

**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**

**(340) 718-1311  
EXT. 3647/3849**

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. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. A notarized Affidavit attesting to this must be furnished.
8. Two 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 directly 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. Site: [www.fsmb.org](http://www.fsmb.org) .
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

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

PRINT PROFESSION

Please Fill Out and Returned Immediately

Do Not Write Below  
Fee Stamp

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 exami-  
nation. 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

App. Of Qualifications

PRE. BY \_\_\_\_\_

DATE \_\_\_\_\_

PROF. BY \_\_\_\_\_

EXP. BY \_\_\_\_\_

DATE \_\_\_\_\_

Approval of License

BY \_\_\_\_\_

DATE \_\_\_\_\_

BY \_\_\_\_\_

LIC. NO. \_\_\_\_\_

TO CAND. \_\_\_\_\_

\*\*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 \_\_\_\_\_ )  
County or City of \_\_\_\_\_ ) ss

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.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
Date of photograph

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.

<u>Please Print Name</u>	<u>Personal Signature</u>	<u>P.O. Address</u> (Including street & city)	<u>Known Since</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(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 \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Type of Practice \_\_\_\_\_ Date \_\_\_\_\_

-----

Name of Institution and/or Supervising Physician \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Type of Practice \_\_\_\_\_ Dates \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

In order for the Virgin Islands Board of Medical Examiners to assess and verify my educational background and professional qualifications, I hereby authorize the Board to:

- make inquiries concerning such information about me to my employers (past and present), hospital(s), institution(s) or organization(s), my references, 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 Virgin Islands Board of Medical Examiners;
- authorize the Board 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 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

## 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: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

**BOARD SEAL**

## 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 Form 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