GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
-DEPARTMENT OF HEALTH
1303 HOSPITAL GROUND, STE. 10, ST THOMAS, VI 00802

VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS

ST. CROIX (340) 718-1311 EXT. 3849
ST. THOMAS (340) 774-7477 EXT. 5694

Dear 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 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. certification and/or degree prior to this application.

5. Proof of completing an accredited education program (copy of certificate/diploma required).

6. Be twenty-one years of age or older (copy of birth paper and/or similar proof).

7. Notarized Non-Addiction Affidavit.

8. Two (2) original, currently dated Professional Recommendation forms from the Chief Medical Officer (or Chief of Service) of the hospital where you have privileges and/or a licensed physician with whom you have worked with or someone whom you proctored with and who has personal knowledge of your character, personal reputation, background and professional ability. This form must be mailed to the Board.

9. License Verification forms must be filled out and mailed directly to **all** states that you held a license.

10. Submit a completed and notarized Authorization for Release of Information.

11. 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.

12. All applicants are required to have their credentials verified by the Federation of State Medical Board Credentialing Verification Service. Complete the following process at the website link provided: **https://portal.fsmb.org/**. Create a login for access.

13. Delineation of Scope of Practice.

14. Complete license application data form.

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

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

SELECT PROFESSION
☐ **PHYSICIAN ASSISTANT**
☐ **PHYSICIAN ASSISTANT-CERTIFIED**

APPLICATION FOR PHYSICIAN ASSISTANT IN THE U.S. VIRGIN ISLANDS

User Fillable Form Complete and Return to PLHP Office

E-mail _____

Print Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Home Address _____ City_____ State _____ Zip Code_____

Birth date ____/____/____ Birthplace _____

Social Security No. _____

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

High School _____ Location _____

College _____ Location _____

Professional School _____ Location _____

Date graduated ____/____/____ Degree received _____

•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 explanation)

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

*Complete the attached License Application Data Form.

** New address _____

_____

_____

_____

AFFIDAVIT

PASTE PHOTOGRAPH

SECURELY IN THIS SPACE

Write signature on light portion of photograph, not across features

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.

State of _____)
) ss
County or City of_____)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has never been convicted of a crime; that he/she has never been expelled from any professional society; that he/she has not suppressed any information that might affect this application; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.
*A crime would include either a felony or a misdemeanor.

_____ _____

Date of photograph **(Signature of Applicant)**

Sworn to before me this _____ day of
_____ 20_____

_____ _____

Notary Public **Commissioner of Deeds**

My Commission expires on _____/_____/_____

PERSONAL SIGNATURE OF PERSONS RECOMMENDING APPLICANT

This certifies that I have been personally acquainted with the applicant since the year(s) indicated opposite my name; that I believe him/her to be of a good moral character and worthy of licensure in the U.S. Virgin Islands; and that any reservations I may have about the applicant I agree to send by certified mail in a confidential letter to the Board of Medical Examiners of the U.S. Virgin Islands.

Please Print Name	**Personal Signature**	**P.O. Address** (Including street & city)	**Known Since**

(Signatures are required by not fewer than three citizens unrelated to applicant who must be licensed in the profession for which an applicant wishes to be examined or who are members of the staff of the professional school.)

Return Application to: **V.I. Board of Medical Examiners**
Department of Health
P.O. Box 222995
Christiansted, VI 00822-2995

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_____

MailingAddress_____

_____

Type of Practice _____ Date_____

Name of Institution and/or Supervising Physician_____

Mailing Address _____

_____

Type of Practice _____Dates _____

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 Department of Health
1303 Hospital Ground, Suite 10. St. Thomas
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)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

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 _____ My Notary Commission Expires _____

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

PO Box 222995
Christiansted, VI 00822-2995
340-774-7477 xt 5694

PROFESSIONAL RECOMMENDATION

This form must be completed and mailed DIRECTLY to the VI Board of Medical Examiners (VIBME) at PO Box 222995, Christiansted, VI 00822-2995. 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:_____

VERIFICATION OF LICENSURE

APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH HE/SHE ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN ASSISTANT. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

To Whom It May Concern:

I am being considered for physician assistant licensure in the Territory of the U.S. Virgin Islands. The V.I. Board of Medical Examiners requires that this form be completed by each state in which I am now or have ever been licensed to practice my profession. Enclosed is my authorization for release of information. **Please forward this form directly to: VI Board of Medical Examiners, Department of Health, 1303 Hospital Ground, Ste. 10, St Thomas, VI 00802**

_____
Applicant's Signature

Name: _____
Address: _____
_____

My License No. in your State: _____

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.

State of: _____

Full Name of Licensee: _____

License No.: _____ Issuance Date: _____

By: Endorsement/Reciprocity with the following state: _____

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

_____

_____

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

_____

_____

_____

Comments, if any: _____

_____

_____

Signed: _____

Title: _____

BOARD SEAL

State Board: _____

Date: _____

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 taken into account 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:

In order 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 insure 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 t his physician assistant. (Please see instructions)

Name_____

Practice Location_____

Home Address_____

Phone_____(h)_____(w)_____(c)_____(f)

(etc)

(etc)

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)

_____

_____

_____

_____

_____

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 the
(Cardholder's Full Name) **(Merchant's Name)**

credit card account indicated below the amount of _____
US $ Amount

Payment for _____ _____ for _____
First, Middle, Last Name (Licensee/Entity) credential application, registration, license renewal, CON, verification, copies, etc.

Billing Information

Billing Address_____ Cell phone # _____

City, State, Zip _____ Email_____

Card Details

☐ Visa ☐ MasterCard
Cardholder's Name as it Appears on Card _____

Credit Card Number#_____

Expiration Date ____ /_____ CVV _____ Zip Code _____

*"Please include **a copy of a government issued ID** if you are **not** the **applicant or license holder."***

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; so long as the transaction corresponds to the terms indicated in this form.

_____ _____
cardholder original signature date