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

OFFICE OF PROFESSIONAL LICENSURE & HEALTH PLANNING

APPLICATION FOR HEALTH RELATED OCCUPATION BUSINESS LICENSE FILE WITH HEALTH PLANNING, DEPARTMENT OF HEALTH **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: _____

INTENDED NAME /PLACE OF BUSINESS _____

OCCUPATION / TYPE OF BUSINESS: _____

PHYSICAL BUSINESS ADDRESS:_____

EMAIL ADDRESS:_____

MOBILE #: ( ) _____ WORK ( )_____

Mail to: Professional Licensure & Health Planning, Charles Harwood Memorial Hospital PO BOX 222995 Christiansted, VI 00822-2995 Telephone: (340) 718-1311 XT 3849. *Updated March 25, 2022.*

Failure to furnish all required documents will delay processing.

EDUCATION/TRAINING

SCHOOL NAME/ ADDRESS	DATES	GRAD. IY/N1	DEGREE/#HRS	CONTACT NAME/TELEPHONE #	OFFICE USE
	START	Y - N	DEGREE TYPE		
	FINISH	Y - N	#HOURS		
	MARI	Y - N	DEGREE TYPE		
	FINISH	Y - N	#HOURS		
	START	Y - N	DEGREE TYPE		
	FINISH	Y - N	#HOURS		
	START	Y - N	DEGREE TYPE		
	FINISH	Y - N	#HOURS		

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

STATE /PROFESSIONAL/CERTIFICATIONS

STATE/ORGANIZATION	LICENSE#/TYPE	EXPIRATION	CONTACT NAME/TELWADDRESS	OFFICE USE

Mail to: Professional. Licensure & Health Planning, PO BOX 222995 Christiansted, VI 00822-2995
Telephone: (340) 718-1311 XT 3849_*updated 03/25/2022*

Failure to furnish all required documents will delay processing.

WORK EXPERIENCE

EMPLOYER'S ADDRESS	DATES	POSITION	CONTACT NAME/TELEPHONE #	OFFICE USE
	START FINISH			
	START FINISH			
	START FINISH			
	START FINISH			

COPY AND ADD ADDITIONAL SHEETS IF NECESSARY.

Has applicant ever undergone disciplinary hearing? ____YES____ NO
Explain: _____

_____

_____

_____

Has applicant been convicted of felony or misdemeanor?____YES ___ NO
Explain:_____

_____

_____

Has there been a malpractice settlement? ____ YESNO If (YES) How many?_____

When was latest?_____ For what?_____

What was the award?_____What was 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**

NOTARY PUBLIC

_____

_____

_____

BE SURE TO ATTACH:

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 CHARACTER REFERENCE LETTERS (FROM COLLEAGUES OR CLIENTS FAMILIAR WITH YOUR OCCUPATIONAL SKILLS);
8. COPY OF VI POLICE RECORD AND IF LIVING IN THE USVI LESS THAN 2 YEARS, YOU ALSO NEED TO SUBMIT POLICE RECORD FROM LAST CITY/STATE OR COUNTRY OF RESIDENCE PRIOR TO MOVING TO THE USVI;
9. SUBMIT PROOF OF NATIONAL CERTIFICATION IN YOUR RESPPECTIVE OCCUPATION;
10. PROOF OF LIABILITY INSURANCE;
11. COMPLETE **NOTARIZED** AUTHORIZATION OF RELEASE FORM;
12. SUBMIT COPIES OF DIPLOMAS, CERTIFICATIONS, LICENSES, ETC...; AND
13. THE APPLICATION MUST BE **NOTARIZED**.

BE SURE TO KEEP A COPY OF THE APPLICATION FOR YOUR FILE (Do not send any official original documents) AND MAIL THE ORIGINAL APPLICATION TO THE ADDRESS BELOW (FAXED AND EMAIL APPLICATIONS 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
PO BOX 222995
Christiansted, VI, 00822-2995

VI DEPARTMENT OF HEALTH
VIRGIN ISLANDS DEPARTMENT OF HALTH
OFFICIE OF PROFESSIONAL LICENSURE
PO BOX 222995- CHRISTIANSTED, VI 00822-2995

NOTARIZED NON-ADDICTION AFFIDAVIT – ALLIED HEALTH

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