



**GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES  
DEPARTMENT OF HEALTH  
OFFICE OF PROFESSIONAL LICENSURE & HEALTH PLANNING**

**TEMPORARY VETERINARY PERMIT REQUEST**

**RELIEF VETERINARIAN - PLEASE TYPE (HANDWRITTEN APPLICATIONS ARE NOT ACCEPTED)**

DATE: MM/DD/YYYY	FIRST	MIDDLE	LAST	SUFFIX
DOB: MM/DD/YYYY	LAST 4 DIGITS OF SS#	EMAIL ADDRESS		CELL PHONE #
MAILING ADDRESS		CITY	STATE	ZIP CODE
DATE(S) REQUESTED:				
REQUESTING VI DVM:	LICENSE #:	DATE(S) REQUESTED:		
		FROM:	TO:	
PURPOSE FOR REQUEST:				
<b>EDUCATION/TRAINING</b>				
<b>VETERINARY SCHOOL</b>	<b>GRADUATE</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>GRADUATION YEAR</b>	<b>DEGREE</b>	
<b>STATE/PROFESSIONAL CERTIFICATIONS</b>				
STATE LICENSED	LICENSE #	LICENSE DATES		
STATE LICENSED	LICENSE #	LICENSE DATES		
LIABILITY CARRIER	POLICY #	START /END DATE	OFFICE USE ONLY	
<b>BACKGROUND INFORMATION</b>				
HAVE YOU WORKED IN THE VI PREVIOUSLY? IF YES, WHEN AND FOR WHOM?				
DO YOU HAVE ANY CURRENT OR PENDING DISCIPLINARY ISSUES ON YOUR RECORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:				

HAVE YOU EVER UNDERGONE DISCIPLINARY HEARING?  YES  NO

IF YES, PLEASE  
EXPLAIN:

HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR?  YES  NO

IF YES, PLEASE EXPLAIN:

I hereby affirm under the penalties of perjury that the statements made in this application are true, complete, and correct. I further waive, for process of this application, any confidentiality provisions concerning the information required to be provided to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Requesting VI DVM Signature

\_\_\_\_\_  
Date

**PLEASE BE SURE TO ATTACH:**

1. LEGIBLE COPY OF GOVERNMENT ISSUED IDENTIFICATION.
2. COPY OF STATE LICENSE & VERIFICATION.
3. COPY OF INSURANCE.
4. COPY OF DIPLOMA.

**EMAIL TO:** [PLHPDOCUMENTS@DOH.VI.GOV](mailto:PLHPDOCUMENTS@DOH.VI.GOV)

Professional Licensure & Health Planning, VI Department of Health – P.O. Box 222995 Christiansted, VI 00822-2995  
Telephone: 340-718-1311 STX OR 340-774-7477 Ext. 5694 STT