"Wellness is Our Way of Life"

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

PROFESSIONAL LICENSURE
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CHARLES HARWOOD MEMORIAL HOSPITAL
PO BOX 222995
CHRISTIANSTED, VI 00822-2995

ALLIED HEALTH RENEWAL REQUEST

NAME:_____

MAILING ADDRESS:_____

_____

TELEPHONE NUMBER:_____

OCCUPATION:_____DLCA CONTROL#_____

BUSINESS NAME & BUSINESS ADDRESS:_____

_____

DLCA LICENSE # & EXPIRATION:_____

EMAIL ADDRESS:_____

SIGNATURE_____DATE:_____

PLEASE BE SURE TO ATTACH COPIES OF THE FOLLOWING:

1. EIGHT (8) CONTINUING EDUCATION CREDITS ANNUALY;
2. *UPDATED PROFESSIONAL CREDENTIALS;*
3. *UPDATED CERTIFICATIONS AND/OR STATE LICENSES;*
4. *PROOF OF ATTENDANCE TO A 3 HOUR HIV/STD COURSE;AND*
5. *PROOF OF MALPRACTICE INSURANCE.*
6. *PLEASE* **MAIL** *YOUR COMPLETED RENEWAL FORM AND DOCUMENTS DOH-PROFESIONAL LICENSURE, ATTN: RAMONA LIGER, AT PO BOX 222995, CHRISTIANSTED, VI 00822-2995*