GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HEALTH
1303 HOSPITAL GROUND, STE. 10, ST THOMAS, VI 00802

VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS **(340) 774-7477 Ext 5694 (STT)**
(340) 718-1311 Ext 3849 (STX)

Dear PA Applicant:

The V.I. Board of Medical Examiners received your request for licensure procedures to practice as a Physician Assistant in the U.S. Virgin Islands. The following are the requirements needed for Physician Assistant licensure:

1. Submit application on the forms approved and obtainable from the V.I. Board of Medical Examiners.

2. Submit a recent and un-mounted photograph of passport size of himself/herself autographed and dated in ink across the back.

3. Submit a non-refundable application fee in the amount of **$125.00**, made payable to Government of the V.I.

4. Submit chronological account of **all** time spent between receiving your P.A. degree and the time of this application.

5. Submit proof of completing an accredited education program (copy of certificate/diploma required).

6. Submit proof of National Commission on Certification of Physician Assistants (NCCPA) Certification.

7. Be twenty-one years of age or older (copy of birth paper and/or similar proof).

8. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. Please utilize notarized non-addiction form included in this package.

9. Submit two original, signed, currently dated professional reference forms; completed by someone familiar with your clinical skills (use form included in this package).

10. Primary source license verifications must be completed for all States and jurisdictions where you held or currently hold a license. Verifications must be sent directly to the Board office.

11. Submit 25 AMA Category 1 credits dated within a year of this application.

12. Submit a completed and notarized Authorization for Release of Information form(included in this package).

13. All applicants are required to have their credentials verified by the Federation of State Medical Board Credentialing Verification Service (FCVS). Go to: www.fsmb.org.

14. Complete the Delineation of Scope of Practice forms.

15. Complete license application data form.

16. Complete National Practitioner Data Bank (NPDB) self query.

Your interest is appreciated and if we can be of further assistance, please contact the Board at the above numbers.

Uniform Application Physician Assistant Checklist for Licensure

Send this checklist with all other materials being sent to the Board.

Applicant's Full Name ________________________________ Date of Application______________

NOTE: If required items are not submitted, then the application will be considered incomplete and will not be processed until all items requested are received.	**NOT using FCVS to verify credentials**	**Using FCVS to verify credentials**
Completed and submitted online Uniform Application to the Board. Please be sure to list your social security number on your online UA.		
Submit a non-refundable application fee in the amount of **$125.00**, made payable to Government of the V.I.		
Notarized Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months sent to the Board.		
Official transcripts must be sent directly from your PA program.		
License verification letters sent directly from all states in which you have ever obtained a license to practice as a health care professional. Online "Primary Source" verifications accepted.		
Completed addendums 1&2 mailed to the board.		
Supporting documentation of any legal name change sent to the Board.		FCVS handles
Verification of participation in an approved physician assistant program must be received directly from the program director's office.		FCVS handles
Examination Transcripts sent to the Board.		FCVS handles
Submit National Practitioner Data Bank Self Query- mailed directly to the Board.		
2 Professional Character Reference Forms mailed directly to the Board.		

ADDENDUM 1
BOARD OF MEDICAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS

Print Name___________________________________ Last 4 Digits of Social Security No. ____________

(**If you were not born in the United States, your own original certificate of Citizenship or of Declaration of Intention or of Derivative Citizenship must be submitted 60 days before examination. Document will be returned by certified mail).**

High School __________________________________ Location

College ______________________________________ Location

Professional School Location

*If employed, give name and address of employer

Has any State rejected your application or revoked your professional license? (Yes or No)
(If "Yes" attach a separate explanation)

Have you ever been convicted of any crime or unprofessional conduct? (Yes or No)
(If "Yes" attach a separate explanation)

ADDENDUM 2
PHYSICIAN ASSISTANT LICENSE APPLICATION DATA

Physician Assistant Program:

Name: __________________

Mailing Address: __________

Issuance Date of Certificate/Degree

State(s) Licensed In:

State: ____________ ____________ ____________ ____________

Date of Issue: ____________ ____________ ____________ ____________

License Number: ____________ ____________ ____________ ____________

If certified by the National Commission on Certification of Physician Assistants, give date of certification _____________________ .

Previous Practice Affiliations: (Use other side if necessary)

Name of Institution and/or Supervising Physician: ______________________________

Mailing Address: ____

Type of Practice: ________________________________ Dates:______________________

Name of Institution and/or Supervising Physician:

____

Mailing Address: _____________________________________

Type of Practice: ________________________________ Dates:

Name of Institution and/or Supervising Physician:

____

Mailing Address:

Type of Practice: ______________________________ Dates:

BOARD OF MEDICAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS

I. DELINEATION OF SCOPE OF PRACTICE

Medical services that can be rendered by physician assistants in your practice:

1). Obtaining patient histories and performing physical examinations;

2). Ordering and/or performing diagnostic and therapeutic procedures (**does not include the writing of outpatient prescription medication)**

3). Formulating a diagnosis and developing a treatment plan;

4). Monitoring the effectiveness of therapeutic interventions;

5). Assisting at surgery;

6). Offering counseling and education to meet patient needs; and

7). Making appropriate referrals with supervising physician collaboration.

If there are any specific services, which should be added to those above, please complete Form A and submit with application for review by the Board.

II. COMMUNICATION

Please list the names of all supervising physicians for ______________________ (Physician Assistant) along with practice location(s) addresses, e-mail and contact numbers.

Name:_____________________________ Practice Location____________________

Home Address:____

E-mail____

Phone: _________________ (h) _________________ (w)_________________ (cell)

(fax) __________________

(etc)

(etc)

If you are in solo practice, you must complete Form B

III. SUPERVISORY ACCOUNTABILITY

All supervising physicians must possess and maintain an active US Virgin Islands license. The Board requires that a written agreement signed by both the physician assistant and their supervising physician(s). This agreement states that the physician(s) will be responsible for exercising supervision over the physician assistant, as well as retaining all professional and legal accountability for the care rendered by such. A copy of this agreement is to be renewed annually, with a copy forwarded to the board.

Additionally, please complete for C, which describes in what objective and verifiable manner will the physician assistant be evaluated. Evaluations are to be completed every 12 months, at the time of the physician assistant's license renewal.

Instructions for completions of forms:

Form A:

The physician assistant scope of practice is delineated in section I. If there are any other specific duties or levels of care, which you feel the physician assistant that you are supervising should be able to perform and deliver, please list these along with the reason why you feel this should be.

Please remember that a physician assistant's supervision is guided by the training, knowledge, and experience of a particular supervising physician. This should be considered when there will be more than one supervising physician. If you are requesting additional duties and/or levels of care to be delivered, these are physician/specific and will not be viewed as applying to all supervising physicians for that physician assistant. Example: If physician #1 has the training, knowledge, and experience to competently supervise in the delivery of a specific duty, but physician #2 does not, then the physician assistant may not perform that duty while supervised by physician #2.

Form B:

It is a definite requirement that physician assistants be supervised. This includes being able to be in contact with their supervising physicians at all times. If you are in solo practice, Form B delineates, which other physician(s) will supervise your physician assistant in the event of your absence/illness or if you are unable to be in communication with them.

This physician(s) is(are) subject to the same rules and regulations that apply to any other supervising physician and will retain both professional and legal accountability for the care rendered by the physician assistant during your absence.

Please be mindful that, during your absence, the physician assistant may not perform of the additional duties, if any, as listed in Form A, unless the alternate physician has completed Form A.

Form C:

To insure that physician assistants are adequately evaluated by their supervising physicians, please submit how this will be accomplished in your practice. Although no one standard format exists, examples include quarterly chart reviews, quarterly formal meetings, direct observations, etc.

The Board reserves the right to interview both the physician assistant and physician, as well as perform a chart review, to ensure compliance with supervisory accountability.

I have read and agree to abide with the above.

___________________________________ PA Date:

___________________________________MD Date:

___________________________________MD Date:

___________________________________MD Date:

FORM A:

Please list any additional services that can be offered by ____________________________ .
Please include an explanation of why these should be offered.
Additionally, please describe any previous training and/or experience that the physician assistant has offering this service. Finally, delineate each supervising physician's training and/or experience, which would enable them to supervise these additional services(s) appropriately.

1. Service

Supervising Physician

Explanation:

____

____

____

2. ETC.

FORM B:

As a physician in solo practice, you must maintain supervisory capacity and accountability for any physician assistant in your employ. In the case of absence, illness, or any situation where you will not be able to be in communication with the physician assistant, you must designate an alternate physician or alternate physicians as supervisors for this physician assistant. (Please see instructions).

Name: ____

Practice Location ____

Home Address ____

Phone ______________ (h) ____________ (w) _____________ (c) _____________ (f)

FORM C:

Please list how the physician assistant will be formally supervised. It is insufficient to simply co-sign their medical records as proof of formal supervision.

1.____ Random chart review

2.____ Formal meetings: monthly quarterly, or every six months. (Please circle one)

Please list the dates of when these meetings took place:

____

____

____

3.____ Direct observation:

4.____ Other: (Please explain below)

____

____

____

____

____

____

____