VI DEPARTMENT OF HEALTH
VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS
1303 Hospital Ground, Suite 10 | St. Thomas, VI 00802

Tel: St. Thomas (340) 774-7477 ext. 5694
Fax: (340)777-4001
1303 Hospital Ground, STE. 10
St. Thomas, VI 00802

Tel: St. Croix (340) 713-6803
3500 Estate Richmond
Christiansted, VI 00820-4370

Dear Applicant:

The Virgin Islands Board of Medical Examiners received your request for information pertaining to licensure procedures to practice medicine in the U.S. Virgin Islands. Please review these instructions carefully and provide accurate and complete information on your application to avoid delays in processing. Use the checklist provided at the end to ensure that you send all required documentation.

All applicants are required to complete and submit the VI licensure application through the Uniform Application for Physician State Licensure (UA) and the Federation Credentials Verification Service (FCVS) profile on the Federation of State Medical Boards website at http://www.fsmb.org/ under FCVS and Uniform Application (UA) respectively. You should first complete the FCVS application as this process takes a minimum of 8 to 12 weeks.

Enclosed are the remaining instructions for Physician licensure in the U.S. Virgin Islands.

Your interest is appreciated and please feel free to contact any of our offices if you need further assistance.

Sincerely,

Frank A. Odlum, MD
Chairperson
V.I. Board of Medical Examiners

Requirements for Medical Licensure in the U.S. Virgin Islands

You must comply with the following licensure requirements:

- Complete and submit an application for credentials verification online with the Federation Credentials Verification Service (FCVS). This includes but is not limited to:
    - Verification of certificate issued by the Educational Council for Foreign Medical Graduates (ECFMG) if an international graduate.
- Complete and submit the online Uniform Application for Physician State Licensure (UA). This includes but is not limited to:
    - A chronological account of all time spent between the date of graduation from medical school and time of application.
    - Information on any malpractice liability claims.
    - Board-specific Addendum in this packet.
    - License verification from all states in which you are/were licensed.
- Submit a recent dated un-mounted photograph of passport size of yourself, autographed in ink across the back directly to the Board office.
- Submit the $250.00 application fee payable to the "Government of the VI" directly to the Board office.
- Be a graduate of an accredited school of medicine, having satisfactorily completed at least a three (3) year residency recognized by the American Medical Association or the American Osteopathic Association.
- Be twenty-one (21) years of age or older.
- Have passed the United States Medical Licensing Examination (USMLE) Steps 1, 2 & 3 or its equivalent as provided in Rules & Regulations of the Board.
- Be of good moral character as shown by three (3) original, currently dated letters of professional character reference on official letterhead from members of the applicant's hospital training program indicating the inclusive dates and type of training completed or from the Chief Medical Officer (or Chief of Service) of the hospital where you have privileges, or a licensed physician familiar with your clinical skills and abilities. These letters must be mailed directly to the Board office.
- Furnish notarized affidavit attesting that "you are not addicted to intemperate use of alcohol, illicit drugs, any prescription medications including controlled substances or any mind altering substances that may alter or impair your judgement and ability to carry out the duties of the profession" (form is included in your addendum packet).
- Submit a current the National Practitioner Data Bank Self-Query.
- Submit twenty-five (25) American Medical Association (AMA) Category 1 continuing medical education credits dated within one (1) year of application submittal.

Applications for licensure are reviewed quarterly during the months of March, June, September and December.

Read the following instructions carefully. For questions about licensure requirements, please call the Virgin Islands Board of Medical Examiners at (STT) 340-774-7477 extension 5694 or (STX) 340-713-6803.

Instructions for Medical Licensure in the U.S. Virgin Islands

The Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards (FSMB) is a national non-profit representing the 70 medical and osteopathic boards of the United States and its territories, serving as the national resource and voice on behalf of these boards in their protection of the public. Two of the services provided are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

We require the use of FCVS for credentials verification as part of the overall licensure process. FCVS staff verifies primary source documents related to your identity, education, training, and more, creating a personalized profile of credentials that do not need to be re-verified. This profile can be updated and sent to boards and other entities as needed.

To use FCVS, visit http://www.fsmb.org/ and select FCVS from the Licensure or Sign In menu. Sign in and continue as directed. Complete an Initial Application if you are using FCVS for the first time. Complete a Subsequent Application if you need to update your FCVS profile. Designate your profile to be received by the Virgin Islands Board of Medical Examiners.

For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

The Uniform Application for Physician State Licensure (UA)

The UA simplifies the licensure application process by eliminating data entry redundancy. Once the core UA is completed, it can be updated as needed and sent to another participating board when applying for licensure.

As part of the online UA, you will be asked to complete a chronology of activities of all working and non-working time since medical school graduation and provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

To use the UA, visit http://www.fsmb.org/ and select Uniform Application (UA) from the Licensure or Sign In menu. Sign in and continue as directed.

Please note:

- If you see incorrect USMLE, FLEX, or SPEX examination information listed in your UA, email ua@fsmb.org.
- MD and DO license information in the UA cannot be changed by you, as that information is provided directly from the state boards. If you see incorrect or missing pre-filled medical license information in your UA, email ua@fsmb.org with your FCVS ID or nine-digit Federation ID (FID) plus the information to be corrected. Do not select "Other" to add information unless it is for a non-medical professional license.
- Each license must be verified by the issuing board. See the license verification resource at http://www.fsmb.org/licensure/uniform-application/ for information on fees and the preferred verification method for each medical board. Use the UA Licensure Verification Form in this packet for boards that need a written request.

Review all of your entries before submitting your UA at the bottom of the Review & Submit page. You will be able to print a copy of your UA immediately after it is submitted.

First time UA users will be charged a one-time service fee of $50. This is a separate fee collected by FSMB, not by state boards, and is separate from FCVS fees. A receipt will be available for printing immediately after payment is made. A separate receipt will be sent to you via email.

For UA assistance, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq. If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem. Please email a screenshot if you see an error.

National Practitioner Data Bank Self-Query

- Visit https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and begin the process for the Self-Query. Follow all instructions given.
- After your Self-Query has been processed by the NPDB, they will send the Self-Query report directly to you. You must first open this report to make sure that the results were not rejected and all information submitted is correct.
- Send all parts of the Self-Query report directly to our office for final review.
- For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

Please use the checklist on the next page to ensure all required documents are submitted.

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Uniform Application Checklist

- Completed online Uniform Application and addendum in this packet.

- Completed licensure verification from each board that has issued you a healthcare license. For fees and preferred verification method of each board, see the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/. For boards requiring a written request, use the form on the last page of this packet.

Send each of the following items to the VI Board of Medical Examiners:

- Notarized UA Addendum with any additional details required for "Yes" answers.
- Affidavit and Authorization of Release of information form.
- Separate recent and dated un-mounted photograph of passport size of yourself, autographed in ink across the back.
- Be of good moral character as shown by three (3) original, currently dated letters of professional character reference on official letterhead from members of the applicant's hospital training program indicating the inclusive dates and type of training completed or from the Chief Medical Officer (or Chief of Service) of the hospital where you have privileges, or a licensed physician familiar with your clinical skills and abilities. These letters must be mailed directly to the Board office.
- $250.00 application fee payable to the "Government of the VI".
- Current National Practitioner Data Bank Self-Query Report.
- Notarized non-addiction form.
- Copy of Curriculum Vitae.
- Copy of specialty board certificate(s).
- Copy of hospital training documents.
- Twenty-five (25) AMA Category 1 Continuing Medical Education Credits (CMEs) dated within one (1) year of application.
- Complete an oral interview after a successful application review.

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Uniform Application Addendum

Additional Applicant Information

Practice type: ☐ Solo Practice ☐ Group Practice Date of Affiliation: _____

Practice Name: _____

Citizen of: _____
(If you were not born in the United States, proof of Citizenship must be submitted)

DEA Number: _____ UPIN Number: _____ NPI Number _____

International Medical Graduates (except Canada)

Date of ECFMG Certification: _____ Date of VQE Certification: _____

American Medical Specialty Boards

Specialty: _____

Name and Address of Training Institution: _____

_____

Dates of Training: From: _____ To: _____

Board Admissible: ☐ Yes ☐ No Date _____Board Certified: ☐ Yes ☐ No Date _____

Specialty Board Certification Certification Date Expiration Date

1._____

2._____

3._____

If not certified, state your intent with respect to becoming board certified and describe the status of your efforts and eligibility, including past efforts and failures of written or oral exams, if any.

_____

_____

Pre-Professional Education - List all high schools, colleges, and professional schools attended. Attach an additional sheet if necessary.

School Name Location Date of Graduation Degree

1.____

2.____

3.____

4.____

Continuing Medical Education – Provide Continuing Medical Education credits for the past year in the area below. Attach copies of current Continuing Medical Education Credits.

Meeting/Course/Symposium Location CME Sponsor Date(s) CME (Hours)

1.____

2.____

3.____

4.____

Accredited Hospital Training - Attach an additional sheet if necessary.

Name of Hospital Mailing Address Type of Training Dates

1.____

2.____

States Licensed In - Attach an additional sheet if necessary.

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

State: ______ Issue Date: _______________ License No. ____
How obtained: ☐ Written Exam ☐ Oral Exam ☐ Endorsement ☐ Other (Explain) ____________

Attestation Questions - If the answer is YES to any of the following, you must furnish full details on a separate sheet with the Question # noted.

		YES	NO
1.	Have proceedings been instituted to have your license to practice medicine and or hospital privileges (in any jurisdiction) limited, suspended, revoked, denied or subject to probationary conditions?	☐	☐
2.	Have proceedings been instituted to have your DEA or other controlled substance authorization denied, revoked or suspended?	☐	☐
3.	Have proceedings been instituted to have your specialty board certification denied, revoked or suspended?	☐	☐
4.	Are you aware of any potential action(s) or proceeding(s) that may be levied against you?	☐	☐
5.	Have you voluntarily relinquished any license, certification or privileges?	☐	☐
6.	Have you been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?	☐	☐
7.	Have you been reprimanded, sanctioned, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services.	☐	☐
8.	Have you been arrested for or charged with a crime involving children? *If YES, also include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to the applicable Federal punishment for perjury.*	☐	☐
9.	Have you been convicted of a felony or are you presently indicted for a felony?	☐	☐
10.	Have your clinical privileges or employment, medical staff membership or medical staff status at any hospital or healthcare institution been denied, limited, suspended, revoked, not renewed, voluntarily relinquished or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff official or committee or governing board?	☐	☐
11.	Has your request for any specific clinical privilege(s) been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff official or committee or governing board?	☐	☐
12.	Have you been denied membership, or renewal of membership, or have you been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization or professional society, or is any such action pending?	☐	☐
13.	Have you been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military action, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	☐	☐
14.	Are there presently any proceedings or investigations taking place at any hospital or other organization relating to your clinical competence or professional conduct?	☐	☐
15.	Have you withdrawn your application for appointment, reappointment or clinical privileges or resigned from the Medical Staff before a decision was made by a hospital's or health care facility's governing board?	☐	☐
16.	Do you have any condition that would compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting? *If YES, also include a description of accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.*	☐	☐

		YES	NO
17.	Have you engaged in the unlawful use of drugs? *If YES, also identify and describe any rehabilitation program in which you are or were enrolled that assures your abstinence prospectively and your adherence to prevailing standards of professional performance.*	☐	☐
18.	Do you now have or have you ever had a consumption or utilization problem with any of the following: alcohol, illicit drugs, prescription drugs, controlled substances, or any mind altering substances? *If YES, also identify and describe any rehabilitation program(s) you were enrolled in that assures that your consumption or utilization of items listed in #17, will not interfere with your practice of medicine, patient care responsibilities, or adherence to prevailing standards of professional performance.*	☐	☐
19.	Will practicing to the fullest extent of your licensure, qualifications and privileges, with or without reasonable accommodation, in any way, pose a risk of harm to your patients?	☐	☐
20.	Have there been, or are there currently, any claims, settlements or judgments against you, even if not resulting in monetary damages, or have you received any notice of "Intent to File"? I*f your answer is YES, provide detailed information on the Malpractice page in the online Uniform Application. In the "specifics" section, summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative which provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians. Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment.*	☐	☐
21.	Have you had any professional liability insurance coverage canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	☐	☐
22.	Have you been denied professional liability insurance or has your policy ever been canceled or denied renewal?	☐	☐

List ALL insurance carriers (including insurance companies, hospitals, clinics, employers, etc.) who have provided professional liability coverage since your previous appointment. Professional liability insurance minimum required coverage: $250,000.00/claim. Attach an additional sheet if necessary.

Current Insurance Carrier: _____ From: _____ To: _____

Address: _____ Policy Number: _____

City: _____ State: ____ Zip: _____ Years with company: _____

Previous Insurance Carrier: _____ From: _____ To: _____

Address: _____ Policy Number: _____

City: _____ State: ____ Zip: _____ Years with company _____

Previous Insurance Carrier: _____ From: _____ To: _____

Address: _____ Policy Number: _____

City: _____ State: ____ Zip: _____ Years with company _____

Statement of Clinician

I fully understand that the provision of information which contains significant misrepresentations, misstatements, omissions or inaccuracies shall result in automatic and immediate rejection of my application and that I shall not be entitled to any appellate proceedings. If such misrepresentations, misstatements, omissions or inaccuracies are discovered after I have received my license, I understand that my license shall be immediately terminated.

All information submitted by me in this application is true to the best of my knowledge and belief.

By applying for licensure I hereby signify my willingness to appear for any necessary interviews in regard to my application. I hereby authorize the Board and their representatives to consult with administrators and members of the medical staffs of hospitals and institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the Board, its staff and its representatives of all documents including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence as well as my moral and ethical qualifications for licensure.

I hereby release from liability all representatives of the Board of Medical Examiners for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the Board, or its staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby authorize the Board to communicate to other hospitals and to other persons or organizations with legitimate interest therein any information concerning my professional competence, character, ethics, and health status that the Board may have or acquire, and, where such communication is made in good faith and without malice, I consent thereto and agree to hold the Board and its authorized representatives free of liability there from.

I understand and agree that I, as an applicant for licensure in the U.S. Virgin Islands, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and current health status or other qualifications and for resolving any doubts about such qualifications.

I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee splitting. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit other physicians or surgeons to collect fees for me, nor to make joint fees, nor permit any associate of mine to do so.

_____
Physician's Printed Name

_____
Physician's Signature

_____
Date of Signature

_____
Date of Photograph

PASTE PHOTOGRAPH SECURELY
IN THIS SPACE

Write signature on light portion of photograph, not across features

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AUTHORIZATION OF RELEASE

Physician Authorization - In order for the Virgin Islands Board of Medical Examiners (Board) to assess and verify my educational background and professional qualifications, I hereby authorize the Board to:

- make inquiries concerning such information about me to my employers (past and present), hospital(s), institution(s) or organization(s), my references, all governmental agencies and instrumentalities (local, state, federal or foreign);
- authorize the release of such information and copies of related records and documents to the Virgin Islands Board of Medical Examiners;
- authorize the Board 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 Board of Medical Examiners in good faith and without malice in response to such inquiries.

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.

The undersigned, being duly sworn, deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has never been convicted of a felony or misdemeanor; that he/she has never been expelled from any professional society; that he/she has not suppressed any information that might affect this application; that he/she is not addicted to intemperate use of alcoholic stimulants or narcotic drugs; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

_____ _____
Signature of Applicant *Date*

State of _____County of _____

Subscribed and sworn to me before this _____ day of _____, 20____, by _____
(Applicant's name)

_____ _____
Signature of Notary Public *Date*

My commission (is permanent) _____ expires on _____. **S E A L**

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NOTARIZED NON-ADDICTION AFFIDAVIT

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

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VERIFICATION OF LICENSURE

Applicant: Use this form for license verification for each state board through which you have ever been licensed to practice allopathic or osteopathic medicine and surgery that requires a written request. Complete the top portion of this form and send it to the verifying board along with any required fee. Copy this form as necessary.

Full Name (first, middle, last, suffix): _____

Date of Birth: _____ Social Security Number*: _____ Degree: ☐ M.D. ☐ D.O.

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

To Whom It May Concern:

I am being considered for medical licensure in the Territory of the U.S. Virgin Islands. The Virgin Islands Board of Medical Examiners requires that this form be completed by each state in which I am now or ever have been licensed to practice my profession. I authorize the licensing agency of the state/province of _____ to provide any and all information asked for in section 2 below pertaining to license number _____ to the Virgin Islands Board of Medical Examiners. Thank you.

Applicant' Signature: _____ Date: _____

State board: Complete the bottom portion of this form and send this form to the Virgin Islands Board of Medical Examiners at the address in the header. You may provide electronic licensure verification to the Board in lieu of this form.

THIS SECTION TO BE COMPLETED AND SIGNED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE VI BOARD OF MEDICAL EXAMINERS.

State of: _____ Full Name of Licensee: _____

License No.: _____ Issuance Date: _____

By: Endorsement/Reciprocity with the following state: _____

By: Flex Endorsement _____ National Board _____ Local State Board Examination _____

Is license current and in good standing? _____ If NO, furnish details. _____

_____

Has any disciplinary action ever been taken against the above named physician? _____ If YES, furnish details

_____

_____

Comments, if any: _____

_____

Signed: _____

Title: _____

State Board: _____

BOARD SEAL

Date: _____