED, AND ALL INFORMATION SUBMITTED IS CORRECT.
    D. SEND ALL PARTS OF THE SELF-QUERY REPORT DIRECTLY TO OUR OFFICE WITH YOUR APPLICATION.
    E. **FOR NPDB QUESTIONS OR ASSISTANCE, CALL 800-767-6732 OR EMAIL HELP@NPDB.HRSA.GOV**; AND
14. ❑ THE APPLICATION MUST BE **NOTARIZED**.

**BE SURE TO:**

1. KEEP A COPY OF THE APPLICATION FOR YOUR FILE. (DO NOT SEND ANY OFFICIAL ORIGINAL DOCUMENTS).
2. **MAIL** THE ORIGINAL APPLICATION TO THE ADDRESS BELOW (FAXED AND EMAILED APPLICATIONS ARE NOT ACCEPTED)

## AUTHORIZATION FOR RELEASE OF INFORMATION

In connection with my application for Allied Health clearance in the United States Virgin Islands, I hereby authorize and consent to the release of any and all information requested by the Virgin Islands Department of Health's Office of Professional Licensure and Health Planning (PLHP).

Additionally, I release from liability any hospital or agency releasing such information to PLHP in good faith.

- 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 PLHP;
- 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 the Board to make such inquiries;
- Release from liability all those who provide information to the Virgin Islands Department of Health or PLHP 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 to:

**Office of Professional Licensure & Health Planning**
**VI Department of Health**
**P.O. BOX 222995**
**Christiansted, VI, 00822-2995**

**VIRGIN ISLANDS DEPARTMENT OF HEALTH**
**OFFICE OF PROFESSIONAL LICENSURE & HEALTH PLANNING**
**P.O. BOX 222995- CHRISTIANSTED, VI 00822-2995**

## NOTARIZED NON-ADDICTION AFFIDAVIT – ALLIED HEALTH

*I, _____ am not addicted to the intemperate use of illicit*
first, middle, last, suffix)

*alcohol, drugs, any prescription medications including controlled substances or any mind-altering substances that may alter or impair my judgment 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

**OFFICE OF PROFESSIONAL LICENSURE & HEALTH PLANNING**
*P.O. Box 222995, Christiansted, VI 00822-2995 Tel: 340-643-8992*

# PROFESSIONAL RECOMMENDATION

This form must be completed and mailed DIRECTLY to the Office of Professional Licensure & Health Planning (PLHP) at **P.O. Box 222995, Christiansted, VI 00822-2995**. PLHP requires the completion of two (2) Professional Recommendation forms from Colleagues or Licensed Professionals who are familiar with your clinical skills and have personal knowledge of your character, personal reputation, background and professional ability. This form is ***confidential*** and ***required*** as part of the application for licensure or Allied Health clearance. ***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 Office of Professional Licensure & Health Planning.

Applicant's Name:_____ Profession _____

Applicant's Signature:_____ Date:_____

Address:_____City:_____ State:_____Zip Code: _____

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**ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PROFESSIONAL**
**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 | N/A |
|---|---|---|---|---|---|
| **Professional knowledge** | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Clinical judgement** | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Relationships with patients or clients** | ❑ | ❑ | ❑ | ❑ | ❑ |
| **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. If more space is needed please attach.**

_____

_____

_____

5. **The above report is based on: (please indicate with a check mark)**

❑ **Close personal observation** ❑ **General impression** ❑ **A composite of evaluations** ❑ **Other**

**Print Name: _____ Title: _____ Phone: _____**

**Signature: _____ Date: _____ Email: _____**