**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 continued service to the people of the Virgin Islands. Enclosed is the Allied Health Professional Regulatory Clearance Renewal Application. Regulatory clearance confirms that allied health professionals practicing in the Territory remain qualified, in good standing, and able to provide safe care to the public.

Please read the instructions carefully before completing the application, and allow enough time to gather your supporting documents. The National Practitioner Data Bank (NPDB) self-query in particular must be requested from the NPDB and returned to you before you can submit it, so we encourage you to begin the renewal process well before your current clearance expires.

A complete renewal submission includes:

- the typed application, with every page initialed;
- the Applicant Attestation, signed by you in the presence of a notary public and notarized;
- copies of every document listed under “Before You Begin,” including an NPDB self-query report dated within six (6) months; and
- a signed written explanation and supporting records for any “Yes” answer in the Professional Fitness Disclosure.

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

**Incomplete applications will not be processed.** The application is signed under the penalties of perjury, so please answer every question fully and honestly. An incomplete or inaccurate response may delay your application or result in its denial.

Email the completed application and all supporting documents to **alliedhealth@doh.vi.gov**, and mail the signed, notarized original to the Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351.

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

Sincerely,

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

Enclosure: Allied Health Professional Regulatory Clearance Renewal Application (5 pages)

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# ALLIED HEALTH PROFESSIONAL REGULATORY CLEARANCE RENEWAL APPLICATION

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

## BEFORE YOU BEGIN — REQUIRED DOCUMENTS

Gather these documents before you start. Attach legible copies of each, and confirm each one in Section E.

1. Proof of fifteen (15) CE credits for each year of the renewal period
2. Updated professional credentials
3. Current certifications and/or state licenses
4. Proof of a three (3) hour HIV/STD course
5. Proof of current malpractice insurance
6. NPDB self-query report, all parts, dated within six (6) months (see NPDB instructions below)
7. Written explanation and records for any "Yes" answer in Section F (if applicable)

## GENERAL INSTRUCTIONS

**1.** This application must be completed by typing or entering information electronically. Handwritten entries will not be accepted, except for the applicant's signature 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 every document listed under Before You Begin and confirm each in Section E. Failure to furnish all required documents will delay processing.

**4.** Any "Yes" answer in Section F requires a signed, written explanation and supporting documentation (for example, court records or board orders).

**5.** Initial each page where indicated and sign the Applicant Attestation in Section I. The original application mailed to this Office must bear the applicant's original signature and must be notarized in Section J.

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

**7.** Email the completed application and all supporting documents to alliedhealth@doh.vi.gov, AND mail the signed, notarized original application to: Office of Licensure Boards & Regulatory Services, 4006 Estate Diamond, Suite 104, Christiansted, St. Croix, VI 00820-5351.

## 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 renewal of 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.

## FOR OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE

| DATE RECEIVED | RECEIVED BY | FEE PAID / RECEIPT NO. | REVIEWED BY | DOCS COMPLETE (Y/N) |
|---|---|---|---|---|
| | | | | |

| NPDB VERIFIED (Y/N) | ACTION TAKEN | CLEARANCE NO. ISSUED | CLEARANCE EXPIRATION | BOARD / DIRECTOR SIGNATURE |
|---|---|---|---|---|
| | | | | |

APPLICATION DATE (MM/DD/YYYY) | CURRENT VI REGULATORY CLEARANCE NO. | CURRENT CLEARANCE EXPIRATION DATE

## 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

## SECTION B — PROFESSIONAL & PRACTICE INFORMATION

OCCUPATION / PROFESSION | SPECIALTY (IF ANY)

DLCA CONTROL NO. | DLCA BUSINESS LICENSE NO. | DLCA LICENSE EXPIRATION DATE

BUSINESS / EMPLOYER NAME

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

BUSINESS PHONE | SUPERVISING / COLLABORATING PRACTITIONER (IF REQUIRED)

## SECTION C — LICENSES, CERTIFICATIONS & CREDENTIALS HELD (ALL JURISDICTIONS)

List every professional license, certification, and registration you currently hold or have held in any state, territory, or country. Attach additional pages if necessary.

| TYPE / CREDENTIAL | ISSUING STATE / AGENCY | NUMBER | STATUS | EXPIRATION DATE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SECTION D — CONTINUING EDUCATION & PROFESSIONAL LIABILITY INSURANCE

CE REPORTING PERIOD — FROM | CE REPORTING PERIOD — TO | TOTAL CE CREDITS COMPLETED

HIV/STD COURSE TITLE / PROVIDER | HOURS | DATE COMPLETED

MALPRACTICE INSURANCE CARRIER | POLICY NUMBER

| COVERAGE LIMITS (PER CLAIM / AGGREGATE) | EFFECTIVE DATE | EXPIRATION DATE |
|---|---|---|
| | | |

| NPDB SELF-QUERY REPORT DATE | NPDB DOCUMENT CONTROL NO. |
|---|---|
| | |

## SECTION E — REQUIRED DOCUMENTATION CHECKLIST

Check each box to confirm that the document is attached. **Incomplete applications will not be processed.**

- ☐ Proof of fifteen (15) continuing education (CE) credits for each year of the renewal period.
- ☐ Updated professional credentials.
- ☐ Updated certifications and/or state licenses (current and unexpired).
- ☐ Proof of attendance at a three (3) hour HIV/STD course.
- ☐ Proof of current malpractice (professional liability) insurance.
- ☐ Current National Practitioner Data Bank (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 F (if applicable).

## SECTION F — PROFESSIONAL FITNESS DISCLOSURE

Answer each question "Yes" or "No." Unless otherwise stated, each question refers to the period since your last regulatory clearance was issued or renewed, or, if you have not previously held clearance in the Virgin Islands, at any time.

| | | | |
|---|---|---|---|
| **1.** | Has any license, certification, registration, or other authorization to practice a health profession held by you in any jurisdiction been denied, revoked, suspended, restricted, limited, placed on probation, not renewed, or voluntarily surrendered, or have you been reprimanded, fined, or otherwise disciplined? | ○ Yes | ○ No |
| **2.** | 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 been arrested for, charged with, convicted of, or pled guilty or nolo contendere (no contest) to any felony or misdemeanor in any jurisdiction, excluding minor traffic violations? | ○ Yes | ○ No |
| **4.** | Has any professional liability (malpractice) claim or lawsuit been filed against you, or has any judgment or settlement been made on your behalf? | ○ Yes | ○ No |
| **5.** | Have your clinical privileges, staff membership, or employment at any hospital, clinic, or other health care facility 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 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 |

**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 G — BOARD CERTIFIED BEHAVIOR ANALYST (BCBA) RENEWAL

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

**Renewing as a BCBA:** ○ Yes ○ No

### BACB CERTIFICATION

BACB CERTIFICATION NUMBER

CERTIFICATION EXPIRATION DATE

**Have there been any changes to your certification status since your last renewal?** ○ No ○ Yes

IF "YES," EXPLAIN

### CONTINUING EDUCATION

RENEWAL PERIOD — FROM

RENEWAL PERIOD — TO

TOTAL BCBA CE CREDITS COMPLETED

Attach copies of CE certificates or a BACB continuing education transcript.

### PROFESSIONAL LIABILITY INSURANCE

INSURANCE CARRIER

POLICY NUMBER

EFFECTIVE DATE

EXPIRATION DATE

### DISCLOSURES — SINCE YOUR LAST RENEWAL

**1.** Have you had any disciplinary action taken against any professional license, certification, or registration? ○ Yes ○ No

**2.** Have you been convicted of, or pled guilty or nolo contendere (no contest) to, a felony or misdemeanor? ○ Yes ○ No

**3.** Have there been any malpractice claims, settlements, or judgments? ○ Yes ○ No

**If you answered "Yes" to any question above,** identify the question number and explain below, including details of any malpractice claim, settlement, or judgment. Attach supporting documentation.

### REQUIRED BCBA RENEWAL DOCUMENTATION

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

- ☐ Current BACB certification verification.
- ☐ Documentation of required BCBA continuing education credits (CE certificates or BACB continuing education transcript).
- ☐ Current professional liability insurance.
- ☐ Current NPDB self-query dated within six (6) months.
- ☐ Verification of any new Behavior Analyst license obtained since the last renewal.
- ☐ Explanation and supporting documents for any disciplinary, criminal, or malpractice matters reported above.

### BCBA APPLICANT ATTESTATION

I certify under the penalties of perjury that my BCBA certification with the Behavior Analyst Certification Board (BACB) remains active and that all information submitted with this renewal application is true, complete, and correct. 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.

APPLICANT SIGNATURE

DATE

## SECTION H — AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Virgin Islands Department of Health, Office of Licensure Boards & Regulatory Services, and its designated agents, to verify the information contained in this application and to contact and obtain records and information from any licensing board, certifying body, educational institution, employer, health care facility, insurance carrier, law enforcement agency, the National Practitioner Data Bank, or any other person or entity holding information relevant to my qualifications, professional conduct, or fitness to practice. I release all such persons and entities from liability for furnishing such information in good faith. A photocopy or electronic copy of this authorization shall be as valid as the original.

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, including any change in the status of any license, certification, or professional liability insurance, while this application 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)*