GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

Dear Applicant:

Thank you for your interest in serving the people of the Virgin Islands. Enclosed is the Allied Health Professional Regulatory Clearance Application. Regulatory clearance confirms that allied health professionals practicing in the Territory are qualified, in good standing, and able to provide safe care to the public.

Please read the instructions carefully before you begin. Several items must be sent to our office directly by a third party, including your school transcripts, license verifications from every state where you have been licensed, and two Professional Recommendations. Because your application cannot be completed until these arrive, we encourage you to request them as early as possible, along with your National Practitioner Data Bank (NPDB) self-query.

A complete application includes:

- the typed application, with every page initialed, signed before a notary public and notarized;
- the notarized Authorization for Release of Information (Form 1) and Non-Addiction Affidavit (Form 2);
- copies of every document listed under “Before You Begin”; and
- a signed written explanation and supporting records for any “Yes” answer in the Professional Fitness Disclosure.

If you are applying as a Board Certified Behavior Analyst (BCBA), please also complete Section H of the application and include the additional BCBA documentation listed there, including current verification of your certification from the Behavior Analyst Certification Board (BACB). All other applicants should simply mark “No” in Section H.

Incomplete applications will not be processed. The application is signed under the penalties of perjury, so please answer every question fully and honestly. Please send copies rather than official original documents, and keep a copy of your complete application for your records.

Mail your complete, notarized application to the Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351. **Faxed or emailed applications cannot be accepted.**

If you have questions about the application process, please contact our office at (340) 643-8992 or alliedhealth@doh.vi.gov. We appreciate your cooperation and look forward to reviewing your application.

Sincerely,

Justa Encarnacion, RN, BSN, MBA/HCM
Commissioner, VI Department of Health

Enclosures: Application (including Section H for BCBA applicants); Form 1 – Authorization for Release of Information; Form 2 – Non-Addiction Affidavit; Form 3 – Professional Recommendation (2 copies)

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

ALLIED HEALTH PROFESSIONAL REGULATORY CLEARANCE APPLICATION

FILLABLE FORM • TYPE ALL ENTRIES • INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

BEFORE YOU BEGIN — REQUIRED DOCUMENTS

Gather these items before you start. Send copies, not official originals. Items marked ★ must be sent directly to this Office by the issuing source. You will confirm each item in Section F.

1. Legible copy of a current government-issued photo identification
2. ★ Official school transcript(s), sent directly by each school
3. ★ Official license verification from every state in which you have ever been licensed
4. Detailed narrative describing the proposed business (services, location, MOUs, contracts, etc.)
5. Copies of professional credentials
6. Notarized Non-Addiction Affidavit (Form 2)
7. ★ Two (2) Professional Recommendation forms (Form 3), sent directly by each recommender
8. VI police record; if you have lived in the USVI less than two (2) years, also a police record from your last city, state, or country of residence
9. Proof of national certification in your occupation
10. Proof of current professional liability insurance
11. Notarized Authorization for Release of Information (Form 1)
12. Copies of diplomas, certifications, and licenses
13. NPDB self-query report, all parts, dated within six (6) months
14. This application, signed and notarized (Sections I and J)

GENERAL INSTRUCTIONS

1. This application must be completed by typing or entering information electronically. Handwritten entries will not be accepted, except for signatures and initials.

2. Answer every item. Enter "N/A" for any item that does not apply. Incomplete applications will not be processed and will be returned to the applicant.

3. Attach legible **copies** of the documents listed under Before You Begin. **Do not send official original documents.** Keep a complete copy of your application for your records.

4. Request early the items that must come directly from a third party (transcripts, license verifications, and Professional Recommendations). Your application cannot be completed until they are received.

5. Any "Yes" answer in Section G requires a signed, written explanation and supporting documentation. For any criminal matter, attach a certified copy of the court disposition.

6. Initial each page where indicated. Sign the Applicant Attestation (Section I), the Authorization for Release of Information (Form 1), and the Non-Addiction Affidavit (Form 2) in the presence of a notary public.

7. **BCBA applicants** must also complete Section H and attach the documents listed there. All other applicants mark "No" in Section H.

8. Mail the complete, notarized original application and all attachments to: Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351. **Faxed or emailed applications will not be accepted.**

NATIONAL PRACTITIONER DATA BANK (NPDB) SELF-QUERY INSTRUCTIONS

a. Visit the National Practitioner Data Bank (NPDB) website at www.npdb.hrsa.gov and begin the self-query process. Follow all instructions given.

b. After your self-query has been processed, the NPDB will send the self-query report directly to you.

c. Open the report and confirm that the query was not rejected and that all information submitted is correct.

d. Submit all parts of the self-query report to this Office with your application. The report must be dated within six (6) months of the date this application is submitted.

e. For NPDB questions or assistance, call 1-800-767-6732 or email help@npdb.hrsa.gov.

WARNING: Any false, misleading, or incomplete statement, or the omission of any material fact, in this application or its supporting documents may result in denial of this application, suspension or revocation of any regulatory clearance issued, disciplinary action, and referral for criminal prosecution under the laws of the Virgin Islands of the United States.

PRIVACY NOTICE: The information requested in this application is collected to determine the applicant's eligibility for regulatory clearance and to verify the applicant's identity and professional standing. Only the last four digits of the Social Security Number are requested, for identification purposes. Information provided will be used and disclosed only as permitted by applicable law.

APPLICATION DATE (MM/DD/YYYY)

SECTION A — APPLICANT INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME | SUFFIX

OTHER NAMES USED (MAIDEN, PRIOR LEGAL NAMES) | DATE OF BIRTH (MM/DD/YYYY) | SSN (LAST 4 DIGITS)

MAILING ADDRESS | CITY | STATE/TERRITORY | ZIP CODE

RESIDENTIAL ADDRESS (IF DIFFERENT) | CITY | STATE/TERRITORY | ZIP CODE

EMAIL ADDRESS | MOBILE PHONE | WORK PHONE

DATE BEGAN RESIDING IN THE USVI (IF APPLICABLE) | PRIOR CITY, STATE/COUNTRY OF RESIDENCE (IF IN USVI LESS THAN 2 YEARS)

SECTION B — PROPOSED PRACTICE / BUSINESS INFORMATION

OCCUPATION / PROFESSION | TYPE OF BUSINESS / PRACTICE

INTENDED BUSINESS NAME | DLCA CONTROL NO. (IF ASSIGNED)

PHYSICAL BUSINESS ADDRESS | CITY | STATE/TERRITORY | ZIP CODE

BUSINESS PHONE | SUPERVISING / COLLABORATING PRACTITIONER (IF REQUIRED)

Attach a detailed narrative describing the proposed business, including services, location, MOUs, and contracts.

SECTION C — EDUCATION & TRAINING

List all professional education and training. Enter dates as MM/YYYY. Attach additional pages if necessary.

SCHOOL NAME & ADDRESS	START	FINISH	GRAD. Y/N	DEGREE / TYPE	HOURS	CONTACT NAME / PHONE

SECTION D — STATE LICENSES & PROFESSIONAL CERTIFICATIONS

List every license and certification you hold or have ever held, in any state, territory, or country.

STATE / ORGANIZATION	LICENSE / CERT. NO.	TYPE	STATUS	EXPIRATION	CONTACT NAME / PHONE / ADDRESS

SECTION E — WORK EXPERIENCE

List your professional work experience, most recent first. Enter dates as MM/YYYY. Attach additional pages if necessary.

EMPLOYER NAME & ADDRESS	START	FINISH	POSITION	CONTACT NAME / PHONE

SECTION F — REQUIRED DOCUMENTATION CHECKLIST

Check each box to confirm the item is attached or has been requested from the issuing source. **Incomplete applications will not be processed.**

- ☐ Copy of government-issued photo identification.
- ☐ Official transcript(s) requested and sent directly to this Office by each school.
- ☐ Official license verification(s) requested from every state in which I have ever been licensed, sent directly to this Office.
- ☐ Detailed narrative describing the proposed business (services, location, MOUs, contracts, etc.).
- ☐ Copies of professional credentials.
- ☐ Notarized Non-Addiction Affidavit (Form 2).
- ☐ Two (2) Professional Recommendation forms (Form 3) given to recommenders, to be sent directly to this Office.
- ☐ VI police record, and, if residing in the USVI less than two (2) years, police record from my prior place of residence.
- ☐ Proof of national certification in my occupation.
- ☐ Proof of current professional liability insurance.
- ☐ Notarized Authorization for Release of Information (Form 1).
- ☐ Copies of diplomas, certifications, and licenses.
- ☐ NPDB self-query report, all parts, dated within six (6) months of this application.
- ☐ Signed written explanation and supporting documentation for each “Yes” answer in Section G (if applicable).

SECTION G — PROFESSIONAL FITNESS DISCLOSURE

Answer each question "Yes" or "No." Each question refers to any time in the past, in any jurisdiction, unless otherwise stated.

1. Has any license, certification, registration, or other authorization to practice a health profession held by you ever been denied, revoked, suspended, restricted, limited, placed on probation, not renewed, or voluntarily surrendered, or have you ever been reprimanded, fined, or otherwise disciplined? ○ Yes ○ No

2. Have you ever been the subject of a disciplinary hearing, or are you currently the subject of any pending investigation, complaint, or disciplinary proceeding by any licensing board, certifying body, health care facility, or governmental agency? ○ Yes ○ No

3. Have you ever been arrested for, charged with, convicted of, or pled guilty or nolo contendere (no contest) to any felony or misdemeanor, excluding minor traffic violations? (Attach a certified copy of each disposition.) ○ Yes ○ No

4. Has any professional liability (malpractice) claim or lawsuit ever been filed against you, or has any judgment, award, or settlement been made on your behalf? (If "Yes," also complete the malpractice details below.) ○ Yes ○ No

5. Have your clinical privileges, staff membership, or employment at any hospital, clinic, or other health care facility ever been denied, suspended, restricted, terminated, or not renewed for reasons related to your professional competence or conduct, or did you resign while under investigation? ○ Yes ○ No

6. Have you ever been excluded, suspended, or debarred from participation in Medicare, Medicaid, or any other federal or territorial health care program? ○ Yes ○ No

7. Do you currently have any medical, physical, mental, or emotional condition, or do you currently use any chemical substance, that in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ○ Yes ○ No

Malpractice details (complete only if you answered "Yes" to Question 4):

NUMBER OF CLAIMS / SUITS	DATE OF MOST RECENT	TOTAL AWARD AMOUNT	TOTAL SETTLEMENT AMOUNT

NATURE OF CLAIM(S)

If you answered "Yes" to any question, identify the question number and provide a complete explanation below (attach additional signed pages and supporting documentation as needed):

SECTION H — BOARD CERTIFIED BEHAVIOR ANALYST (BCBA) APPLICANTS

Complete this section only if you are applying for regulatory clearance as a Board Certified Behavior Analyst (BCBA). All other applicants: mark "No" below and leave the rest of this section blank.

Applying as a BCBA: ○ Yes ○ No

BACB CERTIFICATION

BACB CERTIFICATION NUMBER	ORIGINAL CERTIFICATION DATE	EXPIRATION DATE

Certification Status: ○ Active ○ Inactive ○ Other

BEHAVIOR ANALYST LICENSURE

Have you ever held a Behavior Analyst license? ○ Yes ○ No

If "Yes," list each license below and attach official verification of each. Attach additional pages if necessary.

STATE / TERRITORY / JURISDICTION	LICENSING AGENCY	LICENSE NO.	STATUS	EXPIRATION

PROPOSED PRACTICE

EMPLOYER OR PRACTICE NAME	SUPERVISING / COLLABORATING PRACTITIONER (IF APPLICABLE)

Practice Setting (check all that apply): ☐ Independent ☐ Healthcare ☐ School ☐ Employer ☐ Other

POPULATION(S) TO BE SERVED

Description of Applied Behavior Analysis services to be provided in the U.S. Virgin Islands (attach additional pages if necessary):

REQUIRED BCBA SUPPORTING DOCUMENTATION

Check each box to confirm the document is attached. These are in addition to the items listed in Section F.

- ☐ Current BACB certification verification showing certification number, status, and expiration date.
- ☐ Official graduate transcript and documentation of education or training in Applied Behavior Analysis.
- ☐ Official verification of every Behavior Analyst license held, if applicable.
- ☐ Proof of current professional liability or malpractice insurance.
- ☐ Current National Practitioner Data Bank self-query dated within six (6) months of the application.
- ☐ Detailed description of the Applied Behavior Analysis services to be provided in the U.S. Virgin Islands.

BCBA APPLICANT ATTESTATION

I affirm that the information provided in this section is true, complete, and correct. I understand that I must maintain current BCBA certification with the Behavior Analyst Certification Board (BACB) and current professional liability coverage at all times while practicing under an Allied Health Professional Regulatory Clearance. I will promptly notify the Office of Licensure Boards & Regulatory Services in writing of any expiration, suspension, restriction, revocation, disciplinary action, or other change affecting my certification or any professional license. I understand that failure to maintain certification or coverage, or to report such a change, may result in suspension or revocation of my regulatory clearance.

APPLICANT INITIALS _____ DATE _____

SECTION I — APPLICANT ATTESTATION (UNDER PENALTY OF PERJURY)

I, the undersigned applicant, hereby affirm under the penalties of perjury that:

1. I have read and understand this application, including all instructions, and I am the person described in it.

2. The statements made in this application and in all documents submitted with it are true, complete, and correct.

3. I understand that any false, misleading, or incomplete statement, or the omission of any material fact, may constitute grounds for denial of this application, suspension or revocation of any regulatory clearance issued, disciplinary action, and criminal prosecution under the laws of the Virgin Islands of the United States.

4. I will promptly notify the Office of Licensure Boards & Regulatory Services in writing of any change in the information provided in this application while it is pending and throughout the term of any clearance issued.

5. For the purpose of processing this application, I waive, to the extent permitted by law, any confidentiality provisions concerning the information required to be provided in this application.

6. I agree to comply with all applicable laws, rules, and regulations of the Virgin Islands of the United States governing the practice of my profession.

APPLICANT SIGNATURE _____ DATE _____

PRINTED NAME OF APPLICANT

SECTION J — NOTARIAL JURAT

TERRITORY / STATE OF

DISTRICT / COUNTY OF

Subscribed and sworn to (or affirmed) before me on this date by the applicant named above, who is personally known to me or who produced satisfactory evidence of identification.

SIGNATURE OF NOTARY PUBLIC _____ DATE _____

PRINTED NAME OF NOTARY _____ COMMISSION NO. _____ COMMISSION EXPIRES _____

(Notary Seal)

FOR OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE

DATE RECEIVED	RECEIVED BY	FEE PAID / RECEIPT NO.	REVIEWED BY

DOCUMENTS COMPLETE (Y/N)	NPDB VERIFIED (Y/N)	ACTION: APPROVED/DENIED/DEFERRED	CLEARANCE NO. ISSUED

CLEARANCE EXPIRATION	BOARD / DIRECTOR SIGNATURE	DATE

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

FORM 1 — AUTHORIZATION FOR RELEASE OF INFORMATION

MUST BE SIGNED BEFORE A NOTARY PUBLIC

In connection with my application for Allied Health Professional Regulatory Clearance in the United States Virgin Islands, I, the undersigned applicant, hereby authorize and consent to the release to the Virgin Islands Department of Health, Office of Licensure Boards & Regulatory Services ("LBRS"), of any and all information requested by LBRS concerning my education, training, licensure, certification, employment, professional conduct, criminal history, and fitness to practice. Specifically, I:

1. Authorize LBRS and its designated agents to make inquiries concerning such information about me to my past and present employers, hospitals, institutions, references, schools, licensing boards, certifying bodies, insurance carriers, the National Practitioner Data Bank, and all governmental agencies and instrumentalities (local, territorial, state, federal, or foreign);

2. Authorize and direct each such person and entity to release such information, and copies of related records and documents, to LBRS;

3. Authorize LBRS to disclose to such persons and entities identifying and other information about me sufficient to enable LBRS and the Board to make such inquiries; and

4. Release from liability all persons and entities who provide information to the Virgin Islands Department of Health or LBRS in good faith and without malice in response to such inquiries.

This authorization remains valid for the duration of my application and the term of any clearance issued. A photocopy or electronic copy of this authorization shall be as valid as the original.

PRINTED FULL NAME OF APPLICANT | **DATE OF BIRTH (MM/DD/YYYY)** | **SSN (LAST 4)**

APPLICANT SIGNATURE | **DATE**

NOTARIAL JURAT

TERRITORY / STATE OF | **DISTRICT / COUNTY OF**

Subscribed and sworn to (or affirmed) before me on this date by the applicant named above, who is personally known to me or who produced satisfactory evidence of identification.

SIGNATURE OF NOTARY PUBLIC | **DATE**

PRINTED NAME OF NOTARY | **COMMISSION NO.** | **COMMISSION EXPIRES**
(Notary Seal)

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

FORM 2 — NON-ADDICTION AFFIDAVIT

MUST BE SIGNED BEFORE A NOTARY PUBLIC

I, the undersigned, being first duly sworn, depose and state:

FULL NAME (FIRST, MIDDLE, LAST, SUFFIX)

PROFESSION

1. I am not addicted to or dependent upon alcohol, illicit drugs, prescription medications (including controlled substances), or any other mind-altering substance.

2. I do not currently use alcohol, any drug, or any other substance in a manner that alters or impairs my judgment or my ability to carry out the duties of my profession with reasonable skill and safety.

3. I understand that any false or misleading statement in this affidavit, or in or in connection with my application, may be cause for denial of my application or revocation of any clearance issued, including on the ground of lack of good moral character, and may subject me to prosecution for perjury under the laws of the Virgin Islands of the United States.

SIGNATURE OF AFFIANT

DATE

PRINTED NAME OF AFFIANT

NOTARIAL JURAT

TERRITORY / STATE OF

DISTRICT / COUNTY OF

Subscribed and sworn to (or affirmed) before me on this date by the applicant named above, who is personally known to me or who produced satisfactory evidence of identification.

SIGNATURE OF NOTARY PUBLIC

DATE

PRINTED NAME OF NOTARY
(Notary Seal)

COMMISSION NO.

COMMISSION EXPIRES

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

FORM 3 — PROFESSIONAL RECOMMENDATION

COPY 1 OF 2 • CONFIDENTIAL • NOT A PUBLIC DOCUMENT

To the Recommending Professional: The applicant named below has applied for Allied Health Professional Regulatory Clearance in the U.S. Virgin Islands and has identified you as a colleague or licensed professional familiar with their clinical skills, character, and professional ability. **Please complete every item in Part 2 and mail this form DIRECTLY to:** Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351. Forms received from the applicant will not be accepted.

PART 1 — TO BE COMPLETED BY THE APPLICANT

APPLICANT'S FULL NAME | PROFESSION | MAILING ADDRESS (STREET, CITY, STATE, ZIP)

By signing below, I authorize the recommending professional to complete this form and to release all information in their files concerning me, favorable or otherwise, directly to LBRS, and I waive any right to review this recommendation.

APPLICANT SIGNATURE | DATE

PART 2 — TO BE COMPLETED BY THE RECOMMENDING PROFESSIONAL (ALL ITEMS REQUIRED)

1. Nature of your professional relationship with the applicant:

TYPE OF SERVICE | APPLICANT SERVED WITH ME AS | FROM (MM/YY) | TO (MM/YY) | FACILITY / LOCATION

2. Please rate the applicant in each area:

	POOR	FAIR	GOOD	SUPERIOR	N/A
Professional knowledge	○	○	○	○	○
Clinical judgment	○	○	○	○	○
Relationships with patients or clients	○	○	○	○	○
Ethical / professional conduct	○	○	○	○	○
Ability to communicate	○	○	○	○	○
Clinical skills	○	○	○	○	○

3. Recommendation (select one):

- ○ Recommend highly, without reservation
- ○ Recommend as qualified and competent
- ○ Recommend with some reservation (explain below)
- ○ Have concerns (explain below)

4. Please comment on the applicant's notable strengths and weaknesses, including personal demeanor, and explain any reservation or concern. Attach additional signed pages if needed.

5. This recommendation is based on (check all that apply):

☐ Close personal observation ☐ General impression ☐ A composite of evaluations ☐ Other

RECOMMENDER PRINTED NAME | TITLE / CREDENTIALS | LICENSE NO. & STATE | PHONE | EMAIL

I certify that this information is true and accurate and is based on my personal knowledge of the applicant's practice.

SIGNATURE OF RECOMMENDING PROFESSIONAL | DATE

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH
OFFICE OF LICENSURE BOARDS & REGULATORY SERVICES

4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351 • Email: alliedhealth@doh.vi.gov • Phone: (340) 643-8992

FORM 3 — PROFESSIONAL RECOMMENDATION

COPY 2 OF 2 • CONFIDENTIAL • NOT A PUBLIC DOCUMENT

To the Recommending Professional: The applicant named below has applied for Allied Health Professional Regulatory Clearance in the U.S. Virgin Islands and has identified you as a colleague or licensed professional familiar with their clinical skills, character, and professional ability. **Please complete every item in Part 2 and mail this form DIRECTLY to:** Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351. Forms received from the applicant will not be accepted.

PART 1 — TO BE COMPLETED BY THE APPLICANT

APPLICANT'S FULL NAME | PROFESSION | MAILING ADDRESS (STREET, CITY, STATE, ZIP)

By signing below, I authorize the recommending professional to complete this form and to release all information in their files concerning me, favorable or otherwise, directly to LBRS, and I waive any right to review this recommendation.

APPLICANT SIGNATURE _____ DATE _____

PART 2 — TO BE COMPLETED BY THE RECOMMENDING PROFESSIONAL (ALL ITEMS REQUIRED)

1. Nature of your professional relationship with the applicant:

TYPE OF SERVICE | APPLICANT SERVED WITH ME AS | FROM (MM/YY) | TO (MM/YY) | FACILITY / LOCATION

2. Please rate the applicant in each area:

	POOR	FAIR	GOOD	SUPERIOR	N/A
Professional knowledge	○	○	○	○	○
Clinical judgment	○	○	○	○	○
Relationships with patients or clients	○	○	○	○	○
Ethical / professional conduct	○	○	○	○	○
Ability to communicate	○	○	○	○	○
Clinical skills	○	○	○	○	○

3. Recommendation (select one):

- ○ Recommend highly, without reservation
- ○ Recommend as qualified and competent
- ○ Recommend with some reservation (explain below)
- ○ Have concerns (explain below)

4. Please comment on the applicant's notable strengths and weaknesses, including personal demeanor, and explain any reservation or concern. Attach additional signed pages if needed.

5. This recommendation is based on (check all that apply):

☐ Close personal observation ☐ General impression ☐ A composite of evaluations ☐ Other _____

RECOMMENDER PRINTED NAME | TITLE / CREDENTIALS | LICENSE NO. & STATE | PHONE | EMAIL

I certify that this information is true and accurate and is based on my personal knowledge of the applicant's practice.

SIGNATURE OF RECOMMENDING PROFESSIONAL _____ DATE _____