



**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 Ext 3849
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 of 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. Odium, 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.
 - Official license verification from all states in which you are/were licensed.
- 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 original notarized affidavit (attached) form attesting non-addiction to “intemperate use of alcohol, illicit drugs, any prescription medications including controlled substances or any mind altering substances that may alter or impair your judgement and ability to carry out the duties of the profession.”
- Submit a current 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.
- 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 xt 5694 or (STX) 340-718-1311 xt 3849.

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

- | |
|--|
| <ul style="list-style-type: none">○ Completed online Uniform Application○ Completed the Uniform Application addendum in this packet. |
| <ul style="list-style-type: none">○ Completed licensure verification from each board that has issued you a healthcare license. For fees and preferred verification method of each board, see the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/. For boards requiring a written request, use the form on the last page of 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.
- Notarized Non-Addiction Affidavit.
- Professional Recommendation Form.
- 25 AMA Category 1 Continuing Medical Education Credits (CMEs) dated within one (1) year of application.
- Oral interview may be required.



**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 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have proceedings been instituted to have your DEA or other controlled substance authorization denied, revoked or suspended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have proceedings been instituted to have your specialty board certification denied, revoked or suspended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware of any <u>potential</u> action(s) or proceeding(s) that may be levied against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you voluntarily relinquished any license, certification or privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you been arrested for or charged with a crime involving children? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>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.</i> | | |
| 9. Have you been convicted of a felony or are you presently indicted for a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are there presently any proceedings or investigations taking place at any hospital or other organization relating to your clinical competence or professional conduct? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 hospital's or health care facility's governing board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>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.</i> | | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>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.</i> | | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If 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 detail 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.</i> | | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you been denied professional liability insurance or has your policy ever been canceled or denied renewal? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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 _____ 20__

Notary Public

My Commission Expires

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				

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: _____



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 is 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

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 _____

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at <https://www.fsmb.org/siteassets/ua/x-pdfs/licensure-verification-information.pdf> to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at <http://www.fsmb.org/policy/contacts> to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type MD DO _____
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	<u>Virgin Islands Board of Medical Examiners</u>
Mailing address	<u>1303 Hospital Ground, Suite 10.</u>
City/State/Zip	<u>St. Thomas, VI 00802</u>

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____
 Name of licensee (last, first, middle, suffix) _____
 License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: Yes No
2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. Yes No Cannot answer under state law
3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. Yes No Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____
 Print name _____
 Title _____ Date _____
 Phone number _____ Fax number _____
 Email _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.